2020 PROCEEDINGS
OF THE
National Association of Insurance Commissioners

2020 Virtual Summer National Meeting

July 27 – August 14, 2020

Concerning Business Conducted

December 11, 2019 to August 14, 2020
The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

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

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

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

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Valuable and in-demand insurance industry-wide statistical data for various lines of business, including auto, home, health and life insurance.

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Useful handbooks, compliance guides and reports on financial analysis, company licensing, state audit requirements and receiverships.

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NAIC/CONSUMER LIAISON COMMITTEE
CERTIFICATE OF INCORPORATION OF
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
a Nonstock Corporation

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

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

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

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

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

VI. Purpose
The NAIC is organized exclusively for charitable and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law), including without limitation, to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:
(a) Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;
(b) Promote, in the public interest, the reliability, solvency and financial solidity of insurance institutions; and
(c) Support and improve state regulation of insurance.

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

B. For any period for which the Corporation may be considered a private foundation, as defined in Section 509(a), the Corporation shall be subject to the following restrictions and prohibitions:
1. The Corporation shall not engage in any act of self-dealing as defined in section 4941(d) of the Code.
2. The Corporations shall make distributions for each taxable year at such time and in such manner so as not to become subject to the tax on undistributed income imposed by section 4942 of the Code.
3. The Corporation shall not retain any excess business holdings as defined in section 4943(c) of the Code.
4. The Corporation shall not make any investments in such manner as to subject it to tax under section 4944 of the Code.
5. The Corporation shall not make any taxable expenditures as defined in section 4945(d) of the Code.

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VIII. Membership

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

IX. Activities

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

X. Powers

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

XI. Immunity

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

XII. Exculpation and Indemnification

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

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

XIII. Dissolution

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

XIV. Bylaws

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

XV. Amendments

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

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

/Signature/

Catherine J. Weatherford, Incorporator

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

ARTICLE I Name, Organization and Location

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

ARTICLE II Membership

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

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

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

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

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

ARTICLE III Officers

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

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

The President shall serve as Chairperson of the Executive Committee and shall preside at all special and regular meetings of the members. The President shall serve as the leader of the organization and its principal spokesperson. The President shall work closely with the Executive Committee to establish and achieve the strategic, business and operational goals of the organization; ensure appropriate policies and procedures for the organization are implemented and followed; and protect the integrity as well as the resources of the organization. After a member completes his or her term or terms as President, he or she shall not be able to hold another officer position for a period of twelve (12) months from the date such member completes his or her term or terms as President, which shall be referred to as a "waiting period"; provided however, the Executive Committee may waive the twelve month waiting period if warranted by exigent circumstances.

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The President-Elect shall serve as Vice-Chairman of the Executive Committee. In the absence of the President at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, the President-Elect shall preside over such meeting to the extent of the President’s absence. The President-Elect shall perform such other duties and tasks as may be assigned by the President. Where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President’s term of office.

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

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

**ARTICLE IV Executive Committee**

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) NAIC OFFICES

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

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

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

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

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

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

The Internal Administration (EX1) Subcommittee shall:

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

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

4. Audit Committee

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

ARTICLE V Zones

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

ARTICLE VI Standing Committees and Task Forces

1. General

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

2. Specific Duties

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

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

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

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

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

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

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

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

3. Task Forces

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

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

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

1. Regular Meetings.

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

2. Special Meetings.

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

3. Waiver of Notice; Postponement.

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

4. Quorum.

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

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

ARTICLE VIII Elections

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

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

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

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

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

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

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

   (b) President-Elect.

   (c) Vice President.

   (d) Secretary-Treasurer.

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

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

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

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

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

**ARTICLE IX Proxies; Waiver of Notice**

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

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

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

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

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

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

ARTICLE XI Amendments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Revisions Adopted by the NAIC Membership, April 1, 2014

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2020 COMMITTEE STRUCTURE

**Plenary**

**Executive Committee**

(Ex1) Subcommittee

**Internal Administration**

Information Systems Task Force

(A) Committee

**Life Insurance and Annuities**

Life Actuarial Task Force

(C) Committee

**Property and Casualty Insurance**

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

(E) Committee

**Financial Condition**

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

(B) Committee

**Financial Stability Task Force**

Government Relations Leadership Council
Innovation and Technology Task Force
Long-Term Care Insurance Task Force

(D) Committee

**Health Insurance and Managed Care**

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

(F) Committee

**Market Regulation and Consumer Affairs**

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

(G) Committee

**Financial Regulation Standards and Accreditation**

International Insurance Relations

NAIC/Consumer Liaison Committee

NAIC/American Indian and Alaska Native Liaison Committee

Updated March 27, 2020
### APPOINTED and DISBANDED GROUPS
Current and Previous Year

#### APPOINTED SINCE JANUARY 2020
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<tr>
<th>Group Description</th>
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<tr>
<td>GI Life Valuation (A) Subgroup</td>
<td>2019-12-10</td>
<td>Reggie Mazyck</td>
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<tr>
<td>MHPAEA (B) Working Group</td>
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<td>Jolie H. Matthews</td>
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#### RENAMED SINCE JANUARY 2020
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#### DISBANDED SINCE JANUARY 2020
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<td>Mark Sagat</td>
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<tr>
<td>NAIC/State Government Liaison Committee</td>
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<tr>
<td>Climate Change and Global Warming (C) Working Group</td>
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<td>Anne Obersteadt</td>
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<td>ComFrame Development and Analysis (G) Working Group</td>
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<td>Ryan Workman</td>
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<td>Lou Felice</td>
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<td>2019-12-09</td>
<td>Aaron Brandenburg</td>
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<tr>
<td>Variable Annuities Issues (E) Working Group</td>
<td>2019-12-10</td>
<td>Dan Daveline</td>
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Updated May 22, 2020

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## 2020 Members by Zone

<table>
<thead>
<tr>
<th>Northeast Zone</th>
<th>Southeast Zone</th>
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<tbody>
<tr>
<td>Elizabeth Kelleher Dwyer, Chair</td>
<td>lname Rhode Island</td>
</tr>
<tr>
<td>Jessica K. Altman, Vice Chair</td>
<td>lname Pennsylvania</td>
</tr>
<tr>
<td>Gary Anderson, Secretary</td>
<td>lname Massachusetts</td>
</tr>
<tr>
<td>Andrew N. Mais</td>
<td>Alan McClain</td>
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<td>Trinidad Navarro</td>
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<td>Raymond G. Farmer</td>
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<td>Linda A. Lacewell</td>
<td>Hodgen Mainda</td>
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<td>Michael S. Pieciak</td>
<td>Tregenza A. Roach</td>
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<td>Scott A. White</td>
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<td>James A. Dodrill</td>
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<th>Midwest Zone</th>
<th>Western Zone</th>
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<tbody>
<tr>
<td>Larry D. Deiter, Chair</td>
<td>lname South Dakota</td>
</tr>
<tr>
<td>Jillian Froment, Vice Chair</td>
<td>lname Ohio</td>
</tr>
<tr>
<td>Doug Ommen, Secretary</td>
<td>lname Iowa</td>
</tr>
<tr>
<td>Robert H. Muriel</td>
<td>Lori K. Wing-Heier, Chair</td>
</tr>
<tr>
<td>Stephen W. Robertson</td>
<td>Michael Conway, Vice Chair</td>
</tr>
<tr>
<td>Vicki Schmidt</td>
<td>Michael Stolli, Secretary</td>
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<tr>
<td>Anita G. Fox</td>
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<td>Steve Kelley</td>
<td>Idaho</td>
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<tr>
<td>Chlora Lindley-Myers</td>
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<td>Bruce R. Ramge</td>
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<td>Jon Godfread</td>
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<td>Glen Mulready</td>
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<td>Mark Afable</td>
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*Updated July 20, 2020*
# 2020 Executive (EX) Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
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<tbody>
<tr>
<td>Raymond G. Farmer, President</td>
<td>South Carolina</td>
</tr>
<tr>
<td>David Altmair, President-Elect</td>
<td>Florida</td>
</tr>
<tr>
<td>Dean L. Cameron, Vice President</td>
<td>Idaho</td>
</tr>
<tr>
<td>Chlora Lindley-Myers, Secretary-Treasurer</td>
<td>Missouri</td>
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<tr>
<td>Eric A. Cioppa</td>
<td>Maine</td>
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## Northeast Zone

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Elizabeth Kelleher Dwyer, Chair</td>
<td>Rhode Island</td>
</tr>
<tr>
<td>Jessica K. Altman, Vice Chair</td>
<td>Pennsylvania</td>
</tr>
<tr>
<td>Gary Anderson, Secretary</td>
<td>Massachusetts</td>
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## Southeast Zone

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<tbody>
<tr>
<td>Jim L. Ridling, Chair</td>
<td>Alabama</td>
</tr>
<tr>
<td>Mike Chaney, Vice Chair</td>
<td>Mississippi</td>
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<tr>
<td>James J. Donelon, Secretary</td>
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## Midwest Zone

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<td>Larry D. Deiter, Chair</td>
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<td>Ohio</td>
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<tr>
<td>Doug Ommen, Secretary</td>
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## Western Zone

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<tr>
<td>Lori K. Wing-Heier, Chair</td>
<td>Alaska</td>
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<tr>
<td>Michael Conway, Vice Chair</td>
<td>Colorado</td>
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<tr>
<td>Andrew R. Stolfi, Secretary</td>
<td>Oregon</td>
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</table>

NAIC Support Staff: Andrew J. Beal/Kay Noonan

*Updated February 21, 2020*
FINANCIAL STABILITY (EX) TASK FORCE
of the Executive (EX) Committee

Marlene Caride, Chair
New Jersey
Eric A. Cioppa, Vice Chair
Maine
Alan McClain
Arkansas
Ricardo Lara
California
Andrew N. Mais
Connecticut
Karina M. Woods
District of Columbia
David Altmaier
Florida
Robert H. Muriel
Illinois
Doug Ommen
Iowa
Gary Anderson
Massachusetts
Chlora Lindley-Myers
Missouri
Bruce R. Ramge
Nebraska
Linda A. Lacewell
New York
Andrew R. Stolfi
Oregon
Jessica K. Altman
Pennsylvania
Kent Sullivan
Texas

NAIC Support Staff: Todd Sells/Tim Nauheimer

Liquidity Assessment (EX) Subgroup
of the Financial Stability (EX) Task Force

Justin Schrader, Chair
Nebraska
Kathy Belfi/John Loughran
Connecticut
Philip Barlow
District of Columbia
Ray Spudeck
Florida
Robert H. Muriel
Illinois
Carrie Mears
Iowa
Fred Andersen
Minnesota
John Rehagen
Missouri
Mike Boerner/Jamie Walker
Texas

NAIC Support Staff: Todd Sells/Tim Nauheimer

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL
of the Executive (EX) Committee

Raymond G. Farmer, Chair
South Carolina
David Altmaier, Vice Chair
Florida
John F. King
Georgia
Dean L. Cameron
Idaho
Sharon P. Clark
Kentucky
Eric A. Cioppa
Maine
Chlora Lindley-Myers
Missouri
Marlene Caride
New Jersey
Jon Godfread
North Dakota
Glen Mulready
Oklahoma
Jessica K. Altman
Pennsylvania
Elizabeth Kelleher Dwyer
Rhode Island
Larry D. Deiter
South Dakota
Todd E. Kiser
Utah
Mike Kreidler
Washington

NAIC Support Staff: Ethan Sonnichsen
INNOVATION AND TECHNOLOGY (EX) TASK FORCE
of the Executive (EX) Committee

Jon Godfread, Chair  North Dakota
Elizabeth Kelleher Dwyer, Vice Chair  Rhode Island
Jim L. Ridling  Alabama
Lori K. Wing-Heier  Alaska
Elizabeth Perri  American Samoa
Evan G. Daniels  Arizona
Alan McClain  Arkansas
Ricardo Lara  California
Michael Conway  Colorado
Andrew N. Mais  Connecticut
Trinidad Navarro  Delaware
Karima M. Woods  District of Columbia
David Altmaier  Florida
Colin M. Hayashida  Hawaii
Dean L. Cameron  Idaho
Robert H. Muriel  Illinois
Stephen W. Robertson  Indiana
Doug Ommen  Iowa
Vicki Schmidt  Kansas
Sharon P. Clark  Kentucky
James J. Donelon  Louisiana
Eric A. Cioppa  Maine
Kathleen A. Birrane  Maryland
Gary Anderson  Massachusetts
Anita G. Fox  Michigan
Mike Kelley  Minnesota
Mike Chaney  Mississippi
Chlora Lindley-Myers  Missouri
Matthew Rosendale  Montana
Bruce R. Range  Nebraska
Barbara D. Richardson  Nevada
Chris Nicolopoulos  New Hampshire
Marlene Caride  New Jersey
Mike Causey  North Carolina
Jillian Froment  Ohio
Glen Mulready  Oklahoma
Andrew R. Stolfi  Oregon
Jessica K. Altman  Pennsylvania
Rafael Cester-Lopategui  Puerto Rico
Raymond G. Farmer  South Carolina
Larry D. Deiter  South Dakota
Hodgen Mainga  Tennessee
Kent Sullivan  Texas
Michael S. Preciak  Vermont
Scott A. White  Virginia
Mike Kreidler  Washington
James A. Dodrill  West Virginia
Mark Afable  Wisconsin

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

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

Jon Godfread, Chair       North Dakota
Mark Afable, Vice Chair   Wisconsin
Jerry Workman             Alabama
Matthew Williams          Alaska
Evan G. Daniels           Arizona
Lucy Jabourian            California
Peg Brown                 Colorado
Joshua Hershman/George Bradner Connecticut
David Altmairer           Florida
Robert H. Muriel          Illinois
Amy Beard                 Indiana
Doug Ommen                Iowa
Satish Akula              Kentucky
Tom Travis                Louisiana
Ron Coleman               Maryland
Phil Vigliaturo           Minnesota
Cynthia Amann             Missouri
Barbara D. Richardson     Nevada
Christian Citarella       New Hampshire
Kathy Shortt/Keith Briggs North Carolina
Lori Barron               Ohio
Ron Kreiter               Oklahoma
Shannen Logue             Pennsylvania
Hodgen Mainida            Tennessee
Christina Rouleau         Vermont
Scott A. White/Eric Lowe  Virginia

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

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

Doug Ommen, Chair
Elizabeth Kelleher Dwyer, Vice Chair
Daniel Davis
Lori K. Wing-Heier
Ken Allen
Andrew N. Mais
Frank Pyle
Karima M. Woods
Mike Yaworsky
Judy Mottar
Rich Piazza
Benjamin Yardley
Robert Baron
Karen Dennis
Martin Fleischhacker/Phil Vigliaturo/
Matthew Vatter
Brent Kabler
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NAIC Support Staff: Jolie H. Matthews
### SENIOR ISSUES (B) TASK FORCE
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PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (Continued)

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NAIC Support Staff: Tim Mullen

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NAIC Support Staff: Greg Welker
## FINANCIAL CONDITION (E) COMMITTEE

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<tr>
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<th>State</th>
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<td>Scott A. White, Chair</td>
<td>Virginia</td>
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<tr>
<td>Eric A. Cioppa, Vice Chair</td>
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<td>Michael Conway</td>
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<td>Jeff Rude</td>
<td>Wyoming</td>
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NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jenson

## Financial Analysis (E) Working Group

of the Financial Condition (E) Committee

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<tr>
<td>Kevin Fry, Chair</td>
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<td>Judy Weaver, Vice Chair</td>
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<td>Kim Hudson</td>
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<td>Kathy Belfi</td>
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<td>Dave Lonchar</td>
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<td>Greg Chew</td>
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<tr>
<td>Amy Malm</td>
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</table>

NAIC Support Staff: Bruce Jenson/Andy Daleo/Jane Koenigsman/Ralph Villegas/Rodney Good/Bill Rivers
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### FINANCIAL CONDITION (E) COMMITTEE (Continued)

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<td>John Jacobson/Steve Drutz</td>
<td>Washington</td>
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#### Valuation Analysis (E) Working Group of the Financial Condition (E) Committee

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<td>Perry Kupferman</td>
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</table>

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Dean L. Cameron  
Stephen W. Robertson  
Doug Ommen  
Vicki Schmidt  
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Chlora Lindley-Myers  
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Marlene Caride  
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Mike Causey  
Jon Godfread  
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Glen Mulready  
Jessica K. Altman  
Elizabeth Kelleher Dwyer  
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Hodgen Mainda  
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Michael S. Pieciak  
Scott A. White  
Mike Kreidler  
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NAIC Support Staff: Robin Marcotte
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<td>Jillian Froment</td>
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**receivership and insolvency (e) task force (continued)**

receivership large deductible workers’ compensation (e) working group
_of the receivership and insolvency (e) task force_

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NAIC support staff: Sherry Flippo

receivership law (e) working group
_of the receivership and insolvency (e) task force_

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<td>kevin baldwin, co-chair</td>
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<td>melanie Anderson</td>
<td>washington</td>
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NAIC Support Staff: Becky Meyer/Sara Franson
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NAIC Support Staff: Ethan Sonnichsen/Ryan Workman
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</table>

NAIC Support Staff: Lois E. Alexander
NAIC/CONSUMER LIAISON COMMITTEE (Continued)

NAIC/American Indian and Alaska Native Liaison Committee

of the NAIC/Consumer Liaison Committee

Lori K. Wing-Heier, Chair
Michael Conway, Vice Chair
Trinidad Navarro
Dean L. Cameron
Steve Kelley
Matthew Rosendale
Russell Toal
Mike Causey
Jon Godfread
Andrew R. Stolfi
Larry D. Deiter
Mike Kreidler
Jeff Rude

Alaska
Colorado
Delaware
Idaho
Minnesota
Montana
New Mexico
North Carolina
North Dakota
Oregon
South Dakota
Washington
Wyoming

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

Alabama Commissioner
Jim L. Ridling Montgomery 36104
Alabama Director
Lori K. Wing-Heier Anchorage 99501
American Samoa Acting Commissioner
Elizabeth Perri Pago Pago 96799
Arizona Director
Evan G. Daniels Phoenix 85007
Arkansas Commissioner
Alan McClain Little Rock 72202
California Commissioner
Ricardo Lara Sacramento 95814
Colorado Commissioner
Michael Conway Denver 80202
Connecticut Commissioner
Andrew N. Mais Hartford 06103
Delaware Commissioner
Trinidad Navarro Dover 19904
District of Columbia Commissioner
Karima M. Woods Washington 20002
Florida Commissioner
David Altmaier Tallahassee 32399
Georgia Commissioner
John F. King Atlanta 30334
Guam Acting Commissioner
Dafne M. Shimizu Barrigada 96913
Hawaii Commissioner
Colin M. Hayashida Honolulu 96813
Idaho Director
Dean L. Cameron Boise 83720
Illinois Director
Robert H. Muriel Springfield 62767
Indiana Commissioner
Stephen W. Robertson Indianapolis 46204
Iowa Commissioner
Doug Ommen Des Moines 50309
Kansas Commissioner
Vicki Schmidt Topeka 66604
Kentucky Commissioner
Sharon P. Clark Frankfort 40601
Louisiana Commissioner
James J. Donelon Baton Rouge 70802
Maine Superintendent
Eric A. Cioppa Augusta 04333
Maryland Commissioner
Kathleen A. Birrane Baltimore 21202
Massachusetts Commissioner
Gary Anderson Boston 02118
Michigan Director
Anita G. Fox Lansing 48933
Minnesota Commissioner
Steve Kelley St. Paul 55101
Mississippi Commissioner
Mike Chaney Jackson 39201
Missouri Director
Chlora Lindley-Myers Jefferson City 65101
Montana Cmsr. of Securities & Insurance/State Auditor
Matthew Rosendale Helena 59601
Nebraska Director
Bruce R. Ramge Lincoln 68508
Nevada Commissioner
Barbara D. Richardson Carson City 89706
New Hampshire Commissioner
Chris Niccolopulos Concord 03301
New Jersey Commissioner
Marlene Caride Trenton 08625
New Mexico Superintendent
Russel Toal Santa Fe 87501
New York Superintendent
Linda A. Lacewell Albany 12257
North Carolina Commissioner
Mike Causey Raleigh 27603
North Dakota Commissioner
Jon Godfred Bismarck 58505
N. Mariana Islands Secretary of Commerce
Mark O. Rabauliman Saipan 96950
Ohio Director
Jillian Froment Columbus 43215
Oklahoma Commissioner
Glen Mulready Oklahoma City 73105
Oregon Commissioner
Andrew R. Stolfi Salem 97301
Pennsylvania Commissioner
Jessica K. Altmann Harrisburg 17120
Puerto Rico Acting Commissioner
Rafael Cestero-Lopategui San Juan 00918
Rhode Island Superintendent
Elizabeth Kelleher Dwyer Cranston 02920
South Carolina Director
Raymond G. Farmer Columbia 29201
South Dakota Director
Larry D. Deiter Pierre 57501
Tennessee Commissioner
Hodgen Mainda Nashville 37243
Texas Commissioner
Kent Sullivan Austin 78701
Utah Commissioner
Todd E. Kiser Salt Lake City 84114
Vermont Commissioner
Michael S. Pieciak Montpelier 05620
Virgin Islands Lt. Governor/Commissioner
Tregenza A. Roach St. Thomas 00802
Virginia Commissioner
Scott A. White Richmond 23219
Washington Commissioner
Mike Kreidler Olympia 98504
West Virginia Commissioner
James A. Dodrill Charleston 25302
Wisconsin Commissioner
Mark Afable Madison 53703
Wyoming Commissioner
Jeff Rude Cheyenne 82020

Updated: 7/20/2020

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<th>MEMBER NAME</th>
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© 2020 National Association of Insurance Commissioners 4
### NAIC Member Tenure List

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<td>State Auditor/Ins. Commissioner</td>
<td>John M. Oathout</td>
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<td>Avery E. Moore</td>
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#### California—Elected; 4-Year Term

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<td>Ricardo Lara</td>
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<td>Dave Jones</td>
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<td>John R. Garamendi</td>
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<td>Harry W. Low</td>
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<td>Insurance Commissioner</td>
<td>Charles ‘Chuck’ Quackenbush</td>
<td>1/2/1995</td>
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<td>John R. Garamendi</td>
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<td>Insurance Commissioner</td>
<td>Richard S. L. Roddis</td>
<td>1/20/1966</td>
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<td>F. Britton McConnell</td>
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<td>Insurance Commissioner</td>
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<td>Wallace K. Downey</td>
<td>2/1/1947</td>
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<td>Insurance Commissioner</td>
<td>Maynard Garrison</td>
<td>10/1/1943</td>
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<td>Insurance Commissioner</td>
<td>Anthony J. Caminetti, Jr.</td>
<td>6/28/1939</td>
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<td>Rex B. Goodcill</td>
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<td>Samuel L. Carpenter, Jr.</td>
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<td>Charles R. ‘Charlie’ Detrick</td>
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<td>George D. Squires</td>
<td>3/22/1923</td>
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<td>E. C. Cooper</td>
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<td>Alexander McCabe</td>
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<td>Insurance Commissioner</td>
<td>Joseph E. Phelps</td>
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<td>Insurance Commissioner</td>
<td>E. Myron Wolf</td>
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<td>Insurance Commissioner</td>
<td>Andrew J. Clunie</td>
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<td>Insurance Commissioner</td>
<td>M. R. Higgins</td>
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## NAIC MEMBER TENURE LIST

### CALIFORNIA—Continued

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<th>YEARS SERVED</th>
<th>MONTHS SERVED</th>
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<tr>
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<td>J. N. E. Wilson</td>
<td>4/8/1890</td>
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<td>Insurance Commissioner</td>
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<td>4/8/1882</td>
<td>4/19/1886</td>
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<td>J. C. Maynard</td>
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### COLORADO—Appointed, at the Pleasure of the Governor; 2-Year Term

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<td>Michael Conway</td>
<td>1/22/2019</td>
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<tr>
<td>Interim Commissioner of Insurance</td>
<td>Michael Conway</td>
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<td>Marguerite Salazar</td>
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<td>Doug Dean</td>
<td>7/8/2013</td>
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<td>David Rivera</td>
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<td>Doug Dean</td>
<td>1/7/2003</td>
<td>4/20/2005</td>
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<td>M. Michael Cooke</td>
<td>8/9/2002</td>
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### NAIC MEMBER TENURE LIST

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

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<th>YEARS SERVED</th>
<th>MONTHS SERVED</th>
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<td>Andrew N. Mais</td>
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<tr>
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<td>Paul Lombardo</td>
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<td>Katharine L. ‘Katie’ Wade</td>
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<td>Anne Melissa Dowling</td>
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#### DELAWARE — Elected; 4-Year Term

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<td>Ignatius C. Grubb</td>
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<td>4/21/1879</td>
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### NAIC MEMBER TENURE LIST

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<td>Hopewell H. Darnelle</td>
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<td>Roswell A. Fish</td>
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<td>Robert P. Dodge (Died May 21, 1887)</td>
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<td>Head, Board of Public Works</td>
<td>Alexander R. Shepherd</td>
<td>5/24/1871</td>
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### FLORIDA—Appointed, at the Pleasure of the Financial Services Commission

| Insurance Commissioner | David Altmaier | 5/2/2016 | incumbent |
| Insurance Commissioner | Kevin M. McCarty | 1/9/2003 | 4/29/2016 | 13 | 0 |
| State Treasurer/Ins. Commissioner | Broward Williams | 1/25/1965 | 1/5/1971 | 5 | 11 |
| State Treasurer/Ins. Commissioner | J. Edwin Larson (Died Jan. 24, 1965) | 1/7/1941 | 1/24/1965 | 24 | 0 |
| State Treasurer/Ins. Commissioner | William V. Knott | 9/28/1928 | 1/7/1941 | 12 | 3 |
| State Treasurer/Ins. Commissioner | John C. Luning (Died Sept. 26, 1928) | 2/19/1912 | 9/26/1928 | 16 | 7 |
| State Treasurer | William V. Knott | 3/1/1903 | 2/19/1912 | 8 | 11 |
| State Treasurer | James B. Whitfield | 6/19/1897 | 3/1/1903 | 5 | 9 |
| State Treasurer | Clarence B. Collins | 1/3/1893 | 6/19/1897 | 4 | 5 |
| State Treasurer | Eduardo J. Triay | 12/31/1891 | 1/3/1893 | 2 | 0 |
## NAIC MEMBER TENURE LIST

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<th>BEG. DATE</th>
<th>END DATE</th>
<th>YEARS SERVED</th>
<th>MONTHS SERVED</th>
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<td>Edward S. Crill</td>
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<td>Henry A. L’Engle</td>
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<td>Walter H. Gwynn</td>
<td>1/9/1877</td>
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<td>Jeffrey H. ‘Jeff’ Atwater</td>
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## NAIC MEMBER TENURE LIST

### IDAHO—Appointed: Four Years, Subject to Earlier Removal by the Governor

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<th>STATE/MEMBER TITLE</th>
<th>MEMBER NAME</th>
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<th>YEARS SERVED</th>
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<td>Dean L. Cameron</td>
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<td>Thomas A. Donovan</td>
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<td>Cmrs. of Commerce and Industry</td>
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### ILLINOIS—Appointed, at the Pleasure of the Governor

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### NAIC Member Tenure List

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

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## NAIC MEMBER TENURE LIST

### KENTUCKY—Continued

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### LOUISIANA—Elected: 4-Year Term

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## NAIC MEMBER TENURE LIST

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<td>Joshua Nye</td>
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<td>Albert W. Paine</td>
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<td><strong>MARYLAND—Appointed, at the Pleasure of the Governor; 4-Year Term</strong></td>
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<td>5/18/2020</td>
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<td>Alfred W. ‘Al’ Redmer, Jr.</td>
<td>1/22/2015</td>
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<td>Peggy J. Watson</td>
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<td>Lawrence E. Ensor</td>
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<td>Carville D. Benson</td>
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### NAIC Member Tenure List

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<tr>
<th>STATE/MEMBER TITLE</th>
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<th>END DATE</th>
<th>YEARS SERVED</th>
<th>MONTHS SERVED</th>
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<td>Emerson C. Harrington</td>
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<td>Benjamin F. Crouse</td>
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<td>Thomas B. Townsend</td>
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<td>I. Freeman Rasin</td>
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<td>Commissioner of Insurance</td>
<td>J. Frederick C. Talbott</td>
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<td>Jesse K. Hines (Died Sept. 20, 1889)</td>
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<td>1/1/1872</td>
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<td>Chief Clerk of the Treasury and Superintendent of Insurance</td>
<td>Charles A. Wailes (Died Jan. 31, 1876)</td>
<td>5/24/1871</td>
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| MASSACHUSETTS—Appointed, at the Discretion of the Governor                        |                                                  |           |           |              |               |
| Commissioner of Insurance                                                          | Gary D. Anderson                                 | 10/31/2017|          | incumbent    |               |
| Acting Commissioner of Insurance                                                   | Gary D. Anderson                                 | 2/23/2017 | 10/31/2017| 0            | 8             |
| Commissioner of Insurance                                                          | Daniel R. Judson                                 | 4/1/2015  | 2/23/2017 | 1            | 10            |
| Acting Commissioner of Insurance                                                   | Gary D. Anderson                                 | 12/1/2014 | 4/1/2015  | 0            | 4             |
| Commissioner of Insurance                                                          | Joseph G. Murphy                                 | 2/8/2010  | 12/1/2014 | 4            | 10            |
| Acting Commissioner of Insurance                                                   | Joseph G. Murphy                                 | 1/1/2007  | 2/1/2007  | 0            | 1             |
| Commissioner of Insurance                                                          | Linda Ruthardt                                   | 8/1/1993  | 4/2/2002  | 8            | 8             |
| Commissioner of Insurance                                                          | Kay Dougherty                                    | 7/1/1991  | 6/30/1993 | 1            | 11            |
| Acting Commissioner of Insurance                                                   | Susan Scott                                      | 1/1/1991  | 7/1/1991  | 0            | 6             |
| Commissioner of Insurance                                                          | Timothy H. Gailey                                | 7/1/1989  | 1/1/1991  | 1            | 6             |
| Commissioner of Insurance                                                          | Roger M. Singer                                  | 7/16/1987 | 7/1/1989  | 2            | 0             |
| Commissioner of Insurance                                                          | Peter Hiam                                       | 4/1/1983  | 7/16/1987 | 4            | 3             |
| Commissioner of Insurance                                                          | C. Eugene Farnam                                | 12/1/1962 | 11/1/1971 | 8            | 11            |
| Commissioner of Insurance                                                          | Otis M. Whitney                                 | 1/1/1959  | 12/1/1962 | 3            | 11            |
| Commissioner of Insurance                                                          | Joseph A. Humphreys                              | 1/1/1954  | 12/31/1958| 4            | 11            |
| Commissioner of Insurance                                                          | Edmund S. Cogswell                               | 1/1/1953  | 12/31/1953| 0            | 11            |
| Commissioner of Insurance                                                          | Dennis E. Sullivan                               | 1/1/1951  | 12/31/1952| 1            | 11            |
| Commissioner of Insurance                                                          | Charles F. J. Harrington                        | 4/1/1938  | 12/31/1950| 12           | 8             |
| Commissioner of Insurance                                                          | Francis J. DeCellettes                          | 4/1/1935  | 4/1/1938  | 3            | 0             |
| Commissioner of Insurance                                                          | Merton L. Brown                                  | 12/1/1928 | 4/1/1935  | 6            | 4             |
| Acting Commissioner of Insurance                                                   | Arthur E. Linnell                                | 9/1/1928  | 12/1/1928 | 0            | 3             |
| Commissioner of Insurance                                                          | Wesley E. Monk                                  | 6/1/1923  | 9/1/1928  | 5            | 3             |
| Commissioner of Insurance                                                          | Clarence W. Hobbs                                | 3/1/1920  | 6/1/1923  | 3            | 3             |
| Acting Commissioner of Insurance                                                   | Clarence W. Hobbs                                | 9/1/1919  | 3/1/1920  | 0            | 6             |
| Commissioner of Insurance                                                          | Frank H. Hardison                                | 11/1/1907 | 9/1/1919  | 11           | 10            |
| Commissioner of Insurance                                                          | Frederick L. “Fred” Cutting                      | 9/30/1897 | 11/1/1907 | 10           | 2             |
| Insurance Commissioner                                                            | George S. Merrill                                | 9/1/1887  | 9/30/1897 | 10           | 1             |
### NAIC Member Tenure List

**Massachusetts—Continued**

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<td>John K. Tarbox</td>
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<td>(Died May 28, 1887)</td>
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**Michigan—Appointed, at the Pleasure of the Governor; 4-Year Term**

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<td>Director, Department of Insurance and Financial Services (DIFS)</td>
<td>Anita G. Fox</td>
<td>1/14/2019</td>
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<tr>
<td>Director, DIFS</td>
<td>Patrick M. McPharlin</td>
<td>5/18/2015</td>
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<td>Annette E. Flood</td>
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<td>Director, DIFS</td>
<td>R. Kevin Clinton</td>
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<td>Ken Ross</td>
<td>4/6/2008</td>
<td>4/15/2011</td>
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### NAIC Member Tenure List

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### NAIC MEMBER TENURE LIST

#### MINNESOTA—Continued

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#### MISSISSIPPI—Elected; 4-Year Term

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

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<td>Claud L. Clark</td>
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<td>Wyllis King</td>
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## NAIC Member Tenure List

### Montana—Elected: 4-Year Term

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<tr>
<th>STATE/MEMBER TITLE</th>
<th>MEMBER NAME</th>
<th>BEG. DATE</th>
<th>END DATE</th>
<th>YEARS SERVED</th>
<th>MONTHS SERVED</th>
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<tr>
<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>Matthew M. ‘Matt’ Rosendale</td>
<td>1/2/2017</td>
<td>incumbent</td>
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<tr>
<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>Monica J. Lindeen</td>
<td>1/5/2009</td>
<td>1/2/2017</td>
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<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>John Morrison</td>
<td>1/1/2001</td>
<td>1/5/2009</td>
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<td>Cmsr. of Insurance/State Auditor</td>
<td>Mark D. O’Keefe</td>
<td>1/4/1993</td>
<td>1/1/2001</td>
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<td>Cmsr. of Insurance/State Auditor</td>
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### Nebraska—Appointed, at the Pleasure of the Governor

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<td>Bruce R. Rame</td>
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<tr>
<td>Acting Director of Insurance</td>
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<tr>
<td>Acting Director of Insurance</td>
<td>Ann M. Frohman</td>
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## NAIC MEMBER TENURE LIST

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<td>Mary A. Fairchild</td>
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<td>W. Bruce Young</td>
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### NEVADA—Appointed, at the Pleasure of the Director of the Department of Business and Industry

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# NAIC Member Tenure List

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## NEW HAMPSHIRE—Appointed; 5-Year Term

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<td>Cmsr. of Banking and Insurance</td>
<td>Carl K. Withers</td>
<td>4/1/1935</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>William H. Kelly</td>
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<td>2/1/1929</td>
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<td>Edward E. Maxson</td>
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<td>William E. Tuttle, Jr. (Died Feb. 11, 1923)</td>
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## NAIC MEMBER TENURE LIST

### NEW JERSEY—Continued

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<td>Henry C. Kelsey</td>
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### NEW MEXICO—Appointed, by the Insurance Nominating Committee

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<td>Russell Toal</td>
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<td>Eric P. Serna</td>
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<td>Donald J. Letherer</td>
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<td>Michael C. Batte</td>
<td>1/1/1999</td>
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<td>George A. Biel</td>
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<td>Eliseo Gonzales</td>
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<td>J. H. Vaughn</td>
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<td>L. B. Gregg</td>
<td>3/3/1921</td>
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<td>Cleofas Romero</td>
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<td>Jacobo Chavez</td>
<td>3/1/1906</td>
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<td>Pedro Perea</td>
<td>9/1/1905</td>
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<td>W. G. Sargent</td>
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<td>Luis M. Ortiz</td>
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<td>Marcelino Garcia</td>
<td>9/1/1895</td>
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<td>Demetrio Perez</td>
<td>9/1/1891</td>
<td>9/1/1895</td>
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<td>Territorial Auditor</td>
<td>Trinidad Alarid</td>
<td>8/1/1888</td>
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### NEW YORK—Appointed, at the Pleasure of the Governor

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<th>END DATE</th>
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<tbody>
<tr>
<td>Superintendent of Financial Services</td>
<td>Linda A. Lacewell</td>
<td>6/21/2019</td>
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<td>incumbent</td>
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<tr>
<td>Superintendent of Financial Services</td>
<td>Maria T. Vullo</td>
<td>6/15/2016</td>
<td>2/1/2019</td>
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<td>Acting Superintendent of Fin. Svcs.</td>
<td>Shirin Emami</td>
<td>12/1/2015</td>
<td>2/1/2016</td>
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<tr>
<td>Acting Superintendent of Fin. Svcs.</td>
<td>Anthony Albanese</td>
<td>6/1/2015</td>
<td>11/30/2015</td>
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<td>Kermit J. Brooks</td>
<td>7/4/2009</td>
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<td>Louis W. ‘Lou’ Petroluongo</td>
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<td>Howard D. Mills III</td>
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<td>Gregory V. ‘Greg’ Serio</td>
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<td>Neil D. Levin</td>
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<td>Salvatore R. Curiale</td>
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<td>Wendy E. Cooper</td>
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<td>Thomas A. Harnett</td>
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<td>Lawrence W. Keepnews</td>
<td>3/18/1975</td>
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<td>Lawrence O. Monin</td>
<td>3/10/1975</td>
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<td>Benjamin R. Schenck</td>
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<td>Henry Root Stern, Jr.</td>
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<td>Samuel C. Cantor</td>
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<td>Thomas Thacher</td>
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<td>Julius S. Wikler</td>
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<td>James A. Beha</td>
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<td>Francis R. Stoddard, Jr.</td>
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<td>Otto Kelsey</td>
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<td>Robert A. Maxwell</td>
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### NAIC Member Tenure List

#### New York—Continued

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

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<td>Wayne Goodwin</td>
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<tr>
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<td>James E. ‘Jim’ Long</td>
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<td>John Randolph Ingram</td>
<td>11/15/1927</td>
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(Represented by Special Delegate William H. Finch)

#### North Dakota—Elected; 4-Year Term

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### OKLAHOMA—Elected; 4-Year Term

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<td>Glen Mulready</td>
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<td>Jess G. Read (Died July 20, 1946)</td>
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### NAIC MEMBER TENURE LIST

**OREGON—Continued**

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

| Insurance Commissioner             | Jessica K. Altman         | 3/20/2018 |           |              | incumbent     |
| Acting Insurance Commissioner      | Jessica K. Altman         | 8/19/2017 | 3/20/2018| 0            | 7             |
| Insurance Commissioner             | Teresa D. Miller          | 6/3/2015  | 8/18/2017| 2            | 2             |
| Acting Insurance Commissioner      | Teresa D. Miller          | 1/20/2015 | 6/3/2015 | 0            | 5             |
| Commissioner of Insurance          | Michael F. ‘Mike’ Consedine | 1/1/2011 | 1/20/2015| 4            | 0             |
| Acting Commissioner of Insurance   | Robert L. Pratter         | 8/1/2010  | 1/1/2011 | 0            | 5             |
| Commissioner of Insurance          | Joel S. Ario              | 7/1/2008  | 8/1/2010 | 2            | 1             |
| Acting Commissioner of Insurance   | Joel S. Ario              | 7/1/2007  | 7/1/2008 | 1            | 0             |
| Acting Commissioner of Insurance   | Randy Rohraugh            | 2/1/2007  | 7/1/2007 | 0            | 5             |
| Acting Commissioner of Insurance   | Gregory S. Martino        | 6/30/1997 | 8/27/1997| 0            | 2             |
| Commissioner of Insurance          | Cynthia M. Maleski        | 4/7/1992  | 1/30/1995| 2            | 10            |
| Commissioner of Insurance          | Constance B. Foster       | 1/20/1987 | 2/28/1992| 5            | 1             |
| Acting Commissioner of Insurance   | Anthony A. Geyelin        | 9/26/1983 | 5/1/1984 | 0            | 7             |
| Acting Commissioner of Insurance   | John J. Sheehy            | 1/2/1979  | 2/23/1979| 0            | 2             |
| Commissioner of Insurance          | Herbert S. Denenberg      | 1/25/1971 | 4/30/1974| 3            | 3             |
| Commissioner of Insurance          | George F. Reed            | 9/11/1969 | 1/25/1971| 1            | 4             |
| Commissioner of Insurance          | Audrey R. Kelly           | 1/15/1963 | 1/17/1967| 4            | 0             |
| Commissioner of Insurance          | Theodore S. Gutowicz      | 7/16/1962 | 1/15/1963| 0            | 6             |
| Commissioner of Insurance          | Francis R. Smith          | 11/18/1955| 7/16/1962| 6            | 8             |
| Commissioner of Insurance          | Gregg L. Neel             | 1/10/1943 | 1/21/1947| 4            | 0             |
| Commissioner of Insurance          | Ralph H. Alexander        | 11/5/1942 | 1/10/1943| 0            | 2             |
| Acting Commissioner of Insurance   | Ralph H. Alexander        | 7/23/1942 | 11/5/1942| 0            | 4             |
| Commissioner of Insurance          | Matthew H. Taggart        | 1/17/1939 | 7/23/1942| 3            | 6             |
| (Died July 23, 1942)               |                           |           |          |              |               |
| Commissioner of Insurance          | Owen B. Hunt              | 1/15/1935 | 1/17/1939| 4            | 0             |
| Acting Commissioner of Insurance   | Charles H. Groff          | 2/5/1934  | 1/15/1935| 0            | 11            |
| Commissioner of Insurance          | Charles F. Armstrong      | 1/20/1931 | 2/4/1934 | 3            | 1             |
| (Died Feb. 4, 1934)                |                           |           |          |              |               |
| Commissioner of Insurance          | Matthew H. Taggart        | 4/18/1927 | 1/20/1931| 3            | 9             |
| Commissioner of Insurance          | Einar Barford             | 8/16/1926 | 4/18/1927| 0            | 8             |
| Commissioner of Insurance          | Samuel W. McCulloch       | 6/15/1923 | 8/16/1926| 3            | 2             |
| Commissioner of Insurance          | Thomas B. Donaldson       | 5/6/1919  | 6/15/1923| 3            | 1             |
| Commissioner of Insurance          | Charles A. Ambler         | 9/10/1917 | 5/6/1919 | 1            | 8             |

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### NAIC MEMBER TENURE LIST

#### PENNSYLVANIA — Continued

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#### PUERTO RICO — Appointed, Indefinite

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#### RHODE ISLAND — Appointed, at the Discretion of the Director of Business Regulation

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<th>BEG. DATE</th>
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<th>YEARS SERVED</th>
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<td>Elizabeth ‘Beth’ Kelleher Dwyer</td>
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<tr>
<td>Deputy Director/Insurance and Banking Superintendent</td>
<td>Joseph Torti III</td>
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<td>Maurice C. Paradis</td>
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<td>Clifton A. Moore</td>
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<td>Thomas J. Coyle</td>
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<td>George A. Bisson</td>
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<td>Henri N. Morin</td>
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<td>Chief, Division of Banking &amp; Ins.</td>
<td>M. Joseph Cummings</td>
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<td>Albert C. Landers</td>
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<td>Commissioner of Insurance</td>
<td>Waldemar A. Mueller</td>
<td>7/18/1944</td>
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<td>Commissioner of Insurance</td>
<td>(Died May 23, 1944)</td>
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<td>Commissioner of Insurance</td>
<td>P. J. Dunn</td>
<td>7/1/1937</td>
<td>3/1/1940</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>William J. ‘Bill’ Dawson</td>
<td>7/1/1933</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>(Died Nov. 15, 1960)</td>
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<td>Commissioner of Insurance</td>
<td>Clyde R. Horswill</td>
<td>7/1/1931</td>
<td>7/1/1933</td>
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<td>Commissioner of Insurance</td>
<td>Donald C. ‘Don’ Lewis</td>
<td>7/1/1927</td>
<td>7/1/1931</td>
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<td>Commissioner of Insurance</td>
<td>G. H. Helgerson</td>
<td>7/1/1925</td>
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<td>Commissioner of Insurance</td>
<td>William N. Van Camp</td>
<td>3/1/1917</td>
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<td>M. Harry O’Brien</td>
<td>10/1/1915</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Otto K. Stablein</td>
<td>9/1/1913</td>
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<td>Commissioner of Insurance</td>
<td>Orville S. Basford</td>
<td>9/1/1907</td>
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<td>SOUTH DAKOTA — Continued</td>
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<td>Commissioner of Insurance</td>
<td>Len U. Doty</td>
<td>10/1/1906</td>
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<td>Commissioner of Insurance</td>
<td>John C. Perkins</td>
<td>9/1/1903</td>
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<td>Commissioner of Insurance</td>
<td>Howard C. Shober</td>
<td>9/1/1901</td>
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<td>Commissioner of Insurance</td>
<td>F. G. King</td>
<td>9/1/1899</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>L. C. Campbell</td>
<td>9/30/1898</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Thomas H. Ayers</td>
<td>9/1/1898</td>
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<td>J. H. Kipp</td>
<td>9/1/1897</td>
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<td>Commissioner of Insurance</td>
<td>H. E. Mayhew</td>
<td>1/1/1897</td>
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<tr>
<td>Auditor of State</td>
<td>J. E. Hipple</td>
<td>1/1/1893</td>
<td>1/1/1897</td>
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<td>Auditor of State</td>
<td>L. C. Taylor</td>
<td>11/2/1889</td>
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<td>TENNESSEE—Appointed, at the Discretion of the Governor</td>
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<td>Hodgjen Mainda</td>
<td>10/1/2019</td>
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<td>Interim Cmrs. of Commerce &amp; Ins.</td>
<td>Carter Lawrence</td>
<td>6/15/2019</td>
<td>9/30/2019</td>
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<td>Cmrs. of Commerce and Insurance</td>
<td>Julie Mix McPeak</td>
<td>1/12/2011</td>
<td>6/14/2019</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Leslie A. Newman</td>
<td>1/1/2007</td>
<td>1/12/2011</td>
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<td>Commissioner of Insurance</td>
<td>Paula Flowers</td>
<td>1/18/2003</td>
<td>1/1/2007</td>
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<td>Commissioner of Insurance</td>
<td>Anne Pope</td>
<td>11/1/1999</td>
<td>1/1/2003</td>
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<td>Commissioner of Insurance</td>
<td>Allan S. Curtis</td>
<td>4/1/1994</td>
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<td>Commissioner of Insurance</td>
<td>Elaine McReynolds</td>
<td>1/1/1987</td>
<td>4/1/1994</td>
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<td>Commissioner of Insurance</td>
<td>William H. Inman</td>
<td>4/1/1986</td>
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<td>Commissioner of Insurance</td>
<td>John C. Neff</td>
<td>1/20/1979</td>
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<td>Commissioner of Insurance</td>
<td>Millard Oakley</td>
<td>1/1/1975</td>
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<td>Commissioner of Insurance</td>
<td>Richard F. Keathley</td>
<td>1/1/1974</td>
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<td>Halbert L. Carter, Jr.</td>
<td>1/15/1971</td>
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<td>Commissioner of Insurance</td>
<td>Milton P. Rice</td>
<td>1/1/1969</td>
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<td>Commissioner of Insurance</td>
<td>David M. Pack</td>
<td>1/1/1967</td>
<td>1/1/1969</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Albert Williams</td>
<td>1/1/1963</td>
<td>1/1/1967</td>
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<td>Commissioner of Insurance</td>
<td>John R. Long, Jr.</td>
<td>1/19/1959</td>
<td>1/1/1963</td>
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<td>Commissioner of Insurance</td>
<td>Leon Gilbert</td>
<td>1/1/1959</td>
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<td>Commissioner of Insurance</td>
<td>Arch E. Northington</td>
<td>1/1/1953</td>
<td>12/23/1958</td>
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<td>Commissioner of Insurance</td>
<td>Robert L. Taylor</td>
<td>1/1/1952</td>
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<td>Commissioner of Insurance</td>
<td>M. O. Allen</td>
<td>1/17/1948</td>
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<td>Commissioner of Insurance</td>
<td>James M. McCormack</td>
<td>1/1/1939</td>
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<td>Commissioner of Insurance</td>
<td>John W. Britton</td>
<td>1/10/1938</td>
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<td>Commissioner of Insurance</td>
<td>James M. McCormack</td>
<td>1/15/1937</td>
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<td>Commissioner of Insurance</td>
<td>Joseph S. Tobin</td>
<td>1/19/1933</td>
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<td>Commissioner of Insurance</td>
<td>Joseph L. Reece</td>
<td>7/15/1931</td>
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<td>Commissioner of Insurance</td>
<td>Albert S. Caldwell</td>
<td>2/1/1923</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Earl N. Rogers</td>
<td>6/30/1921</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Robert L. Carden</td>
<td>1/17/1921</td>
<td>6/30/1921</td>
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<td>Acting Commissioner of Insurance</td>
<td>T. E. Miles</td>
<td>12/1/1920</td>
<td>1/17/1921</td>
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<td>Commissioner of Insurance</td>
<td>L. K. Arrington</td>
<td>7/7/1917</td>
<td>11/31/1920</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>William F. Dunbar</td>
<td>6/1/1915</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>J. Will Taylor</td>
<td>3/1/1913</td>
<td>6/1/1915</td>
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<tr>
<td>State Treasurer</td>
<td>G. T. Taylor</td>
<td>2/20/1911</td>
<td>3/1/1913</td>
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<tr>
<td>State Treasurer</td>
<td>Reau E. Folk</td>
<td>9/1/1901</td>
<td>2/20/1911</td>
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<tr>
<td>State Treasurer</td>
<td>E. B. Craig</td>
<td>9/1/1893</td>
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<tr>
<td>State Treasurer</td>
<td>M. F. House</td>
<td>9/1/1889</td>
<td>9/1/1893</td>
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<tr>
<td>State Treasurer</td>
<td>Atha Thomas</td>
<td>9/1/1886</td>
<td>9/1/1889</td>
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<td>Tennessee — Continued</td>
<td>J. W. Thomas</td>
<td>9/1/1885</td>
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<tr>
<td>State Treasurer</td>
<td>W. L. Morrow</td>
<td>5/24/1871</td>
<td>9/1/1877</td>
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<tr>
<td>State Treasurer</td>
<td>W. R. L. Daniel</td>
<td>2/10/1933</td>
<td>3/1/1939</td>
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<tr>
<td>State Treasurer</td>
<td>Reuben Williams</td>
<td>5/2/1929</td>
<td>2/10/1933</td>
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<tr>
<td>State Treasurer</td>
<td>Walter C. Woodward</td>
<td>3/6/1939</td>
<td>12/17/1940</td>
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<tr>
<td>State Treasurer</td>
<td>J. A. Tarver</td>
<td>6/6/1862</td>
<td>7/1862</td>
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<tr>
<td>State Treasurer</td>
<td>J. L. Johnson</td>
<td>6/6/1862</td>
<td>7/1862</td>
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<tr>
<td>Texas — Appointed: 2-Year Term</td>
<td>Kent Sullivan</td>
<td>9/21/2017</td>
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<tr>
<td>Insurance Commissioner</td>
<td>David C. Mattax</td>
<td>4/12/2015</td>
<td>4/13/2017</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Julia Rathgeber</td>
<td>5/27/2013</td>
<td>1/12/2015</td>
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<td>Commissioner of Insurance</td>
<td>Edna Ramon Butts</td>
<td>9/1/1993</td>
<td>11/1/1993</td>
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<td>Commissioner of Insurance</td>
<td>Tommy McFarling</td>
<td>5/13/1975</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Don B. Odum</td>
<td>1/1/1974</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Clay Cotten</td>
<td>11/15/1965</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>J. N. Nutt</td>
<td>9/1/1963</td>
<td>11/1/1965</td>
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<td>Commissioner of Insurance</td>
<td>William A. Harrison</td>
<td>8/5/1957</td>
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<td>John Osorio</td>
<td>1/1/1957</td>
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<td>Acting Commissioner of Insurance</td>
<td>J. Byron Saunders</td>
<td>1/30/1956</td>
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<td>Acting Commissioner of Insurance</td>
<td>Garland A. ‘Chink’ Smith</td>
<td>10/6/1953</td>
<td>1/30/1956</td>
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<td>Commissioner of Insurance</td>
<td>George B. Butler</td>
<td>2/11/1945</td>
<td>9/28/1953</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Omicron P. Lockhart</td>
<td>5/12/1941</td>
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<td>Reuben Williams</td>
<td>1/2/1941</td>
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<td>Commissioner of Insurance</td>
<td>R. L. Daniel</td>
<td>2/10/1933</td>
<td>3/1/1939</td>
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<td>Commissioner of Insurance</td>
<td>William A. Tarver</td>
<td>5/2/1929</td>
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<td>Commissioner of Life</td>
<td>Robert B. Cousins, Jr.</td>
<td>9/1/1927</td>
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<td>Commissioner of Insurance</td>
<td>John M. Scott</td>
<td>8/21/1923</td>
<td>10/1/1925</td>
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<td>Cmsr. of Insurance and Banking</td>
<td>James L. Chapman</td>
<td>9/1/1922</td>
<td>8/21/1923</td>
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<tr>
<td>Cmsr. of Insurance and Banking</td>
<td>Edward ‘Ed’ Hall</td>
<td>1/20/1921</td>
<td>9/1/1922</td>
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<td>J. T. McMillan</td>
<td>8/1/1920</td>
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<td>John C. Chidsey</td>
<td>4/1/1920</td>
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<tr>
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<td>George Waverly Briggs</td>
<td>2/1/1919</td>
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<td>Cmsr. of Insurance and Banking</td>
<td>Charles O. Austin</td>
<td>8/31/1916</td>
<td>1/31/1919</td>
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<tr>
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<td>John S. Patterson</td>
<td>1/20/1915</td>
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**VERMONT—Appointed, Biannually by the Governor with Senate Consent**

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<th>YEARS SERVED</th>
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# NAIC Member Tenure List

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| VIRGINIA—Appointed, at the Pleasure of the State Corporation Commission |                               |           |          |              |               |
| Commissioner of Insurance          | Scott A. White                | 1/1/2018  |           |              | incumbent     |
| Commissioner of Insurance          | Jacqueline K. Cunningham      | 1/1/2011  | 12/31/2017| 6            | 11            |
| Commissioner of Insurance          | Steven T. Foster              | 2/1/1987  | 4/30/1996 | 9            | 2             |
| Commissioner of Insurance          | Everette S. Francis           | 7/1/1969  | 6/1/1975  | 5            | 11            |
## NAIC MEMBER TENURE LIST

### VIRGINIA—Continued

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### WASHINGTON—Elected; 4-Year Term

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

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### NAIC Member Tenure List

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## NAIC Member Tenure List

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<td>Acting Insurance Commissioner</td>
<td>Monroe D. Lauer</td>
<td>3/1/1986</td>
<td>7/1/1986</td>
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<td>Insurance Commissioner</td>
<td>John T. Langdon</td>
<td>1/1/1975</td>
<td>6/1/1984</td>
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<td>Insurance Commissioner</td>
<td>Ben S. Murphy</td>
<td>1/1/1971</td>
<td>1/1/1975</td>
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<td>Insurance Commissioner</td>
<td>Vincent J. Horn, Jr.</td>
<td>6/1/1970</td>
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<td>Mark Duncan</td>
<td>6/1/1963</td>
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<td>Insurance Commissioner</td>
<td>Gilbert A.D. Hart</td>
<td>5/1/1960</td>
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<td>Robert Adams</td>
<td>3/1/1959</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Ford S. Taft</td>
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<td>Rodney Barrus</td>
<td>3/18/1945</td>
<td>3/1/1951</td>
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<td>Insurance Commissioner</td>
<td>Alex MacDonald</td>
<td>2/1/1939</td>
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<td>Insurance Commissioner</td>
<td>Arthur J. Ham</td>
<td>3/1/1935</td>
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<td>Theodore Thulemeyer</td>
<td>2/13/1929</td>
<td>3/1/1935</td>
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<td>Insurance Commissioner</td>
<td>Lyle E. Jay</td>
<td>6/6/1927</td>
<td>2/13/1929</td>
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<td>John M. Fairfield</td>
<td>3/1/1927</td>
<td>5/21/1927</td>
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<td>Insurance Commissioner</td>
<td>(Died May 21, 1927)</td>
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<td>Insurance Commissioner</td>
<td>Harry A. Loucks</td>
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<td>Insurance Commissioner</td>
<td>Donald M. Forsyth</td>
<td>11/8/1920</td>
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<td>Robert B. Forsyth</td>
<td>3/1/1919</td>
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<td>Robert B. Forsyth</td>
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<td>William O. Owen</td>
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<td>Charles W. Burdick</td>
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<td>Territorial Auditor</td>
<td>Jesse Knight</td>
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<td>3/31/1884</td>
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<td>Territorial Auditor</td>
<td>John H. Nason</td>
<td>1/4/1880</td>
<td>3/31/1882</td>
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<td>Territorial Auditor</td>
<td>James France</td>
<td>12/13/1877</td>
<td>1/4/1880</td>
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Updated: 12/7/2020

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

<table>
<thead>
<tr>
<th>Mtg</th>
<th>M/D/Y</th>
<th>Meeting Site</th>
<th>President</th>
<th>Vice-President</th>
<th>Secretary</th>
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<tbody>
<tr>
<td>1</td>
<td>5/24-6/2/1871</td>
<td>New York, NY</td>
<td>George W. Miller, NY</td>
<td>Llewelyn Breese, WI</td>
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<td>10/18-30/1871</td>
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<td>9/17-20/1873</td>
<td>Boston, MA</td>
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<td>Orlow W. Chapman, NY</td>
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<td>Charles H. Moore, OH</td>
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<td>24</td>
<td>9/12-13/1893</td>
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<td>Christopher H. Smith, MN</td>
<td>John J. Brinkerhoff, IL</td>
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<td>Alexandria Bay, NY</td>
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<td>Frederick L. ‘Fred’ Cutting, MA</td>
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<td>William A. Fricke, WI</td>
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<td>John A. Hartigan, MN</td>
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<td>Frank H. Hardison, MA</td>
<td>Fitz Hugh McMaster, SC</td>
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<td>1st James R. Young, NC</td>
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<td>2nd Willard Done, UT</td>
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<td>Secretary</td>
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<td>8/1923</td>
<td>Minneapolis, MN</td>
<td>Herbert O. Fishback, WA</td>
<td>1st John C. Luning, FL</td>
<td>Joseph L. Button, VA</td>
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<td>Los Angeles, CA</td>
<td>Harry L. Conn, OH</td>
<td>2nd Bruce T. Bullion, AR</td>
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<td>9/1927</td>
<td>Cincinnati, OH</td>
<td>Albert S. Caldwell, TN</td>
<td>1st T. M. Henry, MA</td>
<td>Joseph L. Button, VA</td>
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<td>59</td>
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<td>Rapid City, SD</td>
<td>Albert S. Caldwell, TN</td>
<td>2nd Thomas M. Baldwin, Jr., DC</td>
<td>Joseph L. Button, VA</td>
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<td>Toronto, Canada</td>
<td>Howard P. Dunham, CT</td>
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<td>Portland, OR</td>
<td>Jess G. Read, OK</td>
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<td>Albert S. Caldwell, TN</td>
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<td>10/1932</td>
<td>Dallas, TX</td>
<td>Charles D. Livingston, MI</td>
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<td>Jess G. Read, OK</td>
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<td>Chicago, IL</td>
<td>Garfield W. Brown, MN</td>
<td>1st Daniel C. ‘Dan’ Boney, NC</td>
<td>Jess G. Read, OK</td>
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<td>65</td>
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<td>St. Petersburg, FL</td>
<td>Garfield W. Brown, MN</td>
<td>1st George S. Van Schaick, NY</td>
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<td>Samuel L. Carpenter, Jr., CA</td>
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<td>San Francisco, CA</td>
<td>Frank N. Julian, AL</td>
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<td>6/1940</td>
<td>Hartfort, CT</td>
<td>C. Clarence Nelson, UT</td>
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<td>Jess G. Read, OK</td>
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<td>Boston, MA</td>
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<td>11/1953</td>
<td>Miami Beach, FL</td>
<td>D. D. ‘Pat’ Murphy, SC</td>
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<td>George A. Bowles, VA</td>
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<td>Alfred N. Premo, CT</td>
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<td>Reg.</td>
<td>12/1961</td>
<td>Dallas, TX</td>
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<td>Harvey G. Combs, AR</td>
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<td>Ralph F. Apodaca, NM</td>
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<td>Ralph F. Apodaca, NM</td>
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<td>Vice-President</td>
<td>Secretary</td>
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<td>Alessandro A. 'Al' Ippa, ME</td>
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<td>Joel S. Ariio, OR</td>
<td>Alessandro A. 'Al' Ippa, ME</td>
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1. Sept. 23, 1886: John K. Tarbox (MA) was elected President for the 1887 Convention; Samuel H. Cross (RI) was elected Vice-President; and Robert B. Brinkerhoff (Ohio chief clerk) was elected Secretary. Commissioner Tarbox died May 28, 1887. Auditor Cross was out of office effective June 1, 1887. Mr. Brinkerhoff was out of office effective June 3, 1887. Oliver Pillsbury (NH) was chosen to preside over the 1887 Convention. It is unknown who acted as Vice-President. Jacob A. McEwen (Ohio chief clerk) was chosen to act as Secretary.

2. Aug. 21, 1890: Charles B. Allan (Nebraska deputy auditor) was elected Secretary for the 1891 Convention; however, he resigned before the Convention assembled. Sept. 30, 1891: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1891 Convention.

3. Sept. 18, 1895: William M. Hahn (OH) was elected President for the 1896 Convention and James R. Waddill (MO) was elected Vice-President; however, Superintendent Hahn was out of office effective June 3, 1886. Sept. 22, 1896: Superintendent Waddill was elected President for the 1896 Convention and Stephen W. Carr (ME) was chosen to act as Vice-President.
4. Sept. 23, 1896: James R. Waddill (MO) was elected President for the 1897 Convention and Stephen W. Carr (ME) was elected Vice-President; however, Mr. Waddill was out of office effective March 1, 1897. Sept. 7, 1897: Commissioner Carr was elected President for the 1897 Convention. It is unknown who acted as Vice-President.

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

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

7. Sept. 20, 1900: John A. O’Shaughnessy (MN) was elected President for the 1901 Convention; however, he was out of office at the date of the Convention. Sept. 5, 1899: Edward T. Orear (MO) was elected President for the 1899 Convention.

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

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

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

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

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

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

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

15. Sept. 15, 1898: Elmer H. Dearth (MN) was elected President for the 1899 Convention; however, he was out of office at the date of the Convention. September 1901: William H. Hart (IN) was elected President for the 1901 Convention.

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

17. Sept. 18, 1925: William R. C. Kendrick (IA) was elected President for the 1926 Convention. January 1926: Commissioner Kendrick resigned as NAIC President and Harry L. Conn (OH) was elected President for the 1926 Convention. Commissioner Kendrick remained as Iowa Insurance Commissioner until March 1, 1926.

18. Nov. 19, 1926: Harry L. Conn (OH) was elected President for the 1927 Convention and Albert S. Caldwell (TN) was elected First Vice-President. April 15, 1927: Superintendent Conn resigned as NAIC President and Ohio Insurance Superintendent. May 3, 1927: Commissioner Caldwell was elected President for the 1927 Convention and James A. Beha (NY) was elected First Vice-President.
19. Sept. 26, 1928: Charles R. Detrick (CA) was elected President for the 1929 Convention; James A. Beha (NY) was elected First Vice-President; and Howard P. Dunham (CT) was elected Second Vice-President. Jan. 1, 1929: Superintendent Beha resigned as NAIC First Vice-President and New York Insurance Superintendent. Commissioner Dunham was elected First Vice-President for the 1929 Convention. April 24, 1929: Commissioner Detrick resigned as NAIC President and California Insurance Commissioner. Commissioner Dunham was elected President for the 1929 Convention; Clarence C. Wysong (IN) was elected First Vice-President; and Jess G. Read (OK) was elected Second Vice-President.

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

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

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

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

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

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

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

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

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

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

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

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


33. A constitutional amendment moved NAIC officer elections from June to December (commencing December 1974), President Johnnie L. Caldwell (GA) served a six-month term.
34. Kenneth E. ‘Ken’ DeShetler (OH) was elected President; however, he resigned effective Jan. 13, 1975, as NAIC President and Ohio Insurance Director. William H. Huff, III (IA) was elected by the Executive (EX) Committee to fill the unexpired term.

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

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

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

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

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

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

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

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

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


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

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

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

48. Gordon I. Ito resigned effective Dec. 31, 2018, as NAIC Vice President and Hawaii Insurance Commissioner. A special Plenary interim election was held in La Quinta, California, on Feb. 4, 2019: Florida Insurance Commissioner David Altmaier was elected Vice President to serve from Feb. 4, 2019, to Dec. 31, 2019.
49. March 11, 2020: Due to concerns about the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Spring National Meeting in a virtual format. However, on March 23, 2020, the NAIC officers decided to suspend holding any further sessions of the virtual Spring National Meeting to allow NAIC members and staff more time to focus on the health emergency. The meeting had been scheduled for March 21–24, 2020, at the Phoenix Convention Center and the Sheraton Grand and Hyatt Regency hotels in Phoenix, Arizona.

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

The following is a listing of NAIC model laws, regulations and guidelines referenced in the Proceedings of the 2020 Summer National Meeting.

Actuarial Opinion and Memorandum Regulation (#822)
3-39, 6-471, 10-1451

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4-30

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Health Benefit Plan Network Access and Adequacy Model Act (#74)
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Health Care Professional Credentialing Verification Model Act (#70)
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Health Carrier External Review Model Act (#75)  
7-201, 7-207, 7-225

Health Carrier Grievance Procedure Model Act (#72)  
7-201, 7-207, 7-225

Health Carrier Prescription Drug Benefit Management Model Act (#22)  
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CALL TO ORDER

Welcome to the 229th session of the National Association of Insurance Commissioners (NAIC). This meeting will now come to order.

INTRODUCTION OF HEAD TABLE

Honorable James J. Donelon, NAIC Past President and Louisiana Insurance Commissioner
Honorable Eric A. Cioppa, NAIC Past President and Maine Insurance Superintendent
Honorable David Altmaier, NAIC President-Elect and Florida Insurance Commissioner
Honorable Dean L. Cameron, NAIC Vice President and Idaho Insurance Director
Honorable Chlora Lindley-Myers, NAIC Secretary-Treasurer and Missouri Insurance Director
Honorable Steve Kelley, Minnesota Insurance Commissioner
Andrew J. Beal, NAIC Chief Operating Officer (COO) and Chief Legal Officer (CLO)
Michael F. Consedine, NAIC Chief Executive Officer (CEO)

INTRODUCTION OF VIRTUAL HOST

It’s my great pleasure to introduce our Virtual Summer National Meeting host to speak for a few moments.

VIRTUAL HOST WELCOME

Thank you, Director Farmer!

Hello and welcome to the NAIC’s 2020 Virtual Summer National Meeting. I bring you greetings from Minneapolis, Minnesota. Minneapolis, as you all know was the location for this Summer National Meeting. Minnesota Gov. Tim Walz, Lieutenant Gov. Peggy Flanagan and I were excited about the opportunity to share our city and state with you; however, due to the COVID-19 pandemic, all of our event plans, like many of our summer plans, were changed. Of course, I was disappointed, but the health and safety of our colleagues and attendees is the most important thing, and we are all doing our parts to mitigate the risks of contracting and spreading the coronavirus.

Regardless of whether you’ve visited before, Minneapolis has a lot to offer. As a twin city to St. Paul, Minnesota, and being the largest city in the “Land of 10,000 Lakes,” Minneapolis is known for the Mississippi River, the flour milling heritage that developed from it, and for its beautiful lakes and parks.

Like many other cities though, Minneapolis is still reckoning with the effects of the death of George Floyd on one of its streets. We, like many of you, have seen protests, civil unrest and the long overdue, broad recognition of systemic racism. That’s why I am pleased that the NAIC has appointed the Special (EX) Committee on Race and Insurance and set aside time for the “Special Session on Race and Insurance” being held Aug. 13.

I am confident that these initiatives will have a lasting effect. I’m eager to engage with colleagues in the work of the Special (EX) Committee on Race and Insurance and support the effort to address racial inequities across the insurance industry. Doing our part to effect change as it relates to racial bias is one step toward making a difference. I applaud the NAIC and my colleagues for their commitment to achieving racial equality throughout the industry.

The other important initiative being launched with this national meeting is the Climate and Resiliency (EX) Task Force. The forecast is that you would have experienced some of the best weather Minnesota has to offer if we had been able to proceed with the meeting here. Yet we all recognize that a hotter and more variable climate is with us now and will be in the future, and it poses challenges for insurers and regulators. I am glad we will be discussing this topic along with all the other issues that our meetings typically cover.
I’m certain that if you were here for this summer’s meeting, you would have experienced the best hospitality Minneapolis has to offer! I hope we’ll get the chance to host you again, next time in person.

I am grateful to the NAIC staff for their amazing work in converting this meeting to a virtual meeting and to all of you for joining us. Everyone involved with the planning of this Summer National Meeting should be commended for the role they have played to make this event possible.

As we kick off day one, I hope you are as eager as I am to participate in the meetings and sessions. We will all remember 2020 as the year when many things changed. Through our discussions together, we have the opportunity to be active changemakers to better protect consumers, ensure a healthy insurance marketplace, make our communities more resilient, and eliminate systemic racism.

We have a lot of work to do this week! Enjoy the Summer National Meeting.

PRESIDENTIAL ADDRESS

Welcome to the NAIC Virtual Summer National Meeting. I think it’s fair to say that 2020 is not the year any of us thought it would be. So much has happened in the past eight months, that it is hard to even know where to begin.

Over the past few months, we’ve seen the deaths of Ahmaud Arbery, Breonna Taylor and George Floyd and felt the pain the country is feeling over the loss of their lives. Also, we’re saddened by the profound recent loss of two icons of the civil rights movement, Congressman John Lewis and the Reverend C.T. Vivian. Both men worked alongside Dr. Martin Luther King Jr., standing against racial injustice. The renewed focus on racial equality in society has generated a lot of discussions between our members and stakeholders.

We understand the need to address discrimination and its impact on insurance products and to promote diversity in the insurance sector, particularly in senior leadership roles. On these issues, we will work to honor the legacies of those great civil rights leaders and others, by continuing to push for equal treatment and opportunity for all. We hope this endeavor will engage willing participants across the sector. Moments of historical reflection like this are rare, and none of us should want to be remembered as having taken a pass at doing the right thing and creating a lasting positive change.

We’ve heard from insurance CEOs, and they are committed to making this change. My fellow commissioners and I welcome those words and are going to hold them to it. We are looking at the regulatory side, as well. I promise that we are going to hold a mirror up to ourselves just as we hold it up to the insurance sector.

We expect the NAIC to lead by example. The NAIC as an organization has taken the first of many steps forward. The NAIC is currently recruiting for a diversity officer. They have restructured their operations to create an organization that is focused on culture and leadership—having formed a Diversity, Equity and Inclusion Council, among other action steps—demonstrating an organizational commitment to diversity. It is our duty as commissioners to not only promote diversity within the insurance sector, but to address racial inequality in the development and access of insurance products.

I encourage all of you to attend the “Special Session on Race and Insurance,” Aug. 13 from 3 p.m. to 5 p.m., where we will look at the history of insurance, examine what the NAIC and state insurance regulators can do to identify and address any potentially ongoing racial discriminatory practices. This session will operate primarily as a listening session designed to help inform further targeted NAIC activity. My hope, one shared by my fellow officers, is this initiative will unite us all across the sector in common cause.

Unfair discrimination against a protected class in any form, whether intentional or not, should not stand. A regulatory system, and insurance in general, is a reflection of the society it aims to protect. And while state insurance regulators have worked to eliminate overt discrimination and racism, we all have been increasingly aware that unconscious bias is just as damaging to society.

For that and other reasons, the Executive (EX) Committee appointed the Special (EX) Committee on Race and Insurance. The Special Committee is co-chaired by me and NAIC President-Elect David Altmaier; Vice President Dean L. Cameron and Secretary-Treasurer Chlora Lindley-Myers serve as co-vice chairs for the Special Committee. The Special Committee has the engagement of the vast majority of members, and their passion for this issue is undeniable. I know my colleagues have been moved by other members’ personal stories and struggles with discrimination and prejudice. The Special Committee will engage with a broad group of stakeholders on issues related to race, equity, diversity and inclusion.
By year-end, the Special Committee will report its findings and develop steps that insurance regulators and the insurance industry can take to increase diversity and inclusion and address practices that potentially disadvantage minorities to ensure ongoing engagement of the NAIC on these issues charged to the existing committees, task forces and working groups.

One of the areas the NAIC has already taken a stand on is proxy discrimination. The Artificial Intelligence (EX) Working Group adopted guiding principles to inform an established general expectation for artificial intelligence (AI) actors and systems that emphasize the importance of accountability, compliance and transparency while providing safe, secure and robust outputs. These principles will be used to assist regulators in NAIC committees addressing insurance specific AI applications. We anticipate these principles will be interpreted and applied in a manner that promotes innovation and protects the consumer from harm, while accommodating the nature and pace of change in the use of AI by the insurance industry.

I assure you that my fellow commissioners are committed to addressing these important subjects, and I hope you will engage with us as part of this historic opportunity to make a difference.

It’s a telling sign of the tumultuous year we’ve had thus far that my second topic for today is a historic global pandemic. I don’t think it’s a stretch to say this is the health crisis of our lifetime in terms of its impact on people’s lives, finances and futures. I’m proud to say that when confronted with this crisis, this organization, the sector did not blink, did not break and once again showed strength and resiliency. The pandemic has forced us to think “outside the box” and come up with creative solutions for meetings and work.

After we decided not to meet in person for the Spring National Meeting, the NAIC put together a virtual session on the potential impact of COVID-19. On March 20, experts from government, the industry and consumer advocate groups—as well as nearly 3,000 participants—joined us for what would be the first of many discussions about the impact of the pandemic.

Since that time, the NAIC fielded multiple requests for relief from 22 different industry, consumer and health provider associations. Collectively, insurance commissioners issued more than 1,000 different bulletins, requests and actions, all focused on protecting consumers. The states acted quickly to remove consumer cost-sharing for COVID-19 testing and continue to work with federal officials to implement similar measures approved by the U.S. Congress. In addition, most states issued bulletins to clarify that insurers must cover early prescription drug refills, suspend prior authorization and expand coverage of telemedicine.

They also took steps to ease the administrative burden on carriers and agents by expanding the pool of providers during the outbreak. As with other lines of insurance, several states required life insurers to defer premium payments and suspend cancellations and nonrenewals. Life insurers were also instructed to waive fees and penalties and allow payment plans for premiums to avoid a lapse in coverage.

Insurance producers are in direct contact every day with Americans, helping them to make important financial decisions. Ensuring those producers had the knowledge and personal integrity to fulfill their obligations was critical. The NAIC worked with the National Insurance Producer Registry (NIPR) on recommended best practices and a bulletin template for guidance on the implementation of a temporary license class was distributed to the states. Together, we will continue to do the technical work required for the states to extend renewal deadlines or offer temporary licenses electronically through NIPR.

To help consumers, legislators and business owners understand the impacts of COVID-19, the NAIC created the “Coronavirus Resource Center.” This page on the NAIC website provides access to third-party resources, searchable information on state actions and content specifically created by the NAIC, including archived research from past pandemics. Academics from the Wisconsin School of Business have also weighed in on business interruption insurance and special enrollment periods.

The NAIC Communications Division worked with the states and subject-matter experts to create consumer bulletins on coverage information related to all lines of insurance. As with many crises, fraud remains a major concern. State insurance regulators and the NAIC have also issued warnings to consumers about potential COVID-19-related scams, such as robocalls and text messages advertising bogus miracle cures, free at-home test kits and scams claiming assistance with obtaining federal government stimulus checks.

Throughout this crisis, the NAIC has worked to keep the insurance sector financially strong by assisting state insurance regulators who are monitoring the financial health of insurers. These efforts include finding and evaluating company exposures to COVID-19 related risks.
The NAIC has provided reports to the states for their use in evaluating the potential impact of the market downturn on insurance company assets. Evaluating company exposures has involved identifying those companies whose products put them at the greatest risk of being impacted, as well as those companies that are at great risk due to interest rate cuts.

State insurance regulators, working together through the NAIC, developed a national information request template that gathers data from insurers of their exposure to potential COVID-19 claims and the impact of the related economic downturn on their assets. The NAIC has also completed a resource and guidance document of COVID-19 assumptions that state insurance regulators may use when reviewing carrier rights submissions for 2021. The Statutory Accounting Principles (E) Working Group issued new accounting and reporting guidance for treatment of overdue mortgages and due dates of quarterly filings to allow more time for the insurers to collect premiums before reporting the receivables is not admitted in their statutory financial statements.

I’m proud to say our efforts in this crisis and leading up to it have resulted in the U.S. insurance market being recognized as the most financially secure of any global market in the pandemic.

One of the most talked about insurance lines during this pandemic has been business interruption insurance. My fellow commissioners and I have reviewed hundreds of policies on behalf of our constituents. Not surprisingly, our informal findings mirror the recent industry data call, which found that 83% of all policies included an exclusion for viral contamination or pandemic, and 98% of all policies had a requirement for physical loss. If insurance policies cover claims related to pandemics, insurance companies should pay those claims for the insurance contract.

However, it is not a good idea to apply coverage retroactively. That is why the NAIC issued a statement and submitted written testimony letting Congress know of our concern about requiring insurance companies to retroactively alter contracts to provide coverage that was not contemplated or funded and, in many cases, specifically excluded by the policy.

We believe altering these insurance contracts could jeopardize the financial health of insurance companies or affect their ability to pay other claims and, ultimately, impact the availability of needed coverages in the marketplace. This would undermine the ability of insurance regulators to protect consumers or ensure the solvency and stability of the insurance industry. As Congress considers what to do about the impact of this pandemic, future pandemics and the role insurance might play, the NAIC will remain actively involved in those discussions as a vital and objective resource.

The impact of COVID-19 has been truly global and so has our international engagement. In-person, international meetings have been suspended for the time being, but we have held regular calls to share experiences in dealing with the current situation and responded to a survey to collect informational jurisdictional responses.

Already this year, we’ve had virtual bilateral discussions with key markets like the European Union (EU) and Bermuda, and we are nearing completion of months-long work on the latest International Monetary Fund (IMF) assessment of our system with a number of you. Our work on comparability between the insurance capital standard and the aggregation method has continued. However, the International Association of Insurance Supervisors’ (IAIS) consultation on principles for assessment criteria will be delayed from July to later in 2020.

Turning to some of our financial priorities, work on the group capital calculation (GCC) and the Macroprudential Initiative (MPI) remain important to ensure our system is prepared for the shocks and market disruptions of the future. COVID-19 provided a stark example of not only how financial markets can deteriorate, but also how quickly they can recover. Our system, which incentivizes a buy-and-hold approach to assets, is well suited to insurance liabilities. But we must not become complacent. Adding GCC and MPI tools to our toolbelt is important for regulation here and to support our commitment to strong group supervision internationally.

In short, our approach has been both flexible and focused in dealing with the pandemic. As the pandemic continues to evolve, we will continue to take the actions needed to protect consumers and ensure the ongoing stability of the nation’s insurance sector.

Because the forces of nature do not really care if we’re in the middle of a pandemic, we have continued our efforts to make sure our consumers are prepared for any natural disaster. We are working with Congress, weighing in on proposals on the National Flood Insurance Program (NFIP) and expanding private flood options. The NFIP is set to expire in less than three months, but we cannot let that happen and will continue this critical work.
The NAIC Communications Division, in conjunction with several NAIC working groups, has produced materials on flooding, hurricanes, tornadoes and wildfires. In May, I was interviewed by nearly 30 television and radio stations about natural disaster preparedness and resilience. I offered tips on how to prepare for hurricane season and reminded everyone about the importance of flood insurance. In June, the NAIC hosted a Twitter chat—along with insurance departments across the country, the Federal Emergency Management Association (FEMA) and a number of other stakeholders—stressing the importance of preparedness.

At the beginning of this year, I had two top priorities for my year as president. The first which we just discussed, was resiliency of consumers and their properties in the event of a natural disaster. The second is long-term care insurance. Both issues remain high priorities, even in the midst of COVID-19 and the quest for social justice.

Long-term care insurance provides one of the most significant examples of tension between solvency, regulation and consumer protection. Elderly consumers are experiencing significant premium increases because carriers believe they are necessary to maintain reserves. Our Long-Term Care Insurance (EX) Task Force continues its important work. They have been reviewing various approaches to address actuarially appropriate rate increases for long-term care coverage.

Last month, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup released a document for public comment that identifies benefit options that can be offered to consumers who cannot afford great increases. The principles were developed by 17 state insurance departments and are designed to offer guidance on how to provide consumers with choices about changes to long-term care contract benefits.

Addressing the many issues within this product line is still a priority for us. All the challenges we face in 2020 are new and ever-evolving. Our aim remains the same as they were almost 150 years ago: Protect the consumers in each of our jurisdictions and ensure the safety and stability of the markets we oversee. We will make sure the citizens of our states and territories are treated equitably and without prejudice, and we will keep pace with changing technologies and economic realities to ensure the insurance markets of the United States remain strong and vibrant and are helping people manage the risk of everyday life for another 150 years and beyond.

In closing, 2020 is certainly not the year we expected, but it is the year that we got. I could not be prouder to have the honor of serving this organization with my colleagues across the country. During these trying times, we have tirelessly worked to protect the lives and livelihoods of Americans and ensure that a vibrant insurance sector continues to be there for consumers when it’s needed most.

It has been said of the NAIC and its members, we are at our best when things are at their worst. That has never been truer. These days will pass, and I look forward to when we can meet face-to-face again. Until then, I wish each of you and your families health, happiness and the hope of better days to come. Stay well and God bless.

ADJOURNMENT

Raymond G. Farmer, NAIC President

With that, I officially conclude this Opening Session of the 229th meeting of the National Association of Insurance Commissioners.
Synopsis of the NAIC Committee, Subcommittee and Task Force Meetings
2020 Virtual Summer National Meeting
July 27 – August 14, 2020

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

Committee Action
NAIC staff have reviewed the committee, subcommittee and task force reports and highlighted the actions taken by the committee groups during the 2020 Virtual Summer National Meeting. The purpose of this report is to provide NAIC members, state insurance regulators and interested parties with a summary of these meeting reports.

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)
Aug. 14, 2020
1. Adopted the report of the Executive (EX) Committee. See the Committee listing for details.
2. Adopted the “NAIC Principles on Artificial Intelligence (AI)” (AI Principles).
3. Adopted by consent the committee, subcommittee and task force minutes of the 2019 Fall National Meeting.
4. Adopted its Feb. 13 minutes, which included the following action:
   a. Adopted revisions to the *Suitability in Annuity Transactions Model Regulation (#275).*
5. Received the report of the Life Insurance and Annuities (A) Committee. See the Committee listing for details.
6. Received the report of the Health Insurance and Managed Care (B) Committee. See the Committee listing for details.
7.Received the report of the Property and Casualty Insurance (C) Committee. See the Committee listing for details.
8. Received the report of the Market Regulation and Consumer Affairs (D) Committee. See the Committee listing for details.
9. Received the report of the Financial Condition (E) Committee. See the Committee listing for details.
10. Received the report of the Financial Regulation Standards and Accreditation (F) Committee. See the Committee listing for details.
11. Received the report of the International Insurance Relations (G) Committee. See the Committee listing for details.
12. Adopted technical revisions to the *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48).*
17. Adopted the 2019 revisions to the *Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) as an addition to the Part A Accreditation Standards.*
19. Received a status report on state implementation of NAIC-adopted model laws and regulations.

EXECUTIVE (EX) COMMITTEE
Aug. 13, 2020
1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met July 14 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee took the following action:
   a. Adopted its May 12 minutes.
   b. Adopted the Internal Administration (EX1) Subcommittee’s May 20 minutes, which included the following action:
      1. Received an update on the defined benefit plan portfolio as of March 31.
      2. Received an update on the NAIC long-term investment plan portfolio as of March 31.
      3. Approved a recommendation to replace one of the NAIC’s fund managers responsible for short-term bond funds.
   c. Adopted the report of the Audit Committee, which met June 2 via conference call and received the 2019/2020 Service Organization Control (SOC) 1 and SOC 2 reports.
   d. Received an update on the 2020 financial results and preliminary 2021 budget assumptions and approved an extension of unused 2020 grant funds to the end of 2021.
e. Appointed the Special (EX) Committee on Race and Insurance.

f. Appointed the Climate and Resiliency (EX) Task Force and adopted its draft charges.

g. Received a System for Electronic Rate and Form Filing (SERFF) assessment and directed NAIC staff to prepare and issue a request for proposal (RFP) to solicit proposals to help complete a “modernization pilot” and “Wave One” as recommended in the SERFF assessment.

h. Approved the NAIC staff recommendation to extend the residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) modeling contract with BlackRock for another year.

i. Approved the release of the economic scenario generator (ESG) fiscal for a two-week public comment period prior to a final vote of the Executive (EX) Committee during a future meeting.

j. Approved an information-sharing agreement with the U.S. Department of Labor (DOL).

k. Selected the meeting locations for the 2024 summer and fall national meetings: 1) the 2024 Summer National Meeting will be held in Chicago, IL; and 2) the 2024 Fall National Meeting will be held in Denver, CO.

l. Received the joint chief executive officer (CEO)/chief operating officer (COO) report.

2. Adopted the report of the Executive (EX) Committee, which met May 12, April 2, Feb. 13 and Jan. 10 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee took the following action:

a. Adopted the 2019 Fall National Meeting minutes of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

b. Adopted its April 2, Feb. 13 and Jan. 10 minutes.

c. Adopted the report of the Audit Committee.

d. Adopted the report of the Investment Committee.

e. Adopted the recommendation of the Life Actuarial (A) Task Force to delay the start of principle-based reserving (PBR) experience data reporting from 2020 to 2021.

f. Appointed Commissioner Vicki Schmidt (KS) and Director Bruce R. Ramge (NE) to serve on the National Insurance Producer Registry (NIPR) Board of Directors effective May 12.

g. Heard a report on a change in membership for the SERFF Advisory Board. Andrea Davey (Athene Annuity and Life Company) will serve as the life insurance representative on the SERFF Advisory Board.

h. Discussed the National Association of Registered Agents and Brokers (NARAB) board recommendations.

i. Heard an update on the ESG RFP.

j. Heard an update on the SERFF Assessment.

k. Heard an update on NAIC cybersecurity.

l. Discussed the status of the Mid-Year Roundtable and the Summer National Meeting.

m. Heard a joint CEO/COO report.


o. Received an update on the 2019 year-end financial results.

p. Approved the fiscal impact statement for the Long-Term Care Insurance Data Call and authorized NAIC staff to contract with a selected vendor.

q. Approved the fiscal impact statement for the SERFF Filing Review Tools Pilot.

r. Approved the following non-regulator appointments to the SERFF Advisory Board: Birny Birnbaum (Center for Economic Justice—CEJ) as the consumer representative; Theresa Boyce (Chubb Group) as a property/casualty (P/C) representative; Amanda Wheeler (LifeSecure Insurance Company) as a life insurance representative; and Rachel Benton (Bright Health) as a health insurance representative and vice chair.

s. Appointed Director Chlora Lindley-Myers (MO) as vice chair of the 2020 Consumer Participation Board of Trustees.

t. Appointed Commissioner Mark Afable (WI) to serve on the NIPR Board of Directors effective Feb. 13.

u. Disbanded the Long-Term Care Insurance (B/E) Task Force, the NAIC/State Government Liaison Committee and the NAIC/Industry Liaison Committee.

v. Removed the membership limit on the Life Actuarial (A) Task Force and the Health Actuarial (B) Task Force.

w. Approved the fiscal impact statement for the PBR Yearly Renewable Term Reinsurance Study.

x. Voted to release for public review and comment the Long-Term Care Insurance Data Call and Analysis fiscal impact statement.

y. Approved the debt restructure terms between the NAIC and Interstate Insurance Product Regulation Commission (Compact).

z. Appointed Florida, Idaho, Kentucky, Massachusetts, Missouri, Nebraska, Nevada, Ohio and Oklahoma as members of the NAIC 2020 Audit Committee.

3. Adopted the report of the Financial Stability (EX) Task Force. See the Task Force listing for details.


5. Adopted the report of the Innovation and Technology (EX) Task Force, including the AI Principles. See the Task Force listing for details.
6. Adopted the report of the Long-Term Care Insurance (EX) Task Force, including charges for its three new subgroups: Long-Term Care Insurance (LTCI) Multi-state Rate Review (EX) Subgroup; LTCI Reduced Benefit Options (EX) Subgroup; and LTCI Financial Solvency (EX) Subgroup. See the Task Force listing for details.


8. Received the 2019 annual report of the NAIC Designation Program Advisory Board.

9. Received a status report on implementation of the NAIC State Ahead strategic plan.

10. Received a status report on model law development efforts for amendments to: Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); Annuity Disclosure Model Regulation (#245); Health Maintenance Organization Model Act (#430); Model #440; Model #450; Life Insurance Disclosure Model Regulation (#580); Mortgage Guaranty Insurance Model Act (#630); Unfair Trade Practices Act (#880); and new models, including the Real Property Lender-Placed Insurance Model Act, the Pet Insurance Model Act and the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model Act).

11. Heard a report from the Compact.

**Financial Stability (EX) Task Force**

**Aug. 5, 2020**

1. Adopted its Feb. 26 and 2019 Fall National Meeting minutes, which included the following action:
   a. Announced the reappointment of the Liquidity Assessment (EX) Subgroup.
   b. Discussed comments received on the draft 2019 liquidity stress test framework.
   c. Discussed comments received on a request to join the Financial Condition (E) Committee in opening Model #440 and Model #450 for amendments.

2. Heard an update on Financial Stability Oversight Council (FSOC) developments.

3. Received an update from the Liquidity Assessment (EX) Subgroup on its progress toward achieving its deliverables related to liquidity stress testing.

4. Received an update from the Receivership and Insolvency (E) Task Force on its work to address the Financial Stability (EX) Task Force’s referral letter to undertake analysis relevant to the Macroprudential Surveillance Initiative.

5. Heard an update on collateralized loan obligation (CLO) stress tests.

6. Heard an update on the International Association of Insurance Supervisors (IAIS)

7. Heard an update on the London Interbank Offered Rate (LIBOR).

8. Discussed exposure comments on the draft revisions to Model #440.

**Government Relations (EX) Leadership Council**

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

**Innovation and Technology (EX) Task Force**

**Aug. 7, 2020**

1. Adopted its July 23 and 2019 Fall National Meeting minutes, which included the following action:
   a. Discussed comments regarding the AI Principles as adopted by the Artificial Intelligence (EX) Working Group during its June 30 conference call.
   b. Discussed comments regarding the anti-rebating draft amendments to Section 4H of Model #880.

2. Adopted the report of the Big Data (EX) Working Group, which met Aug. 4 and took the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Received an update from the Casualty Actuarial and Statistical (C) Task Force on its progress drafting a white paper, Regulatory Review of Predictive Models, to provide best practices for the review of predictive models and analytics filed by insurers to justify rates.
   c. Received an update from the Accelerated Underwriting (A) Working Group. The Working Group plans to circulate a first draft of its work product by the end of 2020 and complete its work by the 2021 Summer National Meeting.
d. Received an update on NAIC technical and nontechnical rate review trainings. Starting Nov. 13, 2019, and ending in June 2020, the NAIC Education and Training Department hosted biweekly statistical training for regulatory review of P/C rate models (technical training). State insurance regulators received technical training in exploratory data analysis and statistical techniques insurers are using to develop P/C risk classification and rating plans. The next phase of training was devoted to specific advanced statistical techniques. Course topics included generalized linear models (GLMs), generalized additive models (GAMs), gradient boosted trees, random forest ensembles and decision tree models. Model validation techniques were also covered. The NAIC also sponsored two non-theoretical, practical webinars, designated as “nontechnical webinars.” The NAIC plans to provide training targeted specifically to market conduct examiners.

e. Received an update on NAIC technical services to state insurance regulators for the review of P/C rate models. State insurance regulators will be able to share information through a confidential model database and obtain NAIC technical assistance when reviewing a specific company’s filed P/C rate model.

3. Adopted the report of the Speed to Market (EX) Working Group, including its July 31 minutes. During this meeting, the Working Group took the following action:

a. Adopted its July 15 minutes, which included the following action:
   1. Adopted its June 15 minutes, which included the following action:
      a. Received an update on the SERFF Advisory Board and SERFF metrics.
      b. Received an update from the Compact.
      c. Adopted a suggestion to create a SERFF canned report for rate changes.
      d. Discussed the SERFF State Reports document.
   2. Discussed suggestions for changes to the Uniform Property & Casualty Product Coding Matrix and Uniform Transmittal Document. None of the suggested changes were adopted.

b. Adopted its June 30 minutes, which included the following action:

4. Adopted the report of the Artificial Intelligence (EX) Working Group, including its June 30 minutes. During this meeting, the Working Group took the following action:

a. Adopted its June 3 minutes, which included the following action:
   1. Adopted its May 5 minutes, which included the following action:
      a. Reviewed and discussed comments regarding Version 2 of the draft AI Principles.
      b. Reviewed a proposed timeline for adoption of the AI Principles.
      c. Reviewed a proposed timeline for adoption of the AI Principles.
   2. Reviewed and discussed comments regarding Version 4 of the draft AI Principles.
   3. Reviewed a proposed timeline for adoption of the AI Principles.

b. Reviewed and discussed comments regarding Version 5 of the draft AI Principles.

c. Adopted the AI Principles, which were referred to the Innovation and Technology (EX) Task Force for consideration.

5. Discussed and adopted the AI Principles as amended during the meeting. Amendments to the version adopted by the Artificial Intelligence (EX) Working Group include:

a. Adding “data providers” to the list of entities included as playing an active role in the AI system life cycle.

b. Adding “Consistent with the risk-based foundation of insurance” to the beginning of the Fair and Ethical part b.

c. Adding “and corrects and remediates such consequences when they occur” to the end of Fair and Ethical part b.

d. Deleting the last sentence in the Accountable and Compliant sections.

e. Deleting “including consumers” and adding “can be demonstrated” to the first and second sentences in the Transparent section part a.

f. Making several other “clean up” type changes.

6. Heard presentations from Director Robert Muriel (IL), Chris Stehno (Deloitte) and Patricia Matson (Risk and Regulatory Consulting) on the topic of accelerated underwriting in life insurance and algorithmic auditing.

7. Received an update on the latest draft of the anti-rebating amendments to Section 4H of Model #880 and exposed it for a public comment period ending Aug. 28. Any comments received will be discussed by the Task Force during an interim meeting prior to the Fall National Meeting.
Long-Term Care Insurance (EX) Task Force
Aug. 7, 2020

1. Adopted its July 2 minutes, which included the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Received progress reports on the current activities for the Task Force’s six workstreams.
   c. Exposed a draft reduced benefit option principles document for a 30-day public comment period ending Aug. 3.
   d. Exposed draft 2020 subgroup charges for a 14-day public comment period ending July 17.

2. Appointed three subgroups and related 2020 charges: LTCI Multi-state Rate Review (EX) Subgroup; LTCI Reduced Benefit Options (EX) Subgroup; and LTCI Financial Solvency (EX) Subgroup.

3. Received progress reports on the current activities for two of the Task Force’s workstreams:
   a. The Multi-State Rate Review Practices workstream continues to make progress in conducting a pilot project to perform multi-state rate reviews.
   b. The Reduced Benefit Options and Consumer Notices workstream received comments on a draft principles document outlining the states’ practices in reviewing and approving reduced benefit options. Further discussions of comments received will be held on future conference calls of the LTCI Reduced Benefit Options (EX) Subgroup. The Subgroup also plans to begin development of principles for consumer notices.

4. Received comments from interested parties on the draft reduced benefit options principles document.

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

Information Systems (EX1) Task Force
Aug. 5, 2020

1. Adopted its Fall 2019 National Meeting minutes.
2. Adopted its 2021 proposed charges, which remain unchanged from 2020.
3. Received an information technology (IT) operational report on the NAIC’s IT activities, including: 1) product highlights; 2) innovation and technology; 3) service and support; 4) data collection metrics; 5) team; 6) project portfolio summary; and 7) technology adoption and system usage. The report provides updates for upcoming improvements, impacts to new state technology offerings from the NAIC and general updates on the activities of the NAIC technology team.

4. Received a project portfolio update, including project status reports for 23 active technical projects and a summary of two projects recently completed.

5. Adjourned into regulator-to-regulator session pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE
Aug. 11, 2020

1. Adopted its July 10 minutes, which included the following action:
   a. Adopted its Dec. 30, 2019, and 2019 Fall National Meeting minutes, which included the following action:
      1. Adopted revisions to the appendices of Model #275, as referred by the Annuity Suitability (A) Working Group.
   b. Adopted technical revisions to AG 48.
   d. Adopted AG 49-A.

2. Adopted the report of the Annuity Disclosure (A) Working Group, including its March 13 minutes. During this meeting, the Working Group took the following action:
   a. Adopted revisions to Section 6F(9)(b)(i) of Model #245 clarifying what financial instruments are included in an index, each of which has to have been in existence for at least 15 years.

3. Adopted an extension of the Annuity Disclosure (A) Working Group’s Request for NAIC Model Law Development to amend Model #245.

4. Adopted the report of the Accelerated Underwriting (A) Working Group, which met July 31 and took the following action:
   a. Adopted its March 12, Feb. 20, Feb. 2, Jan. 23, and 2019 Fall National Meeting minutes, which included the following action:
      1. Discussed its work plan.
      2. Heard presentations from consulting firms, lawyers, consumer representative organizations, and the American Academy of Actuaries (Academy).
   b. Heard a presentation on the work of the Working Group, including the process that has been followed, some of the lessons learned, and the timeline for completion of its charge.
5. Adopted the report of the Annuity Suitability (A) Working Group, which met July 29 and took the following action:
   a. Adopted its Dec. 19, 2019, and 2019 Fall National Meeting minutes, which included the following action:
      1. As directed by the Life Insurance and Annuities (A) Committee, reviewed and discussed the comments received on the draft of proposed revisions to Model #275 related to the proposed appendices.
      2. Revised the appendices based on the comments received and forwarded the revised draft to the Committee for consideration during a Dec. 30, 2019, conference call.
   b. Agreed to work on a draft frequently asked questions (FAQ) document to complete the second half of its charge to “consider how to promote greater uniformity across NAIC-member jurisdictions.”
6. Adopted the report of the Life Insurance Illustration Issues (A) Working Group, including its July 24 minutes. During this meeting, the Working Group took the following action:
   a. Continued making progress in the development of a one- to two-page consumer-oriented policy overview document in order to achieve its charge of improving the understandability of the life insurance policy summaries already required in Section 7B of the Life Insurance Illustrations Model Regulation (#582) and Section 5A(2) of Model #580.
   b. Reviewed two alternative draft revisions to Model #580. One version retains the current time frame for delivery of the policy overview at the same time as the buyer’s guide (either at the time of application or at the time of policy delivery if there is a “free look” period.) The other version has the policy overview delivered at the time of application.
   c. Reviewed two alternative versions of the policy overview sample for term life insurance policies. One version shows the sample pre-underwriting, the other after underwriting.
   d. Exposed the policy overview documents for a public comment period ending Aug. 28.
   e. Agreed to request an extension of the Request for NAIC Model Law Development from the Life Insurance and Annuities (A) Committee in order to make progress on draft revisions to Model #580 creating a policy overview and sample templates.
8. Adopted the report of the Life Actuarial (A) Task Force. See the Task Force listing for details.
9. Discussed next steps for the Life Insurance Online Guide (A) Working Group and agreed that NAIC staff would send an email to Committee members:
   a. Describing its planned process to have the Working Group focus on the substance of a guide and have the NAIC Communications Division work on an online design.
   b. Seeking additional state insurance regulator members to be on the Working Group.
10. Discussed next steps for the Retirement Security (A) Working Group and agreed that NAIC staff would send an email to Committee members:
   a. Asking for comments on a revised work plan focusing on areas where state insurance regulators have expertise while leveraging the existing work of other organizations to avoid duplication of efforts.
   b. Seeking additional state insurance regulator members to be on the Working Group.
11. Agreed to discuss on a future conference call whether the Committee should review the design and regulation of life insurance and annuity illustrations and discuss what, if any, changes or additions might be needed.

Life Actuarial (A) Task Force
Aug. 3–6, 2020
1. Adopted its June 25, June 18, June 11, June 4, May 28, May 21, May 14 and May 7 minutes, which included the following action:
   a. Adopted its Feb. 27, Feb. 20, Feb. 13, Feb. 6, Jan. 30 and Jan. 23 minutes, which included the following action:
      1. Adopted its 2019 Fall National Meeting minutes.
      2. Agreed to distribute an RFP for a replacement ESG.
      4. Exposed amendment proposal 2020-03.
      6. Adopted revisions to AG 48.
      7. Agreed to refer proposed revisions to the VM-20 Reserve Supplement Blank to the Blanks (E) Working Group.
      14. Accepted amendment proposal 2020-01 as an editorial change to the Valuation Manual.
      15. Discussed the Oliver Wyman yearly renewable term (YRT) reinsurance reserve credit long-term solution.
      16. Heard a status update on the YRT field test.
b. Adopted changes to Model #805.
c. Adopted amendment proposal 2020-05.
d. Adopted AG 49-A.
e. Adopted amendment proposal 2020-06.
f. Adopted amendment proposal 2020-07.

2. Heard an update on the results of the YRT field test modeling and range of interpretation survey from the Academy YRT Field Test Project Oversight Work Group, Oliver Wyman and NAIC staff.

3. Discussed proposed changes to Model #805 nonforfeiture interest rate floor. The Task Force agreed to expose Section 4B with various nonforfeiture rate floor options between one-half of one percent (0.5%) and zero percent, inclusive.

4. Heard an update from the Academy Annuity Reserves Work Group on the proposed timeline and approach for the development of a PBR framework for non-variable annuities.

5. Adopted the report of the VM-22 (A) Subgroup, including its July 15, July 1, June 11 and May 20 minutes. During these meetings, the Subgroup took the following action:
   a. Discussed developing a standard projection amount (SPA) for VM-22, Statutory Maximum Valuation Interest Rate for Income Annuities.

6. Heard an update from the Compact.

7. Adopted the report of the Longevity Risk (E/A) Subgroup.

8. Adopted the report of the GI Life Valuation (A) Subgroup.

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

10. Adopted the report of the IUL Illustration (A) Subgroup, including its June 2 and May 26 minutes. During these meetings, the Subgroup took the following action:
    a. Discussed proposed revisions to Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49).


12. Exposed amendment proposal 2020-03.


14. Exposed the 2021 Generally Recognized Expense Table (GRET) recommendation.

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


17. Heard an update from the Academy PBR Governance Work Group.


HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Aug. 11, 2020

1. Adopted its April 28, Feb. 26, and 2019 Fall National Meeting minutes, which included the following action:
   a. Received a report from the Health Actuarial (B) Task Force on its work to develop an outline and eventual 2021 rate pricing resource and guidance document for the states to consider when reviewing initial 2021 rates in light of the COVID-19 pandemic.
   b. Discussed and heard comments from stakeholders on areas, such as telehealth requirements and form filing requirements, in which state insurance regulators can provide regulatory flexibility due to the COVID-19 pandemic.
   c. Adopted the Regulatory Framework (B) Task Force’s revised 2020 charges, which added a charge for the newly appointed MHPAEA (B) Working Group. This new Working Group will monitor, report and analyze developments related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and make recommendations regarding NAIC strategy and policy with respect to those developments.

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

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

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

5. Adopted the report of the Consumer Information (B) Subgroup, including its July 9, Jan. 21 and Jan. 7 minutes. During these meetings, the Subgroup took the following action:
   a. Discussed and adopted the revised consumer guide, “Using Your Health Coverage.” The guide helps consumers better understand health coverage they are enrolled in by providing guidance on cost-sharing, provider networks, referrals, coordination of benefits, life changes and other topics.
   b. Discussed its work plan for 2020, including completing its work on a new consumer guide to the claims process, developing materials related to the COVID-19 pandemic and updating its “Frequently Asked Questions About Health Care Reform” document for the plan year 2021.
6. Adopted the report of the Health Innovations (B) Working Group, which met July 30 and took the following action:
   a. Adopted its June 23 minutes, which included the following action:
      1. Discussed the regulation of coverage for telehealth services.
      2. Discussed potential topics for the Working Group’s meeting during the Summer National Meeting.
   b. Heard a presentation on privacy requirements for telehealth communications under the federal Health Insurance Portability and Accountability Act (HIPAA). An attorney with Manatt Health reviewed which HIPAA standards are required versus addressable, the flexibility established under the COVID-19 pandemic, and other considerations for covered entities in complying with privacy requirements.
   c. Heard a panel discussion on telemedicine from representatives of stakeholder groups. The National Alliance on Mental Illness (NAMI) shared poll results and concerns from patients and mental health providers. America’s Health Insurance Plans (AHIP) reviewed the growth in telehealth services, ongoing challenges, and what the states can do to further promote telehealth. The American Academy of Family Physicians (AAFP) discussed changes to provider workflows, regulatory flexibilities and ongoing challenges, including the lack of alignment across payers.
   d. Heard a presentation from the Milbank Memorial Fund on strategies for cost control. It suggested five areas in which state insurance regulators can incentivize and encourage greater health care system affordability.
7. Heard a presentation on health equity and disparities in health care and coverage. The presentation explained what health and health care disparities are, their origin, and why health and health care disparities are a persistent and longstanding issue. The presentation also highlighted how the disparate impacts of COVID-19 mirror and compound underlying health disparities and how progress to address the problem will require long-term efforts across sectors to prioritize equity and address systemic and structural barriers, including racism and discrimination.
8. Heard a presentation on how the COVID-19 pandemic and the resulting recession has affected employer-sponsored insurance coverage. The presentation also discussed consumer considerations and choices after the loss of employer-sponsored insurance coverage. The presentation outlined several policy opportunities and lessons that state and federal regulators could consider when dealing with this issue, such as considering the impact of Medicaid expansion, the timing of enrollment and outreach, and expanded outreach efforts.
9. Heard a presentation on COVID-19 testing and costs. The presentation provided an overview of COVID-19 testing, its essential components and purpose. The presentation also discussed the current framework for COVID-19 testing and how each stakeholder involved—insurers, government, public health entities, and employers—plays a leadership role in ensuring access to such testing for those who need it. The presentation discussed the current costs of COVID-19 tests for diagnostic purposes and antibody testing and the potential impact of the cost of testing on premium rates. The presentation suggested several recommendations, including ensuring that all consumers are able to access COVID-19 testing regardless of coverage status, solidifying comprehensive strategies that incorporate testing to achieve occupational and public health goals, ensuring that testing does not lead to premium spikes in 2021 and protecting against testing fraud.
10. Heard an update on legal actions related to the federal Affordable Care Act (ACA), including U.S. Supreme Court cases from its recent 2019 term, such as the 8-1 decision in favor of insurers challenging the legality of the federal government’s refusal to pay participants for full risk corridor amounts. The update also discussed what to expect from the U.S. Supreme Court in its 2020 term, including oral arguments in a case challenging the constitutionality of the individual mandate and its potential impact on other key ACA provisions and a case challenging the authority of the states to regulate pharmacy benefit managers (PBMs).
11. Received an update on the work of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in completing its charge to develop a new NAIC model regulating PBMs. The Subgroup exposed a draft PBM Model Act for a public comment period ending Sept. 1. Following the end of the public comment period, the Subgroup will meet via conference call to discuss and consider revisions to the draft based on the comments received.
12. Heard a federal legislative update on congressional legislation and administrative actions of interest to the Committee.

Health Actuarial (B) Task Force

Aug. 4, 2020

1. Adopted its May 27, April 23 and Feb. 14 minutes, which included the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Adopted the ACA 2021 coronavirus (COVID-19) rate review guideline Excel template. The guideline was referred to the Health Insurance and Managed Care (B) Committee for consideration.
   c. Discussed the impact of COVID-19 on 2021 ACA rates.
   d. Adopted revisions to the Long-Term Care Experience Reporting Forms, as referred by the Long-Term Care Actuarial (B) Working Group. The forms were referred to the Senior Issues (B) Task Force and the Health Insurance and Managed Care Committee for their consideration.
2. Adopted the report of the Health Care Reform Actuarial (B) Working Group, which has not met in 2020. The Working Group plans to meet as needed via conference call to review any work by the State Rate Review (B) Subgroup pertaining to ACA rating regulations.
3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Aug. 4 and took the following action:
   a. Adopted its Jan. 23 and 2019 Fall National Meeting minutes, which included the following action:
      1. Adopted revisions to the Long-Term Care Experience Reporting Forms. The forms were referred to the Health Actuarial (B) Task Force for consideration.
   b. Adopted the report of the Long-Term Care Valuation (B) Subgroup, which has not met since the 2019 Fall National Meeting. A review group composed of Subgroup members continues to review Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) year-end 2019 filings.
   c. Adopted the report of the Long-Term Care Pricing (B) Subgroup, including its Feb. 6 and Jan. 6 minutes. During these meetings, the Subgroup took the following action:
      1. Discussed LTIC cash value buyouts to policyholders in lieu of rate increases.
      2. Discussed LTIC hybrid products.
   d. Heard an update from the Academy Long-Term Care Valuation Work Group.
   e. Heard an update on SOA on its Long-Term Care (LTC) Experience Study.
   f. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on 2021 ACA rate filings.
   g. Heard an update from the SOA on health insurance research.
   h. Heard an update from the Academy Council on Professionalism.
   i. Heard an update from the Academy Health Practice Council.

Regulatory Framework (B) Task Force
Aug. 4, 2020
1. Adopted its Feb. 20 and 2019 Fall National Meeting minutes, which included the following action:
   a. Appointed the MHPAEA (B) Working Group and adopted its 2020 proposed charges.
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Dec. 19, 2019, minutes. During this meeting, the Subgroup took the following action:
   a. Continued its discussion of the comments received on Section 1 through Section 5 of Model #171.
   b. Exposed Section 6 and Section 7 of Model #171 for a public comment period ending Feb. 7. The Subgroup had planned to begin meeting via conference call in February to complete its discussion of the comments received on Section 1 through Section 5 and begin discussion of the comments received on Section 6 and Section 7; however, due to the COVID-19 public health emergency and the loss of one of its co-chairs, the Subgroup has not met since December 2019.
3. Adopted the report of the ERISA (B) Working Group, which met July 31 minutes and took the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Discussed what the Working Group should focus on in 2021, including reviewing the Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220) to consider its continuing relevance.
   c. Reported that it met July 28 in regulator-to-regulator session pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
4. Adopted the report of the HMO Issues (B) Subgroup, including its July 13 minutes, but not including adoption of the proposed revisions to Model #430. During this meeting, the Subgroup took the following action:
   a. Adopted its June 11 minutes, which included the following action:
      1. Discussed the comments received by the public comment period ending March 18 on proposed revisions to Model #430 to address inconsistencies and redundancies in the model with the provisions in the Life and Health Insurance Guaranty Association Model Act (#520), which added health maintenance organizations (HMOs) as members of the guaranty association.
   b. Adopted proposed revisions to Model #430. The proposed revisions were referred to the Regulatory Framework (B) Task Force for consideration.
5. Adopted the report of the MHPAEA (B) Working Group, including its July 28 minutes. During this meeting, the Working Group took the following action:
   a. Adopted its June 24 minutes, which included the following action:
      1. Adopted its June 5 minutes, which included the following action:
         a. Adopted its March 19 and March 9 minutes, which included the following action:
            1. Discussed current and potential compliance tools available to the states related to the MHPAEA.
            2. Discussed its plan to operate similar to the ERISA (B) Working Group.
            3. Discussed its anticipated work for 2020 consistent with its 2020 charges.
         b. Discussed a draft quantitative treatment limitation/financial requirement (QTL/FR) template.
      2. Discussed the draft Working Group work plan.
3. Discussed the comments received on the draft QTL/FR template received by the June 18 public comment deadline.
   b. Heard a presentation on activities and work being done to assist self-funded group health plans and private employers to comply with mental health parity requirements under the MHPAEA.
   c. Heard a presentation from the American Psychiatric Association (APA) on state activities and legislation related to MHPAEA parity data reporting requirements.
   d. Discussed current parity compliance resources and tools available to the states to determine plan compliance with the MHPAEA parity requirements and potential resources and tools the Working Group developed to supplement, but not supplant, these existing tools and resources.
   e. Discussed next steps in developing supplemental MHPAEA parity compliance resources and tools for the states related to non-quantitative treatment limitations (NQTLs).
   f. Reported that it will meet July 29 in regulator-to-regulator session pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

6. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 16 minutes. During this meeting, the Subgroup took the following action:
   a. Discussed the ad hoc drafting group’s draft of a proposed new NAIC model regulating PBMs.
   b. Exposed the draft PBM Model Act for a public comment period ending Sept. 1. The Subgroup plans to meet via conference call in September to begin discussing any comments received.

7. Heard an update from the Center on Health Insurance Reforms’ (CHIR) work related to implementation of the ACA and other issues of interest to state insurance regulators. The update included a discussion of the CHIR’s efforts to track state activity related to COVID-19’s effect on private coverage of critical services. The CHIR is continuing to track and analyze developments under the ACA’s Section 1332 waiver program and state regulatory approaches to short-term, limited duration (STLD) plans. The CHIR is also continuing its work to track state reforms affecting the individual market and the affordability of comprehensive coverage. The presentation also highlighted the CHIR’s ongoing technical assistance regarding insurance regulatory matters, including state COVID-19 responses through the State Health and Value Strategies Program (SHVSP) and assistance provided to state and federal policymakers regarding regulatory approaches to balance billing.

8. Heard a panel presentation on health care sharing ministries (HCSMs). The CHIR discussed consumer confusion with HCSMs because of how they are marketed by some HCSMs and their similarity in many aspects to traditional health insurance plans, such as defined benefit packages, cost-sharing and premium-like payment requirements. A representative from Samaritan Ministries discussed suggestions for best practices for HCSMs to provide transparency and potentially reduce consumer confusion between HCSMs and traditional health insurance plans.

9. Heard a discussion on premium holidays, early medical loss ratio (MLR) rebate payments, and adjustments to cost-sharing benefits due to fewer claim filings in 2020 because of COVID-19. As part of this discussion, the federal Centers for Medicare & Medicaid Services (CMS) announced that it had just released guidance on a new temporary policy that will allow issuers to offer temporary premium reductions for individuals with 2020 coverage in the individual and small group markets. The guidance can be found at this link: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Markets/Downloads/Premium-Credit-Guidance.pdf.

Senior Issues (B) Task Force

Aug. 3, 2020

1. Adopted its March 3 and 2019 Fall National Meeting minutes, which included the following action:
   a. Discussed its 2020 agenda.
   b. Appointed the LTCI Model Update (B) Working Group, with a charge of determining whether the Long-Term Care Insurance Model Act (#640) and the Long-Term Care Insurance Model Regulation (#641) need to be updated.

2. Heard a federal legislative update, including an update on federal funding for the State Health Insurance Assistance Program (SHIP), as well as the work of the federal task force and its final report.

3. Discussed seniors and COVID-19; specifically, what the states are experiencing in regard to seniors putting off health care needs due to the pandemic.

4. Discussed misleading advertisements that have led seniors unknowingly off their current plan and into Medicare Advantage plans they did not ask for and, in most cases, do not need.

5. Discussed the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and Medicare. It was reported that too many seniors do not know that they must enroll in Medicare even if they are continuing to work past the age 65. A request was made for amendments to the Coordination of Benefits Model Regulation (#120) to help address this issue.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE
Aug. 12, 2020

1. Adopted its June 10 minutes, which included the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   c. Discussed regulatory actions related to COVID-19.
   d. Adopted the Private Passenger Auto Insurance Study.

2. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. See the Task Force listing for details.

3. Adopted the report of the Surplus Lines (C) Task Force. See the Task Force listing for details.

4. Adopted the report of the Title Insurance (C) Task Force. See the Task Force listing for details.

5. Adopted the report of the Workers’ Compensation (C) Task Force. See the Task Force listing for details.

6. Adopted the report of the Cannabis Insurance (C) Working Group, which has not met in 2020. Due to the prioritization of COVID-19 issues, it is unclear when the Working Group will next meet.

7. Adopted the report of the Catastrophe Insurance (C) Working Group, which met July 31 and took the following action:
   a. Adopted its May 29 minutes, which included the following action:
      1. Adopted its 2019 Fall National Meeting minutes.
      2. Adopted the NAIC State Disaster Response Plan.
   b. Heard an update regarding federal flood insurance. The National Flood Insurance Program (NFIP) is under its 15th short-term extension, which will expire at the end of September. The NAIC sent a letter to U.S. House of Representatives and U.S. Senate leaders urging action on a long-term reauthorization. Additionally, the Federal Emergency Management Agency (FEMA) released a guide to help emergency managers and public health officials prepare for disasters while continuing to respond to the coronavirus pandemic.
   c. Heard a presentation from Milliman on the concept of a catastrophe modeling clearinghouse.
   d. Heard a presentation from the Reinsurance Association of America (RAA) on catastrophe modeling.
   e. Heard a presentation from the American Property Casualty Insurance Association (APCIA) on catastrophe modeling.
   f. Heard a presentation from the NAIC Center for Insurance Policy and Research (CIPR) regarding the CIPR wildfire catastrophe modeling project.

8. Adopted the report of the Climate Risk and Resilience (C) Working Group, which met July 31 and took the following action:
   a. Adopted its June 18 minutes, which included the following action:
      1. Received an update on the drafting of the “Insurance Regulatory Discussion Points on Catastrophic Events” document.
      2. Heard an update on California’s development of a sustainable insurance roadmap.
   c. Heard an update on California’s Climate Smart Insurance Product Database. The database lists more than 400 internationally available products that address climate risks, harness new technologies and build resilience.
   d. Heard a presentation on Swiss Re’s approach to climate change and sustainable insurance products. Swiss Re uses an Insurance Resilience Index to measure the contribution to the financial stability of households and organizations. The index indicates the insurance gap has been increasing from 2000 to 2018, with the largest growing protection gap being health.
   e. Heard a presentation on Allianz’s approach to climate change and sustainable insurance products. Allianz views climate change as a risk driver to be managed as part of overarching risk governance architecture. With a focus on decarbonizing investments and strengthening its climate risk disclosure, Allianz uses six criteria to identify sustainable products with a specific environmental and social added value.
   f. Heard a presentation on the APCIA’s domestic and international climate risk-related activities.

9. Adopted the report of the Lender-Placed Insurance Model Act (C) Working Group, which has not met in 2020. The Working Group plans to meet via conference call to complete the drafting of a new model law concerning lender-placed insurance as it relates to mortgages.
10. Adopted the report of the Pet Insurance (C) Working Group, including its July 16 minutes. During this meeting, the Working Group took the following action:
   a. Adopted its March 5 minutes, which included the following action:
      1. Adopted its Feb. 19 minutes, which included the following action:
         a. Adopted its Dec. 19, 2019, minutes, which included the following action:
            1. Discussed Section 3 of the draft Pet Insurance Model Act.
            2. Discussed Section 2 and Section 3 of the draft Pet Insurance Model Act.
      2. Discussed draft referrals for data collection.
      3. Discussed a draft supplement for the annual financial statement.
   b. Discussed Section 4 of the draft Pet Insurance Model Act.

11. Adopted the report of the Terrorism Insurance Implementation (C) Working Group, which met July 30 and took the following action:
   a. Adopted its March 12 minutes, which included the following action:
      1. Adopted its Feb. 11 minutes, which included the following action:
         a. Adopted its 2019 Fall National Meeting minutes.
         b. Discussed the status of the 2020 data call.
         c. Discussed updates to the model bulletin and policyholder disclosures.
      2. Adopted the model bulletin and policyholder disclosures.
   b. Received an update on the 2020 joint state insurance regulator/U.S. Department of the Treasury terrorism risk insurance data call, with data due to both entities by May 15, and the state supplement, which collects ZIP code-level data, with data due Sept. 30.
   c. Heard an overview of the workers’ compensation terrorism risk insurance market, including state-level data on average premiums and take-up rates from 2011 to 2017.
   d. Heard a presentation from NAIC staff regarding results from the state supplement portion of the terrorism risk insurance data call, including take-up rates, average premium rates, portions of premium allocated to terrorism risk and percent of exposures covered by terrorism insurance, at a ZIP code level.

12. Adopted the report of the Transparency and Readability of Consumer Information (C) Working Group, which met July 30 and took the following action:
   a. Adopted its July 16 and June 16 minutes, which included the following action:
      1. Discussed creating social media content and the best formats to use to communicate with consumers.
      2. Discussed flood insurance disclosures.
      3. Heard a presentation from the APCIA, the NAIC Communications Division and consumer representatives regarding best practices each have discovered when using social media to communicate with consumers.
   b. Discussed the need for consumer disclosures regarding significant premium increases on P/C insurance products. States discussed their concerns and solutions for communicating information to consumers regarding premium increases. The Working Group plans to collect and compile information from the states regarding processes that are already in place.


14. Adopted the white paper, Workers’ Compensation Policy and the Changing Workforce, which explores how changes in work and the evolving landscape of legal employment are shifting responsibility for coverage and benefits for occupational injuries, illnesses and fatalities.

15. Adopted the NAIC State Disaster Response Plan, which provides a template for state departments of insurance (DOIs) to use when assisting consumers before, during and after a disaster.

16. Received a recap of the FEMA and DOI disaster workshops.

17. Received a preview of the Southeast Zone flood workshop.

18. Heard a presentation on building codes from the International Code Council (ICC).


20. Heard a proposal from the CEJ to collect additional homeowners and auto insurance data within the annual financial statement.

21. Heard a presentation on race and P/C insurance, including an overview of historical studies related to the issue.
Casualty Actuarial and Statistical (C) Task Force
Aug. 5, 2020

1. Adopted its July 14, May 19, Feb. 18 and Jan. 28 and 2019 Fall National Meeting minutes, which included the following action:
   a. Adopted the report of the Actuarial Opinion (C) Working Group, including its June 11 minutes. During this meeting, the Working Group took the following action:
      1. Discussed potential revisions to the risk repository in the Financial Condition Examiners Handbook.
   b. Discussed a proposed COVID-19 data call.
   c. Adopted a recommendation to the Casualty Actuarial Society (CAS)/SOA task force to defer implementation of the CAS/ SOA continuing education (CE) log for 2020 and allow appointed actuaries to add a column to their existing CE log, indicating the categorization approved by the Task Force (“Appointed Actuary CE Log Categories”).
   e. Discussed the white paper, Regulatory Review of Predictive Analytics.
   g. Adopted a response to the Actuarial Standards Board (ASB) request for input on a potential Actuarial Standard of Practice (ASOP) on P/C rate filings.
   h. Discussed letters the state insurance departments have received from the SOA regarding the definition of “qualified actuary” in state law.
   i. Adopted proposed revisions to the 2020 Annual Statement Instructions to implement the CAS/SOA Appointed Actuary Continuing Education Verification Process. The proposed revisions were referred to the Blanks (E) Working Group for consideration.

2. Adopted the report of the Actuarial Opinion (C) Working Group, which has met in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss examination procedures and other related issues. On July 13, the Working Group exposed, for a 45-day public comment period ending Aug. 27, proposed revisions to the Financial Analysis Handbook and the Financial Condition Examiners Handbook.

3. Adopted the report of the Statistical Data (C) Working Group, which has not met in 2020. The Working Group will begin its work in September.


5. Discussed comments on the white paper, Regulatory Review of Predictive Analytics.


7. Heard reports from the Academy regarding the activities of its Committee on Property and Liability Financial Reporting (COPLFR) and its Casualty Practice Council.

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

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

10. Discussed COVID-19 data calls for multiple lines of insurance.

Surplus Lines (C) Task Force
Aug. 5, 2020

1. Adopted its 2019 Fall National Meeting minutes.

2. Adopted the report of the Surplus Lines (C) Working Group, which met June 29, 2020, March 10, 2020, and Dec. 18, 2019, in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities and individuals) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group approved seven applications for the Quarterly Listing of Alien Insurers.

3. Adopted its 2021 proposed charges. No substantive changes were proposed for the charges.

4. Discussed a memorandum that outlined three potential courses of action regarding modifications to the Nonadmitted Insurance Model Act (#870). The Task Force chair directed NAIC staff to develop a drafting group to produce a summary document that outlines the significant updates needed to modernize Model #870.

5. Discussed comments received regarding a 2021 annual blanks proposal regarding the modification of Schedule T to include a new Part 3 that would add details on “home state” direct premiums written. Following a lengthy discussion, the Task Force tabled the proposal.
Title Insurance (C) Task Force
Aug. 5, 2020
1. Heard a presentation from Veritable Data Solutions on its new smartphone app created to help notaries serve as gatekeepers against identity theft, forgery and title fraud. The app, called Veri-Lock, uses blockchain to ensure the authenticity of notarized documents.
2. Heard a panel discussion on the effectiveness of closing protection letters (CPLs). The American Land Title Association (ALTA) discussed industry safety practices that were reported in its May survey. Old Republic National Title Insurance Company discussed closing protection benefits to insureds and the marketplace. Land Title Guarantee Company discussed market practices from an agent perspective, including changes made to adjust to the pandemic.

Workers’ Compensation (C) Task Force
Aug. 5, 2020
1. Adopted its July 22 and June 2 minutes, which included the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Adopted the white paper, *Workers’ Compensation Policy and the Changing Workforce*.
   d. Discussed key topics and future work product regarding workers’ compensation issues related to COVID-19.
2. Heard a presentation from the Reed Group, which is the owner and publisher of MDGuidelines, on workers’ compensation treatment guidelines and formularies. The Reed Group discussed what it learned from applying these guidelines to California’s workers’ compensation system, in addition to discussing the remaining challenges.
3. Heard a presentation from the National Council on Compensation Insurance (NCCI) regarding issues related to COVID-19 and the NCCI’s Atlas initiative. The NCCI discussed the actions it took regarding the COVID-19 pandemic, as well as discussed some of the presumptions and legislative actions occurring in various states.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE
Aug. 11, 2020
1. Adopted its July 27 minutes, which included the following action:
   a. Adopted a farmowners claims standardized data request (SDR).
   b. Adopted revisions to the Market Conduct Annual Statement (MCAS) blanks for the life and annuities, homeowners, private passenger automobile, and lender-placed auto and homeowners lines of business.
   c. Adopted an “Limited Long-Term Care Examination Standards” chapter to be included in the Market Regulation Handbook.
2. Adopted an inland marine in force SDR and an inland marine claims SDR to be included in the Market Regulation Handbook. These data requests may be used by a state to determine if a company follows appropriate procedures with respect to the issuance and/or termination of inland marine policies and the processing of inland marine claims.
3. Adopted the report of the Antifraud (D) Task Force. See the Task Force listing for details.
5. Adopted the report of the Producer Licensing (D) Task Force. See the Task Force listing for details.
6. Adopted the report of the Advisory Organization Examination Oversight (D) Working Group, which met July 28 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
7. Adopted the report of the Market Actions (D) Working Group, which meets regularly in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
8. Adopted the report of the Market Conduct Annual Statement Blanks (D) Working Group, which met July 31 and took the following action:
   a. Adopted its June 24 minutes, which included the following action:
      1. Adopted its May 28, May 27, May 21 and May 20 minutes, which included the following action:
         a. Adopted its May 6 minutes, which included the following action:
            1. Adopted its Dec. 17, 2019, minutes, which included the following action:
               1. Adopted its Nov. 21, 2019, minutes.
               2. Discussed the review of the MCAS for the life and annuities lines of business.
               3. Discussed the review of the MCAS for the homeowners and private passenger automobile lines of business.
               4. Discussed vendor single-interest concerns for the lender-placed MCAS.
               5. Discussed the MCAS data call for the “other health” lines of business, as adopted by the Market Analysis Procedures (D) Working Group.
f. Discussed the extraordinary circumstance definition for health extension requests.
b. Discussed the review of the MCAS for the life and annuities lines of business.
c. Discussed the review of the MCAS for the homeowners and private passenger auto lines of business.
d. Discussed vendor single-interest concerns for the lender-placed MCAS.
e. Discussed the MCAS data call for the “other health” line of business, as adopted by the Market Analysis Procedures (D) Working Group.

2. Received an update on existing MCAS reviews and the other health MCAS development.
3. Adopted a $50,000 premium threshold for the private flood MCAS reporting.
   a. Discussed survey results and adopted various changes to the MCAS blanks and Data Call and Definitions for the life and annuities, homeowners and private passenger auto MCAS lines of business.
   b. Adopted edits to the lender-placed insurance MCAS regarding blanket vendor single-interest.
   c. Adopted a motion to add an interrogatory for the homeowners and private passenger auto MCAS.

2. Discussed and approved needed clarifications to several MCAS blanks and Data Call and Definitions following the adoption of edits to the life and annuities, homeowners and private passenger auto lines of business.
   a. Discussed homeowners MCAS clarifications related to newly added underwriting data elements.
   b. Discussed possible MCAS updates previously tabled for further discussion.
   c. Heard and discussed industry concerns with addition of newly adopted data element to collect claims closed without payment below the deductible for the private passenger auto MCAS.

10. Adopted the report of the Market Conduct Examination Standards (D) Working Group, including its July 23 minutes. During this meeting, the Working Group took the following action:
   a. Adopted its March 4 minutes, which included the following action:
      1. Adopted its Dec. 18, 2019, minutes, which included the following action:
         b. Discussed a new chapter of limited LTCI examination standards for inclusion in the Handbook. The new examiner guidance is based on the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643).
      2. Discussed draft limited LTCI examination standards for inclusion in the Handbook, which was a carryover item from 2019.
      3. Discussed a new inland marine in force policies SDR and an inland marine claims SDR for incorporation into the reference documents of the Handbook.
      4. Discussed its 2020 charges and potential tasks.
   b. Adopted the Dec. 11, 2019, draft of new “Conducting the Limited Long-Term Care Examination” chapter for inclusion in the Handbook.

11. Adopted the report of the Market Analysis Procedures (D) Working Group, which met July 30 and took the following action:
   a. Adopted its March 23 minutes, which included the following action:
      1. Adopted its Feb. 20 minutes, which included the following action:
         a. Adopted its Jan. 30 minutes, which included the following action:
            1. Adopted its 2019 Fall National Meeting minutes.
            2. Discussed revisions to the MCAS Best Practices Guide.
            3. Discussed a proposal to add travel insurance as the next MCAS line of business.
         b. Discussed revisions to the MCAS Best Practices Guide.
         c. Discussed a proposal to add travel insurance as the next MCAS line of business.
         d. Discussed private flood MCAS scorecard ratios.
      2. Discussed revisions to the MCAS Best Practices Guide. When the revisions are completed, the drafting group will move on to other MCAS documents.
      3. Discussed potential MCAS filing issues arising from work adjustments due to COVID-19. The Working Group agreed to a blanket extension of all lines of business due dates of 60 days. NAIC staff will send each jurisdiction’s MCAS contact a confirming email regarding the extension of the due date.
      4. Adopted travel insurance as the next MCAS line of business.
   b. Discussed the revisions to the MCAS Best Practices Guide. The updates to date were reviewed, and the drafting group will resume its work on the revisions.
   c. Discussed the Market Analysis Framework and asked for comments to be reviewed by the Working Group at its next meeting.
d. Adopted scorecard ratios for the private flood MCAS blank. The ratios closely match the homeowners and private passenger auto MCAS scorecard ratios, with the addition of a ratio to measure lawsuits closed with consideration for the consumer.
e. Discussed the MCAS attestation process. No changes to the current process were made.

12. Adopted the report of the Market Regulation Certification (D) Working Group, including its Feb. 20 minutes. During this meeting, the Working Group took the following action:
a. Adopted its Jan. 30 minutes, which included the following action:
   1. Adopted its Nov. 20, 2019, minutes.
   2. Discussed the pilot volunteers’ suggested revisions to the Voluntary Market Regulation Certification Program.
b. Discussed the pilot volunteers’ suggested revisions to the Voluntary Market Regulation Certification Program.
c. Discussed pass and fail metrics.

13. Adopted the report of the Privacy Protections (D) Working Group, which met July 30 and took the following action:
a. Adopted its May 5 minutes, which included the following action:
   1. Adopted its Feb. 19 minutes, which included the following action:
      a. Adopted its 2019 Fall National Meeting minutes.
      b. Heard an update on state and federal privacy legislation.
      c. Discussed its next steps.
   2. Heard an update on state and federal privacy legislation.
   3. Discussed comments received on the *NAIC Insurance Information and Privacy Protection Model Act (#670)*.
b. Heard an update on state and federal privacy legislation.
c. Heard a presentation that included a comparative analysis and comments from the Blue Cross and Blue Shield Association (BCBSA) and Arbor Strategies LLC on behalf of the Health Coalition.
d. Reviewed plans to begin a gap analysis discussion by Working Group members, interested state insurance regulators and interested parties using the *Privacy of Consumer Financial and Health Information Regulation (#672)* as a baseline model.

14. Adopted the Market Information Systems (D) Task Force’s recommendation to add a “pandemic” subject code and the coverage codes for “business interruptions,” “lender-placed insurance” and “pet insurance” to the NAIC’s Complaint Database System.

15. Adopted the Market Analysis Procedures (D) Working Group’s recommendation to add travel insurance as the next line of business for the MCAS and implement new scorecard ratios for the private flood MCAS blank.

16. Adopted the Market Conduct Annual Statement Blanks (D) Working Group’s recommended clarification to the definition of “individual indexed variable annuity” for the MCAS blank.

17. Heard a presentation from the Alliance of Health Care Sharing Ministries (Alliance). This presentation addressed the background of the Alliance, its history and features, statistics on the number and size of health care sharing ministries (HCSMs), challenges for HCSMs, and the development of an accreditation program for oversight of HCSMs by an independent board of directors.

18. Discussed a template bulletin for state insurance departments to advise insurance companies regarding the waiver of on-site review requirements of managing general agents (MGAs) and third-party administrators (TPAs) during the COVID-19 public health emergency.

**Antifraud (D) Task Force**

*Aug. 3, 2020*

1. Adopted its May 20 minutes, which included the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Received updates concerning antifraud activity specific to COVID-19 from California, Delaware, Florida and Ohio.
   c. Heard updates concerning antifraud activity specific to COVID-19 from the Coalition Against Insurance Fraud (CAIF), the Healthcare Fraud Prevention Partnership (HFPP), the National Healthcare Antifraud Association (NHCAA) and the National Insurance Crime Bureau (NICB).

2. Received updates concerning antifraud activity specific to COVID-19 from California, Florida and Texas.

3. Heard an update concerning antifraud activity specific to COVID-19 from the CAIF.

4. Received an update from the Antifraud Education Enhancement (D) Working Group. The Working Group updated and finalized the content of the “Safety Training for Private Sector Field Employees,” which will be held Aug. 26. The Working Group also updated and finalized the content of the Investigator Safety Training program, which will be held Sept. 30.

5. Received an update from the Antifraud Technology (D) Working Group. The Working Group has worked with NAIC staff to update a revised draft of the *Antifraud Plan Guideline (#1690)*. The Working Group will expose the draft for a public comment period, with conference calls scheduled for September and October to discuss any comments received.

6. Heard reports on antifraud activity from the NICB and the CAIF.
Market Information Systems (D) Task Force
Aug. 4, 2020
1. Adopted its 2019 Fall National Meeting minutes.

2. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met July 22 and July 8 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings.

3. Heard a report on the following Uniform System Enhancement Request (USER) forms: USER form 10051; USER form 10053; USER form 10069A; USER form 10080; USER form 10072; USER form 10069B; and USER form 10082.

4. Adopted USER Form 10069B and USER form 10082 to add an NAIC Complaints Database System (CDS) subject code of “pandemic” and coverage codes for “lender-placed insurance” and “pet insurance.”

5. Heard a presentation on the use of artificial intelligence (AI) in market information.

Producer Licensing (D) Task Force
Aug. 3, 2020
1. Adopted its May 6 minutes, which included the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Discussed producer licensing issues arising from COVID-19, which included a review of suggested practices for the issuance of temporary producer licenses and state implementation of online, proctored examinations.
   c. Discussed uniform and reciprocal licensing of independent adjusters.

2. Discussed producer licensing issues arising from COVID-19. This discussion primarily focused the state implementation of online, proctored examinations. It was reported that 15 states have implemented online, proctored examinations. State insurance regulators generally indicated that approximately 50%-60% of all examinations are now online, proctored examinations. Industry representatives encouraged additional state implementation of online, proctored examinations. The industry all requested that the states continue to work with the industry to convert temporary licenses to permanent licenses. Examination vendors reported that they continue to work with the states to implement online examinations. The examination vendors said they can generally implement online examinations for a state in less than 60 days, and it could be as short as one week.

3. Received an update from the Producer Licensing Uniformity (D) Working Group. The activity of this Working Group has been on hold during the COVID-19 crisis, but it will resume its work in the second half of 2020.

4. Received an update from the Uniform Education (D) Working Group. The activity of this Working Group has been on hold during the COVID-19 crisis, but it will resume its work in the second half of 2020.

5. Received a report from the NIPR Board of Directors. Since the onset of the COVID-19 crisis, 48 states have issued more than 100 separate bulletins regarding producer licensing. Thirty-three bulletins specifically address license renewal extensions, and 30 states issued bulletins offering temporary licensing. These bulletins and state changes required NIPR to complete significant coding work to move the states’ license expiration dates and provide an electronic solution for a new temporary producer license class through NIPR. NIPR has also been developing enhancements to its Attachments Warehouse product, which allows insurance producers and other licensees to upload licensing related documents for review by state insurance regulators.

FINANCIAL CONDITION (E) COMMITTEE
Aug. 11, 2020
1. Adopted its July 1, June 12, May 15 and March 26 minutes, which included the following action:
   a. Adopted its Feb. 27 and 2019 Fall National Meeting minutes, which included the following action:
      1. Adopted a Request for NAIC Model Law Development from the Receivership and Insolvency (E) Task Force to amend Model #440 and Model #450 to address issues regarding continuity of essential services.
      2. Adopted a request for extension from the Mortgage Guaranty Insurance (E) Working Group to amend Model #630.
      3. Adopted a request from the Financial Stability (EX) Task Force to amend Model #440 and Model #450 to establish regulatory authority to require liquidity stress testing processes and confidentiality protections for the data reported from the liquidity stress tests.
   b. Adopted technical revisions to Model #787 and acknowledged the similar technical revisions made to AG 48 by the Life Insurance and Annuities (A) Committee.
   c. Adopted actions from the Capital Adequacy (E) Task Force, the Valuation of Securities (E) Task Force, and the Accounting Practices and Procedures (E) Task Force, with the exception of Interpretation (INT) 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends, which was rejected and sent back to the Accounting Practices and Procedures (E) Task Force.
d. Discussed INT 20-08 and agreed to send it back to the Accounting Practices and Procedures (E) Task Force for additional revision.

e. Adopted a memorandum from the Committee to all NAIC members regarding the treatment of the LIBOR under state investment laws.

f. Adopted guidance for troubled debt restructurings for March 31 – Sept. 30 statutory financial statements and related interim risk-based capital (RBC) filings (where required).

g. Adopted guidance for troubled debt restructurings for March 31 – June 30 statutory financial statements and related interim RBC filings (where required).


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

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

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

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

7. Adopted the report of the Group Capital Calculation (E) Working Group, which met July 29 and took the following action:
   a. Adopted its July 21, June 2 and May 19 minutes, which included the following action:
      1. Adopted its 2019 Fall National Meeting minutes.
      2. Continued to make decisions on previously exposed aspects of the group capital calculation (GCC), including the template, instructions and legislation authority.
   b. Discussed comments received on exposed revised template and instructions and directed NAIC staff to make various changes as discussed during the meeting. Further discussion is expected.

8. Adopted the report of the Group Solvency Issues (E) Working Group, which met July 29 and took the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Reported that it met Feb. 11 in regulator-to-regulator pursuant to paragraph 6 (consultations NAIC with staff on technical guidance) of the NAIC Policy Statement on Open Meetings.
   c. Heard an update on the ongoing work of the ORSA Implementation (E) Subgroup, which met July 13 in joint session with the Risk-Focused Surveillance (E) Working Group. The meeting was held in regulator-to-regulator session pursuant to paragraph 3 (discussions of specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Groups took the following action:
      2. Discussed scheduling a conference call to discuss the impact of COVID-19 on ORSA filings.
   d. Heard an update on recent group-related activities of the IAIS, including the status of ongoing projects of the IAIS Insurance Groups Working Group.
   e. Discussed a request from the Group Capital Calculation (E) Working Group to quantify and evaluate the impact of XXX/AXXX reserves held by grandfathered captives on an insurance groups’ overall capital positions. Noted that a drafting group of state insurance regulators has been appointed to address the request and present its results to the full Working Group.
   f. Discussed comments received on the exposure of a gap analysis conducted by NAIC staff to compare elements of the IAIS’ Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) against existing practices in state solvency regulation. As a result of the discussions, the Working Group agreed to appoint drafting groups to develop targeted enhancements to NAIC handbooks and the NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual for further consideration by the Working Group in ComFrame implementation.

9. Adopted the report of the Financial Analysis (E) Working Group, which met July 15, June 17, May 13, May 12, May 6 and May 5 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses related to second-quarter 2019 financial results.

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

11. Adopted a revised INT 20-08, as referred by the Accounting Practices and Procedures (E) Task Force.

Accounting Practices and Procedures (E) Task Force

Aug. 3, 2020

1. Adopted its July 22, June 22, and 2019 Fall National Meeting minutes, which included the following action:
   a. Adopted revisions to INT 20-08. These revisions were requested by the Financial Condition (E) Committee to add flexibility, which allows a limited-time exception to apply other underwriting expense treatment for certain policies.
c. Adopted INT 20-08 as adopted by the Statutory Accounting Principles (E) Working Group on June 15. This was adopted by a separate vote of the Task Force.

d. Adopted the report of the Blanks (E) Working Group, including its May 28 minutes. During this meeting, the Working Group took the following action:

1. Adopted its Dec. 17, 2019, minutes, which included the following action:
   b. Adopted two items previously exposed:
      2. 2019-27BWG – Remove the alphabetic index from inclusion at the back of the annual financial statement blank, instructions and Blanks (E) Working Group page on the NAIC website.
   c. Adopted its procedures.
   d. Exposed four proposals:
      1. 2019-25BWG – Modify the instruction for Column 10 (Schedule F, Part 3 – Property and Schedule F, Part 2 – Life/Fraternal Workers’ Compensation Carve-out supplement) to remove instruction to exclude adjusting and other reserves from the column and add instruction to include those reserves with the defense and cost containment reserves. Add a new instruction for Column 12 for the same schedules. Add crosschecks to Schedule P, Part 1.
      2. 2019-28BWG – Modify the instruction for Supplemental Investment Risk Interrogatories Line 13.02 through Line 13.11 clarifying when to identify the actual equity interests within a fund and aggregate those equity interests for determination of the 10 largest equity interests.
      4. 2019-30BWG – Add a category and instructions for Reciprocal Jurisdiction Companies in Schedule S for the life/fraternal and health blanks and to Schedule F for the property and title blanks. Add a list of identification numbers in instruction to Schedule Y, Part 1A; Schedule Y, Part 2; and Schedule D, Part 6, Section 1 for reciprocal jurisdiction companies. Add a reference to reciprocal jurisdiction companies in the Trusteed Surplus Statement instructions for life/fraternal, health and property financial statements.
   e. Adopted its editorial listing.

2. Adopted 24 proposals:

   a. 2019-25BWG – Modify the instruction for Column 10 (Schedule F, Part 3 – Property and Schedule F, Part 2 – Life/Fraternal Workers’ Compensation Carve-out supplement) to remove instruction to exclude adjusting and other reserves from the column and add instruction to include those reserves with the defense and cost containment reserves. Add a new instruction for Column 12 for the same schedules. Add crosschecks to Schedule P, Part 1.
   b. 2019-28BWG – Modify the instruction for Supplemental Investment Risk Interrogatories Line 13.02 through Line 13.11 clarifying when to identify the actual equity interests within a fund and aggregate those equity interests for determination of the 10 largest equity interests.
   c. 2019-29BWG – Modify the instruction and blank for Supplemental Investment Risk Interrogatories Question 14.01.
   d. 2019-30BWG – Add a category and instructions for Reciprocal Jurisdiction Companies in Schedule S for the life/fraternal and health blanks and to Schedule F for the property and title blanks. Add a list of identification numbers in instruction to Schedule Y, Part 1A; Schedule Y, Part 2; and Schedule D, Part 6, Section 1 for reciprocal jurisdiction companies. Add a reference to reciprocal jurisdiction companies in the Trusteed Surplus Statement instructions for life/fraternal, health and property financial statements.
   f. 2020-03BWG – Modify the instruction and illustration for 13(11) to the Notes to Financial Statement. Change the numbering from 1 through 13 to A through M to reflect the disclosure addition for Statement of Statutory Accounting Principles (SSAP) No. 41R—Surplus Notes being adopted by the Statutory Accounting Principles (E) Working Group and correct the instruction.
   g. 2020-04BWG – Modify the instruction and illustration for Note 23A – Unsecured Reinsurance Recoverables to reflect the disclosure addition for SSAP No. 62R—Property and Casualty Reinsurance being adopted by the Statutory Accounting Principles (E) Working Group.
h. 2020-05BWG – Modify the instruction and illustration for Note 2 – Accounting Changes and Correction of Errors to reflect the disclosure addition for SSAP No. 3—Accounting Changes and SSAP No. 51R—Life Contracts being adopted by the Statutory Accounting Principles (E) Working Group.

i. 2020-07BWG – Add new disclosure Note 23 – Reinsurance for reinsurance credit (Note 23H – Life/Fraternal, Note 23E – Health and Note 23K – Property) to reflect the disclosure additions for SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance being adopted by the Statutory Accounting Principles (E) Working Group.

j. 2020-08BWG – Add a disclosure instruction for 10C to the Notes to Financial Statement for related party transactions not captured on Schedule Y to reflect the disclosure addition for SSAP No. 25—Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties being adopted by the Statutory Accounting Principles (E) Working Group. Combine existing 10C into 1B instructions and illustration narrative.

k. 2020-09BWG – Modify the Annual Statement Instructions for Schedule F, Part 3 to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified and reciprocal reinsurance.

l. 2020-10BWG – Revise the column 10 header in the Variables Annuities Supplement Blank to be Contract Level Reserves Less Cash Surrender Value. Revise the line descriptions in Lines 1 through 3 in the footer and add a line for the Reserve Credit from Other Reinsurance and for Post-Reinsurance Ceded Aggregate Reserve. Adjust the instructions to correspond with changes made to the blanks, as well as changes in the 2020 Valuation Manual for the new Variable Annuities Framework.

m. 2020-11BWG – For the VM-20 Reserves Supplement Blank, split Part 1 into Part 1A and Part 1B.

n. 2020-12BWG – The proposal will require appointed actuaries to attest to meeting CE requirements and participate in the CAS/SoA CE review procedures, if requested.

o. 2020-13BWG – Remove Line 24.04 from the General Interrogatories, Part 1 and renumber remaining lines for Interrogatory Question 24. Modify Lines 24.05 and 24.06 to require reporting amounts for conforming and nonconforming collateral programs.

p. 2020-14BWG – Modify the columns and rows on the blank pages for the Long-Term Care Experience Reporting Form 1 through Form 5 and make appropriate changes to the instructions for those forms.

q. 2020-15BWG – Contains a new Private Flood Insurance Supplement collecting residential and commercial private flood insurance data and revisions to the Credit Insurance Experience Exhibit (CIEE) to collect lender-placed flood coverages.

r. 2020-16BWG – Modify Question 3.1 and Question 3.2 of General Interrogatories Part 2 and provide instructions.

s. 2020-17BWG – Adjust the asset valuation reserve (AVR) presentation to include separate lines for each of the expanded bond designation categories.

t. 2020-18BWG Modified – Clarify the instructions to indicate which funds reported on Schedule D, Part 2, Section 2 (annual filing) and Schedule D, Part 3 and Part 4 (quarterly filing) must have an NAIC designation, NAIC designation modifier, and SVO administrative symbol. Modify the reference to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) found in the following investment instructions.

u. 2020-19BWG – Add a code of “%” to the code column for all investments which have been reported on Schedule DA, Part 1 and Schedule E, Part 2 for more than one consecutive year. Add certification to the General Interrogatories, Part 1 inclusion of these investments on Schedule DA, Part 1 and Schedule E, Part 2 (SAPWG 2019-20).

v. 2020-20BWG – For Schedule D, Part 1, add code “10” to Column 26 – Collateral Type for ground lease financing. Renumber “Other” code to “11.”

w. 2020-21BWG – Add a new line 4.05 for valuation allowance for mortgage loans to the Summary Investment Schedule and renumber existing line 4.05 to 4.06. Modify the instructions to include a crosscheck for new line 4.05 back to Schedule B – Verification Between Years. Clarify the instructions for 4.01–4.04 to explicitly show crosschecking to Column 8 of Schedule B, Part 1.

x. 2020-23BWG – Add footnote to Exhibit 5 (life/fraternal & health – life supplement) and Exhibit 3 separate accounts to disclose cases when a mortality risk is no longer present or a significant factor; i.e., due to a policyholder electing a payout benefit (SAPWG 2019-08).

3. Adopted its editorial listing.

2. Adopted its 2021 proposed charges, which include one change to the charges for each Working Group:
   a. For the Blanks (E) Working Group, a charge regarding changes to the investment schedules was updated to reference that Capital Adequacy (E) Task Force and all of its working groups instead of a single working group.
   b. For the Statutory Accounting Principles (E) Working Group, a charge to update accounting and reporting to reflect the changes to Model #785 and Model #786 is complete and was deleted.
3. Adopted the report of the Statutory Accounting Principles (E) Working Group, which met July 30 and took the following action:
   a. Adopted its July 15, June 15, May 20, May 5, April 17, April 15, March 26 and March 18 minutes, which included the following action:
      1. Exposed INT 20-09: Basis Swaps as a Result of the LIBOR Transition.
      2. Adopted the consensus in INT 20-08 with modifications.
      3. Exposed agenda item 2020-16EP.
      4. Discussed ACA risk corridors and actions by the U.S. Supreme Court.
   b. Adopted the following substantive revisions to statutory accounting guidance:
      1. Revisions update the reporting line for qualifying cash pools and make clarifying edits.
      2. Revisions eliminate references to the NAIC Bond Fund List in SSAP No. 26R—Bonds and add reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R—Unaffiliated Common Stock.
      3. Revisions clarify that the accounting and reporting of investment income and capital gain/loss, due to early liquidation either through a called bond or a tender offer, shall be similarly applied. This adoption has a Jan. 1, 2021, effective date with early adoption permitted.
      4. Revisions specify that voluntary decisions to choose one allowable reserving methodology over another, which requires commissioner approval under the Valuation Manual, shall be reported as a change in valuation basis.
      5. Revisions add disclosure elements for reported goodwill. The additional disclosures will improve the validity and accuracy of the financial statements, and they will assist with state insurance regulators’ review of reported assets that are not readily available for policyholder claims. These disclosure revisions will be effective for the 2021.
      6. Revisions ensure reporting consistency in that derivatives are reported “gross”; i.e., without the inclusion of financing components. Additionally, amounts owed to/from the reporting entity from the acquisition or writing of derivatives shall be separately reflected. The revisions are effective of Jan. 1, 2021.
      7. INT 20-09. Basis swaps are compulsory derivatives issued by central clearing parties (CCPs) in response to the market-wide transition away from the LIBOR. The interpretation directs that the basis swaps be reported as “hedging - other” and at fair value, thus qualifying for admittance. To be considered or reported as an “effective” hedging, the instrument must qualify as a highly effective hedge under SSAP No. 86—Derivatives.
   c. Adopted the following nonsubstantive revisions to statutory accounting guidance:
      1. Revisions require the identification/disclosure of cash equivalents, or substantially similar investments, that remain on the same reporting schedule for more than one consecutive reporting period. This is an expansion of the current disclosure requirements that only referenced short-term investments and to clarify that the disclosure is satisfied through the use of the code on the investment schedules.
      2. Revisions update the amortization guidance for leasehold improvements. The updated language will allow leasehold improvements to have lives that match the associated lease term, which agrees with U.S. generally accepted accounting principles (GAAP).
      3. Revisions clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation, a disclaimer of control does not eliminate the classification as a related party, and disclosure of material transactions are required under SSAP No. 25. The revisions also propose rejection of several U.S. GAAP standards addressing variable interest entities and update disclosures.
      4. Revisions clarify that perpetual bonds shall be reported at fair value, not to exceed any currently effective call price, with a proposed effective date of Jan. 1, 2021, with early application permitted.
      5. Revisions clarify that a participant’s financial rights in a mortgage participation agreement may include the right to take legal action against the borrower or participate in the determination of legal action, but they do not require that the participant has the right to solely initiate legal action; foreclosure; or to communicate with the borrower.
      7. Exposed agenda item to solicit comments on two options for the accounting of credit tenant loans (CTLs). The Valuation of Securities (E) Task Force will be notified of this exposure with a request for further confirmation that an SVO listing could be developed to capture the CTLs that meet the SVO’s structural and legal analysis and possess bond characteristics.
8. Exposed agenda item to solicit comments on the development of more explicit guidance for policyholder refunds and other premium adjustments. Assistance from industry was requested in developing principles-based guidance, particularly for the varieties of data-telematics policies.

9. Revisions clarify existing levelized commissions guidance in SSAP No. 71—Policy Acquisition Costs and Commissions, which requires full recognition of the funding liabilities incurred to date for commission expenses prepaid on behalf of an insurer. The revisions also clarify that the recognition of commission expense is based on experience to date. The exposed revisions are consistent with the 2019 Fall National Meeting exposure, with the inclusion of guidance to clarify that reporting entities that have not complied with the original intent shall reflect the change as a correction of an error, in accordance with SSAP No. 3, in the year-end 2020 financial statements.

10. Revisions update the subsidiary, controlled and affiliated entities (SCA) review process descriptive language and the procedures for availability and delivery of completed SCA reviews.

11. Revisions remove the statement that guarantees or commitments from the insurance reporting entity to the SCA can result in a negative equity valuation of the SCA.

12. Revisions extend the following interpretations issued in response to COVID-19 to the third quarter 2020 financial statements. With these revisions, these interpretations will expire Dec. 30, 2020; therefore, they will not be applicable for year-end 2020. The exposure has a shortened comment period ending Aug. 14. Adoption of these extensions may be considered via e-vote if there are no concerns with the extensions received:
   b. INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19.
   c. INT 20-05: Investment Income Due and Accrued.

13. The following U.S. GAAP standards were rejected as not applicable to statutory accounting:
   a. ASU 2015-10, Technical Corrections and Improvements.
   b. ASU 2019-09, Financial Services—Insurance (Topic 944): Effective Date.
   c. ASU 2020-01, Investments—Equity Securities (Topic 321), Investments—Equity Method and Joint Ventures (Topic 323), and Derivatives and Hedging (Topic 815), Clarifying the Interactions between Topic 321, Topic 323, and Topic 815.
   d. ASU 2020-05—Effective Dates for Certain Entities.

14. Exposed the following editorial revisions to statutory accounting:
   a. Deleted redundant paragraph references in SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets.
   b. Added a table that lists the questions addressed in Exhibit A - Implementation Questions and Answers in SSAP No. 62R.

15. Rejected agenda item 2020-13: Health Industry Request on 2020 Health Insurance Assessment without statutory revisions. (Note that the sponsor requested withdrawal.)

16. Received an update on the following projects and referrals:
   1. Determined that the following two interpretations, issued in response to COVID-19, are specifically tied to the timeframes described in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). As such, an extension was not deemed necessary at this time.
     a. INT 20-03: Troubled Debt Restructuring Due to COVID-19.
   2. Ref #2019-21: Received an update that the issue paper to consider substantive revisions to SSAP No. 43R—Loan-Back and Structured Securities was exposed through July 31, and a subsequent conference call will be scheduled to consider comments and continue the discussion. It was also noted that NAIC staff have had ongoing conversations with industry representatives and investment providers to discuss differing structures during the exposure period.
   3. Deferred discussion of the following agenda items for a subsequent call or meeting:
   4. Received a referral from the Valuation of Securities (E) Task Force regarding the accounting and reporting treatment of CTLs is being addressed in agenda item Ref #2020-24.
   5. Received a referral from the Financial Condition (E) Committee regarding an American Council of Life Insurers (ACLI) request relative to the accounting treatment of certain “basis swaps” permitted under state law, as a result of the transition away from LIBOR. This referral was addressed with the adoption of INT 20-09.
   6. Received an update on current U.S. GAAP Exposures / Invitations to Comment, noting that no comments by the Working Group are planned during the exposure periods.
   g. Reported that the comment deadline for new and exposed agenda items is Sept. 18, except for INT 20-02, INT 20-04 and INT 20-05, which have a comment deadline of Aug. 14.
Capital Adequacy (E) Task Force
Aug. 5, 2020

1. Adopted its June 30 minutes, which included the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Adopted its April 30 and Jan. 27 minutes, which included the following action:
   c. Adopted its working group proposals:
      1. Proposal 2020-05-CA (Table of Contents).

2. Adopted the report of the Health Risk-Based Capital (E) Working Group, which met July 30 and took the following action:
   a. Adopted its Dec. 17, 2019 minutes, which included the following action:
      1. Adopted its 2019 Fall National Meeting minutes.
      2. Discussed the draft health bond structure; specifically, the bond portfolio adjustment, the investment grade bond factors, the investment income and the time horizon.
   b. Approved the 2019 health RBC statistics to be posted on the Working Group’s page on the NAIC website.
   c. Discussed and referred the ACA Fee Sensitivity Test proposal to the Capital Adequacy (E) Task Force for exposure for all formulas.
   d. Adopted proposal 2020-04-H to add the MAX Function to the formula included in the RBC forecasting file for Line 17 of the excessive growth charge on page XR021 of the health RBC formula.
   e. Heard comments on the health bond factors from the Academy to address questions raised regarding investment income and the time horizon used in the development of the factors.
   f. Adopted updates to the 2020 health RBC working agenda.
   g. Discussed the impact of COVID-19 and pandemic risk in the health RBC formula.
   h. Heard comments on the health care receivable guidance.
   i. Heard an update on the Health Test Ad Hoc Group.

3. Adopted the report of the Life Risk-Based Capital (E) Working Group, which met July 30 and took the following action:
   a. Adopted its July 10, June 30 and June 11 minutes, which included the following action:
      1. Adopted industry-requested RBC mortgage reporting guidance for construction loans; origination and valuation dates, property values and 90 days past due; and contemporaneous property values.
      2. Deferred industry-requested RBC mortgage reporting guidance for net operating income (NOI).
      3. Adopted the instruction and factors for 2020 longevity risk.
   b. Adopted its Feb. 14 and 2019 Fall National Meeting minutes, which included the following action:
      b. Adopted proposal 2020-03-L (C-3 Instructional Changes and C-3 Guidance).
      c. Discussed the life RBC treatment of alien affiliates.
   b. Adopted the life RBC newsletter.
   c. Discussed the 2019 RBC statistics.
   d. Heard an update from the industry on their request for RBC reporting guidance for NOI.
   e. Discussed the Working Group’s working agenda and upcoming conference calls.

4. Adopted the report of the Investment Risk-Based Capital (E) Working Group, including its Feb. 25 minutes. During this meeting, the Working Group took the following action:
   a. Discussed comments received on the bond proposal.
   b. Re-exposed the bond proposal to include updates to the 2020 annual financial statement blanks.

5. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, which met July 30 and took the following action:
   a. Adopted its June 12 and Feb. 3 minutes, which included the following action:
      1. Adopted its 2019 Fall National Meeting minutes.
      2. Adopted its Jan. 22 minutes, which included the following action:
         4. Agreed to refer the Schedule F proposal to the Blanks (E) Working Group.
         5. Received referrals from the Statutory Accounting Principles (E) Working Group and the Restructuring Mechanisms (E) Subgroup.

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b. Adopted the report of the Catastrophe Risk (E) Subgroup, which met July 29 and took the following action:
   1. Adopted its Feb. 3 minutes, which included the following action:
      a. Adopted its 2019 Fall National Meeting minutes.
      b. Adopted its Jan. 22 minutes, which included the following action:
         ii. Adopted proposal 2019-19-P (Vulnerable 6 or Unrated Risk Charge).
         iii. Agreed to refer the Schedule F proposal to the Blanks (E) Working Group.
      c. Received referrals from the Statutory Accounting Principles (E) Working Group and the Restructuring Mechanisms (E) Subgroup.
   2. Heard a presentation from Karen Clark & Company on its catastrophe model.
   3. Discussed the possibility of allowing additional third-party commercial vendor models.
   4. Discussed the internal catastrophe model evaluation process.
   c. Adopted the 2020 P/C RBC newsletter.
   d. Discussed 2020 P/C RBC statistics.
   e. Discussed the possibility of using the NAIC as a centralized location for reinsurer designations.
   f. Discussed the R3 credit risk and Rcat contingent credit risk charges.
   h. Forwarded the request for extension to the Restructuring Mechanisms (E) Subgroup.
   i. Heard updates on current P/C RBC projects from the Academy.
   j. Discussed Line 1 underwriting risk reserves and premium methodology.
6. Adopted its working agenda.
8. Exposed proposal 2020-02-CA (ACA Fee Sensitivity Test Removal) for a 30-day public comment period ending Sept. 4.
9. Exposed its 2021 proposed charges for a 30-day public comment period ending Sept. 4.
10. Adopted proposal 2020-03-L (C-3 Instructional Changes and C-3 Guidance).

Examination Oversight (E) Task Force
The Examination Oversight (E) Task Force did not meet at the Summer National Meeting.

Receivership and Insolvency (E) Task Force
Aug. 7, 2020
1. Adopted its March 4, Jan. 8 and 2019 Fall National Meeting minutes, which included the following action:
   a. Adopted a referral to the Financial Condition (E) Committee to request opening Model #440 and Model #450 related to essential services provided by affiliates in receivership.
   b. Discussed comments received regarding key provisions the states should have in their laws to promote effectiveness and consistency in receiverships affecting multiple states.
3. Adopted the report of the Receivership Financial Analysis (E) Working Group, which met Aug. 4 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings.
4. Adopted the report of the Receivership Large Deductible Workers’ Compensation (E) Working Group, including its March 2 minutes. During this meeting, the Working took the following action:
   a. Received comments on a draft model guideline that provides alternative language for the Insurer Receivership Model Act (#555), Section 712—Administration of Loss Reimbursement Policies.
   b. Appointed a drafting group to address comments received.
5. Exposed, for a 30-day public comment period, a request for feedback on key provisions of receivership and guaranty fund laws. For each provision, the request asks: 1) if it is critical for all states to have in receivership and guaranty fund law in a receivership affecting multiple states; 2) if it should be considered for a limited scope accreditation standard; 3) if other methods should be used to encourage its adoption; and 4) if there are impediments to its adoption.
6. Heard a presentation from representatives of the National Conference of Insurance Guaranty Funds (NCIGF), the Western Guaranty Fund Services (WGFS) and the Illinois Insurance Guaranty Fund (IIGF) on the NCIGF’s white paper, Insurance Resolution: Preparing for Cyber Claims. The presenters requested that state insurance regulators acknowledge potential issues with cyber claims in a receivership and engage in early communication with guaranty funds when an insurer that writes cyber policies becomes troubled.
7. Heard an update on activities of the IAIS Resolution Working Group (ReWG). The ReWG met via conference call in April to continue development of the Application Paper on Resolution Planning. The ReWG expects to finalize the draft during a conference call in September. A draft for consultation is expected to be available in November.

Reinsurance (E) Task Force

Aug. 6, 2020

1. Adopted its June 9 minutes, which included the following action:
   a. Adopted its March 11, Jan. 29 and 2019 Fall National Meeting minutes, which included the following action:
      1. Adopted a recommendation to the Financial Regulation Standards and Accreditation (F) Committee that the 2019 revisions to Model #785 and Model #786 be an accreditation standard for risk retention groups (RRGs).
      2. Discussed whether compliance with AG 48 should be considered “substantially similar” to Model #787 for purposes of accreditation.
      3. Adopted technical revisions to Model #787.
   b. Discussed whether compliance with AG 48 should be considered “substantially similar” to Model #787 for purposes of accreditation.
   c. Adopted the Uniform Checklist for Reciprocal Jurisdiction Reinsurers and updates to the Uniform Application Checklist for Certified Reinsurers.

2. Adopted its 2021 proposed charges.

3. Adopted the report of the Reinsurance Financial Analysis (E) Working Group, which met March 11 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to adopt the new Uniform Checklist for Reciprocal Jurisdiction Reinsurers and updates to the Uniform Application Checklist for Certified Reinsurers.

4. Adopted the report of the Qualified Jurisdiction (E) Working Group, which has not met since the 2019 Fall National Meeting. The Working Group has been approached by three countries about becoming qualified jurisdictions and will begin initial reviews in the next several months.

5. Received a status report on the states’ implementation of the 2019 revisions to Model #785 and Model #786.

Risk Retention Group (E) Task Force

The Risk Retention Group (E) Task Force did not meet at the Summer National Meeting.

Valuation of Securities (E) Task Force

Aug. 7, 2020

1. Adopted its July 1 and May 14 minutes, which included the following action:
   a. Adopted its Feb. 4 and 2019 Fall National Meeting minutes, which included the following action:
      1. Discussed proposed amendments to the P&P Manual to:
         a. Remove the financial modeling instructions for RMBS/CMBS.
         b. Clarify that the sovereign rating limitation applies to filing exemption (FE).
      2. Exposed an updated amendment to the P&P Manual for the definition and instructions for principal protected notes (PPNs).
      3. Adopted an amendment to the P&P Manual to reflect the U.S. Securities and Exchange Commission’s (SEC) adoption of a new rule to modernize the regulation of exchange-traded funds (ETFs).
   b. Adopted an updated amendment to the P&P Manual to map financially modeled RMBS/CMBS designations to NAIC designation categories, including mapping the zero-loss bonds to the 1.A NAIC designation category.
   c. Adopted an amendment to the P&P Manual for PPNs, with an updated description, definition and instructions. This amendment removes PPNs from FE eligibility and requires all PPNs, including those currently designated under the FE process, to be submitted to the Securities Valuation Office (SVO) for review under their Subscript S authority beginning Jan. 1, 2021, and filed with the SVO by July 1, 2021, if previously owned.
   d. Exposed an NAIC Investment Analysis Office (IAO) issue paper on NAIC staff concerns about bespoke securities and reliance on credit rating provider (CRP) ratings. The issue paper, along with the April 28, 2010, adopted recommendations of the Ratings Agency (E) Working Group, were exposed for a 90-day public comment period ending Aug. 16. The Task Force directed IAO staff to begin drafting incremental recommendations for the Task Force to consider addressing the risks identified in the issue paper.
   e. Exposed a proposed amendment to the P&P Manual with updated instructions for nonconforming credit tenant loan (CTL) transactions that relied on credit ratings, along with an update to the Task Force policy on “The Use of Credit Ratings of NRSROs in NAIC Processes.” The amendment was exposed for a 30-day public comment period ending June 17, and it was referred to the Statutory Accounting Principles (E) Working Group for its consideration.
Discussed temporarily extending insurers’ 2020 initial filing deadline from 120 days to 165 days for newly acquired or in-transition securities. The Task Force decided this was a temporary change, and it directed SVO staff to include in the minutes instructions that the filing deadline for the initial filing of newly acquired or in-transition securities for 2020 would be 165 days instead of the usual 120 days.

Heard reports from NAIC staff on: RMBS/CMBS; rating agency actions year-to-date (YTD); requirements for material credit events and issuer amendments or refinancing an existing issue; and SVO year-end process and carryover filings.

Adopted an amendment to the P&P Manual to rename the “U.S. Direct Obligations/Full Faith and Credit Exempt List” as the “NAIC U.S. Government Money Market Fund List” and discontinue the “NAIC Bond Fund List.”

Exposed a proposed amendment to the P&P Manual to map short-term CRP ratings to NAIC designation categories. This amendment was exposed for a 25-day public comment period ending July 27.

Exposed a proposed amendment to the P&P Manual to add supranational entities filed with the SVO to the “Sovereign NAIC Designation Equivalent List.” This amendment was exposed for a 25-day public comment period ending July 27.

Exposed a proposed amendment to the P&P Manual to update guidance for working capital finance investments (WCFIs) consistent with the Statutory Accounting Principles (E) Working Group adoption of changes to SSAP No. 105R—Working Capital Finance Investments. This amendment was exposed for a 45-day public comment period ending Aug. 17.

Exposed an NAIC SVO staff report on the use and regulation of derivatives in ETFs. This report was exposed for a 45-day public comment period ending Aug. 17.

Adopted an amendment to the P&P Manual to map short-term CRP ratings to NAIC designation categories.

Adopted an amendment to the P&P Manual to add supranational entities filed with the SVO to the Sovereign NAIC Designation Equivalent List.

Received a proposed amendment to the P&P Manual to add instructions for ETFs that contain a combination of preferred stocks and bonds. This amendment was exposed for a 30-day public comment period ending Sept. 6.

Received a proposed amendment to the P&P Manual to update guidance on initial and subsequent annual filings, methodologies and documentation. This amendment was expose for a 30-day public comment period ending Sept. 6.

Heard a report from NAIC staff regarding projects before the Statutory Accounting Principles (E) Working Group.

Received its 2021 proposed charges and agreed to discuss and consider adoption during a future meeting.

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

August 12, 2020

1. Adopted its 2019 Fall National Meeting minutes.

2. Adopted, immediately by reference, revisions made during 2019 to NAIC publications that are required for accreditation purposes (e.g., the Accounting Practices and Procedures Manual) and were deemed insignificant.

3. Adopted a referral to confirm that the 2019 and 2011 revisions to Model #785 and Model #786 are applicable to RRGs as an accreditation standard. The revisions address the reinsurance collateral requirements necessary for U.S. ceding companies to take credit for certain reinsurance transactions. The adopted effective date is Sept. 1, 2022, with enforcement to begin Jan. 1, 2023.

4. Adopted technical changes to the new accreditation standard for Model #787 to update a reference that was revised in 2020.


6. Exposed proposed revisions to the Review Team Guidelines for Part B1: Financial Analysis for a 30-day public comment period ending Sept. 11. The proposed revisions consist of a technical clarification related to RRGs and the use of the “Captives and/or Insurers Filing on a U.S. GAAP Basis Worksheet.”

7. Reported that it met Aug. 10, July 21 and June 23 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, and took the following action:
   a. Discussed state-specific accreditation issues.
   b. Voted to award continued accreditation to the insurance departments of Delaware, Louisiana, Maryland, Oregon, Rhode Island and Washington.
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

Aug. 12, 2020

1. Adopted its June 3, Feb. 3, Jan. 30 and Jan. 15 and 2019 Fall National Meeting minutes, which included the following action:
   a. Heard an update on upcoming IAIS committee meetings and activities.
   b. Heard an update on the Organisation for Economic Co-operation and Development (OECD) and other supervisory cooperation activities.
   c. Heard an update on the International Monetary Fund (IMF) Financial Sector Assessment Program (FSAP).
   d. Heard an update on NAIC events.
   f. Heard a recap of IAIS committee meetings and an update on the insurance capital standard (ICS), including the aggregation method (AM) and comparability.
   g. Approved submission of NAIC comments on the IAIS draft Application Paper on Liquidity Risk Management.

2. Heard an update on key 2020 projects of the IAIS, including: 1) the Louisiana Department of Insurance became the latest U.S. member of the IAIS Multilateral Memorandum of Understanding (MMoU); 2) implementation of the holistic framework for systemic risk in the insurance sector; 3) ICS data collection and comparability; 4) and the responses to COVID-19.

3. Heard an update on the 2020 U.S. FSAP, which concluded earlier in the week with the publication of final documents describing the IMF’s findings and opinions on the U.S. financial regulatory system. While there are several findings and conclusions drawn by IMF staff that state insurance regulators may ultimately disagree with, their view that the U.S. insurance system is in line with the IAIS Insurance Core Principles (ICPs) and that key 2015 FSAP recommendations are being addressed is welcomed. As these reports have just been made public, state insurance regulators and NAIC staff will review all of the IMF recommendations and allocate, where appropriate, such recommendations to appropriate NAIC committees and working groups for further consideration.

4. Heard an update on international activities, including recent virtual meetings and events with international colleagues, plans for a virtual NAIC International Fellows Program session this fall, recent meetings of the OECD Insurance and Private Pensions Committee, and recent meetings of the SIF.

NAIC/CONSUMER LIAISON COMMITTEE

Aug. 14, 2020

1. Adopted its June 19 and 2019 Fall National Meeting minutes, which included the following action:
   a. Heard a presentation on consumer protection issues resulting from, or heightened by, COVID-19 and measures to reduce or flatten infection rates.
   b. Heard a presentation on the importance of high-quality, affordable coverage for COVID-19 testing.
   c. Heard a presentation on additional areas for state leadership and consumer protection related to COVID-19.
   e. Heard a presentation regarding United Policyholders’ COVID-19 loss recovery library.

2. Heard a presentation from United Policyholders on COVID-19-related business interruption claims, coverage issues, disputes and litigation. This presentation highlighted the lack of and need for pandemic coverage for business interruption.

3. Heard a presentation from the Automotive Education & Policy Institute (AEPI) on digital claims handling and photo-estimating. This presentation focused on the need for additional consumer education and consumer protection in the form of advance notifications regarding initial claim payments and follow up claim payments, especially during the COVID-19 pandemic.

4. Heard a presentation from the CEJ proposing a model law to modernize insurance rate and form regulation that would address algorithmic bias plans used on patients and markets. This presentation explained how some algorithmic plans have a built-in bias based on discriminatory data points being used. A new model law was proposed to alleviate the inconsistencies currently noted from state to state.

5. Heard a presentation from the National Health Law Program (NHLP), Community Catalyst (CC) and the American Kidney Fund (AKF) on improving equity in health care access. This presentation discussed how the pandemic highlighted the problem of inequity and discrimination in the equal and adequate access to health care for consumers.

6. Heard a presentation from the National Alliance of State and Territorial AIDS Directors (NASTAD) on addressing the needs of patients and consumers in the COVID-19 pandemic. This presentation discussed the importance of reasonable preauthorization standards for the utilization management of formulary medications, especially those used for pre-exposure prophylaxis (PrEP).
7. Heard a presentation from California Health Advocates (CHA) on the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Medicare and Model #120. This presentation recommended that state insurance regulators revise Model #120, so it no longer allows insurers to avoid paying for medical treatment when an insured person is eligible for Medicare but not enrolled in Medicare Part B because they are still covered by their employer.

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE
Aug. 3, 2020

1. Adopted its April 29 minutes, which included the following action:
   a. Adopted its 2019 Fall National Meeting minutes.
   b. Discussed how the states are conducting outreach to Native Americans regarding ACA coverage opportunities.
   c. Discussed retroactive coverage through ACA plans and tribal coverage programs.

2. Discussed the significant impact of COVID-19 on the health and economies of American Indian and Alaska Native populations.

3. Discussed coverage available through the ACA plans and tribal programs.

4. Received and discussed a general overview from Ron Kreiter (OK) regarding what the recent U.S. Supreme Court decision, *McGirt v. Oklahoma*, U.S. Supreme Court, October Term, 2019, decided July 9, 2020, means (or could mean) to the insurance industry, health care, etc.

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

NAIC/STATE GOVERNMENT LIAISON COMMITTEE
The NAIC/State Government Liaison Committee did not meet at the Summer National Meeting.
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Executive (EX) Committee and Plenary
Virtual Summer National Meeting
August 14, 2020

The Executive (EX) Committee and Plenary met via conference call Aug. 14, 2020. The following members participated: Raymond G. Farmer, Chair (SC); David Altmaier, Vice Chair (FL); Dean L. Cameron, Vice President (ID); Chlora Lindley-Myers, Secretary-Treasurer (MO); Eric A. Cioppa, Most Recent Past President, represented by Timothy Schott (ME); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Elizabeth Perri (AS); Evan G. Daniels (AZ); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais (CT); Karima M. Woods (DC); Trinidad Navarro (DE); John F. King represented by Martin Sullivan (GA); Colin M. Hayashida (HI); Doug Ommen (IA); Robert H. Muriel represented by Kevin Fry (IL); Stephen W. Robertson (IN); Vicki Schmidt represented by Barb Rankin (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary Anderson (MA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Steve Kelley (MN); Mike Chaney (MS); Matthew Rosendale represented by Bob Biskupiak (MT); Mike Causey (NC); Jon Godfried (ND); Bruce R. Ramge (NE); Chris Nicolopoulos (NH); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by My Chi To (NY); Jillian Froment (OH); Glen Mulready represented by Brian Downs (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Rafael Cester-Lopategui (PR); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Hodgen Mainda (TN); Kent Sullivan represented by Doug Slape (TX); Todd E. Kiser (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

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

Director Farmer reported that the Executive (EX) Committee met Aug. 13 and adopted the July 14 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Executive (EX) Committee also adopted its interim meeting report from May 12, April 2, Feb. 13 and Jan. 10, which included the following action: 1) adopted the 2019 Fall National Meeting minutes of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee; 2) adopted its April 2, Feb. 13 and Jan. 10 minutes; 3) adopted the report of the Audit Committee; 4) adopted the report of the Investment Committee; 5) adopted the recommendation of the Life Actuarial (A) Task Force to delay the start of Principle-Based Reserving (PBR) Experience Data Reporting from 2020 to 2021; 6) appointed Commissioner Schmidt and Director Ramge to serve on the National Insurance Producer Registry (NIPR) Board of Directors effective May 12; 7) heard a report on a change in membership for the System for Electronic Rate and Form Filing (SERFF) Advisory Board, as Andrea Davey (Athene Annuity and Life Company) will serve as the Life Insurance Representative; 8) discussed the National Association of Registered Agents and Brokers (NARAB) Board recommendations; 9) heard an update on the Economic Scenario Generator (ESG) request for proposal (RFP); 10) heard an update on the SERFF Assessment; 11) heard an update on NAIC cybersecurity; 12) discussed the status of the Mid-Year Roundtable and the Summer National Meeting; 13) heard a joint chief executive officer (CEO)/chief operating officer (COO) report; 14) discussed 2020 NAIC Strategic Priorities in light of COVID-19; 15) received an update on the 2019 Year-End Financial Results; 16) approved the fiscal impact statement for the Long-Term Care Insurance Data Call and authorized Management to contract with a selected vendor; 17) approved the fiscal impact statement for the SERFF Filing Review Tools Pilot; 18) approved the following non-regulator appointments to the SERFF Advisory Board: Birny Birnbaum (Center for Economic Justice—CEJ) as the Consumer Representative; Theresa Boyce (Chubb Group) for Property & Casualty (P&C); Amanda Wheeler (Life Secure Insurance Company) for life insurance; and Rachel Benton (Bright Health) for health insurance and vice chair; 19) appointed Director Lindley-Myers as vice chair of the 2020 Consumer Participation Board of Trustees; 20) appointed Commissioner Afable to serve on the NIPR Board of Directors effective Feb. 13; 21) received an update confirming the committee structure changes: the Executive (EX) Committee disbanded the joint Long-Term Care Insurance (E/B) Task Force, the NAIC/State Government Liaison Committee, and the NAIC/Industry Liaison Committee and removed the membership limit on the Life Actuarial (A) Task Force and the Health Actuarial (B) Task Force; 22) approved the fiscal impact statement for the PBR Yearly Renewable Term (YRT) Reinsurance Study; 23) voted to release for public review and comment the Long-Term Care Insurance Data Call and Analysis fiscal impact statement; 24) approved the debt restructuring terms between the NAIC and the Interstate Insurance Product Regulation Commission (Compact); and 25) appointed Florida, Idaho, Kentucky, Massachusetts, Missouri, Nebraska, Nevada, Ohio and Oklahoma as members of the NAIC 2020 Audit Committee.
The Executive (EX) Committee adopted the reports of its task forces: 1) the Financial Stability (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Innovation and Technology (EX) Task Force, including the Artificial Intelligence (AI) Principles; and 4) the Long-Term Care Insurance (EX) Task Force, including its three new subgroup charges.

The Executive (EX) Committee adopted Requests for NAIC Model Law Development to amend: the Insurance Holding Company System Regulatory Act (#440); the Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450); and the Standard Nonforfeiture Law for Individual Deferred Annuities (#805).

The Executive (EX) Committee received the 2019 Annual Report of the NAIC Designation Program Advisory Board.

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

The Executive (EX) Committee received a status report on model law development efforts for amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); the Annuity Disclosure Model Regulation (#245); the Health Maintenance Organization Model Act (#430); Model #440; Model #450; the Life Insurance Disclosure Model Regulation (#580); the Mortgage Guaranty Insurance Model Act (#630); the Unfair Trade Practices Act (#880); and new models, including the Real Property Lender-Placed Insurance Model Act, the Pet Insurance Model Law, and the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act.

The Executive (EX) Committee heard a report from the Interstate Insurance Product Regulation Commission.

Director Ramge made a motion, seconded by Director Cameron, to adopt the Aug. 13 report of the Executive (EX) Committee. The motion passed.

2. **Adopted the Artificial Intelligence Guiding Principles**

Commissioner Godfread reported that the Artificial Intelligence (EX) Working Group was constituted during the 2019 Summer National Meeting, and it was formally charged to: 1) study the development of artificial intelligence, its use in the insurance sector, and its impact on consumer protection and privacy, marketplace dynamics, and the state-based insurance regulatory framework; 2) develop regulatory guidance, beginning with guiding principles; and 3) make other recommendations by the Summer National Meeting.

The first meeting of the Working Group was held on Sept. 5 when members heard an overview on AI that covered AI principles generally and the Organisation for Economic Co-operation and Development’s (OECD) AI principles, which have been adopted by 42 countries, including the U.S.

During the 2019 Fall National Meeting, the Working Group discussed comments related to this approach and decided to use the OECD Principles as a basis for developing AI principles for the insurance industry.

The Working Group held calls on June 3 and May 5 and adopted the AI Principles on June 30. Comments were accepted and then discussed during the Innovation and Technology (EX) Task Force’s meeting on July 23. The Task Force decided to take some time to consider those and an appropriate response and re-visit them during its Aug. 7 meeting.

Details regarding those comments and how each was ultimately handled in the Principles can be found in the minutes from the Working Group meetings and the July 23 Task Force meeting. Commissioner Godfread stated, “it was agreed that memorializing the intent of the document would be important. That is covered in the introductory section, but of note is clarifying to whom these Principles pertain (AI Actors – which was determined to include third parties), that it is intended to be high level guidelines or ‘aspirational guideposts’; therefore, it does not carry the weight of law and should be used to promote innovation while protecting consumers.” The Fair and Ethical section emphasizes expectations regarding compliance with laws and regulations, and in an effort to accommodate concerns regarding language related to AI actors being expected to proactively avoid proxy discrimination, it notes, “consistent with the risk-based foundation of insurance” to provide context. Additionally, in the Fair and Ethical section, it is noted that while unintentional consequences may occur, the expectation is they must be corrected and remediated when they do. Care was given to acknowledge balancing both the requirement to be compliant with existing laws and regulations while noting that some may not exist today but will in the future as this space evolves. Transparency by AI actors to all relevant stakeholders while maintaining the ability to protect confidentiality of proprietary algorithms, including revealing the kind of data being used and the purposes and consequences included, as well as providing a way to inquire, review and seek recourse for AI decisions made. Language covering the need for AI systems to be secure, safe and robust is also included.
The NAIC Principles on AI, or the AI “FACTS” include Fair and Ethical, Accountable, Compliant, Transparent and Secure.Safe.Robust as the key tenets of the Principles.

Deputy Commissioner To commented that New York applauds the leadership of Commissioner Godfread and all the others involved in this effort. New York issued Circular Letter #1 last year on this topic, making it clear that insurers are responsible for the external data and models they use even when supplied by third-party vendors. Ms. To said, “[w]e see these principles that are about to be adopted as consistent with that. We applaud this step that we are taking collectively. This is a very good foundation for the future. As we look ahead and tying this with the race discussion from yesterday, we have an opportunity to do this right with a new regulatory framework to deal with these new practices and models. I would encourage all of us to be laser focused to make sure consumers are protected and that the market innovates responsibly.”

Commissioner Ommen also applauded Commissioner Godfread and the work that has gone into this. Specifically, he addressed the fact that these principles should guide AI actors to implement systems to avoid unintended consequences. One of his concerns is that rates should not be going into the market with unintended consequences. He said, “[n]othing in this document should relieve regulators from having our eyes open and standing in our place as consumer protectors. Our duty is to make sure these unintended consequences are well thought out prior to reviewing rates.”

Director Fox offered that “unintended consequences” should be changed to “discriminatory,” as the goal is to avoid discriminatory, not necessarily unintended consequences. She said, “[s]ome unintended consequence may be innocuous and some may be good and what we want to say is, we do not want you to do anything harmful to consumers. We do not want an unintended consequence to have a discriminatory effect.”

Commissioner Godfread made a motion, seconded by Commissioner Altman, to adopt the NAIC AI Guiding Principles (Attachment One). The motion passed.

3. **Adopted by Consent the Committee, Subcommittee and Task Force Minutes of the 2019 Fall National Meeting**

Commissioner Chaney made a motion, seconded by Commissioner Navarro, to adopt by consent the committee, subcommittee and task force minutes of the 2019 Fall National Meeting. The motion passed.

4. **Adopted its Feb. 13 Minutes**

The Executive (EX) Committee and Plenary conducted an interim meeting Feb. 13 to adopt revisions to the *Suitability in Annuity Transactions Model Regulation* (#275). Director Froment made a motion, seconded by Commissioner Roach, to adopt the Executive (EX) Committee and Plenary’s Feb. 13 minutes (Attachment Two). The motion passed.

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

Director Froment reported that the Life Insurance and Annuities (A) Committee met Aug. 11 and adopted its July 10 minutes, which included the following action: 1) adopted its Dec. 30, 2019, and 2019 Fall National Meeting minutes; 2) adopted technical revisions to *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830)* (AG 48); 3) adopted *Valuation Manual* amendments; and 4) adopted *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49-A)*.

The Committee adopted the following working group and task force reports: the Annuity Disclosure (A) Working Group, including its March 12 minutes and an extension of the Request for NAIC Model Law Development; the Accelerated Underwriting (A) Working Group, which met July 31 and heard an update presentation on its work and adopted its March 12, Feb. 20, Feb. 2, Jan. 23, and 2019 Fall National Meeting minutes; the Annuity Suitability (A) Working Group, which met July 29 and adopted its Dec. 19, 2019, and 2019 Fall National Meeting minutes and agreed to draft a “frequently asked questions” (FAQ) document to complete the second half of its charge to “consider how to promote greater uniformity across NAIC-member jurisdictions”; the Life Insurance Illustration Issues (A) Working Group, including its July 30 minutes and an extension of the Request for NAIC Model Law Development; and the Life Actuarial (A) Task Force.

The Committee discussed next steps for the Life Insurance Online Guide (A) Working Group and agreed that NAIC staff would send an email to Committee members: 1) to describe its plan to have the Working Group focus on the substance of a guide and have the NAIC Communications Division work on an online design; and 2) to seek additional state insurance regulator members to be on the Working Group.
The Committee discussed next steps for the Retirement Security (A) Working Group and agreed that NAIC staff would email Committee members: 1) asking for comments on a revised work plan focusing on areas where state insurance regulators have expertise while leveraging the existing work of other organizations to avoid duplication of efforts; and 2) seeking additional state insurance regulator members to be on the Working Group.

The Committee agreed to discuss on a future conference call whether the Committee should review the design and regulation of life insurance and annuity illustrations and discuss what, if any, changes or additions might be needed.

6. Adopted the Technical Revisions to Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48)

Director Froment reported that the technical edits to AG 48 have been made to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787). AG 48 needs to remain in sync with Model #787, as there are situations in which both are needed for some period of time to cover their portion of XXX financing arrangements. Of note is a reference change to the Credit for Reinsurance Model Law (#785) and another reference change to the Credit for Reinsurance Model Regulation (#786).

Director Froment made a motion, seconded by Director Cameron, to adopt the technical revisions to AG 48 (Attachment Three). The motion passed.

7. Adopted Amendments to the Valuation Manual

Director Froment reported that there are seven Valuation Manual amendments for consideration, primarily technical in nature. One example is amendment 2020-06, which revises a reference to the London Interbank Offered Rate (LIBOR), which is scheduled to go away in 2021.

Another example is amendment 2020-07, which replaces the 4% floor for the minimum nonforfeiture interest rates with a reference to Internal Revenue Service (IRS) §7702, with which it was originally intended to coordinate.

Director Froment made a motion, seconded by Commissioner Donelon, to adopt the amendments to the Valuation Manual (Attachment Four). The motion was adopted by 54 jurisdictions representing 99.98% of the applicable premiums written. Director Farmer confirmed that the vote satisfied the requirements to amend the Valuation Manual. The motion passed.

8. Adopted the Actuarial Guideline XLVIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49-A)

Director Froment reported that in 2018, commissioners became aware of product innovations that were leading to the illustration of higher credited rates than was contemplated when AG 49 was initially developed. The biggest innovation was the multiplier, which results in more upside than previously seen in related indexed products. The Life Insurance and Annuities (A) Committee charged the Life Actuarial (A) Task Force to address any concerns with these products.

Director Froment reported the Committee adopted AG 49-A during its July 10 conference call. Mr. Birnbaum submitted a comment letter to suggest two changes to AG 49-A: 1) apply AG 49-A to all new illustrations, whether for new policies or for new illustrations on in-force policies regardless of date of issue, on and after the effective date; and 2) prohibit the illustration of crediting rates greater than policy loan rates.

The Task Force discussed and considered these comments along with many other key decision points during the development of AG 49-A. Ultimately, the Task Force decided to apply AG 49-A to new and in force illustrations sold after the effective date of the guideline.

The Task Force considered several approaches and decided that an illustrated Policy Loan Interest Credited Rate should not exceed the illustrated Policy Loan Interest Rate by more than 50 basis points.

This keeps the Guideline consistent with the model regulation and non-indexed universal life (IUL) products, which allows some of this concept to be reflected in illustrations.
The Life Insurance and Annuities (A) Committee plans to hold a call in the near future to discuss the broader issues surrounding the design and regulation of life and annuity illustrations and consider what changes, if any, might be needed.

Deputy Commissioner To said New York would vote “No” on this guideline. “We acknowledge this is a small step in the right direction but feel it falls short of the standard we should impose to ensure consumers are protected. We believe this proposal continues to allow the use of unrealistic and unreasonable crediting rates. Illustrations are supposed to show consumers how an insurance product works and is expected to perform in the future. We know insurers have used these illustrations to compete with each other and to sell equity indexed life insurance products by using unrealistic growth cash values. This misleads consumers. This causes consumers harm. We feel it is critically important for the NAIC to advocate for more realistic and reasonable credit rates and we don’t believe this proposal achieves that.”

Director Froment made a motion, seconded by Director Lindley-Myers, to adopt AG 49-A (Attachment Five). The motion passed with New York voting against the motion.

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

Commissioner Altman reported that the Health Insurance and Managed Care (B) Committee met Aug. 11. During this meeting, the Committee adopted its April 28, Feb. 26, and 2019 Fall National Meeting minutes, which included the following action: 1) received a report from the Health Actuarial (B) Task Force on its work to develop an outline and eventual 2021 rate pricing resource and guidance document for the states to consider when reviewing initial 2021 rates in light of the COVID-19 pandemic; 2) discussed and heard comments from stakeholders on areas, such as telehealth requirements and form filing requirements, in which state insurance regulators can provide regulatory flexibility due to the COVID-19 pandemic; and 3) adopted the Regulatory Framework (B) Task Force’s revised 2020 charges, which added a charge for the newly appointed Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group.

The Committee adopted the following subgroup, working group and task force reports: the Consumer Information (B) Subgroup, including its July 9, Jan. 21 and Jan. 7 minutes; the Health Innovations (B) Working Group; the Health Actuarial (B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

The Committee heard a presentation on health equity and disparities in health care and coverage. The presentation highlighted how the disparate impacts of COVID-19 mirror and compound underlying health disparities and how progress to address the problem will require long-term efforts across sectors to prioritize equity and address systemic and structural barriers, including racism and discrimination.

The Committee heard a presentation on how the COVID-19 pandemic and the resulting recession has affected employer-sponsored insurance coverage. The presentation also discussed consumer considerations and choices after the loss of employer-sponsored insurance coverage. The presentation outlined several policy opportunities and lessons that state and federal regulators could consider when dealing with this issue, such as considering the impact of Medicaid expansion, the timing of enrollment and outreach, and expanded outreach efforts.

The Committee heard a presentation on COVID-19 testing and costs. The presentation provided an overview of COVID-19 testing and its essential components and purpose. The presentation also discussed the current framework for COVID-19 testing and how each stakeholder involved—insurers, government, public health entities, and employers—plays a leadership role in ensuring access to such testing for those who need it. The presentation discussed the current costs of COVID-19 tests for diagnostic purposes and antibody testing and the potential impact of the cost of testing on premium rates. The presentation suggested several recommendations, including ensuring that all consumers are able to access COVID-19 testing regardless of coverage status, solidifying comprehensive strategies that incorporate testing to achieve occupational and public health goals, ensuring that testing does not lead to premium spikes in 2021 and protecting against testing fraud.

The Committee heard an update on legal actions related to the federal Affordable Care Act (ACA), including U.S. Supreme Court cases from its recent 2019 term, including Maine Community Health Options v. U.S. (140 S. Ct. 1408), an 8-1 decision in favor of insurers challenging the legality of the federal government’s refusal to pay participants for full risk corridor amounts. The update also discussed what to expect from the U.S. Supreme Court in its 2020 term, including oral arguments in a case challenging the constitutionality of the individual mandate and its potential impact on other key ACA provisions and a case challenging the authority of the states to regulate PBMs.

The Committee received an update on the work of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in completing its charge to develop a new NAIC model regulating PBMs. The Subgroup exposed a draft PBM model for a public
comment period ending Sept. 1. Following the end of the public comment period, the Subgroup will meet via conference call to discuss and consider revisions to the draft based on the comments received.

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

Commissioner Chaney reported the Property and Casualty Insurance (C) Committee met Aug. 12 and adopted its June 10 minutes, which included the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) adopted edits to the NAIC Uniform Risk Retention Group (RRG) Registration Form for inclusion in the Risk Retention and Purchasing Group Handbook; 3) discussed regulatory actions related to COVID-19; and 4) adopted the Private Passenger Auto Insurance Study.

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

The Committee adopted an extension for development of the new Real Property Lender-Placed Insurance Model Act.

The Committee adopted the Workers’ Compensation Policy and the Changing Workforce white paper, which explores how changes in work and the evolving landscape of legal employment are shifting responsibility for coverage and benefits for occupational injuries, illnesses and fatalities.

The Committee adopted the State Disaster Response Plan, which provides a template for state departments of insurance (DOIs) to use when assisting consumers before, during and after a disaster.

The Committee also: 1) received a recap of the Federal Emergency Management Agency (FEMA) and DOI disaster workshops; 2) received a preview of the Southeast Zone flood workshop; 3) heard a presentation on building codes from the International Code Council (ICC); 4) heard a report on results from the state insurance regulator business interruption data call and other issues regarding business interruption claims related to COVID-19; 5) heard a proposal from the CEJ to collect additional homeowners and auto insurance data within the Annual Statement; and 6) heard a presentation on race and P&C insurance, including an overview of historical studies related to the issue.

11. Adopted the Considerations for State Insurance Regulators in Building the Private Flood Insurance Market

Commissioner Chaney reported that a drafting group under the Catastrophe Insurance (C) Working Group began drafting a “Considerations for State Insurance Regulators in Building the Private Flood Insurance Market” document in 2018, as state insurance regulators wanted additional strategies to encourage the development of the private flood insurance market within their states. The Working Group took comments on a draft document and ultimately passed it to the Property and Casualty Insurance (C) Committee on Dec. 9, 2019, where the Committee adopted the document.

The document is meant to be used by state insurance regulators to help build the private flood insurance market in their state. The considerations document provides information regarding state actions that can be taken, including: 1) supporting private flood insurance legislation; 2) approving private flood insurance products; 3) tailoring rate and form requirements for private flood insurance coverage; 4) allowing private flood insurers to submit rates on an informational basis; 5) removing diligent search requirements; 6) conducting consumer outreach; 7) listing private flood insurance products on a DOI website; 8) conducting agent education; 9) implementing specific continuing education (CE) requirements for producers; 10) increasing the weight of flood insurance questions on producer licensing exams; and 11) conducting agent education.

The considerations document provides detailed information regarding ways in which state DOIs can apply the information described to enhance the private flood insurance market in their state. The Catastrophe Insurance (C) Working Group plans to continue building on this document by including information in a “living” Appendix showing additional steps that states have taken to grow the private flood insurance market.

Commissioner Chaney noted that work on this document ultimately led to the Committee recommending Annual Statement changes to collect private flood data on a Supplement, as well as a data call that is currently being conducted by all states that will collect 2018 and 2019 data in September.
Deputy Commissioner To stated that “New York supports this initiative as flood insurance is more important than ever as we see climate changes across the country. We support anything that would develop the private flood insurance market and consider this considerations document as a step in the right direction. We consider it helpful as a whole. We don’t agree with all items. We feel consumers would be better served if all flood insurance products were subject to regulatory review. Flood insurance should not be placed on the export list to facilitate flood insurance being written on the excess lines market as opposed to the admitted market.”

Commissioner Chaney made a motion, seconded by Superintendent Toal, to adopt the “Considerations for State Insurance Regulators in Building the Private Flood Insurance Market” document (Attachment Six). The motion passed.

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

Commissioner Richardson reported the Market Regulation and Consumer Affairs (D) Committee met Aug. 11 and adopted its July 27 minutes, which included the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) adopted a Farm Owners Claims Standardized Data Request; and 3) adopted revisions to the Market Conduct Annual Statement (MCAS) Blanks for Life and Annuities, Homeowners Insurance, Private Passenger Automobile, and Lender-Placed Auto and Homeowners insurance.

The Committee adopted a Limited Long-Term Care Examination Standards Chapter to be included in the NAIC Market Regulation Handbook for state reference.

The Committee adopted an Inland Marine In Force Standardized Data Request and an Inland Marine Claims Standardized Data Request to be included in the NAIC Market Regulation Handbook. These data requests may be used by a state to determine if a company follows appropriate procedures with respect to the issuance and/or termination of inland marine policies and the processing of inland marine claims.

The Committee adopted the reports of its task forces and working groups: the Antifraud (D) Task Force, the Market Information Systems (D) Task Force, the Producer Licensing (D) Task Force, the Advisory Organization Examination Oversight (D) Working Group, the Market Actions (D) Working Group, the Market Conduct Annual Statement Blanks (D) Working Group, the Market Conduct Examination Standards (D) Working Group, the Market Analysis Procedures (D) Working Group, the Market Regulation Certification (D) Working Group, and the Privacy Protections (D) Working Group. The adoption of the reports included adoption of the following: 1) the Market Information Systems (D) Task Force recommendation to add a “pandemic” subject code and the coverage codes for “business interruptions,” “lender-placed insurance,” and “pet insurance” to the NAIC’s Complaints Database System (CDS); 2) the Market Analysis Procedures (D) Working Group’s recommendation to add Travel Insurance as the next line of business for the MCAS and implement new scorecard ratios for the Private Flood MCAS blank; and 3) the Market Conduct Annual Statement Blanks (D) Working Group’s recommended clarification to the definition of Individual Indexed Variable Annuity for the MCAS blank.

The Committee heard a presentation from the Alliance of Health Care Sharing Ministries (AHCSM). This presentation addressed the background of the AHCSM, its history and features, statistics on the number and size of HCSMs, challenges for HCSMs, and the development of an accreditation program for oversight of HCSMs by an independent Board of Directors.

The Committee discussed a template bulletin for state insurance departments to advise insurance companies regarding the waiver of on-site review requirements of managing general agents (MGAs) and third-party administrators (TPAs) during the COVID-19 public health emergency.

13. Adopted the NAIC Continuing Education Reciprocity (CER) Agreement – 2019 Version

Commissioner Richardson reported the Market Regulation and Consumer Affairs (D) Committee and Producer Licensing (D) Task Force adopted the 2019 Continuing Education Reciprocity (CER) Agreement during the 2019 Fall National Meeting. The CER Agreement supports the use of the Uniform Continuing Education Reciprocity Course Filing Form, which continuing education (CE) providers and states use to streamline the course-approval process in multiple states. Through the reciprocal approval process, which this Agreement supports, a CE provider’s home state conducts a substantive review of a CE course, which eliminates the need for a non-resident state to perform a similar course review.

Commissioner Richardson reported that the CER Agreement is intended to facilitate the affirmative commitment of each NAIC member to reciprocal CE course approval. Each NAIC member, through coordination with their Producer Licensing Director, will receive a communication from NAIC staff to formally sign the CER Agreement.

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Commissioner Richardson made a motion, seconded by Commissioner Clark, to adopt the NAIC CER Agreement – 2019 Version (Attachment Seven). The motion passed.

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

Commissioner White reported that the Financial Condition (E) Committee met Aug. 11 and adopted its July 1, June 12, May 15 and March 26 minutes, which included the following action: 1) adopted its Feb. 27 and 2019 Fall National Meeting minutes and the Feb. 27 minutes, which included the following action: a) adopted a Request for NAIC Model Law Development from the Receivership and Insolvency (E) Task Force; b) adopted a Request for NAIC Model Law Development from the Financial Stability (EX) Task Force; and c) adopted a request for extension from the Mortgage Guaranty Insurance (E) Working Group regarding ongoing work on an NAIC model; 2) adopted technical revisions to Model #787 and acknowledged the similar technical revisions made to AG 48 by the Life Insurance and Annuities (A) Committee; 3) adopted actions from the Capital Adequacy (E) Task Force, the Valuation of Securities (E) Task Force, and the Accounting Practices and Procedures (E) Task Force, with the exception of Interpretation (INT) 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends, which was rejected and sent back to the Accounting Practices and Procedures (E) Task Force; 4) adopted a memorandum from the Financial Condition (E) Committee to all commissioners regarding the treatment of LIBOR under state investment laws; 5) adopted an extension of mortgage forbearance previously adopted by the Committee through Sept. 30, 2019; and 6) adopted mortgage forbearance through June 30.

The Committee adopted the reports of the following task forces and working groups: the Accounting Practices and Procedures (E) Task Force, the Capital Adequacy (E) Task Force, the Receivership and Insolvency (E) Task Force, the Reinsurance (E) Task Force, the Valuation of Securities (E) Task Force, the Accounting Practices and Procedures (E) Task Force, and the Group Solvency Issues (E) Working Group.

The Committee adopted the revised INT 20-08.

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

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

Commissioner Kiser reported the Financial Regulation Standards and Accreditation (F) Committee met Aug. 10, July 21 and June 23 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Delaware, Louisiana, Maryland, Oregon, Rhode Island and Washington.

The Committee met Aug. 12 and adopted its 2019 Fall National Meeting minutes.

The Committee adopted, immediately by reference, revisions made during 2019 to NAIC publications that are required for accreditation purposes (e.g., the Accounting Practices and Procedures Manual [AP&P Manual]) and were deemed insignificant.

The Committee adopted a referral to confirm that the 2019 and 2011 revisions to Model #785 and Model #786 are applicable to RRGs as an accreditation standard. The revisions address the reinsurance collateral requirements necessary for U.S. ceding companies to take credit for certain reinsurance transactions. The adopted effective date is Sept. 1, 2022, with enforcement to begin Jan. 1, 2023.

The Committee adopted technical changes to the new accreditation standard for Model #787 to update a reference that was revised in 2020.
The Committee exposed proposed revisions to the Review Team Guidelines and the Self-Evaluation Guide for Part C: Organizational and Personnel Practices, for a 30-day public comment period ending Sept. 11. The revisions incorporate consideration of where each department’s average salaries fall in relation to the range, as defined in the Financial Analysis Handbook and the Financial Condition Examiners Handbook.

The Committee exposed proposed revisions to the Review Team Guidelines for Part B1: Financial Analysis for a 30-day public comment period ending Sept. 11. The proposed revisions consist of a technical clarification related to RRGs and the use of the “Captives and/or Insurers Filing on a U.S. GAAP Basis Worksheet.”

16. Adopted the 2019 Revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) as an Addition to the Part A Accreditation Standards

Commissioner Kiser reported that at the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted the 2019 revisions to Model #785 and Model #786 as an update to the Reinsurance Ceded accreditation standard. These revisions outline the requirements for companies to take credit for reinsurance when ceded to a Reciprocal Jurisdiction, and they are designed to incorporate the relevant provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement). States are required to adopt these revisions within 60 months of the signing of the Covered Agreements to avoid potential federal preemption of state credit for reinsurance laws.

The model revisions were adopted by the NAIC in June 2019. The Reinsurance (E) Task Force then drafted the significant elements for the accreditation standard, which were exposed for a 30-day public comment period before being referred to the Committee.

Part of the referral was for a waiver of process to adopt the accreditation standard on an expedited basis. This allows the effective date of the accreditation standard to align with the end of the review period for federal preemption determinations related to the Covered Agreements, which is Sept. 1, 2022. All states are encouraged to adopt the models in the set timeframe to reduce the potential for federal preemption.

In addition, following adoption of the revisions to the accreditation standard, state insurance regulators recognized the need to clarify applicability to risk retention groups (RRGs). This question was vetted by both the Reinsurance (E) Task Force and the Risk Retention Group (E) Task Force. Both concluded that the revisions to the standard, as well as the previously adopted 2011 revisions to the standard for both models should apply to RRGs, and the Committee adopted a referral from NAIC staff confirming this stance during its Aug. 12 meeting.

Commissioner Kiser made a motion, seconded by Commissioner Pieciak, to adopt the Financial Regulation Standards and Accreditation (F) Committee’s decision to adopt the following: 1) the 2019 revisions to Model #785 and Model #786 as an addition to the Part A accreditation standards for both traditional insurers and RRGs; 2) a waiver of procedure, as provided for in the Accreditation Program Manual to expeditiously adopt the revisions to this standard; and 3) an effective date of Sept. 1, 2022, the end of the 60-month period when federal preemption determinations must be completed, with enforcement of the standard to commence Jan. 1, 2023 (Attachment Eight). The motion passed.

17. Adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as a New Part A Accreditation Standard

Commissioner Kiser reported the Financial Regulation Standards and Accreditation (F) Committee adopted Model #787 as a new Part A accreditation standard during the 2019 Fall National Meeting. This model establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees. Model #787 also includes provisions to ensure that funds backing these captive reinsurance transactions, which consist of primary security and other security, are held in the forms and amounts that are appropriate.

The recommendation for accreditation, which includes that significant elements of Model #787 be adopted in a substantially similar manner and that related revisions to Model #785 be considered acceptable but not required for accreditation, was initially exposed and up for adoption at the 2017 Fall National Meeting. However, the Covered Agreements had recently been signed, and the Committee agreed to defer a decision on Model #787 until the effect of the Covered Agreements was known.
With the adoption of the revisions to the credit for reinsurance models last year, Model #787 was brought back before the Committee and it was adopted by the Committee as a new accreditation standard, also effective Sept. 1, 2022.

Subsequently, in the Spring of 2020, the Reinsurance (E) Task Force adopted technical revisions to Model #787 to update references to a section in Model #785, which were renumbered as part of the 2019 revisions. The renumbered section was also referenced by the significant elements of the accreditation standard that we are considering here today. During its Aug. 12 meeting, the Committee adopted technical revisions to the standard to account for the renumbering that occurred. The referral is included in your materials, along with the original referral containing the accreditation significant elements.

Commissioner Kiser made a motion, seconded by Commissioner Mais, to adopt the Financial Regulation Standards and Accreditation (F) Committee’s decision to adopt the following: 1) Model #787 as a new Part A accreditation standard; 2) the 2016 revisions to Model #785 should be considered acceptable but not required; 3) a waiver of procedure, as provided for in the Accreditation Program Manual to expeditiously adopt the revisions to this standard; and 4) an effective date of Sept. 1, 2022, with enforcement of the standard to commence Jan. 1, 2023 (Attachment Nine). The motion passed.

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

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Aug. 12 and adopted its June 3, Feb. 3, Jan. 30, Jan. 15, and 2019 Fall National Meeting minutes, which included the following action: 1) heard an update on upcoming International Association of Insurance Supervisors (IAIS) committee meetings and activities; 2) heard an update on the OECD and other supervisory cooperation activities; 3) heard an update on the International Monetary Fund (IMF) Financial Sector Assessment Program (FSAP); 4) heard an update on NAIC international-related events; 5) approved submission of NAIC comments on the IAIS and Sustainable Insurance Forum (SIF) draft Issues Paper on the Implementation of the Recommendations of the Task Force on Climate-related Financial Disclosures; 6) heard a recap of IAIS committee meetings and an update on the insurance capital standard (ICS), including the aggregation method (AM) and comparability; 7) approved submission of NAIC comments on the IAIS draft Application Paper on Liquidity Risk Management; 8) adopted the report of the ComFrame Development and Analysis (G) Working Group; 9) adopted its 2020 proposed charges; 10) heard an update on key 2019 projects of the IAIS; 11) heard an update on international activities; and 12) heard an update on the FSAP.

The Committee heard an update on key 2020 projects of the IAIS, including: 1) the Louisiana DOI became the latest U.S. member of the IAIS Multilateral Memorandum of Understanding (MMoU); 2) implementation of the holistic framework for systemic risk in the insurance sector; 3) ICS data collection and comparability; and 4) the responses to COVID-19.

The Committee heard an update on the 2020 U.S. FSAP, which concluded earlier in the week with the publication of final documents describing the IMF’s findings and opinions on the U.S. financial regulatory system. While there are several findings and conclusions drawn by IMF staff that state insurance regulators may ultimately disagree with, their view that the U.S. insurance system is in line with the Insurance Core Principles (ICPs) and that key 2015 FSAP recommendations are being addressed is welcomed. As these reports have just been made public, state insurance regulators and NAIC staff will review the IMF recommendations and allocate, where appropriate, such recommendations to relevant NAIC committees and working groups for further consideration.

The Committee heard an update on regional supervisory cooperation and other international activities, including recent virtual meetings and events with international colleagues, plans for a virtual NAIC International Fellows Program session this fall, recent meetings of the OECD Insurance and Private Pensions Committee, and recent meetings of the SIF.

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

Director Farmer referred to the written report for updates on the states’ implementation of NAIC-adopted model laws and regulations (Attachment Ten).

Having no further business, the Executive (EX) Committee and Plenary adjourned.
National Association of Insurance Commissioners (NAIC) Principles on Artificial Intelligence (AI)

RECOMMENDS that insurance companies and all persons or entities facilitating the business of insurance that play an active role in the AI system life cycle, including third parties such as rating, data providers and advisory organizations (hereafter referred to as “AI actors”) promote, consider, monitor and uphold the following principles according to their respective roles; and

THIS DOCUMENT is intended to establish consistent high-level guiding principles for AI actors. These principles are guidance and do not carry the weight of law or impose any legal liability. This guidance can serve to inform and establish general expectations for AI actors and systems emphasizing the importance of accountability, compliance, transparency, and safe, secure, fair and robust outputs.

Further, THIS DOCUMENT

Should be used to assist regulators and NAIC committees addressing insurance-specific AI applications. The level of regulatory oversight may vary based on the risk and impact to the consumer. These principles should be interpreted and applied in a manner that accommodates the nature and pace of change in the use of AI by the insurance industry and promotes innovation, while protecting the consumer.

Fair and Ethical

a. AI actors should respect the rule of law throughout the AI life cycle. This includes, but is not limited to, insurance laws and regulations, such as those relating to trade practices, unfair discrimination, access to insurance, underwriting, privacy, consumer protection and eligibility practices, ratemaking standards, advertising decisions, claims practices, and solvency.

b. Consistent with the risk-based foundation of insurance, AI actors should proactively engage in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and to avoid proxy discrimination against protected classes. AI systems should not be designed to harm or deceive people and should be implemented in a manner that avoids harmful or unintended consequences and corrects and remediates for such consequences when they occur.
**Accountable**

a. AI actors should be accountable for ensuring that AI systems operate in compliance with these principles consistent with the actors’ roles, within the appropriate context and evolving technologies. Any AI system should be compliant with legal requirements governing its use of data and algorithms during its phase of the insurance life cycle. Data supporting the final outcome of an AI application should be retained and be able to be produced in accordance with applicable insurance laws and regulations in each jurisdiction. AI actors should be responsible for the creation, implementation and impacts of any AI system, even if the impacts are unintended. AI actors should implement mechanisms and safeguards consistent with the degree and nature of the risks posed by AI to ensure all applicable laws and regulations are followed, including ongoing (human or otherwise) monitoring and, when appropriate, human intervention.

**Compliant**

a. AI actors must have the knowledge and resources in place to comply with all applicable insurance laws and regulations. AI actors must recognize that insurance is primarily regulated by the individual states and territories of the United States as well as by the federal government, and that AI systems must comply with the insurance laws and regulations within each individual jurisdiction. Compliance is required whether the violation is intentional or unintentional. Compliance with legal requirements is an ongoing process. Thus, any AI system that is deployed must be consistent with applicable laws and safeguards against outcomes that are either unfairly discriminatory or otherwise violate legal standards, including privacy and data security laws and regulations.

**Transparent**

a. For the purpose of improving the public’s confidence in AI, AI actors should commit to transparency and responsible disclosures regarding AI systems to relevant stakeholders. AI actors must have the ability to protect confidentiality of proprietary algorithms, provided adherence to individual state law and regulations in all states where AI is deployed can be demonstrated. These proactive disclosures include revealing the kind of data being used, the purpose of the data in the AI system and consequences for all stakeholders.

b. Consistent with applicable laws and regulations, stakeholders (which includes regulators and consumers) should have a way to inquire about, review and seek recourse for AI-driven insurance decisions. This information should be easy-to-understand and describe the factors that lead to the prediction, recommendation or decision. This information may be presented differently and should be appropriate for applicable stakeholders.
Secure, Safe and Robust

a. AI systems should be robust, secure and safe throughout the entire life cycle so that in conditions of normal or reasonably foreseeable use, or adverse conditions, they can function in compliance with applicable laws and regulations. To this end, AI actors should ensure a reasonable level of traceability in relation to datasets, processes and decisions made during the AI system life cycle. AI actors should enable analysis of the AI system’s outcomes, responses and other insurance-related inquiries, as appropriate in keeping with applicable industry best practices and legal requirements.

b. AI actors should, based on their roles, the situational context and their ability to act, apply a systematic risk management approach to each phase of the AI system life cycle on a continuous basis to address risks related to AI systems, including privacy, digital security and unfair discrimination as defined by applicable laws and regulations.
Executive (EX) Committee and Plenary
Orlando, Florida
February 13, 2020

The Executive (EX) Committee and Plenary met in joint session in Orlando, FL, Feb. 13, 2020. The following members participated: Raymond G. Farmer, Chair (SC); David Altmaier, Vice Chair (FL); Dean L. Cameron, Vice President (ID); Chlora Lindley-Myers, Secretary-Treasurer (MO); Eric A. Cioppa, Most Recent Past President (ME); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Allen W. Kerr (AR); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais (CT); Karima M. Woods (DC); John F. King (GA); Dafne M. Shimizu (GU); Colin M. Hayashida represented by Martha Im (HI); Doug Ommen (IA); Robert H. Muriel (IL); Stephen W. Robertson (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary Anderson (MA); Al Redmer Jr. (MD); Anita G. Fox (MI); Mike Chaney (MS); Mike Causey (NC); Jon Godfried (ND); Bruce R. Ramge (NE); Marlene Caride (NJ); Barbara D. Richardson (NV); Linda A. Lacewell (NY); Jillian Froment (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Rafael Cestero-Lopategui (PR); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Hodgen Mainda (TN); Kent Sullivan (TX); Todd E. Kiser (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill represented by Tonya Gillespie (WV); and Jeff Rude (WY).

1. Adopted Revisions to the Suitability in Annuity Transactions Model Regulation (#275)

Director Froment presented draft revisions to the Suitability in Annuity Transactions Model Regulation (#275) that will enhance the model in protecting consumers by requiring a heightened standard of conduct for producer recommendations of an annuity to be made in “the best interest” of the consumer, and it will require insurers to develop procedures to comply with these requirements.

Director Froment noted that the model has been protecting consumers since it was adopted in 2003. The Annuity Suitability (A) Working Group sent draft revisions to the Life Insurance and Annuities (A) Committee for its consideration at the 2019 Fall National Meeting. The Committee gave preliminary approval to the proposed revisions, but it tasked the Working Group to complete additional revisions to the appendices. The Working Group revised the appendices and sent them to the Committee for consideration.

The Committee met Dec. 30, 2019, to discuss the revisions to the model, including the revised appendices, and adopted the revisions.

The resulting revisions establish a “best interest” standard of conduct and require producers and insurers to satisfy the requirements outlined in four obligations: 1) a care obligation; 2) a disclosure obligation; 3) a conflict of interest obligation; and 4) a documentation obligation. The revisions also include enhancements to the current model’s insurer supervision system to assist in compliance.

The revisions make it clear that all recommendations by producers and insurers must be “in the best interest of the consumer,” and producers and insurers may not place their financial interests ahead of the consumer’s interest in making a recommendation. The revisions also require producers and insurers to act with “reasonable diligence, care and skill” in making a recommendation.

The revisions require producers to: 1) know the consumer’s financial situation, insurance needs and financial objectives; 2) understand the available recommendation options; 3) have a reasonable basis to believe the recommended option effectively addresses the consumer’s financial situation, insurance needs and financial objectives, and communicate the basis of the recommendation to the consumer; 4) disclose their role in the transaction, their compensation and any material conflicts of interest; and 5) document, in writing, any recommendation and the justification for such recommendation.

The revisions also include heightened supervision requirements for insurers to achieve compliance with this regulation. This includes procedures to review recommendations by producers to ensure that the recommended annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives.
The insurer is also required to establish systems for complying with all four obligations outlined in this regulation. Additionally, insurers must eliminate any sales contests, sales quota, bonuses and non-cash compensation that are based on the sales of specific annuities within a limited period of time.

Recognizing that the sale of annuities and those who sell annuities can be subject to multiple regulatory authorities, the Working Group made significant efforts to remain cognizant of the work being done by these state insurance regulators. As a result, these revisions also align well with the U.S. Securities and Exchange Commission’s (SEC’s) Regulation Best Interest.

Additionally, the revisions expand the model’s current safe harbor provisions to apply the safe harbor to any producer that is regulated as a broker-dealer, investment adviser or plan fiduciary. The producer must be in compliance with business rules, controls and procedures that satisfy a “comparable standard” to this model’s new standard of conduct. This could include the SEC’s Regulation Best Interest.

Superintendent Lacewell stated that New York recognizes this proposal as better than what existed before and that some states would like to go further but face obstacles that do not allow them individually to get there. She stated that she believes the role of the NAIC should be to “lift up” all states and not use “the common denominator of what can be agreed to by 50-plus jurisdictions.” New York’s standard is the “best interest of the consumer without consideration of the producer’s financial or other interest in the matter.” Superintendent Lacewell stated that she believes this is not the standard applied in the model. New York standards also apply to life insurance, not just annuities, and apply to in-force transactions and decisions made under the in-force transaction.

Superintendent Lacewell stated:

New York’s view is that we regulate industry, and it is our obligation to facilitate the safety and soundness of the industry, but a large component of safety and soundness of industry is the integrity of the industry and the impact on the millions of people served and protected by the products and services of industry. The consumer should have access to all the information that they need and accurate information before they part with their money or make financial decisions in their lives. That is not achieved here because if the producer is going to make a recommendation and say, ‘Here is what I think you should do …,’ implicit in that recommendation is ‘Trust me.’ I would like us to find ways of communicating and helping states who want to get there and cannot do it on their own.

Commissioner Ommen stated that supporting this model is supporting a framework to go back to your states and find out through your own constituency what is good for your states. He stated, “We think that this rule as a model does reach where we need to be in Iowa, and it is very reflective of additional consumer protection that we believe does achieve best interest.”

Superintendent Cioppa stated, “Maine supports the model as a step forward from the current ‘suitability’ model we have and respects other states’ opinions, but it achieves a good consensus. I think the harmonization is important, but most importantly, I think it steps up our game in protecting consumers. The requirements of the model will help consumers in the end and benefit them.”

Commissioner Lara stated that California has been an active participant in promoting the strongest standards possible to protect consumers when purchasing annuities. He stated, “In California, some of our standards are stronger, including a provision that requires that any annuity be in the best interest of the consumers overall. California does support, and would prefer, a standard that establishes a fiduciary duty that producers sell products that put consumers first instead of commissions or other producer incentives. I believe this model is not perfect. I will be voting in favor of the draft amendments to the model regulation because they do contain significant amendments that afford increased consumer protections over the existing protections. Although some of the draft amendments are problematic for California, it would be better for consumers than the existing model regulation.”

Commissioner Redmer requested a clarification to the safe harbor provisions allowing satisfaction by a “comparable standard even if that standard does not otherwise apply to that product.” Commissioner Ommen stated that some producers are licensed in both securities and insurance. He stated:
Historically, and what is in our current model, is a safe harbor for those agencies (broker dealers/agents) registered under the Financial Industry Regulatory Authority (FINRA) and subject to the FINRA suitability and supervision regiment applied also in the sales and recommendation surrounding fixed index products. This language in the model extends that safe harbor to true fiduciaries, which would include the investment advisors that are in the securities side of the business.

Commissioner Ommen also stated:

If the supervision and suitability structure, which now has been raised to a best interest and supervision structure, is comparable to what we require here under this rule, that would be deemed compliant. It also should be noted that the insurance regulator does not lose its authority to go in and actually determine whether or not they are comparable; we still have oversight, and there is additional language that does not relieve the insurance company of using their oversight in order to ensure compliance.

Superintendent Dwyer stated that Rhode Island has taken action against companies that had not dealt appropriately with consumers in Rhode Island in the sales of annuities under the old NAIC model act and have been successful. She states, “To me, this is a step up, and we can take action against bad actors to protect consumers.”

Director Fox expressed support for the revised standard and also the amendments that were made to the safe harbor. She stated, “We recognize fiduciary duties from other contexts and make sure that we have continuity of regulation, but, like Commissioner Ommen stated, it did not detract in any way from our ability to make things comparable.”

Commissioner Richardson stated that she will support the amendment, “but, like California and Rhode Island, we believe that there are already some protections in place, and in Nevada, specifically, we have a fiduciary standard in place. For us, this is raising the water.”

Director Froment made a motion, seconded by Commissioner Chaney, to adopt the revisions to the Suitability in Annuity Transactions Model Regulation (#275) (Attachment Two-A). The motion passed, with New York opposing.

Having no further business, the Executive (EX) Committee and Plenary adjourned.
SUITABILITY IN ANNUITY TRANSACTIONS
MODEL REGULATION

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Section 1. Purpose
A. The purpose of this regulation is to require producers, as defined in this regulation, to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately and effectively addressed.

B. Nothing herein shall be construed to create a private cause of action for a violation of this regulation or to subject a producer to civil liability under the best interest standard of care outlined in Section 6 of this regulation or under standards governing the conduct of a fiduciary or a fiduciary relationship.

Drafting Note: The language of subsection B comes from the NAIC Unfair Trade Practices Act. If a State has adopted different language, it should be substituted for subsection B.

Drafting Note: Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (“Dodd-Frank Act”) specifically refers to this model regulation as the “Suitability in Annuity Transactions Model Regulation.” Section 989J of the Dodd-Frank Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation.

Section 2. Scope

This regulation shall apply to any sale or recommendation to purchase, exchange or replace an annuity made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase, exchange or replacement recommended.

Section 3. Authority

This regulation is issued under the authority of [insert reference to enabling legislation].

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Drafting Note: States may wish to use the Unfair Trade Practices Act as enabling legislation or may pass a law with specific authority to adopt this regulation.

Section 4. Exemptions

Unless otherwise specifically included, this regulation shall not apply to transactions involving:

A. Direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to this regulation;

B. Contracts used to fund:

(1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(2) A plan described by sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer;

(3) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under section 457 of the IRC; or

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

C. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

D. Formal prepaid funeral contracts.

Section 5. Definitions

A. “Annuity” means an annuity that is an insurance product under State law that is individually solicited, whether the product is classified as an individual or group annuity.

B. “Cash compensation” means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer, intermediary, or directly from the consumer.

C. “Consumer profile information” means information that is reasonably appropriate to determine whether a recommendation addresses the consumer’s financial situation, insurance needs and financial objectives, including, at a minimum, the following:

(1) Age;

(2) Annual income;

(3) Financial situation and needs, including debts and other obligations;

(4) Financial experience;

(5) Insurance needs;

(6) Financial objectives;

(7) Intended use of the annuity;
(8) Financial time horizon;
(9) Existing assets or financial products, including investment, annuity and insurance holdings;
(10) Liquidity needs;
(11) Liquid net worth;
(12) Risk tolerance, including but not limited to, willingness to accept non-guaranteed elements in the annuity;
(13) Financial resources used to fund the annuity; and
(14) Tax status.

BD. “Continuing education credit” or “CE credit” means one continuing education credit as defined in [insert reference in State law or regulations governing producer continuing education course approval].

CE. “Continuing education provider” or “CE provider” means an individual or entity that is approved to offer continuing education courses pursuant to [insert reference in State law or regulations governing producer continuing education course approval].

DEF. “FINRA” means the Financial Industry Regulatory Authority or a succeeding agency.

EG. “Insurer” means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

F. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

H. “Intermediary” means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer’s annuities by producers.

I. (1) “Material conflict of interest” means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.
(2) “Material conflict of interest” does not include cash compensation or non-cash compensation.

J. “Non-cash compensation” means any form of compensation that is not cash compensation, including, but not limited to, health insurance, office rent, office support and retirement benefits.

K. “Non-guaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

L. “Producer” means a person or entity required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities. For purposes of this regulation, “producer” includes an insurer where no producer is involved.

GM. (1) “Recommendation” means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that was intended to result or does result in a purchase, an exchange or a replacement of an annuity in accordance with that advice.
**Attachment Two-A**

**Executive (EX) Committee and Plenary**

8/14/20

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(2) Recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

**HN.** “Replacement” means a transaction in which a new policy or contract annuity is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is whether or not a producer is involved, that by reason of the transaction, an existing annuity or other insurance policy or contract has been or is to be any of the following:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or
5. Used in a financed purchase.

**Drafting Note:** The definition of “replacement” above is derived from the NAIC Life Insurance and Annuities Replacement Model Regulation. If a State has a different definition for “replacement,” the State should either insert the text of that definition in place of the definition above or modify the definition above to provide a cross-reference to the definition of “replacement” that is in State law or regulation.

**I.** “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including the following:

1. Age;
2. Annual income;
3. Financial situation and needs, including the financial resources used for the funding of the annuity;
4. Financial experience;
5. Financial objectives;
6. Intended use of the annuity;
7. Financial time horizon;
8. Existing assets, including investment and life insurance holdings;
9. Liquidity needs;
10. Liquid net worth;
11. Risk tolerance; and
12. Tax status.

**O.** “SEC” means the United States Securities and Exchange Commission.

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Section 6. Duties of Insurers and of Insurance Producers

A. Best Interest Obligations. A producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer’s or the insurer’s financial interest ahead of the consumer’s interest. A producer has acted in the best interest of the consumer if they have satisfied the following obligations regarding care, disclosure, conflict of interest and documentation:

A. In recommending to a consumer the purchase of an annuity, or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer’s suitability information, and that there is a reasonable basis to believe all of the following:

(1) (a) Care Obligation. The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:

(i) Know the consumer’s financial situation, insurance needs and financial objectives;

(ii) Understand the available recommendation options after making a reasonable inquiry into options available to the producer;

(iii) Have a reasonable basis to believe the recommended option effectively addresses the consumer’s financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and

(iv) Communicate the basis or bases of the recommendation.

(b) The requirements under subparagraph (a) of this paragraph include making reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.

(c) The requirements under subparagraph (a) of this paragraph require a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer’s financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.

(d) The requirements under this subsection do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in this regulation.

(e) The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer’s financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

(f) The requirements under subparagraph (a) of this paragraph include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.
(g) The requirements under subparagraph (a) of this paragraph apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any.

(h) The requirements under subparagraph (a) of this paragraph do not mean the annuity with the lowest one-time or multiple occurrence compensation structure shall necessarily be recommended.

(i) The requirements under subparagraph (a) of this paragraph do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.

(j) In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:

(i) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(ii) The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

(iii) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.

(k) Nothing in this regulation should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

(2) Disclosure obligation.

(a) Prior to the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form substantially similar to Appendix A:

(i) A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;

(ii) An affirmative statement on whether the producer is licensed and authorized to sell the following products:

(I) Fixed annuities;

(II) Fixed indexed annuities;

(III) Variable annuities;

(IV) Life insurance;

(V) Mutual funds;
(VI) Stocks and bonds; and

(VII) Certificates of deposit;

(iii) An affirmative statement describing the insurers the producer is authorized, contracted (or appointed), or otherwise able to sell insurance products for, using the following descriptions:

(I) One insurer;

(II) From two or more insurers; or

(III) From two or more insurers although primarily contracted with one insurer.

(iv) A description of the sources and types of cash compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary or other producer or by fee as a result of a contract for advice or consulting services; and

(v) A notice of the consumer’s right to request additional information regarding cash compensation described in subparagraph (b) of this paragraph;

Drafting Note: If a state approves forms, a state should add language to subparagraph (a) reflecting such approvals.

(b) Upon request of the consumer or the consumer’s designated representative, the producer shall disclose:

(i) A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and

(ii) Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages; and

Drafting Note: If a State has adopted the NAIC Annuity Disclosure Model Regulation, the State should insert an additional phrase in paragraph (1) subparagraph (c) above to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the NAIC Annuity Disclosure Model Regulation.

(c) Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe the consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components and market risk.

Drafting Note: If a State has adopted the NAIC Annuity Disclosure Model Regulation, the State should insert an additional phrase in paragraph (1) subparagraph (c) above to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the NAIC Annuity Disclosure Model Regulation.

(2) The consumer would benefit from certain features of the annuity, such as tax deferred growth, annuitization or death or living benefit;

(3) The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
(4) In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:

(a) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(b) The consumer would benefit from product enhancements and improvements; and

(c) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

(3) Conflict of interest obligation. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.

(4) Documentation obligation. A producer shall at the time of recommendation or sale:

(a) Make a written record of any recommendation and the basis for the recommendation subject to this regulation;

(b) Obtain a consumer signed statement on a form substantially similar to Appendix B documenting:

(i) A customer’s refusal to provide the consumer profile information, if any; and

(ii) A customer’s understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and

(c) Obtain a consumer signed statement on a form substantially similar to Appendix C acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer’s recommendation.

Drafting Note: If a state approves forms, a state should add language to subparagraphs (b) and (c) of this paragraph reflecting such approvals.

B. Prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain the consumer’s suitability information.

C. Except as permitted under subsection D, an insurer shall not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer’s suitability information.

(5) Application of the best interest obligation. Any requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

DB. Transactions not based on a recommendation.
(1) Except as provided under paragraph (2) of this subsection, neither an insurance producer, nor an insurer, shall have any obligation to a consumer under subsection A(1) or C related to any annuity transaction if:

(a) No recommendation is made;

(b) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;

(c) A consumer refuses to provide relevant suitability consumer profile information and the annuity transaction is not recommended; or

(d) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer.

(2) An insurer’s issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

C. Supervision system.

(1) Except as permitted under subsection B, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives based on the consumer’s consumer profile information.

E. An insurance producer or, where no insurance producer is involved, the responsible insurer representative, shall at the time of sale:

(1) Make a record of any recommendation subject to section 6A of this regulation;

(2) Obtain a customer signed statement documenting a customer’s refusal to provide suitability information, if any; and

(3) Obtain a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer’s or insurer’s recommendation.

F. An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer’s and its insurance producers’ compliance with this regulation, including, but not limited to, the following:

(a) The insurer shall establish and maintain reasonable procedures to inform its insurance producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant insurance-producer training manuals;

(b) The insurer shall establish and maintain standards for insurance-producer product training and shall establish and maintain reasonable procedures to require its insurance producers to comply with the requirements of section 7 of this regulation;

(c) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its insurance producers;

(d) The insurer shall establish and maintain procedures for the review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommended annuity would effectively address the particular consumer’s financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system for the purpose of
identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(e) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not suitable in compliance with subsections A, B, D and E. This may include, but is not limited to, confirmation of the consumer’s suitability, consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the suitability, consumer profile information or other required information under this section after issuance or delivery of the annuity; and

(f) The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section;

(g) The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information;

(h) The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subparagraph are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time; and

Drafting Note: The intent of this subparagraph (h) is to prohibit sales contests, sales quotas, bonuses and non-cash compensation based on the sale of a particular product within a limited period of time, but not to prohibit general incentives regarding the sales of a company’s products with no emphasis on any particular product.

(4) (i) The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(2)(3) (a) Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under paragraph (1) this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer’s compliance with subparagraph (b) of this paragraph.

(b) An insurer’s supervision system under paragraph (1) this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:

(i) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

(ii) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.
(a) A producer’s recommendations to consumers of products other than the annuities offered by the insurer; or

(b) Include consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

GD. Prohibited Practices. Neither a producer nor an insurer shall An insurance producer shall not dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer’s request for confirmation of the suitability consumer profile information;

(2) Filing a complaint; or

(3) Cooperating with the investigation of a complaint.

HE. Safe harbor.

(1) Recommendations and sales of annuities Sales made in compliance with comparable standards FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner’s ability to investigate and enforce (including investigate) the provisions of this regulation.

Drafting Note: Non-compliance with comparable standards FINRA requirements means that the broker-dealer transaction recommendation or sale is subject to compliance with the suitability requirements of this regulation.

(2) Nothing in paragraph (1) shall limit the insurer’s obligation to comply with Section 6C(1) of this regulation, although the insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

(2)(3) For paragraph (1) to apply, an insurer shall:

(a) Monitor the FINRA member broker dealer relevant conduct of the financial professional seeking to rely on paragraph (1) or the entity responsible for supervising the financial professional, such as the financial professional’s broker-dealer or an investment adviser registered under federal [or state] securities laws using information collected in the normal course of an insurer’s business; and

(b) Provide to the FINRA member broker dealer entity responsible for supervising the financial professional seeking to rely on paragraph (1), such as the financial professional’s broker-dealer or investment adviser registered under federal [or state] securities laws, information and reports that are reasonably appropriate to assist the FINRA member broker dealer such entity to maintain its supervision system.

(4) For purposes of this subsection, “financial professional” means a producer that is regulated and acting as:

(a) A broker-dealer registered under federal [or state] securities laws or a registered representative of a broker-dealer;
(b) An investment adviser registered under federal [or state] securities laws or an investment adviser representative associated with the federal [or state] registered investment adviser; or

(c) A plan fiduciary under Section 3(21) of the Employee Retirement Income Security Act of 1974 (ERISA) or fiduciary under Section 4975(e)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

Drafting Note: The requirement that a producer be “regulated and acting” as a broker-dealer, an registered representative of a broker-dealer, an investment adviser, an investment adviser representative or a plan fiduciary means that a producer who is not explicitly acting in compliance with the relevant comparable standards, as specified in paragraph (4) below, is not eligible for this safe harbor and is subject to compliance with the requirements of this regulation.

(5) For purposes of this subsection, “comparable standards” means:

(a) With respect to broker-dealers and registered representatives of broker-dealers, applicable SEC and FINRA rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including, but not limited to, Regulation Best Interest and any amendments or successor regulations thereto;

(b) With respect to investment advisers registered under federal [or state] securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on such investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940 [or applicable state securities law], including but not limited to, the Form ADV and interpretations; and

Drafting Note: State-registered investment advisers in this safe harbor are included in brackets so that each individual state that implements this model regulation may determine whether to include the state-registered investment advisers. Given the varying treatment of annuities, particularly variable annuities, under state law, the varying structures of state securities and insurance departments, and the varying levels of cooperation between the two agencies, this is a decision best made in each individual state.

(c) With respect to plan fiduciaries or fiduciaries, means the duties, obligations, prohibitions and all other requirements attendant to such status under ERISA or the IRC and any amendments or successor statutes thereto.

Section 7. Insurance Producer Training

A. An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer’s standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

B. (1) (a) An insurance producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider.

(b) Insurance producers who hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this regulation. Individuals who obtain a life insurance line of authority on or after the effective date of this regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

(2) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credits, but may be longer.
(3) The training required under this subsection shall include information on the following topics:

(a) The types of annuities and various classifications of annuities;

(b) Identification of the parties to an annuity;

(c) How product specific annuity contract features affect consumers;

(d) The application of income taxation of qualified and non-qualified annuities;

(e) The primary uses of annuities; and

(f) Appropriate standard of conduct, sales practices, replacement and disclosure requirements.

(4) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer’s products. Additional topics may be offered in conjunction with and in addition to the required outline.

(5) A provider of an annuity training course intended to comply with this subsection shall register as a CE provider in this State and comply with the rules and guidelines applicable to producer continuing education courses as set forth in [insert reference to State law or regulations governing producer continuing education course approval].

(6) A producer who has completed an annuity training course approved by the department of insurance prior to [insert effective date of amended regulation] shall, within six (6) months after [insert effective date of amended regulation], complete either:

(a) A new four (4) credit training course approved by the department of insurance after [insert effective date of amended regulation]; or

(b) An additional one-time one (1) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider on appropriate sales practices, replacement and disclosure requirements under this amended regulation.

(7) Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with [insert reference to State law or regulations governing producer continuing education course approval].

(8) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with [insert reference to State law or regulations governing producer continuing education course approval].

(9) The satisfaction of the training requirements of another State that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this State.

(10) The satisfaction of the components of the training requirements of any course or courses with components substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this state.

(11) An insurer shall verify that an insurance producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored
database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Section 8. Compliance Mitigation; Penalties: Enforcement

A. An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its insurance producer, the commissioner may order:

(1) An insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this regulation by the insurer’s supervisory duties or by its insurance producer’s violation of this regulation;

(2) A general agency, independent agency or the insurance producer to take reasonably appropriate corrective action for any consumer harmed by the insurance producer’s violation of this regulation; and

(3) Appropriate penalties and sanctions.

B. Any applicable penalty under [insert statutory citation] for a violation of this regulation may be reduced or eliminated [according to a schedule adopted by the commissioner] if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

Drafting Note: Subsection B above is intended to be consistent with the commissioner’s discretionary authority to determine the appropriate penalty for a violation of this regulation. The language of subsection B is not intended to require that a commissioner impose a penalty on an insurer for a single violation of this regulation if the commissioner has determined that such a penalty is not appropriate.

Drafting Note: A State that has authority to adopt a schedule of penalties may wish to include the words in brackets. In that case, “shall” should be substituted for “may” in the same sentence. States should consider inserting a reference to the NAIC Unfair Trade Practices Act or the State’s statute that authorizes the commissioner to impose penalties and fines.

C. The authority to enforce compliance with this regulation is vested exclusively with the commissioner.

Section 9. [Optional] Recordkeeping

A. Insurers, general agents, independent agencies and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information used in making the recommendations that were the basis for insurance transactions for [insert number] years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

Drafting Note: States should review their current record retention laws and specify a time period that is consistent with those laws. For some States this time period may be five (5) years.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Drafting Note: This section may be unnecessary in States that have a comprehensive recordkeeping law or regulation.

Section 10. Effective Date

The amendments to this regulation shall take effect [six (6)X] months after the date the regulation is adopted or on [insert date], whichever is later.
APPENDIX A

INSURANCE AGENT (PRODUCER) DISCLOSURE FOR ANNUITIES
Do Not Sign Unless You Have Read and Understand the Information in this Form

Date: ________________________

INSURANCE AGENT (PRODUCER) INFORMATION (“Me”, “I”, “My”)

First Name: _________________________________________  Last Name: _____________________________________

Business/Agency Name: ___________________________________  Website: ___________________________________

Business Mailing Address: ___________________________________________________________________________

Business Telephone Number: __________________________________________________________________________

Email Address: ______________________________________________________________________________________

National Producer Number in [state]: __________________________________________________________________

CUSTOMER INFORMATION (“You”, “Your”)

First Name: _________________________________________  Last Name: _______________________________________

What Types of Products Can I Sell You?

I am licensed to sell annuities to you in accordance with state law. If I recommend that You buy an annuity, it means I believe that it effectively meets Your financial situation, insurance needs, and financial objectives. Other financial products, such as life insurance or stocks, bonds and mutual funds, also may meet Your needs.

I offer the following products:

- [ ] Fixed or Fixed Indexed Annuities
- [ ] Variable Annuities
- [ ] Life Insurance

I need a separate license to provide advice about or to sell non-insurance financial products. I have checked below any non-insurance financial products that I am licensed and authorized to provide advice about or to sell.

- [ ] Mutual Funds
- [ ] Stocks/Bonds
- [ ] Certificates of Deposits

Whose Annuities Can I Sell to You?

I am authorized to sell:

<table>
<thead>
<tr>
<th>Annuities from Only One (1) Insurer</th>
<th>Annuities from Two or More Insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

[ ] Annuities from Two or More Insurers
although I primarily sell annuities from:

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How I’m Paid for My Work:

It’s important for You to understand how I’m paid for my work. Depending on the particular annuity You purchase, I may be paid a commission or a fee. Commissions are generally paid to Me by the insurance company while fees are generally paid to Me by the consumer. If You have questions about how I’m paid, please ask Me.

Depending on the particular annuity You buy, I will or may be paid cash compensation as follows:

- Commission, which is usually paid by the insurance company or other sources. If other sources, describe:
  ____________________.
- Fees (such as a fixed amount, an hourly rate, or a percentage of your payment), which are usually paid directly by the customer,
  Other (Describe): ____________________.

If you have questions about the above compensation I will be paid for this transaction, please ask me.

I may also receive other indirect compensation resulting from this transaction (sometimes called “non-cash” compensation), such as health or retirement benefits, office rent and support, or other incentives from the insurance company or other sources.

**Drafting Note:** This disclosure may be adapted to fit the particular business model of the producer. As an example, if the producer only receives commission or only receives a fee from the consumer, the disclosure may be refined to fit that particular situation. This form is intended to provide an example of how to communicate producer compensation, but compliance with the regulation may also be achieved with more precise disclosure, including a written consulting, advising or financial planning agreement.

**Drafting Note:** The acknowledgement and signature should be in immediate proximity to the disclosure language.

By signing below, you acknowledge that you have read and understand the information provided to you in this document.

________________________________________________
Customer Signature

________________________________________________
Date

________________________________________________
Agent (Producer) Signature

________________________________________________
Date
APPENDIX B

CONSUMER REFUSAL TO PROVIDE INFORMATION

Do Not Sign Unless You Have Read and Understand the Information in this Form

Why are you being given this form?

You're buying a financial product – an annuity.

To recommend a product that effectively meets your needs, objectives and situation, the agent, broker, or company needs information about you, your financial situation, insurance needs and financial objectives.

If you sign this form, it means you have not given the agent, broker, or company some or all the information needed to decide if the annuity effectively meets your needs, objectives and situation. You may lose protections under the Insurance Code of [this state] if you sign this form or provide inaccurate information.

Statement of Purchaser:

I REFUSE to provide this information at this time.

I have chosen to provide LIMITED information at this time.

________________________________________________________________________

Customer Signature

________________________________________________________________________

Date
APPENDIX C

Consumer Decision to Purchase an Annuity NOT Based on a Recommendation

Do Not Sign This Form Unless You Have Read and Understand It.

Why are you being given this form? You are buying a financial product – an annuity.

To recommend a product that effectively meets your needs, objectives and situation, the agent, broker, or company has the responsibility to learn about you, your financial situation, insurance needs and financial objectives.

If you sign this form, it means you know that you’re buying an annuity that was not recommended.

Statement of Purchaser:

I understand that I am buying an annuity, but the agent, broker or company did not recommend that I buy it. If I buy it without a recommendation, I understand I may lose protections under the Insurance Code of [this state].

Customer Signature

________________________________________________

Date

________________________________________________

Agent/Producer Signature

________________________________________________

Date

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Project History

SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION (#275)

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

In 2017, the Life Insurance and Annuities (A) Committee established the Annuity Suitability (A) Working Group and charged the Working Group to review and revise, as necessary, the Suitability in Annuity Transactions Model Regulation (#275) and as part of that charge, consider how to promote greater uniformity across NAIC-member jurisdictions. The Committee adopted the charge and established the Working Group, in part, in response to the U.S. Department of Labor’s (DOL) fiduciary rule, which was finalized in April 2016 but vacated in its entirety in March 2018. The DOL fiduciary rule would have expanded the scope of who is considered a fiduciary to federal Employee Retirement Income Security Act of 1974 (ERISA) retirement plans and individual retirement accounts (IRAs) to include a broader set of insurance agents, insurance brokers and insurers. Separately, the U.S. Securities and Exchange Commission (SEC) released a proposed rule package in May 2018, which included Regulation Best Interest (Reg BI). The SEC finalized Reg BI in June 2019. The final Reg BI establishes a best interest standard of conduct for broker-dealers beyond the existing suitability obligation. The new standard of conduct requires a broker-dealer when making a recommendation of any securities transaction or investment strategy involving securities to a retail customer to act in the best interest of the retail customer at the time a recommendation is made without placing the financial or other interest of the broker-dealer or associated persons ahead of the interest of the retail customers.

While acknowledging the SEC’s and the DOL’s role in the regulatory landscape and believing that consumers are better protected when, to the extent possible, there is harmonization of the regulations enforced by the states, the SEC and the DOL, the Working Group continued its work to draft revisions to Model #275 to establish a framework for an enhanced standard of conduct that is more than the model’s current suitability standard but not a fiduciary standard.

In 2018, the Working Group held two two-day interim meetings—one in June in Kansas City, MO, and one in October in Chicago—to discuss drafts of proposed revisions to Model #275. Additionally, the Working Group held several conference calls and additional in-person meetings at each national meeting.

After the SEC finalized its Reg BI in June 2019, as directed by the Life Insurance and Annuities (A) Committee at the 2019 Spring National Meeting, the Working Group met soon after in mid-June during an in-person interim meeting in Columbus, OH, to level set and work toward its goal of fleshing out the meaning of “best interest” and incorporating a best interest standard of conduct into the Model #275 revisions. During its June meeting, the Working Group discussed and agreed on a framework for the model revisions to include a best interest standard and a path forward for completing its work as soon as possible.

Based on this framework, the Working Group developed a draft of proposed model revisions including a best interest standard of care a producer or insurer can meet if the producer or insurer satisfies the four obligations under this standard of care: 1) the care obligation; 2) disclosure obligation; 3) material conflict of interest obligation; and 4) documentation obligation. The Working Group exposed the draft for public comment until Sept. 30, 2019.

The Working Group met Oct. 8, Oct. 15, Oct. 29 and Nov. 5, 2019, via conference call to discuss the comments received. The Working Group received comments from many stakeholders, including industry, consumers and producers. More than 100 interested parties and state insurance regulators participated in each of the conference calls. The Working Group adopted the proposed revisions to Model #275 on Nov. 5, 2019, via conference call. The Working Group agreed that it had completed its work as directed by the Life Insurance and Annuities (A) Committee during the 2019 Spring National Meeting and forwarded the draft to the Committee for its consideration. The Committee chair exposed the draft for a public comment period ending Nov. 26, 2019. At the 2019 Fall National Meeting, the Committee discussed the comments received and made some revisions to the Working Group’s draft of proposed revisions to Model #275. During this meeting, the Committee provided preliminary approval to the proposed Model #275 revisions. The Committee also directed the Working Group to discuss the comments received on the proposed appendices during a meeting following the 2019 Fall National Meeting. The Working Group met Dec. 19, 2019, via conference call to discuss the Nov. 26, 2019, comments received on the proposed appendices. During this meeting, the Working Group revised the appendices and forwarded its work to the Committee for its consideration. The Committee met Dec. 30, 2019, via conference call to consider adoption of the proposed revisions to Model #275. The Committee adopted the proposed revisions to Model #275 by a vote of 11 to 1.
The proposed revisions establish a best interest standard of conduct for producers and insurers. This new standard of conduct is more than the model’s current suitability standard, but it is not a fiduciary standard. Under this new standard of conduct, when making a recommendation of an annuity, a producer or insurer shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer’s or the insurer’s financial interest ahead of the consumer’s financial interest. To satisfy this best interest obligation, a producer or an insurer must satisfy the four obligations: 1) care; 2) disclosure; 3) conflict of interest; and 4) documentation. The proposed revisions also revise the model’s current insurer supervision requirements, including a new supervision requirement for the insurer to establish and maintain reasonable procedures to identify and eliminate certain sales incentives that are based on sales of specific annuities within a limited period of time. The proposed revisions also include new appendices to provide guidance to producers and insurers in satisfying the new disclosure and documentation obligations.

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

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee drafted the proposed revisions to Model #275. The members of the Working Group were: Alabama, California, Delaware, Idaho, Iowa, Kansas, Nebraska, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, Tennessee and Wisconsin. Idaho chaired the Working Group in 2017 and 2018, and Ohio chaired the Working Group in 2019. The Life Insurance and Annuities (A) Committee also discussed and drafted proposed revisions to Model #275 after the Working Group completed its work. The members of the Committee were: Alabama, Arizona, Delaware, District of Columbia, Idaho, Iowa, Louisiana, Nebraska, Nevada, New York, North Dakota, Ohio, Puerto Rico, Tennessee and Wisconsin.

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

The Life Insurance and Annuities (A) Committee established the Annuity Suitability (A) Working Group in 2017 to carry out the charge below:

“Review and revise, as necessary, the Suitability in Annuity Transactions Model Regulation (#275) and consider how to promote greater uniformity across NAIC-member jurisdictions.”

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

Beginning in March 2017 and ending in December 2019, the Working Group reviewed and discussed all of the comments received as part of the drafting process. Numerous interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, insurers and producer representatives. Each draft of proposed revisions was posted to the Working Group’s web page and the Committee’s web page on the NAIC website. All comment letters received also were posted. The Working Group held open in-person interim meetings and met via conference call during the drafting process. The Working Group also met in person at each NAIC national meeting.

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

Beginning in March 2017 and ending in December 2019, the Working Group reviewed and discussed all of the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers and producer representatives. Each draft of proposed revisions was posted to the Working Group’s web page and the Committee’s web page on the NAIC website. All comment letters received also were posted. The Working Group held open in-person interim meetings and met via conference call during the drafting process. The Working Group also met in person at each NAIC national meeting.
6. A Discussion of the Significant Issues (items of some controversy raised during the drafting process and the group’s response)

Several significant issues were raised throughout the drafting process. Those issues included: 1) expanding Model #275 to include investment-type life insurance products; 2) specifically applying the proposed revisions to in-force annuity products; 3) applying the proposed revisions to producers who may not have direct contact with the consumer, but participated in a material way to developing and making the recommendation purchase an annuity; and 4) including the drafting note stating that the proposed model revisions are a successor to the 2010 model revisions.

With respect to expanding Model #275 to include investment-type life insurance products, the Working Group discussed this issue during one of its first in-person interim meetings. The Working Group decided that given its charge to “review and revise, as necessary, the Suitability in Annuity Transactions Model Regulation (#275) and consider how to promote greater uniformity across NAIC-member jurisdictions,” expanding Model #275 to include investment-type life insurance products was beyond the scope of its charge. The Working Group concluded that the Life Insurance and Annuities (A) Committee was the appropriate forum for raising and considering this issue.

Another significant issue discussed was whether the model revisions should specifically apply to in-force annuity contracts. The Working Group discussed this issue extensively during multiple meetings. It decided ultimately not to include language in the proposed revisions specifically applying to in-force annuity contracts. However, during these discussions, it was suggested that in certain situations, in making a recommendation, a producer or insurer would have to and would be expected to consider a consumer’s existing insurance products, including annuities, to determine whether the recommended option effectively addresses the consumer’s financial situation, insurance needs and financial objectives as part of satisfying the best interest standard of conduct.

The Working Group also extensively discussed whether the model revisions should apply to producers not having direct contact with a consumer, but exercised material control or influence in the making of the recommendation. The Working Group decided to add language applying the model revisions to such producers under certain circumstances. Specifically, in Section 6A(5), the model revisions provide that any requirement applicable to a producer under Section 6—Duties of Insurers and Producers applies to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale regardless of whether the producer has had any direct contact with the consumer.

Another issue the Working Group discussed was whether the revised model establishing the new best interest standard of conduct would be considered for purposes of Section 989J of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank Act) a successor to the 2010 model revisions, which established the suitability standard of conduct. The proposed revisions include a drafting note in Section 1—Purpose expressly stating the proposed revisions are a successor to the 2010 model revisions. The Working Group deferred the issue to the NAIC Legal Division for additional research. The NAIC Legal Division did not expressly provide an opinion, but initial research found that with or without the Section 1 drafting note, the revised model most likely would be considered a successor to the 2010 model. The Working Group determined that this was a policy issue for the Committee, the Executive (EX) Committee and Plenary to decide. The model revisions, as adopted by the Committee, retain the proposed drafting note.

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

None.
Actuarial Guideline XLVIII
(Appplies to 2017 and Subsequent Year Valuations)

ACTUARIAL OPINION AND MEMORANDUM REQUIREMENTS FOR THE REINSURANCE OF POLICIES REQUIRED TO BE VALUED UNDER SECTIONS 6 AND 7 OF THE NAIC VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION (MODEL #830)

Background

The NAIC Principle-Based Reserving Implementation (EX) Task Force (“PBRI Task Force”) serves as the coordinating body for all NAIC technical groups involved with projects related to the Principle-Based Reserves (PBR) initiative for life and health policies. The PBRI Task Force was also charged with further assessing, and making recommendations regarding, the solvency implications of life insurance reserve financing mechanisms addressed in the June 6, 2013 NAIC White Paper of the Captives and Special Purpose Vehicle Use (E) Subgroup of the Financial Condition (E) Committee. Some of these reinsurance arrangements have been referred to as “XXX/AXXX Captive arrangements,” although not all such arrangements actually involve reinsurers organized as captives. In this connotation, XXX denotes the reserves prescribed by Section 6 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model #830) while AXXX denotes the reserves prescribed by Section 7 of Model #830, and by Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38). On June 30, 2014, the PBRI Task Force adopted a framework as found in Exhibits 1 and 2 of the June 4, 2014 report from Rector & Associates, Inc. (the “June 2014 Rector Report”). Exhibit 2 of the report included a charge to the Life Actuarial (A) Task Force (LATF) to develop a level of reserves (the “Required Level of Primary Security”) that must be supported by certain defined assets (“Primary Security”). The level of reserves is to be calculated by a method referred to as the “Actuarial Method.” Another charge to LATF was to promulgate an actuarial guideline specifying that, in order to comply with the NAIC Actuarial Opinion and Memorandum Regulation, Model 822 (“AOMR”) as it relates to XXX/AXXX reinsurance arrangements, the opining actuary must issue a qualified opinion as to the ceding insurer’s reserves if the ceding insurer or any insurer in its holding company system has engaged in a XXX/AXXX reserve financing arrangement that does not adhere to the Actuarial Method and Primary Security forms adopted by the NAIC. The initial version of Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) was developed in response to that charge, with an effective date of January 1, 2015.

Coordination between this Actuarial Guideline and the NAIC Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787)

Subsequently, on January 8, 2016, the NAIC adopted revisions to the Credit for Reinsurance Model Law (Model #785). Among other things, the revisions to Model #785 provide commissioners with the authority to enact, by regulation, additional requirements for ceding insurers to claim credit for reinsurance with respect to certain XXX/AXXX financing arrangements. On December 13, 2016, the NAIC adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787) as the regulation permitted by Model #785. LATF subsequently received a charge to redraft AG 48 to make it as consistent as possible with the provisions of Model #787. The current version of this actuarial guideline is the result.

The following is an overview of the interrelationship between this actuarial guideline and Model #787, and the regulatory strategy that led to the adoption of each:

1. The initial version of this actuarial guideline immediately established national standards for the use of XXX/AXXX financing arrangements in an attempt to quickly set minimum standards based on the framework adopted by the PBRI Task Force on June 30, 2014. This initial version applied to such reinsurance arrangements entered into on or after 1/1/2015.

2. The revised statute (the NAIC Credit for Reinsurance Model Law (Model #785)) and a new regulation (the NAIC Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787)) were then developed and adopted by the NAIC.
3. Except as noted in #4 below, this actuarial guideline will cease to be effective, on a state by state basis, as individual states enact Model #785 and adopt Model #787 to replace it.

4. Notwithstanding, it is anticipated that in a small number of states, Model #787 will need to be adopted on a “prospective” basis only (that is, it will only apply to ceded policies issued on or after the effective date thereof). In those cases, this actuarial guideline will remain as the authority for ceded policies subject to this actuarial guideline but to which Model #787, as adopted in a given state, does not apply. So although its role might diminish, this actuarial guideline will remain an essential part of the regulatory framework for a small number of states for many years to come.

5. To ensure uniformity of treatment between states, companies, and ceded policies (whether governed by this actuarial guideline or by Model #787) and to avoid confusion, this actuarial guideline is being updated, effective as of January 1, 2017, to make it as substantively identical to Model #787 as possible.

Authority, Avoidance, and Purpose

The requirements in this actuarial guideline derive authority from Section 3 of the AOMR, or, after the Operative Date of the Valuation Manual, from Section 1 of VM-30 of the Valuation Manual. Both Section 3 of the AOMR and Section 1 of VM-30 provide that the commissioner has the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items. As contained in the framework adopted by the PBRI Task Force on June 30, 2014, this actuarial guideline defines new terms, such as Primary Security and Required Level of Primary Security, specifies the Actuarial Method used to calculate the Required Level of Primary Security, and specifies other requirements that must be followed when reinsurance is involved in order for the appointed actuary to render an actuarial opinion that is not qualified.

No statute, regulation or guideline can anticipate every potential XXX/AXXX captive arrangement. Common sense and professional responsibility are needed to assure not only that the text of this actuarial guideline is strictly observed, but also that its purpose and intent are honored scrupulously. To that end, and to provide documentation to the appointed actuary as to the arrangements that are subject to review under this actuarial guideline, the appointed actuary may request from each ceding insurer, and may rely upon, the certification by the Chief Financial Officer or other responsible officer of each ceding insurer filed with the insurer's domiciliary regulator that the insurer has not engaged in any arrangement or series of arrangements involving XXX or AXXX reserves that are designed to exploit a perceived ambiguity in, or to violate the purpose and intent of, this actuarial guideline.

The purpose and intent of this actuarial guideline is to establish uniform, national standards governing XXX or AXXX reserve financing arrangements in conformity with the PBRI Task Force framework and, in connection with such arrangements, to ensure that Primary Security, in an amount at least equal to the Required Level of Primary Security, is held by or on behalf of the ceding insurer. As described further in Section 4.B., the provisions of this actuarial guideline are not intended to apply to policies that were issued prior to 1/1/2015 if those policies were included in a captive reserve financing arrangement as of 12/31/2014. Further, the requirements of this actuarial guideline should be viewed as minimum standards and are not a substitute for the diligent analysis of reserve financing arrangements by regulators. A regulator should impose requirements in addition to those set out in this actuarial guideline if the facts and circumstances warrant such action.

Text

1. Authority

Pursuant to Section 3 of the AOMR or, after the Operative Date of the Valuation Manual, to Section 1 of VM-30 of the Valuation Manual, the commissioner shall have the authority to specify specific methods of actuarial analysis and

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3 In general, reserve financing arrangements are those where the security/assets backing part or all of the reserves have one or more of the following characteristics: such security/assets (1) are issued by the ceding insurer or its affiliates; and/or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; and/or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any if its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance arrangement).
actuarial assumptions when, in the commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

2. Scope

This actuarial guideline applies to reinsurance contracts that cede liabilities pertaining to Covered Policies as that term is defined in Section 4.

3. Exemptions

This actuarial guideline does not apply to the situations described in Subsections A through F.

A. Reinsurance of:

(1) Policies that satisfy the criteria for exemption set forth in Section 6F or Section 6G of Model #830; and which are issued before the later of:

(a) The effective date of Model #787 in the state of domicile of the ceding insurer, and

(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than January 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in Section 6E of Model #830 and which are issued before the later of:

(a) The effective date of Model #787 in the state of domicile of the ceding insurer, and

(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than January 1, 2020;

(3) Any universal life policy that meets all of the following requirements:

(a) Secondary guarantee period, if any, is five (5) years or less;

(b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables and valuation interest rate applicable to the issue year of the policy; and

(c) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period;

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year; or

B. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Section 2D of Model #785; or

C. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Sections 2A, 2B or 2C, of Model #785, and that, in addition:
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(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer’s reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures (“SSAP No. 1”); and

(2) Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in the NAIC Risk-Based Capital (RBC) for Insurers Model Act (Model #312) when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or

D. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Sections 2A, 2B or 2C, of Model #785, and that, in addition:

(1) Is not an affiliate, as that term is defined in Section 1A of the NAIC Insurance Holding Company System Regulatory Model Act (Model #440), of:

   (a) The insurer ceding the business to the assuming insurer; or

   (b) Any insurer that directly or indirectly ceded the business to that ceding insurer;

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

(3) Is both:

   (a) Licensed or accredited in at least 10 states (including its state of domicile), and

   (b) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in Model #312 when its risk-based capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer’s reported surplus; or

E. Reinsurance ceded to an assuming insurer that meets the requirements of either Section 5B(4)(a) of Model #785, pertaining to certain certified reinsurers or Section 5B(4)(b) of Model #785, pertaining to reinsurers meeting certain threshold size and licensing requirements; or

F. Reinsurance not otherwise exempt under Subsections A through E if the commissioner, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this actuarial guideline (as described in the Authority, Avoidance and Purpose section above);

(2) The risks are included within the scope of this actuarial guideline only as a technicality; and

(3) The application of this actuarial guideline to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall publicly disclose any decision made pursuant
to this Section 3F to exempt a reinsurance treaty from this actuarial guideline, as well as the general basis therefor (including a summary description of the treaty).

**Drafting Note:** The exemption set forth in Section 3F was added to address the possibility of unforeseen or unique transactions. This exemption exists because the NAIC recognizes that foreseeing every conceivable type of reinsurance transaction is impossible; that in rare instances unanticipated transactions might get caught up in this actuarial guideline purely as a technicality; and that regulatory relief in those instances may be appropriate. The example that was given at the time this exemption was developed pertained to bulk reinsurance treaties where the ceding insurer was exiting the type of business ceded. The exemption should not be used with respect to so-called “normal course” reinsurance transactions; rather, such transactions should either fit within one of the standard exemptions set forth in Sections 3A, B, C, D, or E or meet the substantive requirements of this actuarial guideline.

4. **Definitions**

   A. “Actuarial Method” means the methodology used to determine the Required Level of Primary Security, as described in Section 5.

   B. “Covered Policies” means the following: Subject to the exemptions described in Section 3, Covered Policies are those policies, other than Grandfathered Policies, of the following policy types:

   (1) Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or,

   (2) Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

   **Note:** Although “Covered Policies” is defined to include all the policies described in Subsections B1 and B2 above, it is noted that whether a given “Covered Policy” is subject to this actuarial guideline or, instead, to Model #787 should be determined under Section 8 (Sunset).

   C. “Grandfathered Policies” means policies of the types described in Subsections B1 and B2 above that were:

   (1) Issued prior to January 1, 2015; and

   (2) Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in Section 3 had that section then been in effect.

   D. “Non-Covered Policies” means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.

   E. “Required Level of Primary Security” means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.

   F. “Primary Security” means the following forms of security:

   (1) Cash meeting the requirements of Section 3A of Model #785;

   (2) Securities listed by the Securities Valuation Office meeting the requirements of Section 3B of Model #785, but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and
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(3) For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:
   
   (a) Commercial loans in good standing of CM3 quality and higher;
   
   (b) Policy Loans; and
   
   (c) Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

G. “Other Security” means any security acceptable to the commissioner other than security meeting the definition of Primary Security.

H. “Valuation Manual” means the valuation manual adopted by the NAIC as described in Section 11B(1) of the Standard Valuation Law, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.


5. The Actuarial Method

A. Description of Actuarial Method

The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this actuarial guideline shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

(1) For Covered Policies described in Section 4B(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in Section 4B(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations. The mortality basis for the NPR shall be the 2017 CSO Mortality Table.

(2) For Covered Policies described in Section 4B(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met. The mortality basis for the NPR shall be the 2017 CSO Mortality Table.

(3) Except as provided in Paragraph (4) below, the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.

(4) If the reinsurance treaty cedes less than one hundred percent (100%) of the risk with respect to the Covered Policies then the Required Level of Primary Security may be reduced as follows:

   (a) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under Subparagraph (c) below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;
(b) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(c) If a portion of the Covered Policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be reduced by the amount resulting by applying the Actuarial Method including the reinsurance section of VM-20 to the portion of the Covered Policy risks ceded in the exempt arrangement, except that for Covered Policies issued prior to Jan 1, 2017, this adjustment is not to exceed \[\frac{c_x}{2 * \text{number of reinsurance premiums per year}}\] where \(c_x\) is calculated using the same mortality table used in calculating the Net Premium Reserve; and

(d) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security.

It is possible for any combination of Subparagraphs (a), (b), (c), and (d) above to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than one hundred percent (100%) of the risk.

The Adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

(5) In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

(6) If the ceding insurer cedes risks with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this actuarial guideline, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this actuarial guideline.

(7) If a reinsurance treaty subject to this actuarial guideline cedes risk on both Covered and Non-Covered Policies:

(a) The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies; and

(b) Any Primary Security and/or Other Security used to meet any requirements pertaining to the Non-Covered Policies may not be used to satisfy any requirements related to the Required Level of Primary Security and/or Other Security for the Covered Policies.
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B. Valuation Used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

1. For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer’s general account and without taking into consideration the effect of any prescribed or permitted practices; and

2. For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the NAIC’s Life Actuarial (A) Task Force no later than the December 31st on or immediately preceding the valuation date for which the Required Level of Primary Security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.

6. Required Actuarial Analysis and Actuarial Opinion and Memorandum Requirements

A. Required Actuarial Analysis

Before the due date of each actuarial opinion, as to each reinsurance treaty in which Covered Policies have been ceded, the appointed actuary of each ceding insurer must perform an analysis on a treaty by treaty basis, of such Covered Policies to determine whether, as of the immediately preceding December 31st (the valuation date):

1. Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of Section 3 of Model #785, on a funds withheld, trust, or modified coinsurance basis; and

2. Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (1) above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of Section 3 of Model #785; and

Note: For the sake of clarity, funds consisting of Primary Security pursuant to Paragraphs (1) may exceed the Required Level of Primary Security, and Other Security is only required under Paragraph (2) to the extent that there is any portion of the statutory reserves as to which Primary Security is not so held. For example, if a ceding insurer’s statutory reserves equal $1 Billion, its Required Level of Primary Security is $600 Million, and it holds $1 Billion in Primary Security pursuant to Paragraph (1), no Other Security is required under Paragraph (2).

3. Any trust used to satisfy the requirements of this Section 6 complies with all of the conditions and qualifications of Section 1244 of the NAIC Credit for Reinsurance Model Regulation (Model #786), except that:

(a) Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in Section 5B, be valued according to the valuation rules set forth in Section 5B, as applicable; and

(b) There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of Section 6A(1); and
AG XLVIII

(c) The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by Section 6A(1)) below 102% of the level required by Section 6A(1) at the time of the withdrawal or substitution.

B. Qualified Actuarial Opinion; Remediation

(1) The appointed actuary of the ceding insurer performing the analysis required by Section 6A above must issue a qualified actuarial opinion as described in Section 6.D. of the AOMR or Section 3A(10) of VM-30 of the Valuation Manual, as applicable, unless:

(a) The requirements of Section 6A(1) and 6A(2) were fully satisfied as of the valuation date as to such reinsurance treaty; or

(b) Any deficiency has been eliminated before the due date of the Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of Section 6A(1) and 6A(2) to be fully satisfied as of the valuation date; or

(c) The ceding insurer has established a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to Section 6A(1).

(2) In addition to the requirement set forth in Section 6B(1) above, the appointed actuary of the ceding insurer performing the analysis required by Section 6A above must issue a qualified actuarial opinion as described in Section 6.D. of the AOMR or Section 3A(10) of VM-30 of the Valuation Manual, as applicable, if the appointed actuary for any affiliated reinsurer of the ceding insurer issues a qualified actuarial opinion with respect to such affiliated reinsurer where (a) the affiliate reinsures Covered Policies of the ceding insurer and (b) the qualified actuarial opinion pertaining to the affiliated reinsurer results, in whole or in part, from the analysis required by this actuarial guideline.

Note: The remediation option set forth in Section 6B(1)(c) mirrors that set forth in Model #787. Under this option, a ceding company may choose to avoid the consequence (a qualified opinion under this actuarial guideline) by establishing a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held. For example, suppose a ceding insurer has established statutory reserves of $1 Billion and has Primary Security of $550 Million and Other Security of $450 Million. Suppose further that the actuary determines that the insurer’s Required Level of Primary Security is $600 Million. Under Section 6B(1)(c), the insurer may avoid a qualified opinion by establishing a liability equal to $450 Million (the difference between the statutory reserve of $1 Billion and the $550 Million amount of Primary Security actually held).

C. Additional Requirements for the Actuarial Opinion and Memorandum for Companies that have Covered Policies Requiring the Analysis Pursuant to this actuarial guideline

(1) In the statement of actuarial opinion, the appointed actuary of the ceding insurer must state whether (i) he has performed an analysis, as to each reinsurance arrangement under which Covered Policies have been ceded, of the security supporting the Covered Policies and whether funds consisting of Primary Security in an amount at least equal to the Required Level of Primary Security are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis and (ii) funds consisting of Primary Security or Other Security in an amount equal to the statutory reserves are held by or on behalf of the ceding insurer as security under the reinsurance arrangement.
AG XLVIII

(2) In the actuarial memorandum as described by Section 7 of the AOMR or Section 3B of VM-30 of the Valuation Manual, as applicable, the appointed actuary of the ceding insurer must document the analysis and requirements applied by this actuarial guideline as to each reinsurance arrangement under which Covered Policies are ceded.

(3) In the event that a reinsurance treaty contains both (1) Covered Policies subject to this actuarial guideline rather than to Model #787, and (2) Covered Policies subject to Model #787 rather than to this actuarial guideline, the treaty shall be tested as a whole for purposes of a ceding insurer’s compliance with both (a) the requirements of Section 6A(1) and Section 6A(2) of this actuarial guideline and (b) the requirements of Section 7A(3) and Section 7A(4) of Model #787; provided further, that:

(a) If funds consisting of Primary Security are held in amounts less than the Required Level of Primary Security, such funds consisting of Primary Security shall be allocated first to fulfill the Required Level of Primary Security for the Covered Policies subject to this actuarial guideline, with any remainder allocated to those Covered Policies subject to Model #787; and

(b) If funds consisting of Other Security are held in amounts less than the requirements of Section 6A(2), such funds consisting of Other Security shall be allocated first to fulfill the Other Security requirements for the Covered Policies subject to this actuarial guideline, and any remainder shall be allocated to those Covered Policies subject to Model #787.

7. Effective Date

This actuarial guideline shall become effective as of January 1, 2017 with respect to all Covered Policies. This actuarial guideline supersedes and replaces all previous versions thereof with respect to actuarial opinions rendered as to valuation periods ending on or after January 1, 2017.

Note: For the avoidance of doubt, actuarial opinions issued with respect to the year ended December 31, 2016, shall be governed by the version of AG 48 in effect on December 31, 2016, as included in the Accounting Practices and Procedures Manual.

8. Sunset Provision

This actuarial guideline shall cease to apply as to Covered Policies that are both (a) issued by ceding insurers domiciled in a jurisdiction that has in effect, as of December 31st of the calendar year immediately preceding the year in which the actuarial opinion is to be filed, a regulation substantially similar to Model #787 adopted by the NAIC on December 13, 2016; and (b) subject to Model #787 as so adopted by the ceding insurer’s jurisdiction of domicile. This Actuarial Guideline shall continue to apply, without interruption, to any and all Covered Policies not included in both (a) and (b) of the immediate preceding sentence.

Note: It is anticipated that, for most states, this actuarial guideline will sunset pursuant to (a) and (b) of Section 8 and will continue only with respect to the limited number of states in which their version of Model #787 applies prospectively only, i.e., applies only to Covered Policies issued on or after the effective date of their version of Model #787. It is anticipated, however, that most states will be able to adopt a version of Model #787 that, like the Model itself, applies to all Covered Policies (subject to the applicable exemptions and grandfathering provisions) that are “in force” on or after the effective date, even if the policies were originally issued prior to that effective date. The goal of Section 8 is to ensure that all Covered Policies ceded in reinsurance transactions within the scope of this actuarial guideline continue to be subject to this actuarial guideline unless and until they become subject to Model #787.
Amendments for the 2021 Valuation Manual for the Consideration of Joint Meeting of the Executive (EX) Committee and Plenary July 10, 2020

<table>
<thead>
<tr>
<th>LATF VM Amendment</th>
<th>Valuation Manual Reference</th>
<th>Valuation Manual Amendment Proposal Descriptions</th>
<th>LATF Adoption Date</th>
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<tr>
<td>2019-58</td>
<td>Section A.1</td>
<td>Clarify that prescribed templates are subject to the VM governance requirements for substantive changes</td>
<td>5/21/20</td>
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<tr>
<td>2019-61</td>
<td>Section II, Subsection 1.D.3</td>
<td>The Life PBR Exemption restriction is intended to apply to ULSG with material secondary guarantees regardless of whether the secondary guarantee is an embedded guarantee or is a separate rider.</td>
<td>2/6/20</td>
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<tr>
<td>2020-05</td>
<td>VM-20 3.C.4</td>
<td>Clarify that the NPR assumes continuous deaths and immediate payment of claims, and does not apply to surrenders</td>
<td>6/11/20</td>
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<tr>
<td>2020-07</td>
<td>VM-02 Section 3.A</td>
<td>Remove 4% Floor from Life Standard Nonforfeiture Rate</td>
<td>6/25/20</td>
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</table>
1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   Staff of Office of Principle-Based Reserving, California Department of Insurance – Address the topic of prescribed templates.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
   Valuation Manual (January 1, 2020 edition), Introduction, Section I, A.1

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

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

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**NAIC Staff Comments:**

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ISSUE:

Now that the concept of a prescribed template has been introduced into VM-31, it should be made clear what the rules are surrounding making changes to such templates.

SECTIONS:

Introduction, Section I, Process for Updating the Valuation Manual, Section A.1

REDLINE:

1. Substantive Items

Substantive changes to the Valuation Manual are proposed amendments to the Valuation Manual that would change or alter the meaning, application or interpretation of a provision. All changes to the Valuation Manual (or to templates prescribed for use by the Valuation Manual) will be considered substantive, unless specifically identified as either a nonsubstantive item or an update to a table by simple majority vote of the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force. Any item placed on the Active List as substantive will be exposed by the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force for a public comment period commensurate with the length of the draft and the complexities of the issue, but for no less than 21 days. The comment period will be deemed to have begun when the draft has been placed on the appropriate public NAIC web page. The Life Actuarial (A) Task Force/Health Actuarial (B) Task Force will hold at least one open meeting (in person or via conference call) to consider comments before holding a final vote on any substantive items. Subsequent exposures of substantive items will be for a minimum of seven days. Meeting notices for Life Actuarial (A) Task Force/Health Actuarial (B) Task Force meetings will indicate if a vote is anticipated on any substantive items. Adoption of all changes at the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force will be by simple majority.

REASONING:

Help assure readers that there no back doors through which to create new requirements.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   Rachel Hemphill, Texas Department of Insurance
   Mary Bahna-Nolan, Pacific Life
   VM-20 restriction on using different credibility methods for significantly different blocks of business

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
   VM-20 Sections 9.C.5.a and 9.C.7.b.ii
   January 1, 2020 NAIC Valuation Manual

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   Currently, a company must select a single credibility methodology, Limited Fluctuation or Bühlmann, for all business that company has that is subject to VM-20 and requires credibility percentages. The Bühlmann methodology is technically allowed for Simplified Issue business within the Valuation Manual; however, at present, it is not practically possible since there are no industry factors available for Simplified Issue. Therefore, only the Limited Fluctuation method can currently be used for determining credibility for Simplified Issue business. The factors in VM-20 for the Bühlmann were developed to only be used in conjunction with the 2015 VBT. Thus, currently, a company with any Simplified Issue business subject to VM-20 that requires credibility calculations must use the Limited Fluctuation method for all of their business subject to VM-20 that requires credibility calculations, including the fully underwritten business. We do not see this as a reasonable restriction. VM-20 already requires that companies not change their credibility method once selected unless they receive commissioner approval for the change, and we believe that that constraint is sufficient to avoid any significant gaming of the credibility method selection.

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Notes: APF 2019-60
VM-20 Section 9.C.5.a

5. Credibility of Company Experience

a. For valuations in which the industry basic mortality table is the 2008 VBT, determine an aggregate level of credibility over the entire exposure period using a methodology to determine the level of credibility that follows common actuarial practice as published in actuarial literature (for example, but not limited to, the Limited Fluctuation Method or Bühlmann Empirical Bayesian Method).

For valuations in which the industry basic mortality table is the 2015 VBT, determine an aggregate level of credibility following either the Limited Fluctuation Method by amount, such that the minimum probability is at least 95% with an error margin of no more than 5% or Bühlmann Empirical Bayesian Method by amount. Once chosen, the credibility method must be applied to all business subject to VM20 and requiring credibility percentages.

Not all blocks of a company’s business subject to VM-20 necessarily need to use the same credibility method. However, a company seeking to change the credibility methods for a given block of business must request and subsequently receive the approval of the insurance commissioner. The request must include the justification for the change and a demonstration of the rationale supporting the change.

VM-20 Section 9.C.7.b.ii

7. Process to Determine Prudent Estimate Assumptions

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

b. If the company uses company experience mortality rates as the anticipated experience assumptions, the following process shall be used to develop prudent estimate assumptions:

i. Determine the values of A, B and C from the Grading Table below, based on the level of credibility of the data as provided in Section 9.C.5.

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<tr>
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<th>A</th>
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<tr>
<td>20% - 30%</td>
<td>10</td>
<td>2</td>
<td>8</td>
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<tr>
<td>31%–32%</td>
<td>11</td>
<td>3</td>
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<td>33%–34%</td>
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<td>35%–36%</td>
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<td>41%–42%</td>
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<td>43%–44%</td>
<td>17</td>
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<td>45%–46%</td>
<td>18</td>
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<td>47%–48%</td>
<td>19</td>
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<td>11</td>
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<tr>
<td>49%</td>
<td>20</td>
<td>3</td>
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</tr>
<tr>
<td>50%</td>
<td>20</td>
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</tr>
<tr>
<td>51%</td>
<td>21</td>
<td>4</td>
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ii. Determine the value of D, which represents the last policy duration that has a substantial volume of claims, using the chosen data source(s) as specified in Section 9.C.2.b. D is defined as the last policy duration at which there are 50 or more claims (not the first policy duration in which there are fewer than 50 claims), not counting riders. This may be determined at either the mortality segment level or at a more aggregate level if the mortality for the individual mortality segments was determined using an aggregate level of mortality experience pursuant to Section 9.C.2.d.
Guidance Note: The same level of aggregation is used in Section 9.C.2.d for determining company experience mortality rates, Section 9.C.5.b for determining credibility, and Section 9.C.7.b.ii for determining the value of D. Thus, when determining the value of D, all claims being aggregated will have used the same credibility method in Section 9.C.5.
1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
The Life PBR Exemption restriction is intended to apply to ULSG with material secondary guarantees regardless of whether the secondary guarantee is an embedded guarantee or is a separate rider.

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

VM Section II, Subsection 1.D.3
January 1, 2020 NAIC Valuation Manual

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

See attached.

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

ULSG policies with material secondary guarantees are intended to be excluded from the Life PBR Exemption, regardless of whether the secondary guarantee is embedded in the base policy or is a separate rider. The VM does say that non-ULSG base policies with secondary guarantee riders follow the reserving requirements for ULSG policies in Section II, Subsection 6.C: “ULSG and other secondary guarantee riders shall be valued with the base policy and follow the reserve requirements for ULSG policies under VM-20, VM-A and/or VM-C, as applicable.” It should be made clear that following the reserve requirements for ULSG includes exclusion from the Life PBR Exemption, when the secondary guarantee is material.

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Notes: APF 2019-61
VM Section II, Subsection 1.D.3

3. Policies Excluded from the Life PBR Exemption:
a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee, or policies – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form*

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

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
January 1, 2020, edition of the Valuation Manual with NAIC adoptions through August 6, 2019 Locations with proposed changes: VM-20 and VM-31

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
The Valuation Manual already requires that if there is additional risk arising from the conversion of term life insurance, whether group or individual, it must be reserved for. The purpose of this APF is to emphasize this requirement and to provide guidance on what must be included in the Life PBR Actuarial Report with respect to conversions.

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

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| Notes: VM APF 2019-62 rev.02-10-20; 14-day re-exposure through 2/26/20; Adopted 2/27/20 |
VM-20 Section 9.C.4 - Add Section 9.C.4.d

c. The mortality rates from the resulting anticipated experience assumptions must be no lower than the mortality rates that are actually expected to emerge and that the company can justify.

d. In satisfying Section 9.C.4.c, the company must ensure that any excess mortality is appropriately reflected in the anticipated experience mortality rates. This includes but is not limited to excess mortality associated with policies issued via conversion from term policies or from group life contracts.

Exposure of the proposed section 9.C.4.c includes the following changes which have been reviewed and accepted by the Task Force:

VM-31 Section 3.B.3 [Executive Summary – policy overview]

3. Policies – A summary of the base policies within each VM-20 reserving category. Include information necessary to fully describe the company’s distribution of business. For direct business, use PBR Actuarial Report Template A located on the NAIC website (https://www.naic.org/pbr_data.htm?tab_3) to provide descriptions of each base policy product type and underwriting process (including a description of the process, the time period in which it was used, and the level of any additional margin), with a breakdown of policy count and face amount by base policy product type and underwriting process. Also include the target market, primary distribution system, and key product features that affect risk, including conversion privileges.


d. Assumption and Margin Development – The following information for each risk factor: description of the methods used to determine anticipated experience assumptions and margins, including the sources of experience (e.g., company experience, industry experience, or other data); how changes in such experience are monitored; any adjustments made to increase mortality margins above the prescribed margin (such as to reflect increased uncertainty with due to newer underwriting approaches; and any other considerations, such as conversion features, helpful in or necessary to understanding the rationale behind the development of assumptions and margins, even if such considerations are not explicitly mentioned in the Valuation Manual.

VM-31 Section 3.D.3.x-[new section] [Life Report – Mortality]

(We suggest placing after Adjustments for Mortality Improvement and before Mortality for Impaired Lives)

j. Mortality for Converted Policies – Description of the treatment of mortality for Mortality policies issued under group or term conversion privileges including:

i. A description of the method(s) by which any excess conversion mortality was taken into account in the development of company experience mortality rates (e.g., through the use of separate mortality segments for policies issued upon conversion, through aggregation of claim experience, or through use of other methods), the rationale for the method(s) used, and any changes in the method(s) from those used in previous years.

ii. The source(s) of the data used in the method(s) employed.
Mortality for Impaired Lives or Policyholder Behavior – Disclosure of:

i. the percentage of business that is on impaired lives;

ii. whether impaired lives were included or excluded from the mortality study upon which company experience mortality was based; and

iii. whether any adjustments to mortality assumptions for impaired lives or policyholder behavior were found to be necessary and, if so, the rationale for the adjustments that were used.

Item (iii) above is a required disclosure for post-level term mortality assumptions even if the company uses a 100% shock lapse assumption, since it pertains to the analysis demonstrating whether there are post-level term profits.


k. Post-Level Term Testing – For products with a level term period:

i. Summary results of the seriatim comparison of the present value of postlevel term cash inflows and outflows for the DR as required by VM-20 Section 9.D.6.

ii. If this comparison showed that there were post-level term profits, describe how anti-selection was handled in the post-level term period, including the prudent estimate premium, mortality and lapse assumptions used.

iii. If the comparison showed that there were post-level term losses, confirm that the prudent estimate premium, mortality and lapse assumptions for the post-level period were addressed in Section 3.D.1.a and were used in the reserve calculation.

l. Term Conversions – Description of how the company reflects the impact of any term conversions privilege contained in the policy.

m. Lapse Rates for Converted Policies – Description of and rationale for lapse rates used for policies issued under any group or term conversion privilege.


a. Agreements – For those reinsurance agreements included in the calculation of the minimum reserve as per VM-20 Section 8.A, a description of each reinsurance agreement, including, but not limited to, the type of agreement, the counterparty, the risks reinsured, any provisions related to converted policies, the portion of business reinsured, identification of both affiliated and non-affiliated, as well as captive and non-captive, or similar relationships, and whether the agreement complies with the requirements of the credit for reinsurance under the terms of the AP&P Manual.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   Jason Kehrberg, Vice President, PolySystems, Inc.

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

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

   4. The NPR shall reflect the immediate payment of claims.

   Proposed VM-20 3.C.4 (revised):
   4. The NPR shall reflect continuous deaths and the immediate payment of death claims, including death claims on any riders or supplemental benefits for which the NPR is being calculated.

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   I believe the intent was that 3.C.4 apply to death claims, e.g. not to payment of positive cash surrender values upon lapse, and that on a present value basis the calculated periodic death claim payments equate to immediate claim payment on deaths assumed to occur continuously.

NAIC Staff Comments:

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Notes: VM APF 2020-05R
Re-Exposure of APF 2020-06  Updated 6/11/20 v.2
This version of APF is the same as the initial version exposed after the June 11 LATF call with the exception that the following sentences

“When LIBOR is terminated or its use becomes de minimis, the LIBOR rates will be replaced with the most appropriate replacement rates for the specified purpose. The NAIC will monitor these market observable values and, in the event the then current values are discontinued or replaced, will recommend an appropriate replacement to the Life Actuarial (A) Task Force.”

have been replaced by the sentence below

When the NAIC determines LIBOR is no longer effective, the NAIC shall recommend a replacement to LATF which shall be effective upon adoption by Life Actuarial (A) Task Force.

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

**Amendment Proposal Form**

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   
   Brian Bayerle, ACLI – Interest Rate Swap Spread Determination

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


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

   See attached.

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

   Interest Rate Swap Spreads are currently being calculated by the NAIC under methodology outlined in the Valuation Manual. This APF changes the methodology for calculation of the 3-month and 6-month swap spreads to use market observable values for Treasury rates and LIBOR, rather than the average of these values from JP Morgan and Bank of America.

   With the forthcoming termination of LIBOR, the requirements of the Valuation Manual will need to change. This APF provides broad guidance allowing for one or more currently unnamed rate to replace LIBOR in these calculations.

   Additionally, this APF allows the company to calculate its own current swap spreads based on market observable values. The spread requirements are currently included in VM-20, with VM-21 referencing the applicable sections. With the potential of VM-22 likely having similar references, LATF may want to consider moving these and other asset requirements to their own section.

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Notes: VM APF 2020-06
Options for LATF consideration: Per the 6/11 LATF discussion, in addition to adopting the full text of the APF, regulators wanted to consider not allowing for companies to produce their own current swap spreads. This option would be to retain “prescribed” instead of “calculated”, would strike the paragraph beginning “The company may elect to produce their own current swap curves...”, and would remove the VM-31 Section 3.D.6.v and VM-31 Section 3.F.4.h language.

**VM-20 Section 9.F.8.d**

Interest rate swap spreads over Treasuries shall be prescribed/calculated by the NAIC for use throughout the cash-flow model wherever appropriate for transactions and operations including, but not limited to, purchase, sale, settlement, cash flows of derivative positions and reset of floating rate investments. A current and long-term swap spread curve shall be prescribed/calculated for year one and years four and after, respectively, with yearly grading in between. The three-month and six-month points on the swap spread curves represent the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries, shall be the market-observable values for these tenors. Currently, this shall be the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries. When LIBOR is terminated or its use becomes de minimis, the LIBOR rates will be replaced with the most appropriate replacement rates for the specified purpose. The NAIC will monitor these market-observable values and, in the event the then-current values are discontinued or replaced, will recommend an appropriate replacement to the Life Actuarial (A) Task Force. When the NAIC determines LIBOR is no longer effective, the NAIC shall recommend a replacement to LATF which shall be effective upon adoption by LATF.

The company may elect to produce their own current swap spread curves based on current observable rates. The company will document the data source(s) of the observable rates and the methodology of interpolation of non-published rates in the VM-31 report.

**VM-20 Appendix 2.F.1**

**F. Current Benchmark Swap Spreads**

1. For tenors of one-year to thirty-years, extract swap spread data determined as of the last business day of the month by maturity. For Bank of America data, convert the swap rate for each maturity to a swap spread by subtracting the corresponding maturity Treasury yield from the swap rate. For JP Morgan, the swap spread is provided for each maturity.

**VM-31 Section 3.D.6.v (additional bullet):**

v. Current Swap Spreads Data Source: If the company used something other than the NAIC produced current swap spreads as permitted by VM-20 Section 9.F.8.d, documentation of the data source(s) used in the determination of the swap spreads, and the methodology used to determine the non-published tenors.

**VM-31 Section 3.F.4.h (additional bullet):**
v. Current Swap Spreads Data Source: If the company used something other than the NAIC produced current swap spreads as permitted by VM-20 Section 9.F.8.d, documentation of the data source(s) used in the determination of the swap spreads, and the methodology used to determine the non-published tenors.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
Amendment Proposal Form*

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

Identification:
Brian Bayerle, ACLI

Title of the Issue:
Remove 4% Floor from Life Standard Nonforfeiture Rate.

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

January 1, 2020 NAIC Valuation Manual – VM-02 Section 3.A

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

See attached.

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

Upon any possible tax code (IRC, S. 7702) modifications to remove the hardcoded interest rate floor starting in 1/1/2021, the life standard nonforfeiture rate is being updated to ensure the minimum funding under state requirements does not exceed the maximum funding under federal requirements for life insurance contracts issued starting in 1/1/2021.

NAIC Staff Comments:

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Notes: VM APF 2020-07
VM-02

Version 1: Remove floor

Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the Valuation Manual shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the applicable interest rate used prescribed to meet the definition of life insurance in the Cash Value Accumulation Test under Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code 4%. 

Guidance Note: For flexible premium universal life insurance policies as defined in Section 3.D of the Universal Life Insurance Model Regulation (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.

W:\National Meetings\2020\Summer\Plenary\Att 4 2020 VM Package.pdf
Actuarial Guideline XLIX-A
THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST SOLD AFTER [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption*]

Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements that are linked to an index or indices should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for inforce illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective for all new business and in force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption].

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

i. The policy is subject to Model #582.

ii. The policy offers Indexed Credits.
3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The Annual Rate of Indexed Credits for each Index Account does not exceed the lesser of the maximum Annual Rate of Indexed Credits for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the Annual Rate of Indexed Credits for each Index Account shall not exceed the average of the maximum Annual Rate of Indexed Credits for the illustrated scale and the guaranteed Annual Rate of Indexed Credits for that account. However, the Annual Rate of Indexed Credits for each Index Account shall never be less than the guaranteed Annual Rate of Indexed Credits for that account.

ii. If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding hedge assets for Indexed Credits), less provisions for investment expenses and default cost, allocated to support the policy. Charges of any kind cannot be used to increase the Annual Net Investment Earnings Rate.

C. Annual Rate of Indexed Credits: The total annualized Indexed Credits expressed as a percentage of the account value used to determine the Indexed Credits.

D. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. The Hedge Budget used to determine the cap in 3 (D) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind cannot be used to increase the annual cap.

vii. There are no enhancements or similar features that provide additional Indexed Credits in excess of the interest provided by 3 (D) (i) through 3 (D) (v), including but not limited to experience refunds, multipliers, or bonuses.

viii. There are no limitations on the portion of account value allocated to the account.

ix. A single Benchmark Index Account will be determined for each policy. This can be either an Index Account offered with the illustrated policy or determined according to Section 4 (A) (ii) for purposes of complying with this guideline. A policy shall have no more than one Benchmark Index Account.

E. Fixed Account: An account where there are no Indexed Credits.
F. **Hedge Budget:** For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This total annualized amount should be consistent with the hedging program of the company.

G. **Index Account:** An account where some or all of the amounts credited are Indexed Credits.

H. **Indexed Credits:** Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Amounts credited to the policy resulting from a floor greater than zero on an account with any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices are included.

I. **Loan Balance:** Any outstanding policy loan and loan interest, as defined in the policy.

J. **Policy Loan Interest Rate:** The current annual interest rate as defined in the policy that is charged on any Loan Balance. This does not include any other policy charges.

K. **Policy Loan Interest Credited Rate:** The annualized interest rate credited that applies to the portion of the account value backing the Loan Balance:

   i. For the portion of the account value in the Fixed Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate.

   ii. For the portion of the account value in an Index Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the Annual Rate of Indexed Credits, net of any applicable Supplemental Hedge Budget, for that account.

L. **Supplemental Hedge Budget:** For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

4. **Illustrated Scale**

The total Annual Rate of Indexed Credits for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for the Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

   i. If the insurer offers a Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the Benchmark Index Account in 4 (A).

   ii. If the insurer does not offer a Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of the Benchmark Index Account, and shall use that cap in 4 (A).

B. For the Benchmark Index Account the Annual Rate of Indexed Credits shall not exceed the minimum of (i) and (ii):

   i. the arithmetic mean of the geometric average annual credited rates calculated in 4 (A).

   ii. 145% of the Annual Net Investment Earnings Rate.
C. For any other Index Account that is not the Benchmark Index Account in 3 (D), the Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii):

i. The Annual Rate of Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the Index Account.

ii. The Annual Rate of Indexed Credits reflecting the fundamental characteristics of the Index Account and the appropriate relationship to the expected risk and return of the Benchmark Index Account. The illustration actuary shall use actuarial judgment to determine this value using lookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.

D. For the purposes of compliance with Section 6 (C) of Model #582, the Supplemental Hedge Budget is subtracted from the Annual Rate of Indexed Credits before comparing to the earned interest rate underlying the disciplined current scale.

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for Indexed Credits in an account, the assumed earned interest rate underlying the disciplined current scale for that account, inclusive of all general account assets, both hedge and non-hedge assets, that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed the lesser of (i) and (ii):

i. the Annual Net Investment Earnings Rate, plus 45% of the lesser of (1) and (2):

1. Hedge Budget minus any annual floor, to the extent that the floor is supported by the Hedge Budget.

2. The minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account.

ii. the Annual Rate of Indexed Credits plus the Annual Net Investment Earnings Rate minus the Hedge Budget.

These rates should be adjusted for timing differences in the hedge cash flows to ensure that fixed interest is not earned on the Hedge Budget minus any annual floor, to the extent that the floor is supported by the Hedge Budget.

Guidance Note: The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate underlying the disciplined current scale.

For a policy with multiple Index Accounts, a maximum rate in 5 (A) should be calculated for each account. All accounts, fixed and indexed, within a policy can be tested in aggregate.

B. If an insurer does not engage in a hedging program for Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the Annual Net Investment Earnings Rate.

C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy’s account value.
6. Policy Loans

If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate by more than 50 basis points. For example, if the illustrated Policy Loan Interest Rate is 4.00%, the Policy Loan Interest Credited Rate shall not exceed 4.50%.

7. Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical Indexed Credits using current index parameters for the most recent 20-year period.
Comments for the Center for Economic Justice

To the NAIC Executive Committee and Plenary

Regarding Proposed Revisions to Actuarial Guideline XLIX (“Proposed AG49-A”) for Indexed Universal Life Illustrations

August 5, 2020

The Center for Economic Justice (CEJ) urges the NAIC Executive Committee and Plenary to fix two critical problems with the proposed revisions to Actuarial Guideline 49 forwarded by the Life and Annuities (A) Committee.

1. Protect all consumers by applying the revised AG49 to all new illustrations – whether for new policies or for new illustrations on in-force policies regardless of date of issue – on and after the effective date. This requested change is:

   1. Effective Date

   This Actuarial Guideline shall be effective for all new business and in force illustrations on policies regardless of the date the policy was sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption]

2. Eliminate misleading and deceptive loan arbitrage by prohibiting illustration of crediting rates greater than policy loan rates. This requested change is:

   6. Policy Loans

   If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate by more than 50 basis points. For example, if the illustrated Policy Loan Interest Rate is 4.00%, the Policy Loan Interest Credited Rate shall not exceed 4.0050%.

   It is important to point out that these two issues are not technical issues, but core policy decisions regarding protection of consumers from misleading and deceptive marketing information. And these policy issues received no discussion during the A Committee meeting in which proposed AG49-A was accepted.
CEJ Comments to NAIC Executive Committee and Plenary: Amend Proposed AG49-A
August 5, 2020
Page 2

Background – What is AG49?

AG49 is an actuarial guideline that, once effective, has the force of law in the states. AG49 was originally developed in 2015 to rein in unrealistic and misleading illustrations for indexed universal life (IUL) products. Insurers promptly started to game AG49 with new product designs that avoided the caps on the illustrated credits for the products. These so-called “innovations” – complex product designs requested by no consumers – included “multipliers,” “bonuses,” and “cap buy-ups”. The result was even more unrealistic projected policy value accumulations despite lower crediting rates and much higher policy fees. The proposal before you is an attempt to stop this some of the abuses in IUL illustrations.

Why are the AG49 consumer protections so important?

IUL products are marketed as safe investments that allow policyholders to achieve high returns without the market risk associated with the higher-return, higher-risk investments. Illustrations showing how much the policy value will grow over time are the principal marketing tool and the competition among insurers is to design products – including complex crediting schemes and indexes – that maximize the illustrated accumulation amount.

Consumers purchasing IUL are led to believe that these products will provide income for retirement. In volatile economic times, consumers are particularly susceptible to promises about safe and high returns on investments. Yet, the IUL illustrations are profoundly misleading and set unrealistic expectations for consumers about product performance.

The problems with IUL illustrations have been an ongoing issue and the proposal before you – AG49A – is the latest attempt to rein in the unrealistic and misleading illustrations.

The AG49A proposal fails to protect all current IUL policyholders.

The AG49A proposal before you addresses some of the abuses in IUL illustrations – but only for illustrations on new policies issued on or after the effective date of the guideline. It continues to permit the same unrealistic and misleading illustrations for new illustrations on policies issued before the effective date. As a result, those consumers who were the victims of misleading illustrations will continue to see misleading illustrations and are excluded from the protections in the revised AG49.

The failure to protect current policyholders from ongoing deception is both inexplicable and contrary to your past decisions about AG49. In 2018, you revised AG49 specifically to apply to all new illustrations – for new and existing policies – on and after the effective date.

The purpose of the AG49 revision exercise is to stop unrealistic illustrations and provide consumers with better information and expectations about how the IUL product will operate and perform. Logic dictates that the consumer protections in a revised AG49 should be available to all consumers – whether they are consumers receiving an illustration as part of a new policy purchase or as a new, updated illustration for an in-force policy.
What was the rationale for denying consumers of in-force policies with the new consumer protections? Industry offered two arguments – it would be a “retroactive” change to the policy and it would confuse the consumer. The “retroactive” claim is without merit because application of revised AG49 to new illustrations after the effective date does not change any contract provisions or features. It merely gives the consumer of an in-force policy who gets a new illustration a better illustration – better by definition of the purpose of the revisions to AG49.

Claims about consumer confusion with application to all new illustrations are without any empirical support and given current illustrations, the claims about consumer confusion by getting a more realistic illustration are insulting. It makes no sense to permit insurers to continue with an illustration methodology that regulators have acknowledged as failing to protect consumers. There is absolutely no logic to the argument that because insurers used unrealistic illustrations for a product in the past they should be permitted to continue to use a methodology that perpetuates unrealistic and misleading illustrations.

If this point wasn’t already clear, Mr. Sanders of NAIFA drove it home with his comments that giving a consumer a more realistic new illustration on an in-force policy would erode the producer-client relationship because the client might ask the producer why the illustration has changed and not be satisfied with the answer – perhaps becoming unhappy with the product.

According to Mr. Sanders’ logic, the consumer should continue to get illustrations that are now unrealistic because providing the consumer with more realistic expectations about the performance of the product might reduce the client’s confidence in the producer and that this client is better off not learning that the illustrations they had been receiving were unrealistic until years later when it may be too late to take any action to protect their retirement savings or after the producer has retired. This logic may make sense in the world of insurer or insurance producer trade associations, but it is insane from the perspective of consumer protection.

To ensure all consumers received the protections of proposed AG49-A, the following change is needed.

1. Effective Date

This Actuarial Guideline shall be effective for all new business and in force illustrations on policies regardless of the date the policy was sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption]
The proposed AG49-A fails to rein in deceptive loan arbitrage.

A fundamental flaw in the life insurance illustration regime is the presentation of account values accumulating at the same amount year after year with no demonstration of the risk or impact of the volatility of returns. If policy loan interest rates can be illustrated at values less than the account crediting rates, the IUL will illustrate like a riskless ATM.

Current AG49 and proposed AG49-A permit policy loans to be illustrated with a policy loan interest rate less than the crediting rate for illustrating account value accumulation. Stated differently, if you illustrate account value credits at 6.5% every year, you can illustrate a policy loan cost at 6%. This is an example of illustrating riskless arbitrage – the consumer can borrow money at one rate and use it earn a higher rate of return without any risk. This is analogous to taking out a mortgage on your home and using that money to invest in the stock market – because the market has averaged returns of, say, 8%, while your mortgage loan rate is 3%. Of course this would be terrible financial advice because the loan cost is fixed – you have to pay the interest regardless of what your investment returns might be and the investment returns are erratic and may be negative in several years.

By being able to illustrate riskless loan arbitrage, IUL illustrations are used to present future loans on the policy as cash disbursements that never need to be paid back because the policy is continuing to earn the constant better-than-loan-interest-rate returns. Does anyone recall the vanishing premium illustration debacle?

By being able to illustrate riskless loan arbitrage, IUL products are sold in connection with premium finance loans, in which a consumer borrows money to buy an IUL policy.

If the NAIC’s stated commitment to ensuring retirement security for consumers is to have any meaning at all, loan arbitrage in AG49 must be eliminated. The following change to proposed AG49-A is needed.

6. Policy Loans

If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate by more than 50 basis points. For example, if the illustrated Policy Loan Interest Rate is 4.00%, the Policy Loan Interest Credited Rate shall not exceed 4.0050%.
CONSIDERATIONS FOR STATE INSURANCE REGULATORS IN BUILDING THE PRIVATE FLOOD INSURANCE MARKET

DECEMBER 9, 2019
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Flood Coverage Being “At Least as Broad as” the NFIP

Continuous Coverage
STATE INSURANCE REGULATORS HAVE FIRST-HAND EXPERIENCE WITH THE DEVASTATING EFFECTS THAT FLOODS HAVE ON THE CONSTITUENTS IN THEIR STATES, AND THEY BELIEVE IT IS CRITICAL THAT FLOOD INSURANCE IS BOTH AVAILABLE AND AFFORDABLE IN ORDER TO ENCOURAGE PURCHASES THAT THEREBY PROTECT HOMES, BUSINESSES AND PERSONAL PROPERTY. ALTHOUGH PRIVATE FLOOD INSURANCE IS BEING WRITTEN LARGELY IN THE COMMERCIAL MARKET, THIS PAPER WILL FOCUS ON THE RESIDENTIAL FLOOD INSURANCE MARKET.

FOR MORE THAN A HALF-CENTURY, THE FEDERAL GOVERNMENT’S NATIONAL FLOOD INSURANCE PROGRAM (NFIP) HAS BEEN THE PRIMARY PLAYER IN THE RESIDENTIAL FLOOD INSURANCE MARKET, UNDERWRITING MOST POLICIES WHILE PRIVATE INSURERS HAVE LARGELY FOCUSED ON A RELATIVELY SMALL RESIDENTIAL SUPPLEMENTAL MARKET. WHILE THE NFIP HAS DONE A LAUDABLE JOB IN MAKING FLOOD INSURANCE AVAILABLE FOR MILLIONS OF RESIDENTIAL PROPERTIES, A SIGNIFICANT FLOOD INSURANCE GAP EXISTS ACROSS THE U.S. WITH FLOOD EVENT AFTER FLOOD EVENT REVEALING A SUBSTANTIAL NUMBER OF DAMAGED PROPERTIES BEING UNINSURED. A FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) ANALYSIS FROM 2018 INDICATES THAT 69% OF AMERICAN HOMES IN HIGH-RISK FLOOD ZONES DO NOT HAVE FLOOD INSURANCE. CONCURRENTLY, THERE HAS BEEN A HEIGHTENED INTEREST AMONGST PRIVATE CARRIERS TO EXPAND THEIR RESIDENTIAL FLOOD INSURANCE OFFERINGS, GREATLY ASSISTED BY THE DEVELOPMENT OF MORE SOPHISTICATED FLOOD MAPPING AND RISK MODELING TECHNOLOGIES.


STATE INSURANCE REGULATORS AND THE NAIC SUPPORT A LONG-TERM NFIP REAUTHORIZATION, AS WELL AS THE FACILITATION OF INCREASED PRIVATE SECTOR INVOLVEMENT IN THE SALE OF FLOOD INSURANCE, WHICH CAN HELP ENSURE THAT CONSUMERS HAVE ACCESS TO MULTIPLE OPTIONS. IN 2016, THE NAIC DEVELOPED THE “NAIC PRINCIPLES FOR NATIONAL FLOOD INSURANCE PROGRAM (NFIP) REAUTHORIZATION” AND HAS TESTIFIED IN CONGRESS ON THE IMPORTANCE OF ENSURING A VIABLE PRIVATE FLOOD INSURANCE MARKET AS AN ALTERNATIVE TO THE NFIP.

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Following from this NAIC action, the purpose of this document is to provide state insurance regulators with concrete actions that can be and/or have been taken to assist with the development of the burgeoning private insurance market for residential flood insurance.
OVERALL STATE OF THE FLOOD INSURANCE MARKET

According to the most recent data collected by the NAIC (Table 1), approximately $644 million of direct premium was written in the private flood insurance market in 2018 throughout the U.S. In 2018, the private flood insurance market represented 15% of the total flood insurance market ($4.2 billion). The private flood insurance market has been growing over the past few years, with the $644 million in direct premium written in 2018 being an increase of 9% from 2017 direct written premiums, and an increase of 71% since 2016. In 2018, California, Florida, Louisiana, New Jersey, New York, Pennsylvania, Puerto Rico and Texas each had $20 million or more of private flood insurance direct written premium (Table 1), with these eight states/jurisdictions representing nearly 60% of the total private flood insurance market.

It is important to note that the NAIC Annual Statement data used in Table 1 and Table 2 does not differentiate between residential private flood insurance premium and commercial private flood insurance premium. The NAIC is exploring data collection via a supplement and/or data call to collect data for residential private flood insurance and commercial private flood insurance separately.

Beyond this aggregate view of premium being written by state, for a relative sense of market penetration and growth of the private flood market, two other views of the NAIC data are presented: 1) private flood as a percentage of total flood written per state in 2018 (Table 1); and 2) private flood growth by state from 2016 to 2018 (Table 2).

<table>
<thead>
<tr>
<th>State</th>
<th>Direct Premium Written – Private</th>
<th>Direct Written Premium – NFIP</th>
<th>Total</th>
<th>Private Flood Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>$726,128</td>
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<td>$2,899,862</td>
<td>25%</td>
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<tr>
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<td>$37,369,849</td>
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<tr>
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<td>$38,356</td>
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<td>$34,401,662</td>
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<td>$184,728,154</td>
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<td>$19,394,560</td>
<td>$21,264,999</td>
<td>9%</td>
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<tr>
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<td>$348,208</td>
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<td>6%</td>
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<td>HI</td>
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<td>$40,778,877</td>
<td>$44,290,305</td>
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<td>$8,096,167</td>
<td>$13,715,977</td>
<td>41%</td>
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</table>

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Table 1: Private Flood as a Percentage of Total Flood Written Per State in 2018 (cont’d)

<table>
<thead>
<tr>
<th>State</th>
<th>Direct Premium Written – Private</th>
<th>Direct Written Premium – NFIP</th>
<th>Total</th>
<th>Private Flood Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>KY</td>
<td>$5,562,791</td>
<td>$19,859,236</td>
<td>$25,422,027</td>
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<tr>
<td>LA</td>
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<td>$332,451,130</td>
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<td>$77,215,928</td>
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<tr>
<td>MD</td>
<td>$6,161,138</td>
<td>$38,179,561</td>
<td>$44,340,699</td>
<td>14%</td>
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<td>ME</td>
<td>$1,826,143</td>
<td>$8,778,305</td>
<td>$10,604,448</td>
<td>17%</td>
</tr>
<tr>
<td>MI</td>
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<td>26%</td>
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<td>-</td>
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<td>MT</td>
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<td>NC</td>
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<tr>
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<td>22%</td>
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<td>NE</td>
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<td>$7,645,531</td>
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<td>-</td>
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<td>CA</td>
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<tr>
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<tr>
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<tr>
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<td>$6,248,012</td>
<td>$4,730,473</td>
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<td>PA</td>
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<tr>
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<td>TX</td>
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<td>$53,512,832</td>
<td>$31,771,120</td>
<td>18%</td>
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<tr>
<td>UT</td>
<td>$2,712,200</td>
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<td>11%</td>
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<td>4%</td>
</tr>
<tr>
<td>WI</td>
<td>$5,896,222</td>
<td>$4,140,377</td>
<td>$2,300,499</td>
<td>42%</td>
</tr>
<tr>
<td>WV</td>
<td>$1,804,872</td>
<td>$1,986,325</td>
<td>$1,614,061</td>
<td>-9%</td>
</tr>
<tr>
<td>WY</td>
<td>$899,933</td>
<td>$959,541</td>
<td>$713,965</td>
<td>-6%</td>
</tr>
<tr>
<td>Total</td>
<td>$643,879,997</td>
<td>$589,147,189</td>
<td>$376,130,254</td>
<td>9%</td>
</tr>
</tbody>
</table>

Clearly, this data suggests that there are considerable opportunities for private flood insurance placement and market development. However, it is important to note that in 2018, the majority of growth occurred in the private commercial flood insurance market. The residential private flood insurance market showed a slight decline from 2017.7

As insurers’ familiarity with flood catastrophe models grows, as underwriting experience develops and as state regulatory structures evolve, the number of private flood insurance policies in force could continue to grow, including among admitted carriers. Therefore, it is important to understand what the states have done (or not done) to enhance this growth.

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STATE ACTION

During the six years of uncertainty regarding the federal banking rules for private flood insurance, a number of states began undertaking efforts to encourage the growth of a private flood insurance market in their state. Florida’s efforts to establish a private flood insurance market have been applauded as a potential model to be used in other states looking to expand their residential private flood insurance offerings. Florida has the largest flood insurance market in the country; approximately 35% of NFIP policies are written there. Florida has enacted legislation to create a statutory framework, allowing private insurers to offer multiple types of flood coverage ranging from standard coverage, which mirrors the NFIP, to other enhanced coverages. This legislation includes: 1) streamlining the rate filing process for private flood insurers; 2) eliminating the diligent search requirement for flood policies issued by surplus lines carriers until July 2019; and 3) providing a process by which the Office of Insurance Regulation (OIR) will certify that a private insurer’s policy equals or exceeds coverage provided by the NFIP. Florida’s OIR issued an informational memorandum providing guidance on how private insurers will need to demonstrate the financial capacity to assume this risk, as well as options for developing private flood rates and policy forms.

In addition to Florida, we can draw upon the existing experiences from other states in developing a robust flood insurance market along the key aspects of insurance regulation.

The NAIC reached out to the states on the drafting group to provide information that was not readily available on the states’ websites, as well as to gather information from other resources, including: 1) the Wharton School of the University of Pennsylvania study *The Emerging Private Residential Flood Insurance Market in the United States*; 2) Government Accountability Office (GAO) reports; and 3) a recently updated Congressional Research Service (CRS) report regarding private flood insurance and the NFIP. In the future, the NAIC might want to consider sending a more detailed questionnaire to the states to gather more information regarding the developing private flood insurance market.

State efforts to grow a viable private flood insurance market include:

**Legislative and Regulatory Changes**
- Supporting private flood insurance legislation.
- Approving private flood insurance products.
- Tailoring rate and form requirements for private flood insurance coverage.
- Allowing private flood insurers to submit rates on an informational basis.
- Removing diligent search requirements.

**Consumer Information**
- Conducting consumer outreach.
- Listing private flood insurance products on a department of insurance’s (DOI) website.
- Collecting residential private flood insurance data.

**Agent and Lender Actions**
- Implementing specific continuing education (CE) requirements for producers.
- Increasing the weighting of flood insurance questions on producer licensing exams.
- Conducting agent education.
- Conducting lender education.

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LEGISLATIVE AND REGULATORY CHANGES

Supporting Private Flood Insurance Legislation
In addition to Florida's legislation, West Virginia has passed legislation requiring insurers to file their private flood insurance plan of operation with the insurance commissioner and authorizing expedited processing of surplus lines policies for flood insurance.

Approving Private Flood Insurance Products
Personal lines private flood insurance products are being approved by a number of states. Currently, Alabama, California, Mississippi and Pennsylvania are among states approving new personal lines private flood insurance products for entry into the market.

In January 2018, the Insurance Services Office (ISO) developed a new private flood insurance form, for both personal and commercial flood insurance. The ISO forms are similar to a homeowner’s policy form. However, the damage to the property must be caused by flooding. As of March 2018, ISO personal flood insurance forms have been filed in 43 jurisdictions, and commercial flood insurance forms have been filed in 45 jurisdictions. The states with independent rating bureaus are not reflected in these numbers.

TAILORING RATE AND FORM REQUIREMENTS FOR PRIVATE FLOOD INSURANCE COVERAGE

The states might want to consider permitting insurers to file private flood insurance products without a prior approval requirement. For example, Florida law permits private flood insurance rates to be implemented without prior approval at the time of filing. However, insurers are required to keep supporting actuarial data for two years. Furthermore, Florida law allows insurers to request the state to certify that a private policy provides flood coverage that equals or exceeds that offered by NFIP. (See Appendix I for information on Florida’s process.)

Maryland, South Carolina and Pennsylvania have not relaxed the rate and form filing requirements. However, they are committed to an efficient and swift overview of private flood insurance filings, and they will work with insurers to make the filing and approval process as smooth as possible.

EXPORT LIST / WAIVING DILIGENT SEARCH REQUIREMENTS

Insurance generally must be sold in the admitted market. Only after a “diligent search” of the admitted market is performed and coverage is denied can insurance be placed in the surplus lines market. However, states make exceptions for those types of insurance that are known to not be available in the admitted market. These insurance products are listed on what is known as an “Export list.” When a type of insurance is listed on an Export list, the applicant can go straight to the surplus lines market without the need for the diligent search, thereby obtaining coverage more easily and quickly. At least 14 states have placed flood insurance on their “Export list,” including: Alaska, Arizona, Connecticut, Idaho, Louisiana, New Jersey, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Virginia, West Virginia and Wisconsin.

Allowing Private Flood Insurers to Submit Rates on an Informational Basis
Allowing insurers to submit rates on an informational basis in states with prior approval rate filing laws is another way to encourage the growth of the private flood insurance market. Two states that have taken this approach include Florida and New Jersey. (See Appendix I for information on Florida’s process.)
CONSUMER INFORMATION

Consumer Outreach

It is important to understand that everyone lives in a flood zone. Some people live in higher-risk flood zones than others, but we all live in a flood zone.

When people say they live or do not live in a flood zone, they typically mean what is known as a “special flood hazard area”. A “special flood hazard area” is an area within FEMA’s 100-year flood plain. This is where flood insurance is typically mandatory as a condition of obtaining a property loan. But there are flood zones outside of the 100-year flood plain as well. For example, there is also what FEMA classifies as moderate risk flood zones. These are the properties in the 500-year flood plain. By definition, and according to FEMA, these properties have between a 0.2% and a 1% chance of flooding in any given year. That might sound small, but over the course of a 30-year mortgage, these properties, according to FEMA, have between a 6% and 26% chance of being inundated by a flood. And flood insurance is not mandatory as a condition of obtaining a property loan in these moderate-risk flood zones.

Consumers need to understand that their property may still be at risk for flooding even if they do not live in a special flood hazard area and are not required to purchase it. They also need to understand that flood insurance can be relatively inexpensive, especially when the property is not in the highest-risk flood zones. There are options available to them, from both the NFIP and the private flood insurance market. And they can purchase lower limits of coverage; they do not need to insure the full replacement cost of their home if they do not wish to do so. Purchasing just $20,000 of coverage, for example, might go a long way in the event of a flood and may be cheaper to purchase than believed. Further, renters can buy policies that cover only their personal property and not the dwelling that they rent.

There are also many consumers under the misconception that flood damage will be covered by their homeowners insurance policy or rental insurance policy. Therefore, they are unaware of their actual flood risk, and they learn that they are uninsured for this catastrophic peril only after a flood event for which they have no coverage.

State DOIs, as well as the NAIC, are launching consumer outreach programs to help address this coverage gap.

Some states now require a flood disclosure with homeowners policies. For example, Texas recently passed a law requiring a conspicuous disclosure when homeowners policies do not include flood coverage.

The NAIC Communications Department has also launched a flood campaign this year to inform consumers of the importance of purchasing flood insurance, either private flood insurance or flood insurance provided by the NFIP. Additionally, the NAIC recently released a special section of its website dedicated to educating consumers about the risks of flooding and what kinds of coverage options are available to protect against those risks.

Finally, the NAIC’s Transparency and Readability of Consumer Information (C) Working Group has created both a basic flood insurance document and several graphic materials containing flood facts, to be used by DOIs for consumer outreach via social media.

Listing Private Flood Insurance Writers on a DOI Website

While many DOIs include information regarding NFIP policies on their websites, some states, including Florida, Louisiana, New Jersey and Pennsylvania, provide a list of private flood insurance writers and their contact information on their websites.

It is worthwhile to note that surplus lines writers are generally not listed by the line of business they write. However, it has been suggested that there would be value for the states to provide information regarding which surplus lines writers are writing residential private flood insurance. Pennsylvania lists the surplus lines producers placing residential flood insurance on its website.

Collecting Residential Private Flood Insurance Data

Florida and Texas both collect comprehensive data regarding residential private flood insurance. As described previously, the NAIC has been collecting private flood insurance data since the data year 2016. Before that, the private flood insurance line was not a separate entry in the annual statement. While residential and commercial private flood insurance are not separated in the property/casualty (P/C) annual statement blank, the NAIC, through its Property and Casualty Insurance (C) Committee, is considering enhancements to the annual statement that would require insurers to report the residential private flood insurance premiums and commercial private flood insurance premiums independently. The Surplus Lines (C) Task Force is considering similar changes to alien surplus lines private flood insurance data that is reported to the International Insurers Department (IID).

The Wholesale & Specialty Insurance Association (WSIA) is also providing the Reinsurance Association of America (RAA) with data regarding surplus lines insurance. The RAA is working on an open source database that provides information regarding private flood insurance.

These changes would allow state insurance regulators and FEMA to better measure the growth of the private residential flood insurance market.

AGENT AND LENDER ACTIONS

Continuing Education and Producer Licensing Requirements

FEMA requires all insurance producers licensed in property, casualty or personal lines of authority who sell flood insurance through the NFIP to complete a one-time course, as required by the federal Flood Insurance Reform Act of 2004. This is also the only educational requirement in many states.

At least one state has increased the weighting of the flood insurance questions on their producer licensing exam.

Agent Education

Selling flood insurance requires an agent to understand the intricacies of NFIP and private flood insurance policies. When purchasing insurance, many times the insurance agent is the consumer’s first point of contact. Therefore, it would be valuable if an agent could explain the risks of flooding, even if a consumer does not own or rent property in a high-risk flood zone. Recent flood events remind us that where it can rain, it can flood, and many floods occur outside of a high-risk flood zone. If agents help to educate the consumer, it will help eliminate the cost of inaction, as the occurrence of a flood event could be financially unbearable for homeowners or renters if they are not insured or are underinsured. It is critical

for agents to make a special effort to educate homeowners regarding the need for flood insurance, even if a business or home is not located in a high-risk flood zone.

DOIs can provide agents with information that they have learned as a result of a flood event, and they can foster agent education by requiring CE requirements to improve an agent’s knowledge of flood insurance.

Other states’ adoption of such practices would likely improve agents’ knowledge of flood insurance, therefore helping their clients to obtain more effective flood coverage, whether through the NFIP or the private market.

**Lender Education**

A large percentage of Americans have a mortgage on their home. Therefore, lender education is another opportunity for consumer flood insurance education. Recent catastrophic flooding events have illustrated that floods can happen anywhere. Therefore, it may be in the best interest of homeowners to purchase flood insurance even if they do not live in a high-risk flood zone.

While state insurance regulators do not have the authority to regulate lenders, lenders should still be educated regarding the importance of flood insurance. When navigating the loan process, lenders do not always discuss purchasing flood insurance unless the borrower’s home is in a high-risk flood zone. A discussion about purchasing flood insurance even if the homeowner does not live in a high-risk flood zone should ideally be addressed with the borrower.

DOIs can raise awareness regarding flood insurance by bringing agents, consumers, lenders, FEMA, private flood insurance writers, etc. together in communities to discuss the importance of a homeowner purchasing flood insurance.

**MARKET UNCERTAINTY AND THE DEVELOPMENT OF A PRIVATE FLOOD INSURANCE MARKET**

The May 2019 CRS report, “Private Flood Insurance and the National Flood Insurance Program,” identified some of the barriers to the development of a private flood insurance market. Some of the barriers identified in the report include: 1) regulatory uncertainty; and 2) continuous coverage.

Most directly relevant for the NAIC members is the notion of regulatory uncertainty, which is covered below. The remaining topics will be addressed in Appendix II.

In 2016, the U.S. experienced several major flood catastrophes, causing billions of dollars in property losses. Following these storms, it was found that somewhere between 50% and 80% of these losses were not insured, which implies that communities are unable to bounce back quickly following large catastrophic events.

Floods are expected to cost U.S. households $20 billion each year. An Insurance Information Institute (I.I.I.) survey indicated that 15% of American homeowners had a flood insurance policy in 2018 and that there were approximately 5.18 million flood insurance policies held by the NFIP. Milliman estimates the potential private residential flood insurance market to represent between $34 billion and

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13 Milliman
14 https://www.iii.org/fact-statistic/facts-statistics-flood-insurance
15 https://www.fema.gov/total-policies-force-calendar-year
$48 billion in direct written premium.\textsuperscript{16} This data clearly indicates an opportunity for growth in the residential private flood insurance market in the U.S.

Recently, comments have surfaced regarding the possibility of the residential private flood insurance market cherry-picking their risks. It is important to remember the NFIP was meant to be a temporary solution that was put into place 50 years ago due to private insurers not insuring flood. While the NFIP is important, every state has some type of residual market that aids in insuring and providing insurance coverage for those who are unable to obtain insurance coverage available in the market. While not directly related to flood insurance, two good examples of successful residual markets are Florida Citizens and Louisiana Citizens. As the market has grown and shrunk in both Florida and Louisiana, both Florida Citizens and Louisiana Citizens needed to and provided a safe and reliable source of insurance for consumers. The NFIP can continue to evolve and do the same thing. Milliman believes Risk Rating 2.0 will help the NFIP and provide helpful information regarding the actual risk of a flood insurance policy; however, it was recently announced that the implementation of Risk Rating 2.0 will be delayed until Oct. 1, 2021 to allow for more analysis of its impact.

Milliman is of the opinion that a private market can coexist alongside the NFIP. Private flood insurance can be written in the admitted and non-admitted market. However, it needs to be determined if the guaranty funds will cover flood insurance in the admitted market, as flood may be excluded in many states.

Many private insurers have not serviced or written flood insurance policies. Additionally, private insurers do not have access to historical data; this poses a problem. It will be important to balance the need to protect consumers against the need to promote the private flood insurance market.

New entrants to the private flood insurance market are likely to purchase significant amounts of reinsurance. Flood insurance is inherently high-risk and volatile, so insurers may require higher amounts of profit and contingencies built into rates than for a typical homeowner’s insurance product. States allowing these options might make it easier for an insurer to offer private flood insurance. For example, Wisconsin has no limitations or requirements for reinsurance cost and profit provision assumptions.

The issue of continuous coverage is problematic. In order for an NFIP policyholder to preserve any subsidies provided by the NFIP, a policyholder is required to have continuous flood insurance coverage. Currently, a policyholder loses subsidies or cross-subsidies when private flood insurance is purchased, if the policyholder chooses to return to the NFIP.

Unless there is legislation in place allowing private flood insurance to be deemed as continuous coverage, homeowners may be averse to purchasing private flood insurance. Homeowners do not want to find themselves in a situation causing them to lose their subsidy should they elect to return to the NFIP for flood insurance coverage. While legislation has been introduced in the U.S. House of Representatives allowing private flood insurance to count towards continuous coverage, legislation has yet to be passed.

The availability of private flood insurance provides the added benefit of increasing consumer choice. As private insurers are entering the flood insurance market, some of the policies offered are providing broader coverage than that provided by the NFIP. Additionally, some policyholders are finding private flood insurance policies to be less expensive than those offered by the NFIP.\textsuperscript{17}

\textsuperscript{16} Milliman
\textsuperscript{17} Congressional Research Service report, “Private Flood Insurance and the National Flood Insurance Program, May 7, 2019
SUMMARY

In the past few years, many states have experienced catastrophic flooding. Following the flood events, it has become even more apparent that a significant number of consumers are either uninsured or underinsured for the flood peril.

While the NFIP still writes a majority of the residential flood insurance policies, there are considerable opportunities for the development of the residential private flood insurance market.

This document provides details about how a few states have put procedures in place to enhance the private flood insurance market in a state. These procedures include: 1) supporting private flood insurance legislation and initiatives; 2) tailoring rate and form requirements for residential private flood insurance products; and 3) consumer, agent and lender education.

It is noteworthy to say that the states experiencing large flooding events have seen growth in the private flood insurance market regardless of any other actions. For example, following Hurricane Harvey, Texas saw growth in its residential private flood insurance market. Catastrophic events are a reminder to consumers of the devastation caused by flooding.

While there are several barriers for the residential private flood insurance market, the most significant barrier for private insurers may be uncertainty about the state regulatory environment.

To avoid unintended consequences policymakers interested in facilitating a private flood insurance market should familiarize themselves with the requirements for residential customers with a federally backed mortgage to purchase flood insurance coverage and with the existing private insurance markets that provide coverage for flood damage, including coverage provided under: (a) commercial policies, (b) residential policies providing coverage in excess of required flood insurance coverage limits, (c) residential policies for those not mandated to purchase flood insurance, and (d) comprehensive auto coverages. With such knowledge, legislative and regulatory changes can be tailored to accomplish the policy objectives without adversely impacting existing flood insurance markets.

The attached appendices discuss steps that Florida has taken in its approach to cultivate the private residential flood insurance market and discussion of other barriers to the entrance of residential private flood insurers.
Appendix I — Actions Florida Has Taken

FLORIDA’S FORM FILING PROCESS EXAMPLE
Florida reviews form filings, providing flood coverage differently based on the type of flood coverage being provided.

Subject to the Requirements of Florida’s Flood Statute
The coverage provided under the policy must meet one of the definitions of type of flood coverage, as defined by S. 627.715, F.S. Of the five defined types, "standard," "preferred" and "customized" are defined to meet or exceed the coverage provided by the standard NFIP policy. "Flexible" flood insurance must cover losses from the peril of "flood" as defined by the statute, but it does not have to provide coverage comparable to the entire NFIP policy. "Supplemental" flood coverage is meant to supplement an NFIP or private flood policy. Policies that fall under these definitions may have certain provisions that differ from that which would otherwise be required if not written under the flood statute.

Items Not Subject to the Requirements of Florida’s Flood Statute
The coverage does not have to meet or exceed the coverage provided by the standard NFIP policy. However, the provisions of the flood statute that allow changes to the form and rate requirements, as well as allowing for a certification provided by the Florida OIR, do not apply. This means that forms and rates would be subject to all the requirements of Florida law, and the coverage does not have to meet the definition of "flood" under the statute.

Florida’s private flood insurance statute, S. 627.715 F.S., does not apply to the commercial lines market. Forms providing commercial flood coverage must comply with all applicable Florida laws.

REVIEW OF FLORIDA’S FORM FILING PROCESS
How the Florida OIR Reviews Form Filings Subject to its Flood Statute
The Florida OIR coordinates with FEMA about training to educate forms analysts about the details and nuances of a federal NFIP policy. Forms analysts:

- Review the policy or endorsement and compare it to the NFIP policy.
- Review the provisions of the underlying policy that are not superseded by changes made in the endorsement.
- Make sure that the flood coverage in total (including definitions, deductibles, limits, conditions, property not covered, exclusions, etc.) are as broad as that provided under the NFIP policy.
- Exclude provisions, specific to the NFIP, that would not make sense to be in a private company’s policy.

State Law Conflict
There are certain provisions in the federal private flood definition that may conflict with a state’s law.

For example, the statute of limitations under the standard NFIP policy is one year after the date of denial. In Florida, the statute of limitations for most claims is five years from the date of loss. The insurer could use the standard NFIP provision, or the insurer could use a provision such as one year after the date of denial of a claim or five years from the date of the loss, whichever is greater. The modified provision would be considered as providing better coverage.

Another potential area in which there could be conflict between the standard NFIP policy and state law is the requirement for notice of cancellation. The NFIP requires 45 days, which may be more or less than state provisions.
In Florida, to comply with the flood statute or other than Flexible or Supplement flood insurance, the insurer would have to give at least 45 days notice.

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The general filing requirement for forms is found in S. 627.410, F.S., which requires the Florida OIR to approve forms before use.

For commercial flood coverage, the insurer has the option to file the forms as informational pursuant to S. 627.4102, F.S.
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**FLORIDA RATE PROCESS EXAMPLE**

Florida allows insurers to offer personal residential flood insurance coverage that meets the requirements of the flood statute. Insurers may decide to either submit the rate filings subject to the normal filing requirements of review and approval or (until Oct. 1, 2025) submit the filing for informational purposes.

Personal residential flood insurance rates submitted for informational purposes are subject to examination by the Florida OIR for a period of two years from the effective date to determine if the rates are excessive, inadequate or unfairly discriminatory.

If the coverage does not meet the requirements of the “flood statute,” the rate filing is subject to the normal filing requirements of review and approval. Commercial non-residential property rates (including that for flood coverage) are informational due to a separate provision of Florida laws, and they are an exception to these filing requirements.

**FLORIDA FLOOD STATUTE – FLOOD POLICY TYPES**

Florida’s flood statute (S. 627.715, F.S.) sets up five types of flood coverage that may be written using the special deviations allowed for flood insurance.

- Standard flood insurance (equivalent to coverage provided under the standard flood policy under the NFIP).
- Preferred flood insurance.
- Customized flood insurance.
- Flexible flood insurance.
- Supplemental flood insurance.

Flexible and supplemental coverage are the only flood coverage types under the statute that do not require flood insurance coverage to meet or exceed what is provided under the standard NFIP policy. Flexible coverage must provide coverage for the peril of flood as defined by the statute (which mirrors that of the NFIP). However, there are ancillary coverages that are not required to be provided.
APPENDIX II – BARRIERS TO THE RESIDENTIAL PRIVATE FLOOD INSURANCE MARKET

Flood Coverage Being “At Least as Broad as” the NFIP

Biggert-Waters specifies that private flood insurance satisfies the mandatory purchase mortgage requirement when a private flood insurance policy affords coverage that is “at least as broad as” the coverage offered by an NFIP flood insurance policy.18

Since there was not a federal banking rule in place regarding private flood insurance following the passage of Biggert-Waters, it was challenging to implement the use of private flood insurance for the mandatory purchase mortgage requirement. Some lending institutions thought that they did not have the knowledge necessary to assess whether a flood insurance policy met the definition of private flood insurance set forth in Biggert-Waters.

The federal banking rule became effective July 1, 2019. The rule fulfills the condition in Biggert-Waters that regulated lending institutions accept private flood insurance policies satisfying the conditions specified in the Act. Furthermore, the federal banking rule allows lending institutions to accept an insurer’s written assurances stated in a private flood insurance policy that the appropriate criteria is met. The rule also permits lending institutions to accept some flood insurance coverage plans provided by mutual aid societies.

Theoretically, the federal banking rule removes the acceptance of private flood insurance as a barrier to the private flood insurance market. However, educating the banking industry is clearly still needed as state insurance regulators are still hearing that lenders are telling borrowers that the only flood insurance policy that is acceptable is an NFIP flood policy. Thus, further education regarding the federal banking rule needs to be done. States may want to consider drafting a bulletin that can be used for these purposes.

Lenders may accept private flood insurance that meets the “discretionary acceptance” definition, which states that lending institutions may accept private flood insurance policies that do not meet the “mandatory acceptance” requirements, provided that certain conditions are met, such as that the policy provides sufficient protection of the loan, consistent with general safety and soundness principles.19 This distinction may be important for insurers with a product designed with higher-deductible options and/or a shorter cancellation notice for nonpayment of premiums.

Finally, many property owners are not required to purchase flood insurance because their home is outside of a Special Flood Hazard Area (SFHA) or because they do not have a federally backed mortgage. As a result, any flood insurance policy covering such properties is not required to be as broad as the NFIP policy.

Continuous Coverage

If an NFIP policy holder lets an NFIP policy lapse, by either not paying premium or going to a private flood insurer, any subsidy the NFIP policy holder would have received is immediately eliminated.20 Legislation currently being considered by Congress to reauthorize the NFIP includes the ability of policyholders to leave the NFIP in order to purchase a private flood insurance policy and then return to the NFIP without penalty.

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18 42 U.S.C §4012a(b).
19 Ibid
20 As required by §100205(a)(1)(B) of Biggert-Waters (P.L. 112-141, 126 Stat. 917), only for NFIP policies that lapsed in coverage as a result of the deliberate choice of the policyholder.
Non-Compete Clause
FEMA dropped its non-compete clause in 2018. FEMA now allows Write Your Own (WYO) companies to sell NFIP policies. Therefore, this is no longer a barrier.

NFIP Subsidized Rates
One of the hurdles facing private flood insurance growth involves the NFIP’s subsidized rates, as NFIP premiums do not always reflect the full risk of flooding. NFIP rates allow certain policyholders to have more affordable premiums. Additionally, NFIP rates do not incorporate profit, which is an important element for private flood insurers. Private flood insurers need to charge rates that represent the full risk of the peril.

If the NFIP were to reform its rate structure to collect full-risk rates, it might result in the encouragement of more private insurers to write policies in the private flood insurance market. Full-risk NFIP rates would fall closer to what a private insurer would charge. It is important to note that full-risk rates would likely lead to higher rates than those that currently exist.

Presently, FEMA is in the process of redesigning its rating system. The new NFIP rating system will be known as Risk Rating 2.0. This new rating structure will add replacement cost value and consider the distance between a property and a source of water. Additionally, Risk Rating 2.0 takes into consideration things that are not reflected in the current rating structure, such as intense rainfall. As stated previously it was recently announced that Risk Rating 2.0 will be delayed until Oct. 1, 2021 to allow for more analysis on its impact.

Ability to Assess Flood Risk Accurately
On June 11, 2019, the NFIP released data on flood losses and claims. Prior to the release of this data, insurers viewed the lack of access to NFIP data on flood losses and claims as a barrier for private companies offering flood insurance.

For private flood insurers to manage and diversify their risk exposure, consumer participation to manage and diversify their risk exposure is required. Many private insurers have expressed the view that broader participation in the flood insurance market would be necessary to address adverse selection and maintain a sufficiently large risk pool.

An established goal of the NFIP is to increase the number of flood insurance policies in force. Even though there is a mandatory purchase requirement for homeowners to purchase flood insurance in certain flood zones, this does not always occur.

As more insurers begin to write private flood insurance, it is likely that consumers will be offered more choices. Private flood insurers may also offer coverages not available through the NFIP. These coverages might include coverage such as basement coverage, business interruption, additional living expenses, etc. Private insurers might also be able to offer higher coverage limits than those offered by the NFIP.

Private flood insurance offered as an endorsement to a standard homeowners insurance policy could possibly eliminate instances where it is necessary to differentiate between flood and wind damage.

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22 Ibid.
23 Ibid.
24 Ibid.
PROJECT HISTORY

Catastrophe Insurance (C) Working Group’s
Considerations for State Insurance Regulators in Building the Private Flood Insurance Market

1. Description of the project, issues addressed, etc.

The Property and Casualty Insurance (C) Committee referred the charge of writing a document to discuss things state insurance regulators could do to build the private flood insurance market to the Catastrophe Insurance (C) Working Group.

The considerations document is a document the state insurance departments can use to provide state insurance regulators with things their department of insurance (DOI) can do to help build the private flood insurance market in their state. The considerations document provides information regarding state actions that can be taken, including: 1) supporting private flood insurance legislation; 2) approving private flood insurance products; 3) tailoring rate and form requirements for private flood insurance coverage; 4) allowing private flood insurers to submit rates on an informational basis; 5) removing diligent search requirements; 6) conducting consumer outreach; 7) listing private flood insurance products on a DOI website; 8) conducting agent education; 9) implementing specific continuing education (CE) requirements for producers; 9) increasing the weighing of flood insurance questions on producer licensing exams; and 10) conducting agent education.

The considerations document provides detailed information regarding ways in which state DOIs can apply the information listed above to enhance the private flood insurance market in their state. The Catastrophe Insurance (C) Working Group plans to continue building on this document by including information used by additional states as the private flood insurance market grows.

2. Name of group responsible for drafting the model and states participating.

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee was responsible for drafting the considerations document and formed a drafting group to draft the document. Participating states included: Alabama; Connecticut; Florida; Illinois; Louisiana; Mississippi; Missouri; Pennsylvania; Rhode Island; South Carolina; and Texas.

3. Project authorized by what charge and date first given to the group.

The project was authorized by the charges of the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee to: “Continue to examine ways to help state insurance regulators facilitate the private flood insurance market.”

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

In 2018, the Catastrophe Insurance (C) Working Group began discussing items to be included in a private flood document to aid state insurance regulators regarding helping states enhance and/or develop a private flood insurance market in their states. The Working Group formed a drafting group to work on the document. The drafting group met via conference call on a frequent basis to complete the drafting of the document.

5. A general description of the due process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited).

The drafting group of the Catastrophe Insurance (C) Working Group met regularly via conference call, during which the Working Group heard comments and discussed suggested revisions from state insurance regulators. Following the drafting of the document, the document was exposed on July 10, 2019, for a 30-day public comment period. The considerations document was adopted by the Catastrophe Insurance (C) Working Group on Aug. 3, 2019. The considerations document was then adopted by the Property and Casualty Insurance (C) Committee during its Aug. 5, 2019, meeting at the 2019 Summer National Meeting.
6. A discussion of the significant issues (items of some controversy raised during the due process and the group's response).

There were no items of controversy raised during the due process.

7. Any other important information (e.g., amending an accreditation standard).

Not applicable.

W:\National Meetings\2020\Summer\Plenary\Att 6 ConsiderationsofPrivateFlood_Final 2-7-20.pdf
NAIC CONTINUING EDUCATION RECIPROCITY (CER) AGREEMENT - 2019 VERSION
Adopted by the Market Regulation and Consumer Affairs (D) Committee Dec. 9, 2019
Adopted by the Producer Licensing (D) Task Force Dec. 7, 2019

Whereas, the Commissioners find that it is in the best interest of each of their states and insurance producers to simplify the CER course approval process and reduce barriers to non-resident continuing education (CE) providers.

Whereas, the undersigned Insurance Commissioners of the NAIC, hereafter the Commissioners, have determined that it is redundant for each state to perform a substantive review of CE courses or individual instructors that have previously been approved by another state.

Definitions:

Home State: the state in which the CE provider organization maintains his, her or its principal place of residence or principal place of business.

Home State Course Approval: approval of a course that has had a substantive review in a home state.

Reciprocal State: state other than the home state and a party to this CER agreement.

Substantive Review: a thorough review of the course to confirm compliance with the home state’s applicable laws and regulations for the approval of insurance CE. The review includes a determination of whether the:

i. Subject matter meets the criteria for insurance education, to include approvable and non-approvable topic guidelines.

ii. Provider has procedures for reviewing course material in order to keep it up to date and timely.

iii. Course design and instructional strategies are appropriate for the method of delivery.

iv. Credit hours are properly calculated based on the instruction method.

v. Criteria for completing the course meets the standards applicable to the instruction method.

The Commissioners agree as follows:

1. Each state will conduct a substantive review of CE courses submitted for home state approval. When a CE provider has received a home state course approval, a reciprocal state will not conduct a substantive review of that same course as a condition of approval. A CE provider’s home state means the state in which the CE provider organization maintains his, her or its principal place of residence or principal place of business. If the laws or regulations of the home state restrict or limit the minimum or maximum number of credit hours for which a course may be approved for in that state, or restricts certain course topics, the CE provider may elect to recognize another home state in order to obtain a home state course approval.

2. Unless specifically limited by state laws and regulations, a reciprocal state will award a course the same number of credits as approved by the CE provider’s home state.

3. A reciprocal state agrees to approve a course submission within 30 days of receipt, provided that the course is filed using the NAIC Uniform CER Course Filing Form (Appendix A) or an equivalent electronic submission method and contains a home state course approval.

4. Each state will accept the NAIC Uniform CER Course Filing Form (Appendix A), or a substantially similar form, including an equivalent electronic submission method, and the required home state course approval document as the sole requirement for a reciprocal course submission.
5. Each state accepts and will use the following standards for substantive course reviews:
   
   a. For classroom and webinar courses, one credit will be awarded for every 50 minutes of contact instruction.
   
   b. For self-study/online courses, credit will be awarded based on the NAIC’s Recommended Continuing Education Guidelines for Online Courses and Course Guidelines for Classroom Webinar/Webcase Delivery (Appendix B and Appendix C).
   
   c. The minimum number of credits that will be awarded is one credit; no partial credits will be awarded, and there is no maximum number of credits.
   
   d. Credits will only be awarded for courses whose subject matter will increase technical knowledge of insurance principles, coverages, ethics, laws or regulations and will not be awarded for topics such as personal improvement, motivation, time management, supportive office skills or other matters not related to technical insurance knowledge. If any credits are awarded for sales and/or marketing, those credits will be separately noted on the course approval document. Credits for sales and/or marketing will only be awarded in states that are permitted by law or regulation to accept credit for those topics. Additional guidance can be found in the NAIC’s Recommended Approved/Not Approved Course Topics (Appendix D).
   
   e. Each state will use its own method to determine if an instructor is qualified, and no instructor will be approved unless the CE provider has provided sufficient information to demonstrate that the instructor is qualified, according to that state’s laws and regulations, to teach the topics covered in the outline.
   
6. A state’s course approval document or approved course application will include, at a minimum, the following information: course title, credit hours, credit category, method of instruction, and if it is a home state approval.

7. Each state reserves the right to disapprove individual instructors or CE providers who have been the subject of disciplinary proceedings or have otherwise failed to comply with a state’s laws and regulations.

8. Each state agrees that it will notify other states when a CE provider or instructor has been the subject of a formal administrative action or other disciplinary action by that state.
## Provider Information

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>FEIN # (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact Person</strong></td>
<td><strong>E-mail Address of Contact Person</strong></td>
</tr>
<tr>
<td>Phone Number ( ) - ext.</td>
<td>Fax Number ( ) -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home State</th>
<th>Home State Provider #</th>
<th>Reciprocal State</th>
<th>Reciprocal State Provider #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Mailing Address</strong></th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Submitter Name</strong> (if different from provider contact person above)</th>
<th><strong>Submitter Phone Number</strong></th>
<th><strong>E-mail Address of Submitter</strong></th>
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</thead>
</table>

## Course Information

<table>
<thead>
<tr>
<th><strong>Course Title</strong></th>
<th><strong>Date of Course Offering</strong> (if applicable)</th>
<th><strong>Existing Course Number</strong> (if applicable)</th>
</tr>
</thead>
</table>

## Method of Instruction

<table>
<thead>
<tr>
<th><strong>Non-Contact / Asynchronous</strong></th>
<th><strong>Contact / Synchronous</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self – Study</td>
<td>Classroom</td>
</tr>
<tr>
<td>☐ Correspondence</td>
<td>☐ Seminar/Workshop</td>
</tr>
<tr>
<td>☐ On-Line Training (Self-Study)</td>
<td>☐ Other __________________</td>
</tr>
<tr>
<td>☐ Recorded Media</td>
<td>☐ Virtual Class/Webinar/Video Conference</td>
</tr>
<tr>
<td>☐ Other __________________</td>
<td>☐ Other __________________</td>
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</table>

<table>
<thead>
<tr>
<th>Word Count</th>
<th>Mandatory Run-time (Interactive Components of Course)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Measurement used for successful completion:</th>
<th>☐ Attendance</th>
<th>☐ Final Exam</th>
<th>☐ Other ____________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is this course open to the public?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>National Designation?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, Designation Type:</td>
<td>__________________________</td>
<td></td>
</tr>
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Credit Hours Requested and Course/Hours Decision

<table>
<thead>
<tr>
<th>Course Concentration</th>
<th>Hrs Requested by Provider</th>
<th>Hrs Approved by Home State</th>
<th>Hrs Approved by Reciprocal State</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Sales/Mktg</td>
<td>Insurance</td>
<td>Sales/Mktg</td>
</tr>
<tr>
<td>A. Producer Topics:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Circle Appropriate Course Concentration)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life / Health</td>
<td></td>
<td></td>
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<tr>
<td>Property / Casualty/Personal Lines</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ethics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General (Applies to all lines)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Laws</td>
<td></td>
<td></td>
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<tr>
<td>Other (LTC, NFIP, Viaticals, Annuities, etc.)</td>
<td></td>
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<tr>
<td>Total Hours</td>
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<tr>
<td>B. Adjuster Topics</td>
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<tr>
<td>(Circle Appropriate Course Concentration)</td>
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<tr>
<td>General</td>
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<tr>
<td>Workers Comp</td>
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<tr>
<td>Ethics</td>
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<tr>
<td>Other</td>
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<tr>
<td>Total Hours</td>
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<tr>
<td>C. Public Adjuster</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(Circle Appropriate Course Concentration)</td>
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</tr>
<tr>
<td>General</td>
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<td>Ethics</td>
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<tr>
<td>Other</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Hours</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Information Below is for Regulator Use Only

- Approval Date
- Course Number assigned
- Course approval expiration date
- Signature of Home State Regulator/Representative
  - **OR ATTACH** Provider Home State Approval Form
- Signature of Reciprocal State Regulator/Representative
  - **OR ATTACH** Reciprocal State Approval Form

Difficulty (Check): □ Basic □ Intermediate □ Advanced
**INSTRUCTION SHEET**

**NOTE:** This course may NOT be advertised or offered as approved in the state to which application has been made until approval has been received from the insurance department.

1. **If you are a PROVIDER filing for approval from the Home State:**
   1.1 Complete all the fields in the “Provider Information” section except “Reciprocal State” and the adjacent “Provider #” fields.
   1.2 Complete the Course Information Section.
   1.3 In the “Credit Hours Requested and Course/Hours Decision” section, complete the “Hrs. Requested by Provider” columns, detailing in the respective columns the number of hours for sales – and marketing-related instruction and the number of hours for other insurance-related instruction. Please note the following:
      1.3.1 When using this application, which is governed by the NAIC CE Reciprocity Agreement in conjunction with ‘states’ laws, only whole numbers of credit hours will be approved – partial hours will be eliminated.
      1.3.2 States that approve sales/marketing topics will consider the hours in the “sales/Mktg” column and the hours in the “Insurance” column when deciding the number of hours to approve. States that do not permit sales/marketing topics as part of continuing education credit hours will only consider the hours shown in the “Insurance” column when making their credit-hour approval decisions.
      1.3.3 Contact the individual state to determine whether there are any state specific requirements for submitting courses.
   1.4 Submit the application form along with required course materials, a detailed course outline, instructor information, if required, and the required course application fee.

2. **If you are a PROVIDER filing for approval from a Reciprocal State:**
   2.1 Make a sufficient number of photocopies of the Home State approval form to enable you to submit a copy of this application to each of the Reciprocal States where you are seeking credit.
   2.2 On each application, write the Reciprocal State and the provider number assigned to you by that state in the “Reciprocal State” and adjacent “Provider #” fields.
   2.3 Send the CER application, home state approval, if home state issues one, a detailed course outline, and the required fee to the reciprocal state. If this is a National Course *, the Providers will be allowed to submit an agenda that must include date, time, each topic and event location in lieu of a detailed course outline.
   2.4 Subsequent national course offerings should only be reported for events that are conducted in the “home” state.

* **National Course** is defined as an approved program of instruction in insurance related topics, offered by an approved provider, and leads to a national professional designation or is a course offered to individuals who must update their designation once it is earned.

3. **If you are the HOME STATE or designated representative of the Home State:**
   3.1 After reviewing the course materials, complete the “Hrs Approved by Home State” column.
      3.1.1 Multiple types of credit and delivery methods can be approved using one CER Form.
   3.2 Enter the date of approval, course # assigned, course approval expiration date. Sign the CER Form OR attach the home state approval form.
   3.3 If the course is not approved, note it on the bottom of the CER Form.

4. **If you are the RECIPROCAL STATE or designated representative of the Reciprocal State:**
   4.1 After reviewing “Hrs approved by Home State” complete the “Hrs Approved by Reciprocal State”.
      4.1.1 It is unnecessary for each state to perform a substantive review of continuing education courses that have previously been approved by the Home State.
      4.1.2 Reciprocal states cannot award different credits than the home state unless certain aspects are not allowed by state law.
   4.2 Enter the date of approval, course number assigned, course approval expiration date. Sign the CER Form OR attach the reciprocal state approval form.
   4.3 If the course is not approved, note it on the bottom of the CER Form.
   4.4 The reciprocal state agrees to approve the CER submission within 30 days of receipt.

**Substantive Review** – A thorough review of the course to confirm compliance with the home state’s applicable laws and regulations for the approval of insurance continuing education. The review includes a determination whether the:

1. Subject matter meets the criteria for insurance education, to include approvable and non-approvable topic guidelines;
2. Provider has procedures for reviewing course material in order to keep it up to date and timely;
3. Course design and instructional strategies are appropriate for the method of delivery;
4. Credit hours are properly calculated based on instruction method;
5. Criteria for completing the course meets the standards applicable to the instruction method.

* Drafting Note: The instructor information matrix was eliminated in 2018 as this information should be readily available on individual state/jurisdiction websites.
APPENDIX B

Continuing Education Recommended Guidelines for Online Courses
Adopted by NAIC Membership March 2015.

Goal: To deliver functional computer-based internet courses that offer quality insurance and/or risk management material in a password-protected online environment.

Key Components:
- Material that is current, relevant, accurate, and that includes valid reference materials, graphics and interactivity.
- Clearly defined objectives and course completion criteria
- Technical support/provider representative should be available during business hours and response provided within 24 hours of initial contact.
- Instructors/subject matter experts must be available to answer student questions during provider business hours.
- Process to authenticate student identity such as passwords and security prompts.
- Method for measuring the student’s successful completion of course which includes the material, exam and any proctor requirements.
- Process for requesting and receiving CE course-completion certificate and reporting student results to the appropriate regulator.
- Require each agent to enroll for the course before having access to course material.
- Prevent access to the course exam before review of the course materials.
- Prevent downloading of any course exam.
- Provide review questions at the end of each unit/chapter and prevent access to the final exam until each set of questions are answered at a 70% rate.
- Provide final exam questions that do not duplicate unit/chapter questions.
- Prevent alternately accessing course materials and course exams. This does not apply if the state allows for “open book” exams.
- Have monitor affidavit containing specific monitor duties and responsibilities printed for monitor’s use to direct the taking of the final exam. Monitor will complete the affidavit after the exam is completed. (This only for states that require a monitored exam).

Final Assessment (exam) Criteria:
- Minimum of 10 questions for 1 credit hour course with additional 5 questions for each subsequent credit hour and a score of 70% or greater.
- At least enough questions to fashion a minimum of 2 versions with a least 50% of questions being new/different in each subsequent version.
- Inability to print the exam or to view the exam prior to reviewing material.
- Proctor, if required by the state, who verifies identity by photo identification and processes affidavit testifying the student received no outside assistance.

Procedures to determine Appropriate Number of Credit Hours:

Word Count/Difficulty Level:
- Divide total number of words by 180 (documented average reading time) = number of minutes to read material
- Divide number of minutes by 50 = credit hours
- Course difficulty level is identified by the CE provider on the CER form and should be based on the NAIC CE Standardized Terms-Definitions for basic, intermediate and advanced course difficulty levels.
- Multiply number of hours by 1.00 for a basic level course; 1.25 for an intermediate level; 1.50 for an advanced course for additional study time = total number of credit hours (fractional hours rounded up if .50 or above and rounded down if .49 or less).
Interactive Course Content
- Elements included in the online course, in addition to text, such as video, animation, interactive exercises, quizzes, case studies, games, and simulations.
- Interactive elements should be applicable to course material and facilitate student learning.
- Only mandatory interactive elements should be included in the calculation of CE credit hours.
- Calculation of CE hour credits should be based on the run time of the interactive elements.
- CE providers will indicate run time of the interactive elements in the course content and upon request provide access to the state for review of the course.

Professional Designation Course
- Course that is part of a nationally recognized professional designation
- Credit hours equivalent to hours assigned to the same classroom course material

Final Assessment
- Time spent completing the final assessment should not be used in calculation of CE credit hours.

Adopted by the NAIC Membership March 2015
APPENDIX C

COURSE GUIDELINES FOR CLASSROOM WEBINAR/WEBCAST DELIVERY

Adopted by NAIC Membership April 2014.

- These guidelines are intended to apply to courses conducted and viewed in real time (live) in all locations and are not intended to apply when courses have been recorded and are viewed at a later time or to other online courses.

- Each student will be required to log in to the webinar using a distinct username, password and/or email. Students that view webinars in group settings which is two or more individuals should alternatively verify their participation in the form of sign-in and sign-out sheets submitted by a monitor with an attestation or verification code.

- The provider will verify the identity and license number, or National Producer Number (NPN), of all students.

- A provider representative, using computer-based attendance-monitoring technology, must monitor attendance throughout the course.

- The provider must have a process to determine when a participant is inactive or not fully participating, such as when the screen is minimized, or the participant does not answer the polling questions and/or verification codes.

- For webinars not given in a group setting, no less than two polling questions and/or attendance verification codes must be asked, with appropriate response provided, at unannounced intervals during each one-hour webinar session to determine participant attentiveness.

- The provider will maintain an electronic roster to include records for each participant’s log-in/log-out times. If required by states chat history and polling responses should be captured as part of the electronic record.

- When a student is deemed inactive or not fully participating in the course by the course monitor of failure to enter appropriate polling question response or verification codes, continuing education (CE) credit is denied.

- All students and the instructor do not need to be in the same location.

- Students in all locations must be able to interact in real time with the instructor. Students should be able to submit questions or comments at any point during the webinar session.

- The course pace must be set by the instructor and does not allow for independent completion.

- Instruction time is considered the amount of time devoted to the actual course instruction and does not include breaks, lunch, dinner or introductions of speakers.

- One credit will be awarded for each 50 minutes of webinar/webcast instruction, and the minimum number of credits that will be awarded for webinar/webcast courses is one credit.

- The provider must have a procedure that informs each student in advance of course participation requirements and consequences for failing to actively participate in the course.

- A comprehensive final examination is not required.
APPENDIX D

RECOMMENDED APPROVED/NOT APPROVED TOPICS FOR CE CREDIT

Adopted by NAIC Membership August 2018.

Approved Topics

1. Actuarial mathematics, statistics and probability – in relation to insurance
2. Assigned risk – in relation to insurance
3. Claims adjusting
4. Courses leading to and maintaining insurance designations
5. Employee benefit plans – in relation to insurance
6. Errors and omissions – in relation to insurance
7. Estate planning/taxation – in relation to insurance
8. Ethics
9. Fundamentals/principles of insurance (including but not limited to: annuities, crop and hail, life, accident and health, property/casualty [P/C], etc.)
10. Insurance accounting/actuarial considerations
11. Insurance contract/policy comparison and analysis
12. Insurance fraud
13. Insurance laws, rules, regulations and regulatory updates
14. Insurance policy provisions
15. Insurance product-specific knowledge
16. Insurance rating/underwriting/claims
17. Insurance tax laws
18. Legal principles – in relation to insurance
19. Long-term care/partnership
20. Loss prevention, control and mitigation – in relation to insurance
21. Managed care
22. Principles of risk management – in relation to insurance
23. Proper uses of insurance products
24. Real Estate Settlement Procedures Act (RESPA) – in relation to insurance
25. Restoration – addresses claims, loss control issues and mitigation – in relation to insurance
26. Retirement planning – in relation to insurance
27. Securities – in relation to insurance
28. Suitability in insurance products
29. Surety bail bond
30. Underwriting principles – in relation to insurance
31. Viaticals/life settlements – in relation to insurance

Other topics approved that contribute substantive knowledge relating to the field of insurance and expands competence of the licensee.
RECOMMENDED APPROVED/NOT APPROVED TOPICS FOR CE CREDIT

Adopted by NaIC Membership August 2018.

Not Approved Topics

1. Automation
2. Clerical functions
3. Computer science
4. Computer training/skills or software presentations
5. Courses on investments – stocks, bonds, mutual funds, Financial Industry Regulatory Authority (FINRA)/U.S. Securities and Exchange Commission (SEC) compliance (National Association of Securities Dealers [NASD]/SEC), etc.
6. Courses that are primarily intended to impart knowledge of specific products of specific insurers
7. Customer service
8. General management training
9. Goal-setting
10. Health/stress/exercise management
11. Marketing/telemarketing
12. Motivational training
13. Company and vendor-specific product launches
14. Office skills or equipment or procedures
15. Organizational procedures and internal policies of an individual insurer
16. Personal improvement
17. Prospecting
18. Psychology
19. Relationship building
20. Restoration – promoting products or services
21. Sales training
22. Service standards or service vendors
23. Time management

Other topics or courses not related to insurance knowledge or competence of the licensee.

W:\National Meetings\2020\Summer\Plenary\Att 7 2019 CER Agreement Adopted 12.9.19.pdf
(Traditional insurers) Nov. 15, 2019 referral adopted by the Financial Regulation Standards and Accreditation (F) Committee – Dec. 7, 2019

(Risk retention groups) In addition, the March 3, 2020 referral also attached will be considered for adoption by the Financial Regulation Standards and Accreditation (F) Committee on August 12, 2020. This referral clarifies that the model provisions in the Nov. 15 referral also apply to risk retention groups. It is recommended, for clarity purposes, the Executive (EX) Committee and Plenary consider adoption of both referrals at the same time.

MEMORANDUM

To: Financial Regulation Standards and Accreditation (F) Committee

From: Reinsurance (E) Task Force

Date: November 15, 2019

Re: 2019 Revisions to Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786)

Executive Summary

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786). These revisions were intended to incorporate the relevant provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017. The Covered Agreement would eliminate reinsurance collateral and local presence requirements for European Union (EU) reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or post collateral in any EU jurisdiction. On Dec. 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK). In addition, the 2019 revisions extend similar treatment to Qualified Jurisdictions and accredited NAIC jurisdictions.

At the 2019 Summer National Meeting, Director Chlora Lindley-Myers (MO), Chair of the NAIC Reinsurance (E) Task Force, made the following recommendation to the Financial Regulation Standards and Accreditation (F) Committee: 1) the Committee recognize that states may begin adoption of provisions that are substantially similar to the 2019 revisions to Model #785 and Model #786 and remain in compliance with the Reinsurance Ceded accreditation standard; 2) the accreditation standard be modified in accordance with the normal processes and procedures outlined in the Accreditation Program Manual, and that the Task Force and Financial Condition (E) Committee prepare a formal recommendation to the Financial Regulation Standards and Accreditation (F) Committee for consideration at the 2020 Spring National Meeting; and 3) in the interim, states should be
encouraged to adopt the 2019 revisions in the form adopted by Plenary within the 60-month timeframe set forth in the Covered Agreement to best avoid potential federal preemption. Committee Chair Commissioner Todd E. Kiser (UT) asked if there were any objections to the approach proposed in the referral from the Reinsurance (E) Task Force, and none were noted.

At its meeting on October 22, the Reinsurance (E) Task Force agreed to submit the following new recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

1. The 2019 revisions to Model #785 and Model #786 should be adopted as a new accreditation standard by the NAIC, Reciprocal Jurisdictions, with significant elements as outlined in Appendix A.

2. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this standard. The Task Force recommends that the accreditation standard become effective Oct. 1, 2022, the end of the 60-month period when federal preemption determinations must be completed, with enforcement of the standard to commence Jan. 1, 2023. [Note: after the Oct. 22 conference call, NAIC staff had conversations with representatives of the Federal Insurance Office (FIO), in which they advised NAIC staff that in their opinion the end of the 60-month period when federal preemption determinations must be completed is Sept. 1, 2022].

A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

The current Reinsurance Ceded accreditation standard requires that state law shall contain the significant elements from Model #785 and Model #786. The models serve to provide regulators with an effective method of monitoring the reinsurance activities of U.S. companies. U.S. primary insurance companies may be given reinsurance credit on their statutory financial statements for insurance risk they transfer via reinsurance that meets the legal and accounting risk transfer requirements and other relevant laws. Both the 2011 revisions to the credit for reinsurance models, which served to reduce reinsurance collateral requirements for certified reinsurers domiciled in qualified jurisdictions, and the 2019 revisions with respect to Reciprocal Jurisdictions, address the reinsurance collateral requirements necessary for U.S. ceding companies to take credit for certain reinsurance transactions.

A statement as to why ultimate adoption by every jurisdiction may be desirable:

The Dodd-Frank Wall Street Reform and Consumer Protection Act provides that a state insurance measure shall be preempted to the extent that the Director of FIO “determines” that the measure is inconsistent with the covered agreement and results in less favorable treatment of a non-U.S. insurer domiciled in a foreign jurisdiction that is subject to a “covered agreement” than a U.S. insurer domiciled, licensed or otherwise admitted in that state. A “covered agreement” under Dodd-Frank is an agreement entered into between the U.S. and foreign government(s) on prudential measures with respect to the business of insurance or reinsurance that achieves a level of protection for consumers that is “substantially equivalent” to the level of protection under state law. The revisions to Model #785 and #786 are considered by the Reinsurance (E) Task Force to be consistent with the requirements of the Covered Agreements entered into with the EU and UK.

Article 9(4) of the Covered Agreements provide, as follows with respect to Implementation of the Agreement:

4. Provided that this Agreement has entered into force, on a date no later than the first day of the month, 42 months after the date of signature of this Agreement [22 September 2017], the United States shall begin evaluating a potential preemption determination under its laws and regulations with respect to any U.S. State insurance measure that the United States determines is inconsistent with this Agreement and results in less favourable treatment of an EU insurer or reinsurer than a U.S. insurer or reinsurer domiciled, licensed, or otherwise admitted in that U.S. State. Provided that this Agreement has entered into force, on a date no later than the first day of the month 60 months after the date of
signature of this Agreement [22 September 2017], the United States shall complete any necessary preemption determination under its laws and regulations with respect to any U.S. State insurance measure subject to such evaluation. For the purposes of this paragraph, the United States shall prioritise those States with the highest volume of gross ceded reinsurance for purposes of potential preemption determinations. [Emphasis added].

To summarize, FIO may begin evaluating potential preemption “determinations” 42 months after the signature of the Covered Agreement, or March 1, 2021. FIO must complete any necessary preemption determinations 60 months after signature, which they believe to be Sept. 1, 2022. In order to avoid potential federal preemption determinations by the FIO Director, each state should adopt the 2019 revisions to Model #785 and Model #786 in a timely manner.

A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:

The pre-2011 versions of Model #785 and Model #786 are currently part of the Reinsurance Ceded accreditation standard, and the significant elements have been adopted in substantially similar form by all NAIC-accredited jurisdictions. The 2011 revisions to these models implemented reinsurance collateral reduction for Reinsurance Ceded to Certified Reinsurers domiciled in qualified jurisdictions. At the current time, all NAIC accredited jurisdictions have adopted the 2011 revisions to Model #785, and only 5 jurisdictions have not adopted the 2011 revisions to Model #786, which became part of the accreditation standard effective January 1, 2019.

We are not currently aware of any states that have adopted the 2019 revisions to Model #785 and Model #786, although we have been advised that many states have begun their legislative processes for adoption of these revisions. We are not aware of any negative impact to any jurisdiction or its domiciliary ceding insurers that has adopted these revisions, which are similar in function and format to the Reciprocal Jurisdiction requirements of the 2019 revisions.

A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:

The current accreditation standard for Model #785 and Model #786 requires state adoption on a substantially similar basis. In addition, the Covered Agreements themselves and the Dodd-Frank Act require that the United States cannot impose reinsurance collateral or local presence requirements that result in less favorable treatment for EU or UK reinsurers, and further that any state insurance measures cannot be inconsistent with the Covered Agreements. Therefore, the Reinsurance (E) Task Force recommends that the attached proposed significant elements for Reciprocal Jurisdictions (Appendix A) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. Note: While the Task Force is recommending that the Committee adopt a “substantially similar” standard for accreditation purposes, it should be noted that Dodd-Frank requires the state insurance measure to be “consistent” with the Covered Agreement in order to avoid federal preemption, which may be interpreted as a higher standard. It is the recommendation of the Task Force that states adopt the 2019 revisions in close to identical form to the models in order to best avoid the possibility of federal preemption.

An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:

The NAIC has not performed a cost/benefit analysis with respect to the 2019 revisions to Model #785 and Model #786, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable.
31 U.S.C. §313(f) provides the process for making a “determination” in this context:

(2) Determination.—

(A) Notice of potential inconsistency.—Before making any determination under paragraph (1), the Director shall—

(i) notify and consult with the appropriate State regarding any potential inconsistency or preemption;

(ii) notify and consult with the United States Trade Representative regarding any potential inconsistency or preemption;

(iii) cause to be published in the Federal Register notice of the issue regarding the potential inconsistency or preemption, including a description of each State insurance measure at issue and any applicable covered agreement;

(iv) provide interested parties a reasonable opportunity to submit written comments to the Office; and

(v) consider any comments received.

***

(C) Notice of determination of inconsistency.—Upon making any determination under paragraph (1), the Director shall—

(i) notify the appropriate State of the determination and the extent of the inconsistency;

(ii) establish a reasonable period of time, which shall not be less than 30 days, before the determination shall become effective; and

(iii) notify the Committees on Financial Services and Ways and Means of the House of Representatives and the Committees on Banking, Housing, and Urban Affairs and Finance of the Senate.

(3) Notice of effectiveness.—Upon the conclusion of the period referred to in paragraph (2)(C)(ii), if the basis for such determination still exists, the determination shall become effective and the Director shall—

(A) cause to be published a notice in the Federal Register that the preemption has become effective, as well as the effective date; and

(B) notify the appropriate State.
10. Reinsurance Ceded

State law should contain the NAIC Credit for Reinsurance Model Law (#785), the NAIC’s Credit for Reinsurance Model Regulation (#786) and the NAIC Life and Health Reinsurance Agreements Model Regulation (#791) or substantially similar laws.

### Credit for Reinsurance Model Law (#785)

**a.** Credit allowed for reinsurance ceded to a licensed insurer?

**b.** Credit allowed for reinsurance ceded to an accredited insurer who meets requirements similar to those in Section 2B and 2I of the model law?

**c.** Credit allowed for reinsurance ceded to an insurer domiciled and licensed in a state which employs substantially similar standards regarding credit for reinsurance and who maintains capital and surplus of at least $20,000,000 and submits to this state’s authority to examine its books and records?

**d.** Credit allowed for reinsurance ceded to an insurer who maintains a trust fund, established in a form approved by the commissioner, in a qualified U.S. financial institution for the payment of the valid claims of its U.S. policyholders and ceding insurers, their assigns and successors in interest and who reports financial information annually to the commissioner to determine the sufficiency of the trust fund?

**e.** In instances where reinsurance is ceded to insurers maintaining a trust fund, trustees of the trust required to report to the department annually, on or before February 28, the balance of the trust and a listing of the trust’s assets as of the end of the year and a certification of the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31?

**f.** Credit for reinsurance allowed under c. or d. above only permitted where assuming insurer agrees in the reinsurance agreements: 1) that in the event of a failure of the assuming insurer to perform its obligations, the assuming insurer shall submit to the jurisdiction of any court of competent jurisdiction in any state of the U.S.; and 2) to designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process instituted by or on behalf of the ceding company?
g. Credit allowed for reinsurance ceded to an insurer not meeting the requirements of a., b., c., or d. above, or with respect to a certified reinsurer described below, in an amount not exceeding the liabilities carried by the ceding insurer and only in the amount of funds held by or on behalf of the ceding insurer in the form of cash, securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets, clean, irrevocable, unconditional letters of credit, and other forms of security acceptable to the commissioner?

h. Ceding insurers must be subject to notification requirements with respect to reinsurance concentration risk substantially similar to those in Section 2J2K of Model #785.

**Life and Health Reinsurance Agreements Model Regulation (#791)**

i. Scope similar to Section 3?

j. No insurer, for reinsurance ceded establishes any asset or reduces any liability due to the terms of the reinsurance agreement, in substance or effect if any of the conditions in Section 4A exist?

k. Agreements entered into after the effective date of this regulation which involve the reinsurance of business issued prior to the effective date of agreements, along with subsequent amendments shall be filed by the ceding company with the commissioner within 30 days from the execution date along with attachments noted in Section 4C(1)?

l. Any increase in surplus net of federal income tax resulting from arrangements described in Section 4C(1) to be reported as described in Section 4C(2)?

m. Written agreements with provisions similar to Section 5?

n. Insurers required to reduce to zero any reserve credits or assets established with respect to existing reinsurance agreements entered into prior to the effective date of this regulation which would not be recognized under the provisions of this regulation?

**Credit for Reinsurance Model Regulation (#786)**

o. Credit for reinsurance allowed for reinsurance ceded by domestic insurers to assuming insurers that were licensed in the state as of the last date of the ceding insurers’ statutory financial statement?

p. Credit for reinsurance provisions for accredited reinsurer similar to Section 5?

q. Credit for reinsurance provisions for reinsurers licensed and domiciled in other states similar to Section 6?
r. Credit for reinsurance provisions for reinsurers maintaining trust funds similar to Section 7?

s. Credit for reinsurance required by law similar to Section 9?

t. Reduction from liability for reinsurance ceded to an unauthorized assuming insurer similar to Section 10?

u. Provisions for trust agreements similar to Section 11?

v. Provisions for letters of credit similar to Section 12?

w. Provisions for unencumbered funds similar to Section 13?

x. Provisions for reinsurance contracts similar to Section 14?

y. The adoption of Form AR-1—Certificate of Assuming Insurer.

Reinsurance Ceded to Certified Reinsurers

z. A state’s laws and regulations shall allow credit for reinsurance ceded to a certified reinsurer, including affiliated reinsurance transactions. Its laws and regulations shall contain provisions that are substantially similar to those applicable to certified reinsurers contained in Section 2E of Model #785 and Section 8 of Model #786.

i. The credit allowed is based upon the security held by or on behalf of the ceding insurer in accordance with the rating assigned to the certified reinsurer by the commissioner? The amount of security required in order for full credit to be allowed shall not be less than that required under Section 8A(1) of Model #786.

ii. The security provided by the certified reinsurer is in a form consistent with the provisions of Section 2E(5) of Model #785 and Section 8A of Model #786?

iii. The commissioner requires the certified reinsurer to post 100% security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer?

iv. A state’s laws or regulations shall include provisions for granting a certified reinsurer a deferral period for posting security applicable to catastrophe recoverables, substantially similar to Section 8A(4) of Model #786. The deferral period shall not exceed one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the commissioner, and shall not apply to lines of business other than those provided in Section 8A(4) of Model #786.
v. Credit for reinsurance ceded to a certified reinsurer shall apply only to reinsurance contracts meeting requirements substantially similar to Section 8A(5) of Model #786?

aa. In order to be a certified reinsurer, an assuming insurer must be certified by the commissioner in accordance with the process similar to Section 8B of Model #786?

i. The commissioner is required to post notice upon receipt of any application for certification substantially similar to the requirements of Section 8B(1) of Model #786?

ii. The commissioner is required to publish a list of all certified reinsurers and their ratings substantially similar to the requirements in Section 2E(4) of Model #785 and Section 8B(2) of Model #786?

iii. A certified reinsurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner?

iv. A certified reinsurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000, calculated in accordance with Section 8B(4)(h) of Model #786? This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

v. A certified reinsurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner, and the maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as set forth in Section 8B(4)(a) of Model #786? These ratings must be based on interactive communication between the rating agency and the assuming insurer and not based solely on publicly available information.

vi. A certified reinsurer is rated by the commissioner on a legal entity basis, with consideration given to the group rating where appropriate (an association including incorporated and individual unincorporated underwriters that have been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating)? Factors may be considered in the evaluation process similar to those provided under Section 8B(4) and (5) of Model #786.
vii. A certified reinsurer must submit a properly executed Form CR-1 as evidence of its submission to the jurisdiction of the state, appointment of the commissioner as an agent for service of process in the state, and agreement to provide security for one hundred percent (100%) of its liabilities attributable to reinsurance ceded by ceding insurers if it resists enforcement of a final U.S. judgment? The commissioner must not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

viii. A certified reinsurer must agree to meet applicable information filing requirements substantially similar to those provided under Section 8B(7) of Model #786, both with respect to an initial application for certification and on an ongoing basis?

ix. Changes in rating or revocation of certification of a certified reinsurer are applied by the commissioner in a manner substantially similar to the provisions of Section 2I2J of Model #785 and Section 8B(8) of Model #786?

x. A certified reinsurer must file audited financial statements, regulatory filings and actuarial opinion (as filed with the certified reinsurer’s supervisor, with a translation into English) consistent with the requirements set forth in Section 8B(4)(h) and Section 8B(7)(d) of Model #786? Upon the initial application for certification, the commissioner will consider audited financial statements for the last two (2) years filed with its non-U.S. jurisdiction supervisor?

bb. The commissioner is required to create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer?

i. In determining whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner evaluates the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, under criteria substantially similar to those provided under Section 8C(2) of the model regulation?

ii. The commissioner shall consider the list of qualified jurisdictions published by the NAIC in determining qualified jurisdictions? If the commissioner approves a jurisdiction as qualified that does not appear on the NAIC list of qualified jurisdictions, the commissioner must provide thoroughly documented justification with respect to criteria substantially similar to that provided under Section 8C(2) of Model #786.

iii. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program are recognized as qualified jurisdictions?
cc. A state’s laws and regulations shall allow a commissioner to defer to the certification and rating of a certified reinsurer issued by another NAIC accredited jurisdiction. Recognition of certification is made in accordance with provisions substantially similar to Section 8D of Model #786.

dd. Reinsurance contracts entered into or renewed with a certified reinsurer must include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer for reinsurance ceded to the certified reinsurer.

Reciprocal Jurisdictions

ee. A state’s laws and regulations shall allow credit for reinsurance ceded to an assuming insurer that has its head office or is domiciled in, and is licensed in, a Reciprocal Jurisdiction. Its laws and regulations shall contain provisions that are substantially similar to those contained in Section 2F of Model #785 and Section 9 of Model #786. Its laws and regulations must provide that a Reciprocal Jurisdiction is a jurisdiction that meets one of the following:

i. A non-U.S. jurisdiction that is subject to an in-force covered agreement meeting the requirements of Section 2F(1)(a)(i) of Model #785 and Section 9B(1) of Model #786.

ii. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program pursuant to Section 2F(1)(a)(ii) of Model #785 and Section 9B(2) of Model #786.

iii. A Qualified Jurisdiction that meets all of the requirements of Section 2F(1)(a)(iii) of Model #785 and Section 9B(3) of Model #786.

ff. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction, and which meets each of the conditions set forth in Section 2F(1)(b) – (g) of Model #785 and Section 9C of Model #786.
i. The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction of no less than $250,000,000 similar to Section 2F(1)(b) of Model #785 and Section 9C(2) of Model #786. This minimum capital and surplus requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) or own funds of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

ii. The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as set forth in Section 2F(1)(c) of Model #785 and Section 9C(3) of Model #786.

iii. The assuming insurer must submit a properly executed Form RJ-1 consistent with Section 2F(1)(d) of Model #785 and Section 9C(4) of Model #786:

   - The assuming insurer must agree to provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law pursuant to Section 2F(1)(d)(i) of Model #785 and Section 9C(4)(a) of Model #786.

   - The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process pursuant to Section 2F(1)(d)(ii) of Model #785 and Section 9C(4)(b) of Model #786. The commissioner may also require that such consent be provided and included in each reinsurance agreement under the commissioner’s jurisdiction.

   - The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained pursuant to Section 2F(1)(d)(iii) of Model #785 and Section 9C(4)(c) of Model #786.
• Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable pursuant to Section 2F(1)(d)(iv) of Model #785 and Section 9C(4)(d) of Model #786?

• The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state’s ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide one hundred percent (100%) security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement pursuant to Section 2F(1)(d)(v) of Model #785 and Section 9C(4)(e) of Model #786?

• The assuming insurer must agree in writing to meet the applicable information filing requirements pursuant to Section 9C(4)(f) of Model #786?

iv. The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the documentation to the commissioner as outlined in Section 2F(1)(e) of Model #785 and Section 9C(5) of Model #786:

• For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report pursuant to Section 9C(5)(a) of Model #786?

• For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor pursuant to Section 9C(5)(b) of Model #786?

• Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States pursuant to Section 9C(5)(c) of Model #786?
Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer pursuant to Section 9C(5)(d) of Model #786?

v. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements consistent with Section 2F(1)(f) of Model #785 and Section 9C(6) of Model #786?

vi. The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the minimum capital and surplus requirements and the minimum solvency or capital ratio requirements as required under Section 2F(1)(g) of Model #785 and Section 9C(7) of Model #786?

gg. The commissioner is required to timely create and publish a list of Reciprocal Jurisdictions similar to Section 2F(2) of Model #786 and Section 9D of Model #786?

i. If the commissioner approves a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions, the commissioner must provide thoroughly documented justification in accordance with criteria published through the NAIC Committee Process pursuant to Section 2F(2)(a) of Model #785 and Section 9D(1) of Model #786?

ii. The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a Reciprocal Jurisdiction pursuant to Section 2F(2)(b) of Model #785 and Section 9D(2) of Model #786, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section 9B(1) and (2) of Model #786?

hh. The commissioner shall timely create and publish a list of assuming insurers to which cessions shall be granted credit consistent with Section 2F(3) of Model #785 and Section 9E of Model #786? Such assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require.

i. If an NAIC accredited jurisdiction has determined that the conditions set forth in Section 2F of Model #785 and Section 9 of Model #786 have been met, the commissioner has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance pursuant to Section 2F(3) of Model #785 and Section 9E(1) of Model #786? The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC with respect to such reinsurer.
ii. When requesting that the commissioner defer to another NAIC accredited jurisdiction’s determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require pursuant to Section 9E(2) of Model #786?

ii. If the commissioner determines that an assuming insurer no longer meets one or more of the requirements set forth in Section 2F of Model #786 and Section 9 of Model #786, the commissioner may revoke or suspend the eligibility of the assuming insurer consistent with Section 2F(4) of Model #785 and Section 9F of Model #786?

i. While an assuming insurer’s eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer’s obligations under the contract are otherwise secured pursuant to Section 2F(4)(a) of Model #785 and Section 9F(1) of Model #786?

ii. If an assuming insurer’s eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer’s obligations under the contract are otherwise secured in a form acceptable to the commissioner pursuant to Section 2F(4)(b) of Model #785 and Section 9F(2) of Model #786?

iii. Before denying statement credit or imposing a requirement to post security or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall follow the process set forth in Section 9G of Model #786?

ii. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities in accordance with Section 2F(5) of Model #785 and Section 9H of Model #786?

kk. Nothing shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by other applicable law or regulation similar to Section 2F(6) of Model #785?

ll. Credit may be taken only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal consistent with the provisions of Section 2F(7) of Model #785?
MEMORANDUM

To: Financial Regulation Standards and Accreditation (F) Committee

From: NAIC Staff

Date: March 3, 2020

Re: 2011 & 2019 Revisions to Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786)—Applicability to Risk Retention Groups (RRGs)

Executive Summary

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786). These revisions were intended to incorporate the relevant provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017. At the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted these revisions to the Reinsurance Ceded accreditation standard effective Sept. 1, 2022, for consideration by the Executive (EX) Committee and Plenary for final adoption at the Spring National Meeting.

The purpose of this memorandum is to clarify the applicability of these revisions to risk retention groups (RRGs) organized as captives. The recommendation to this Committee is that the 2019 revisions to Model #785 and Model #786, as well as the 2011 revisions establishing certified reinsurers and qualified jurisdictions (which became applicable as an accreditation standard Jan. 1, 2019), also should be made applicable to RRGs.

Risk Retention Groups Organized as Captives

Article 3 (Reinsurance) of the Covered Agreement is applicable to ceding insurers, which Article 2(j) defines as “an undertaking which is authorized or licensed to take up or engage in the business of direct or primary insurance.” This would arguably include RRGs that are organized or incorporated by states as captive insurers. Reinsurance Ceded is part of the Part A accreditation requirements for RRGs, and requires that state law should contain Model #785 and Model #786, or substantially similar laws. The primary difference between the current reinsurance accreditation standard for RRGs is that “a state’s laws and regulations may allow RRGs to take credit for reinsurance without posting collateral in circumstances not contemplated by the Credit for Reinsurance Model Law and Regulation. For such cases, the Accreditation Interlineations include ‘Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers’ and a state’s laws and regulations must comply with the guidelines in order to be considered substantially similar with this standard.”

NAIC staff has reviewed the laws and regulations with respect to the fifteen (15) NAIC jurisdictions which currently license multi-state RRGs as captive insurers (AL, AZ, CO, DE, DC, HI, KY, ME, MT, NV, NC, OK, SC, TN and VT), and each meets the current Reinsurance Ceded accreditation standard in a very similar manner. First, each states’ laws require that an RRG must be licensed as a captive insurer (and in some instances, a specific type of captive insurer) subject to its captive insurance laws. Second, the captive insurance laws generally exempt captive
insurers from the general laws with respect to traditional insurers, except as is otherwise specified in statute. Finally, the statutes make RRGs that are licensed as captive insurers subject to the state’s credit for reinsurance laws, either generally (e.g., an RRG licensed as a captive insurer must comply with all of the laws, rules, regulations and requirements applicable to insurers chartered and licensed in the state) or specifically (e.g., an RRG licensed as a captive insurer must comply with the laws specified in this chapter, including specifically the credit for reinsurance laws). We also reviewed the proposed legislation of the five states currently considering adoption of the 2019 revisions to the models (ME, OK, SC, TN & VT), and the proposed legislation would not change this outcome.

Recommendation

NAIC staff recommends that the Committee consider making the 2019 revisions to Model #785 and Model #786 an accreditation standard for RRGs effective Sept. 1, 2022, with enforcement of the standard to commence Jan. 1, 2023. Staff further recommends that the 2011 revisions to the models relating to certified reinsurers and qualified jurisdictions also be made a part of the accreditation standard, because the 2019 revisions are in large part based on these earlier revisions. Finally, we recommend that the changes in the attached redlined accreditation standard be adopted as the new accreditation standard for reinsurance ceded to RRGs.

Note: The Risk Retention Group (E) Task Force met on March 2, and approved these recommendations. The Reinsurance (E) Task Force will meet March 11 to consider approval of the recommendations.
10. Reinsurance Ceded

State law should contain the NAIC Credit for Reinsurance Model Law (#785), the NAIC’s Credit for Reinsurance Model Regulation (#786) or substantially similar laws.

Complete the following question only if this is an interim annual review:

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<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tr>
<td>Have there been any changes to the department’s ceded reinsurance requirements since last year’s review?</td>
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</table>

If the response is NO, there is no further information needed regarding this standard, please proceed to the next standard.

If the response is YES, in the reference column please provide the applicable citation for each of the questions in this particular standard. Additionally, please attach a copy of the statutes or regulations that had a change and ensure that they are clearly marked for the changes that have been made (i.e., highlight the changes, redlined version, etc.) Please place an asterisk (*) in the reference column on the right-hand side of the page by each citation that has been changed. Also, please include below a brief description of the nature or reason for the change.

If the department is completing the self-evaluation guide due to an upcoming full review, please provide the applicable citation for each of the questions in this particular standard. Additionally, please attach a copy of the statutes or regulations that are listed in the reference column.

**Credit for Reinsurance Model Law (#785)**

<table>
<thead>
<tr>
<th>a. Credit allowed for reinsurance ceded to a licensed insurer? If the reinsurer is licensed as a RRG, then the ceding RRG or its members must qualify for membership with the reinsurer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Credit allowed for reinsurance ceded to an accredited insurer who meets requirements similar to those in Section 2B of the model law?</td>
</tr>
<tr>
<td>c. Credit allowed for reinsurance ceded to an insurer domiciled and licensed in a state which employs substantially similar standards regarding credit for reinsurance and who maintains capital and surplus of at least $20,000,000 and submits to this state’s authority to examine its books and records?</td>
</tr>
<tr>
<td>d. Credit allowed for reinsurance ceded to an insurer who maintains a trust fund, established in a form approved by the Commissioner, in a qualified U.S. financial institution for the payment of the valid claims of its U.S. policyholders and ceding insurers, their assigns and successors in interest and who reports financial information annually to the Commissioner to determine the sufficiency of the trust fund?</td>
</tr>
<tr>
<td>e. In instances where reinsurance is ceded to insurers maintaining a trust fund, trustees of the trust required to report to the department annually, on or before February 28, the balance of the trust and a listing of the trust’s assets as of the end of the year and a certification of the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31?</td>
</tr>
</tbody>
</table>
f. Credit for reinsurance allowed under c. or d. above only permitted where assuming insurer agrees in the reinsurance agreements: 1) that in the event of a failure of the assuming insurer to perform its obligations, the assuming insurer shall submit to the jurisdiction of any court of competent jurisdiction in any state of the U.S.; and 2) to designate the Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process instituted by or on behalf of the ceding company?

g. Credit allowed for reinsurance ceded to an insurer meeting requirements similar to those in Section 2E (Certified Reinsurers) of the model law?

h. Credit allowed for reinsurance ceded to an insurer meeting requirements similar to those in Section 2F (Reciprocal Jurisdictions) of the model law?

i. Although not required for accreditation, a state’s laws and regulations may allow RRGs to take credit for reinsurance without posting collateral in circumstances not contemplated by the Credit for Reinsurance Model Law and Regulation. For such cases, the Accreditation Interlineations include “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers” and a state’s laws and regulations must comply with the guidelines in order to be considered substantially similar with this standard. If your state’s laws and regulations do allow credit for reinsurance without collateral as discussed in the Accreditation Interlineations, please include the citation.

Note: An RRG’s reinsurers as of Jan. 1, 2011, are grandfathered in as acceptable without meeting the requirements in the Reinsurance Guidelines. The requirements in the Reinsurance Guidelines should be used for new reinsurers with which business is placed after Jan. 1, 2011.

j. Credit allowed for reinsurance ceded to an insurer not meeting the requirements of a., b., c., d., g., h. or i. above in an amount not exceeding the liabilities carried by the ceding insurer and only in the amount of funds held by or on behalf of the ceding insurer in the form of cash, securities listed by the Securities Valuation Office of the NAIC and qualifying as admitted assets, clean, irrevocable, unconditional letters of credit, and other forms of security acceptable to the Commissioner?

Credit for Reinsurance Model Regulation (#786)

k. Credit for reinsurance allowed for reinsurance ceded by domestic reinsurers to assuming insurers that were licensed in the state as of the last date of the ceding insurers’ statutory financial statement? If the reinsurer is licensed as a RRG, then the ceding RRG or its members must qualify for membership with the reinsurer.

l. Credit for reinsurance provisions for accredited reinsurer similar to Section 5?
m. Credit for reinsurance provisions for reinsurers licensed and domiciled in other states similar to Section 6?

n. Credit for reinsurance provisions for reinsurers maintaining trust funds similar to Section 7?

o. Credit for reinsurance required by law similar to Section 9, to the extent permitted by 15 USC 3902(a)?

p. Reduction from liability for reinsurance ceded to an unauthorized assuming insurer similar to Section 10? Note: See significant element g. above regarding allowance of credit for reinsurance in certain situations not contemplated by the Model Law.

q. Provisions for trust agreements similar to Section 11?

r. Provisions for letters of credit similar to Section 12?

s. Provisions for unencumbered funds similar to Section 13?

t. Provisions for reinsurance contracts similar to Section 14? Note: For those reinsurance contracts for which credit is allowed under significant element g. above, the reinsurance contract should contain language similar to Section II of the “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers.”

u. The adoption of Form AR-1—Certificate of Assuming Insurer. Note: For situations in which credit for reinsurance is taken under significant element g. above, the reinsurance contract should contain language similar to Section II of the “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers.”

v. Credit for reinsurance provisions for certified reinsurers similar to Section 8?

w. Credit for reinsurance provisions for reciprocal jurisdictions similar to Section 9?

Appendix A (proposed accreditation standard and significant elements) includes a tracked change to significant element “b”. This change is the result of technical changes to Model #787 adopted by the Reinsurance (E) Task Force and does not change the substance of the proposed standard. The F Committee is scheduled to consider adoption of this technical change on Aug. 12, 2020. It is recommended that the Executive (EX) Committee and Plenary consider adoption of the technical change in conjunction with adoption of the Aug. 24, 2017 referral.

MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: Reinsurance (E) Task Force

DATE: August 24, 2017

RE: Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

Executive Summary

The NAIC membership adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) at the 2016 Fall National Meeting on Dec. 13, 2016. At that same time, the NAIC membership also adopted revisions to Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) to conform with the provisions of Model #787, effective Jan. 1, 2017. Model #787 establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees, and ensures that funds consisting of primary security and other security are held in the forms and amounts required.

At its meeting on Aug. 7, 2017, the Reinsurance (E) Task Force agreed to submit the following recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

1. Model #787 should be adopted as a new accreditation standard by the NAIC, with significant elements as outlined in Appendix A.

2. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this standard. The Task Force recommends that the accreditation standard become effective Jan. 1, 2020. The
Task Force further recommends that a state’s adoption of AG 48 will serve to satisfy this accreditation standard until such time that the state adopts the significant elements of Model #787.

3. The 2016 revisions to the Credit for Reinsurance Model Law (#785) should be considered acceptable but not required by the states.

In addition to the preceding recommendations, the Task Force is offering the following additional information in order to assist the Financial Regulation Standards and Accreditation (F) Committee in reviewing the proposed accreditation standard for Model #787.

**Substantially Similar**

The Task Force has recommended in the draft accreditation standard that the “substantially similar” standard be utilized to meet the minimum requirements of the standard. However, the Task Force did note that Drafting Notes to Section 2, Section 3 and Section 5 of Model #785 might suggest a stronger standard of review than “substantially similar.” The Drafting Notes provide, as follows: “To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are **substantially similar in all material respects** to NAIC adopted model regulations in the handling and treatment of such reinsurance arrangements.” [Emphasis added]. In recognition of this, and to assist in review of the actuarial method used to determine the required level of primary security as described in Section 6 of Model #787, the Task Force recommends that the NAIC Legal Division specifically note any material changes in a state’s regulation during an accreditation review for consideration by the Financial Regulation Standards and Accreditation (F) Committee.

**State Adoption of AG 48**

The Task Force recommends that the accreditation standard become effective on an expedited basis beginning Jan. 1, 2020. However, the Task Force further recognizes that meeting the expedited date may not be feasible for some states in instances due, in whole or part, to other legislative priorities of the states. It is the recommendation of the Task Force that, in such cases, a state’s compliance with AG 48 should be considered as satisfactory to the Financial Regulation Standards and Accreditation (F) Committee as substantial compliance with Model #787. AG 48 became effective Jan. 1, 2015, and became part of the Accounting Practices and Procedures Manual through its inclusion in Appendix C, and has been amended to conform with Model #787 effective Jan. 1, 2017.

**2016 Revisions to Model #785**

The Task Force does not recommend that the 2016 revisions to Model #785 be included in the proposed accreditation standard. These revisions provide that the commissioner may adopt regulations with respect to: 1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; 2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; 3) variable annuities with guaranteed death or living benefits; 4) long-term care insurance policies; and 5) other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance. The revisions to Model #785 also contain a “professional reinsurer exemption” for reinsurers that maintain at least $250 million in capital and surplus when determined in accordance with the Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is: 1) licensed in at least 26 states; or 2) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

The reasoning of the Task Force is that Model #787 only applies to term life and universal life with secondary guarantees (XXX/AXXX) captive reinsurance transactions, and that variable annuities, long-term care insurance and other life and health insurance and annuity products are not currently addressed. Therefore, it would be considered to be premature to require the states to adopt these provisions. In addition, the professional reinsurer exemption of Section 5B(4) of Model #785 is specifically referenced in the draft accreditation standard. Therefore, it is the recommendation of the Task Force that the 2016 revisions to Model #785 are optional, and should be considered as acceptable but not required by the states.
Appendix A

Proposed Accreditation Standard

Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

State statute and/or regulation should be substantially similar to uniform, national standards that govern reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees, to ensure that both the total security and the primary security are provided in forms and amounts that are in compliance with the requirements set forth in the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

a. Provides that the Credit for Reinsurance Model Regulation (#786) and Model #787 shall both apply to reinsurance treaties that cede liabilities pertaining to Covered Policies; provided, that in the event of a direct conflict between the provisions of Model #787 and the provisions of Model #786, the provisions of Model #787 shall apply, but only to the extent of the conflict, substantially similar to Section 3 of Model #787?

b. Provides that Model #787 does not apply to reinsurance exempt by the provisions of Section 4 of Model #787, including reinsurance ceded to an assuming insurer that meets the requirements of either Section 5B(4)(a) of the Credit for Reinsurance Model Law (#785), which pertains to certain certified reinsurers, or Section 5B(4)(b) of Model #785, which pertains to reinsurers meeting certain threshold size and licensing requirements? [Note: this change is due to technical changes to Model #787 adopted by the Reinsurance (E) Task Force and does not change the substance of the standard – see March 3 referral attached]

c. Provides definitions of “Covered Policies,” “Grandfathered Policies,” “Required Level of Primary Security,” “Actuarial Method,” “Primary Security,” “Other Security” and “Valuation Manual” that are substantially similar to such terms as defined in Section 5 of Model #787?

d. Provides for an Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation that is substantially similar to the methodology as set forth in Section 6A of Model #787?

e. Provides for valuations to be used 1) in calculating the Required Level of Primary Security pursuant to the Actuarial Method; and 2) in determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, that are substantially similar to the valuations set out in Section 6B of Model #787?

f. Provides for requirements to obtain credit for reinsurance with respect to ceded liabilities pertaining to Covered Policies that are substantially similar to the requirements set out in Section 7A of Model #787?

g. Provides for requirements at inception date and on an ongoing basis substantially similar to Section 7B(1) of Model #787?

h. Provides that if the requirements to hold Primary Security and total security are not both satisfied, the ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held, unless any deficiency has been eliminated pursuant to remediation provisions substantially similar to Section 7B(2) of Model #787?

i. Includes a prohibition against avoidance provision similar to Section 9 of Model #787?
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: John F. Finston (CA)
Chair, Reinsurance (E) Task Force

DATE: March 20, 2017

RE: 2016 Revisions to Credit for Reinsurance Model Law (#785)
Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

Executive Summary

On June 30, 2014, the Principle-Based Reserving Implementation (EX) Task Force adopted the recommendations in the report of Rector & Associates, Inc. dated June 4, 2014, regarding a proposal for the XXX/AXXX Reinsurance Framework. The Framework sought to address concerns regarding reserve financing transactions and to do so without encouraging them to move offshore. The changes would be prospective and apply only to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life with secondary guarantees business (XXX/AXXX). The NAIC Executive (EX) Committee adopted the Framework (in concept) on Aug. 17, 2014. As an interim step to implementing the Framework, the NAIC adopted Actuarial Guideline XLVIII Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48) on Dec. 16, 2014. It was expected that AG 48 would eventually be replaced by effective codification through the Credit for Reinsurance Model Law (#785) and creation of a new model regulation to establish requirements regarding the reinsurance of XXX/AXXX policies.

The NAIC adopted revisions to Model #785 on Jan. 8, 2016, which give insurance commissioners authority to issue regulations codifying AG 48 and the XXX/AXXX Reinsurance Framework. The Reinsurance (E) Task Force adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) at the Summer National Meeting on Aug. 27, 2016, and it was adopted by the Financial Condition (E) Committee with slight revisions via conference call on Sept. 30, 2016. Model #787 was then adopted by the Executive (EX) Committee and Plenary on Dec. 13, 2016. At that same time, the NAIC also revised AG 48 to conform with the provisions of Model #787, effective Jan. 1, 2017.

The Reinsurance (E) Task Force hereby submits the following recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

1. The 2016 revisions to Model #785 and new Model #787 should be adopted as a new accreditation standard by the NAIC.

2. The F-Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this standard. The Task Force would recommend that the accreditation standard become effective January 1, 2020.
A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

The 2016 revisions to Model #785 provide that the commissioner may adopt regulations with respect to (1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; (2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; (3) variable annuities with guaranteed death or living benefits; (4) long-term care insurance policies; and (5) other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance. The revisions to Model #785 also contain a “professional reinsurer exemption” for reinsurers that maintain at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is (1) licensed in at least 26 states; or (2) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

Model #787 does not materially change the ability of insurers to obtain credit for reinsurance ceded to “certified” reinsurers or to obtain credit for reinsurance ceded to “licensed” or “accredited” reinsurers that follow statutory accounting and risk-based capital (RBC) rules. As a practical matter, the Model #787 requirements apply to reinsurance ceded to captive insurers, SPVs, reinsurers that are not eligible to become “certified” reinsurers, or reinsurers that materially deviate from statutory accounting and/or RBC rules. In those situations, subject to certain exemptions and grandfathering provisions, the ceding insurer may receive credit for reinsurance if:

- The ceding insurer continues to establish gross reserves, in full, using applicable reserving guidance;
- Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis;
- The Actuarial Method used to establish the Required Level of Primary Security for each reinsurance treaty subject to Model #787 is based on VM-20, applied on a treaty-by-treaty basis;
- Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held are held by or on behalf of the ceding insurer as security under the reinsurance contract; and
- The reinsurance arrangement is approved by the ceding insurer’s domestic regulator.

A statement as to why ultimate adoption by every jurisdiction may be desirable:

The NAIC Principle-Based Reserving Implementation (EX) Task Force serves as the coordinating body for all NAIC technical groups involved with projects related to the Principle-Based Reserves (PBR) initiative for life and health policies. This Task Force was also charged with further assessing, and making recommendations regarding the solvency implications of life insurance reserve financing mechanisms addressed in the June 6, 2013, NAIC White Paper Captives and Special Purpose Vehicles, which provides in relevant part:

The Captive and Special Purpose Vehicle (SPV) Use (E) Subgroup studied the use of captives and SPVs formed by commercial insurers. The Subgroup concluded that commercial insurers cede business to captives for a variety of business purposes. The Subgroup determined that the main use of captives and SPVs by commercial insurers was related to the financing of XXX and AXXX perceived reserve redundancies. The implementation of principle-based reserving (PBR) could reduce the need for
commercial insurers to create new captives and SPVs to address perceived reserve redundancies; however, existing captives and SPVs are likely to remain in existence for several years or decades, until the existing blocks of business are run-off. **Regulators need to be able to assess and monitor the risks that captives and SPVs may pose to the holding company system, and the current regulatory process should be enhanced to provide standardized tools and processes to be used by all regulators when reviewing such transactions.** Commercial insurer-owned captives and SPVs should not be used to avoid statutory accounting. **To the extent that insurer-affiliated captives and SPVs may be created in the future for unforeseen purposes, additional guidance should be developed by the NAIC to assist the states in a uniform review of transactions.** [Emphasis added].

In addition, in coordination with the adoption in principle of the XXX/AXXX Reinsurance Framework, the Financial Regulation Standards and Accreditation (F) Committee was given the following charge: “As the various work products are adopted by the Principle-Based Reserving (EX) Task Force, Executive Committee, and Plenary, consider them for inclusion in the Part A and Part B Accreditation Standards.”

Finally, effective Jan. 1, 2016, the NAIC amended the Preamble for Part A: Laws and Regulations of the NAIC Policy Statement on Financial Regulation Standards to apply to the regulation of a state’s domestic insurers licensed and/or organized under its captive or special purpose vehicle statutes or any other similar statutory construct with respect to XXX/AXXX business, which is deemed to satisfy the Part A accreditation requirements if the applicable reinsurance transaction satisfies the XXX/AXXX Reinsurance Framework requirements adopted by the NAIC. Further, the revised Preamble provided, as follows: “The revisions to the Credit for Reinsurance Model Act (#785) and the new XXX/AXXX Model Regulation will need to be specifically considered for accreditation purposes once adopted by the NAIC.”

**A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:**

AG 48 became effective Jan. 1, 2015, and became part of the NAIC Accounting Practices and Procedures Manual through its inclusion in Appendix C. As such, provisions similar to the proposal have been effective in all states since that date.

As of this date, three states (Louisiana, Oklahoma and Utah) have gone beyond AG 48 and have adopted the 2016 revisions to Model #785 giving commissioners authority to issue regulations codifying AG 48 and the XXX/AXXX Reinsurance Framework, with several other states currently considering such revisions.

The new Part A Preamble became effective Jan. 1, 2016, with regard to XXX/AXXX reinsurance captives. NAIC staff worked with necessary state insurance departments to assess compliance with the new Part A Preamble related to captives that assume XXX/AXXX business, and reported its findings at the 2016 Fall National Meeting to the Financial Regulation Standards and Accreditation (F) Committee. NAIC staff reviewed all of the Dec. 31, 2015, XXX/AXXX Reinsurance Supplements that were filed with the NAIC to first ascertain whether the appropriate level of primary and other securities was being held to back the non-exempt XXX/AXXX reinsurance transactions. NAIC staff reported that all of the transactions held the required amount of securities, and therefore, all of the transactions satisfied the new Part A requirements.

**A statement as to the provisions needed to meet the minimum requirements of the standard.** That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:
Regulators needed to be able to assess and monitor the risks posed with respect to XXX/AXXX captive reinsurance transactions, and the regulatory process was enhanced through the adoption of the XXX/AXXX Reinsurance Framework, AG 48 and Model #787 to provide standardized tools and processes to be used by all regulators when reviewing such transactions. However, these new tools are complex and technical in nature, requiring the use of a new actuarial methodology to achieve the desired financial solvency results. Therefore, the Reinsurance (E) Task Force recommends that any new accreditation standard developed for Model #787 be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. In addition, all of the elements of the XXX/AXXX Reinsurance Framework have been put into place, with the exception of the new accreditation standard. Therefore, F-Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this new standard effective as of January 1, 2020.

An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:

The NAIC has not performed a cost/benefit analysis with respect to Model #787, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, it should be noted that Model #787 does not require dramatic changes from how insurance companies have been financing XXX/AXXX captive reinsurance transactions since the NAIC’s adoption of AG 48. As with AG 48, Model #787 provides “standardized tools and processes to be used by all regulators when reviewing such transactions.” Prior to the adoption of AG 48, insurers would enter into various captive reinsurance transactions to “finance” different portions of the statutory reserve differently—i.e., to fund different portions of the reserve using different kinds of assets—based on what insurers believed to be a better correlation between the kind of asset used and the probability that it would be needed. Many state regulators were comfortable with these transactions in theory, but there was significant unease regarding how these transactions were being implemented, and especially as to the lack of consistency from insurer to insurer and regulator to regulator regarding key aspects as to how these transactions may have been approved. Such transactions are still permitted under Model #787, but now a clear and consistent process has been implemented to ensure that the proper amount and type of assets have been applied with respect to these transactions in order to ensure that they continue to meet strong financial solvency standards.
TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: NAIC Staff

DATE: March 3, 2020

RE: Technical Revisions to the Term and Universal Life insurance Reserve Financing Model Regulation (\#787) as an Accreditation Standard

At the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (\#787), commonly known as the XXX/AXXX model, as a new accreditation standard. The decision is pending approval by Plenary.

Following adoption by the Committee, the Reinsurance (E) Task Force adopted technical changes to Model \#787, which included Section 4E as follows:

E. Reinsurance ceded to an assuming insurer that meets the requirements of either [insert provision of state law equivalent to Section 5B(4)(a) of the Credit for Reinsurance Model Law, pertaining to certain certified reinsurers] or [insert provision of state law equivalent to Section 5B(4)(b) of the Credit for Reinsurance Model Law, pertaining to reinsurers meeting certain threshold size and licensing requirements]; or

The technical changes were due to revisions to the Credit for Reinsurance Model Law (\#785) adopted by the NAIC in June 2019, which impacted sections referenced in Model \#787. The referenced Section 5B(4) provides an exemption to Model \#787 for what is commonly referred to as “professional reinsurers.” As defined in the 2016 version of Model \#785 Section 5B(4)(a) and (b), these professional reinsurers are reinsurers that meet certain minimum capital requirements and are certified reinsurers in a certain minimum number of states. The 2019 revisions to Model \#785 add a new Section 5B(4)(a) to provide a similar exemption for reinsurers domiciled in reciprocal jurisdictions, as defined in Section 2F of Model \#785. This shifted the original (a) and (b) to (b) and (c). A copy of the revised Section 5 is attached. To accurately reflect the exemption intended by the reference in Model \#787, the entire Section 5B(4) is now referenced in Model \#787.

NAIC staff therefore recommend that an equivalent change also be made to the accreditation standard. The proposed change affects significant element “b” as follows:

b. Provides that Model \#787 does not apply to reinsurance exempt by the provisions of Section 4 of Model \#787, including reinsurance ceded to an assuming insurer that meets the requirements of either Section 5B(4)(a) of the Credit for Reinsurance Model Law (\#785), which pertains to certain certified reinsurers, or Section 5B(4)(b) of Model \#785, which pertains to reinsurers meeting certain threshold size and licensing requirements?

The original referral from the Reinsurance (E) Task Force with the recommendation to the Committee regarding Model \#787 as an accreditation standard, including the accreditation significant elements, is attached for reference.
CREDIT FOR REINSURANCE MODEL LAW

Table of Contents

Section 1. Purpose
Section 2. Credit Allowed a Domestic Ceding Insurer
Section 3. Asset or Reduction from Liability for Reinsurance Ceded by a Domestic Insurer to an Assuming Insurer not Meeting the Requirements of Section 2
Section 4. Qualified U.S. Financial Institutions
Section 5. Rules and Regulations
Section 6. Reinsurance Agreements Affected

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Section 5. Rules and Regulations

A. The commissioner may adopt rules and regulations implementing the provisions of this law.

Drafting Note: It is recognized that credit for reinsurance also can be affected by other sections of the enacting state’s code, e.g., a statutory insolvency clause or an intermediary clause. It is recommended that states that do not have a statutory insolvency clause or an intermediary clause consider incorporating such clauses in their legislation.

B. The commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in Paragraph (1) of this Section 5B.

Drafting Note: This new regulatory authority is being added in response to reinsurance arrangements entered into, directly or indirectly, with life/health insurer-affiliated captives, special purpose vehicles or similar entities that may not have the same statutory accounting requirements or solvency requirements as US-based multi-state life/health insurers. To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such policies and reinsurance arrangements.

(1) A regulation adopted pursuant to this Section 5B, may apply only to reinsurance relating to:

(a) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;
(b) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;
(c) Variable annuities with guaranteed death or living benefits;
(d) Long-term care insurance policies; or
(e) Such other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(2) A regulation adopted pursuant to Paragraph 1(a) or 1(b) of this Section 5B, may apply to any treaty containing (i) policies issued on or after January 1, 2015, and/or (ii) policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

Drafting Note: The NAIC’s Actuarial Guideline XLVIII (AG 48) became effective January 1, 2015, and covers policies ceded on or after this date unless they were ceded as part of a reserve financing arrangement as of December 31, 2014. One regulation contemplated by this revision to the NAIC Credit for Reinsurance Model Law (9785) is intended to substantially replicate the requirements for the amounts and forms of security held under the rules provided in AG 48. AG 48 was written to sunset upon a state’s adoption (pursuant to the enabling authority of the preceding paragraph) of a regulation with terms substantially similar to AG 48. The preceding paragraph is intended to provide continuity of rules applicable to those policies and reinsurance arrangements, including continuity as to the policies covered by such rules. The preceding paragraph is not intended to change the scope of, or collateral requirements for policies and treaties covered under AG 48.
(3) A regulation adopted pursuant to this Section 5B may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under Section 11B(1) of the NAIC Standard Valuation Law, including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

(4) A regulation adopted pursuant to this Section 5B shall not apply to cessions to an assuming insurer that:

(a) Meets the conditions set forth in Section 2F of the Credit for Reinsurance Model Law (#785) in this state or, if this state has not adopted provisions substantially equivalent to Section 2F of the Credit for Reinsurance Model Law (#785), the assuming insurer is operating in accordance with provisions substantially equivalent to Section 2F of the Credit for Reinsurance Model Law (#785) in a minimum of five (5) other states; or

(b) Is certified in this state or, if this state has not adopted provisions substantially equivalent to Section 2E of the Credit for Reinsurance Model Law (#785), certified in a minimum of five (5) other states; or

(c) Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is

(i) licensed in at least 26 states; or

(ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

(5) The authority to adopt regulations pursuant to this Section 5B does not limit the commissioner’s general authority to adopt regulations pursuant to Section 5A of this law.
Date: 7/16/2020

State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Adoption of the new *Insurance Data Security Model Law* (#668)—This model was adopted by the Executive (EX) Committee and Plenary at the 2017 Fall National Meeting. Eleven states have enacted this model.

Life Insurance and Annuities (A) Committee

- Amendments to the *Suitability in Annuity Transactions Model Regulation* (#275)—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020 conference call. Two states have enacted these revisions to the model.

- Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Summer National Meeting. One state has enacted these revisions to the model.

Health Insurance and Managed Care (B) Committee

- Amendments to the *Health Insurance Reserves Model Regulation* (#10) *(Cancer Expense Table)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Spring National Meeting. Two states have enacted these revisions to the model.

- Amendments to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2018 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the *Limited Long-Term Care Insurance Model Act* (#642)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the *Limited Long-Term Care Insurance Model Regulation* (#643)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.

Property and Casualty Insurance (C) Committee

- Adoption of the *Travel Insurance Model Act* (#632)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Six states have enacted this model.

Market Regulation and Consumer Affairs (D) Committee

- Amendments to the *Privacy of Consumer Financial and Health Information Regulation* (#672)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Spring National Meeting. Eleven states have enacted these revisions to the model.
Financial Condition (E) Committee

- Amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2017 Fall National Meeting. 32 states have enacted these revisions to the model.

- Amendments to the *Credit for Reinsurance Model Law* (#785)—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019 conference call. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Credit for Reinsurance Model Regulation* (#786)—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019 conference call. NAIC staff are not aware of any state activity regarding this model.

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EXECUTIVE (EX) COMMITTEE

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The Executive (EX) Committee met via conference call Aug. 13, 2020. The following Committee members participated: Raymond G. Farmer, Chair (SC); David Altmaier, Vice Chair (FL); Dean L. Cameron, Vice President (ID); Chlora Lindley-Myers, Secretary-Treasurer (MO); Eric A. Cioppa, Most Recent Past President (ME); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Michael Conway (CO); Doug Ommen (IA); James J. Donelon (LA); Gary D. Anderson (MA); Mike Chaney (MS); Jillian Froment (OH); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); and Larry D. Deiter (SD). Also participating were Jon Godfread (ND); and Scott A. White (VA).

1. **Adopted the July 14 Report of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee**

Director Farmer reported that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee met July 14 in a joint session. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings.

During this joint meeting, the Committee and Subcommittee took the following action: 1) adopted its May 12 minutes; and 2) adopted the Internal Administration (EX1) Subcommittee’s May 20 minutes, which included the following action: a) received an update on the Defined Benefit Plan portfolio as of March 31; b) received an update on the NAIC long-term investment plan portfolio as of March 31; and c) approved a recommendation to replace one of the NAIC’s fund managers responsible for short-term bond funds.

The Committee and Subcommittee also: 1) adopted the report of the Audit Committee, which met via conference call June 2 and received the 2019/2020 Service Organization Control (SOC) 1 and SOC 2 reports; 2) received an update on the 2020 financial results and preliminary 2021 budget assumptions and approved an extension of unused 2020 grant funds to the end of 2021; 3) established a Special Committee on Race and Insurance; 4) established the Climate & Resiliency (EX) Task Force and adopted its draft charges; 5) received a System for Electronic Rate and Form Filing (SERFF) Assessment and directed NAIC staff to prepare and issue a request for proposal (RFP) to solicit proposals to help complete a “modernization pilot” and “Wave One” as recommended in the SERFF Assessment; 6) approved Management’s recommendation to extend the residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) modeling contract with BlackRock for another year; 7) approved the release of the Economic Scenario Generator (ESG) fiscal for a two-week public review period prior to a final vote of the Executive (EX) Committee during a future meeting; 8) approved a U.S. Department of Labor (DOL) Information Sharing Agreement; 9) selected the meeting locations for the 2024 summer and fall national meetings: the 2024 Summer National Meeting will be held in Chicago, IL, and the 2024 Fall National Meeting will be held in Denver, CO; and 10) received the joint chief executive officer (CEO)/chief operating officer (COO) report.

Commissioner Conway made a motion, seconded by Director Froment, to adopt the July 14 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed unanimously.

2. **Adopted its May 12, April 2, Feb. 13 and Jan. 10 Interim Meeting Report**

Director Lindley-Myers made a motion, seconded by Commissioner Altman, to adopt the Committee’s May 12, April 2, Feb. 13 and Jan. 10 interim meeting report (Attachment One). The motion passed unanimously.

3. **Adopted the Reports of its Task Forces**

The Committee adopted written reports from the Financial Stability (EX) Task Force, the Government Relations (EX) Leadership Council, the Innovation and Technology (EX) Task Force, and the Long-Term Care Insurance (EX) Task Force.

Commissioner Godfread further reported that the Innovation and Technology (EX) Task Force met Aug. 7 and adopted the Artificial Intelligence (AI) Principles for the insurance industry adopted by the Artificial Intelligence (EX) Working Group on June 30.
During the meeting, the Task Force discussed the outstanding issues raised during its meeting on July 23. Each section of the AI Principles was discussed individually. The Task Force had a productive discussion that ultimately resulted in adoption of the AI Principles as amended during the meeting. The Principles will be presented for further adoption at the joint meeting of Executive (EX) Committee and Plenary on Aug. 14.

Commissioner White further reported that the Long-Term Care Insurance (EX) Task Force also adopted charges for three new subgroups during its Aug. 7 meeting. The Subgroups will move more discussions about the rate review methodology and RBOs and consumer notices work of the Task Force into the public realm. The Subgroup charges are a delegation of the Task Force charges and a consolidation of the six existing workstreams into three subgroups.

Director Wing-Heier made a motion, seconded by Director Cameron, to adopt the reports of the Financial Stability (EX) Task Force; the Government Relations (EX) Leadership Council; the Innovation and Technology (EX) Task Force, including the AI Principles; and the charges of the new subgroups of the Long-Term Care Insurance (EX) Task Force (Attachment Two, Attachment Two-A, Attachment Two-B). The motion passed unanimously.

4. Adopted a Model Law Development Request for Amendments to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450)

Commissioner White reported that at the 2019 Fall National Meeting, the Executive (EX) Committee approved a request from the Financial Condition (E) Committee and the Group Capital Calculation (E) Working Group to open up the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) to make sure the calculation is held confidential.

Commissioner White stated that prior to the scheduled Spring National Meeting, the Financial Condition (E) Committee received and approved two additional requests for amending Model #440 and Model #450. The first request was from the Receivership and Insolvency (E) Task Force to make changes for issues that can arise in a receivership of an insurance company where affiliated entities provide essential services through inter-company agreements. For example, in the cases of claims handling, underwriting and premium collection, the continuation of these services can be critical to the operation of the receivership, particularly when all staffing and information technology (IT) functions are outsourced. The request recommends developing language that gives the commissioner the authority over these situations. The second request was from the Financial Stability (EX) Task Force requesting an avenue to maintain the confidentiality of a liquidity stress test that the Task Force is currently developing for certain very large life insurers. This new requirement is being suggested as the key deliverable on the Macroprudential Initiative (MPI) led by Commissioner Marlene Caride (NJ). Commissioner White acknowledged that the three ongoing amendments may not be completed at the same time, but it is still important to proceed with all the work.

Commissioner Altmaier made a motion, seconded by Commissioner Conway, to adopt the request to develop amendments to Model #440 and Model #450 (Attachment Three). The motion passed unanimously.

5. Adopted a Model Law Development Request for Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805)

Director Froment reported that the Request for NAIC Model Law Development for the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805) came to the Life Insurance and Annuities (A) Committee from the Life Actuarial (A) Task Force, and it arises out of concern with the 1% floor on the minimum nonforfeiture accumulation rate that is currently in the model. This minimum will be difficult for insurers to achieve in the current very low interest rate environment and significantly limit the availability of annuity products. This request to revise Model #805 is to address this minimum nonforfeiture rate floor.

Director Froment made a motion, seconded by Director Lindley-Myers, to adopt the request to develop amendments to Model #805 (Attachment Four). The motion passed unanimously.

6. Received the 2019 Annual Report of NAIC Designation Program Advisory Board Activities

Superintendent Dwyer provided an update on the NAIC Designation Program Advisory Board’s activities and the 2019 achievements for the NAIC Insurance Regulator Professional Designation Program (Attachment Five). In 2019, there was an increase of more than 350 insurance regulator designation enrollments. At year-end, enrollments totaled 2,392 since its inception in 2006. In 2019, 1,310 new professional insurance regulation designations were awarded.
Superintendent Dwyer also reported that the Advisory Board, entered into a contract with Certemy to replace the existing enrollment site with Certemy’s program management system. The Advisory Board made a number of changes to the program as requested by commissioners, including: 1) waiving the first retake fee; 2) removing tenure requirements for Associate Professional in Insurance Regulation (APIR) and Professional in Insurance Regulation (PIR); and 3) allowing courses to be taken “out of sequence.”

Superintendent Dwyer thanked Commissioner Godfried, Mary Mealer (MO), Pat McNaughton (WA), Scott Sanders (GA) and Rachel Chester (RI) for their hard work and dedication in developing this program into the success it is today.

7. Received a Status Report on the NAIC State Ahead Strategic Plan Implementation

Director Farmer provided an update on the NAIC State Ahead implementation efforts. State Ahead is a three-year strategic plan intended to further advance the products, services and support that the NAIC provides to state insurance regulators in order to better meet the changing regulatory landscape. NAIC staff continue to make good progress on the many State Ahead projects (Attachment Six). Given the change in priorities with the COVID-19 outbreak, the development of State Ahead 2.0 is on pause and that important work will continue in 2021.

8. Received a Report of Model Law Development Efforts

Director Farmer presented a written report on the progress of ongoing model law development efforts (Attachment Seven).

9. Heard a Report from the Interstate Insurance Product Regulation Commission (Commission)

Superintendent Dwyer reported that the Commission held a joint meeting with its Management Committee Aug. 14. The Compact has been working on implementing several action items in its strategic plan, which was adopted at the 2019 Fall National Meeting.

Superintendent Dwyer stated that many of the action items in the strategic plan call for examining and enhancing various procedures, notices and information to keep members and others informed and encourage meaningful input. A key initiative in the strategic plan involved the restructuring of the outstanding debt repayment to the NAIC. This new agreement was approved by the Compact during its May meeting, and the Compact made its first of 10 annual payments to the NAIC at the end of May. The Compact is currently kicking off two strategic projects—a governance review and a business assessment. An RFP process was conducted for both projects and the selection process was completed last month. Squire Patton Boggs is performing the governance review project, and Rector & Associates Inc. is performing the business assessment engagement.

The Compact has a Governance Review Committee, which includes three officers—Superintendent Dwyer, Commissioner Mark Afable (WI), and Director Robert H. Muriel (IL)—along with Commissioner Kent Sullivan (TX) and Commissioner James A. Dodrill (WV). The Committee is managing these projects, along with coordinating a state-by-state review being conducted by the Compact Office to document meaningful differences between the Uniform Standards and state statutes.

Superintendent Dwyer also reported that in April, the Colorado Supreme Court issued an opinion in Amica v. Wertz, 462 P.3d 51, on the Compact and its delegated authority. The Compact was recognized as a valid delegation of authority at the district court level. When the case was appealed, the 10th Circuit Court of Appeals certified the delegation of authority question to the Colorado Supreme Court, as it involved a conflict between a state statute with a one-year suicide exclusion and the Compact’s Uniform Standard that had a two-year suicide exclusion. The Colorado Supreme Court concluded that the Compact’s Uniform Standards operate as regulations and with respect to an interstate compact that has not been approved by the U.S. Congress (Congress), the Colorado legislature may not delegate to an interstate agency the authority to adopt regulations that effectively override a Colorado statute. This opinion respects the Compact structure and focuses on where a provision in the Uniform Standards may conflict with a state statute, especially where the state law is more stringent. The Compact staff has been working with states and industry to identify those areas where the Compact standards conflict with a state statute.

Having no further business, the Executive (EX) Committee adjourned.
EXECUTIVE (EX) COMMITTEE
May 12, 2020 / April 2, 2020 / February 13, 2020 / January 10, 2020

Summary Report

The Executive (EX) Committee met May 12, April 2, Feb. 13 and Jan. 10, 2020. These meetings were held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee:

1. Adopted the 2019 Fall National Meeting minutes of the Joint Meeting of the Executive (EX) Committee and Internal Administration (EX1) Subcommittee.
2. Adopted its April 2, Feb. 13 and Jan. 10 minutes.
3. Adopted the report of the NAIC Audit Committee.
4. Adopted the report of the Investment Committee.
5. Adopted the recommendation of the Life Actuarial (A) Task Force to delay the start of Principle-Based Reserving (PBR) Experience Data Reporting from 2020 to 2021.
6. Appointed Commissioner Vicki Schmidt (KS) and Director Bruce R. Ramge (NE) to serve on the National Insurance Producer Registry (NIPR) Board of Directors effective May 12.
7. Heard a report on a change in membership for the System for Electronic Rate and Form Filing (SERFF) Advisory Board. Andrea Davey (Athene Annuity and Life Company) will serve as the Life Insurance Representative on the SERFF Advisory Board.
8. Discussed the National Association of Registered Agents and Brokers (NARAB) Board recommendations.
10. Heard an update on the SERFF Assessment.
11. Heard an update on cybersecurity.
12. Discussed the status of the Mid-Year Roundtable and the Summer National Meeting.
13. Heard a joint chief executive officer (CEO)/chief operating officer (COO) report.
15. Received an update on the 2019 Year-End Financial Results.
16. Approved the fiscal impact statement for the Long-Term Care Insurance Data Call and authorized management to contract with a selected vendor.
17. Approved the fiscal impact statement for the SERFF Filing Review Tools Pilot.
18. Approved the following non-regulator appointments to the SERFF Advisory Board: Birny Birnbaum (Center for Economic Justice—CEJ) as the Consumer Representative; Theresa Boyce (Chubb Group) for Property & Casualty (P&C); Amanda Wheeler (LifeSecure Insurance Company) for Life Insurance; and Rachel Benton (Bright Health) for Health Insurance and Vice-Chair.
19. Appointed Director Chlora Lindley-Myers (MO) as Vice Chair of the 2020 Consumer Participation Board of Trustees.
20. Appointed Commissioner Mark Afable (WI) to serve on the NIPR Board of Directors effective Feb. 13.

21. Received an update confirming the committee structure changes: the Executive (EX) Committee disbanded the joint Long-Term Care Insurance (B/E) Task Force, the NAIC/State Government Liaison Committee, and the NAIC/Industry Liaison Committee; and the Executive (EX) Committee also removed the membership limit on the Life Actuarial (A) Task Force and the Health Actuarial (B) Task Force.

22. Approved the fiscal impact statement for the PBR Yearly Renewable Term Reinsurance Study.

23. Voted to release for public review and comment the Long-Term Care Insurance Data Call and Analysis fiscal impact statement.

24. Approved the debt restructure terms between the NAIC and Interstate Insurance Product Regulation Commission (Compact).

25. Appointed Florida, Idaho, Kentucky, Massachusetts, Missouri, Nebraska, Nevada, Ohio and Oklahoma as members of the NAIC 2020 Audit Committee.
REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Financial Stability (EX) Task Force—The Financial Stability (EX) Task Force met Aug. 5 and took the following action: 1) adopted its Feb. 26, 2020, and 2019 Fall National Meeting minutes; 2) heard an update on Financial Stability Oversight Council (FSOC) developments; 3) adopted the report of the Liquidity Assessment (EX) Subgroup, which provides an update on its progress toward achieving its deliverables related to liquidity stress testing; 4) received an update from the Receivership and Insolvency (E) Task Force on its work to address the Financial Stability (EX) Task Force’s referral letter to undertake analysis relevant to the NAIC Macroprudential Surveillance Initiative; 5) heard an update on collateralized loan obligation (CLO) stress tests; 6) heard an update on the International Association of Insurance Supervisors (IAIS); 7) heard an update on the London Interbank Offered Rate (LIBOR); and 8) discussed exposure comments for the draft revisions to the Holding Company Model Law.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting. The Leadership Council meets weekly via conference call in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Innovation and Technology (EX) Task Force—The Innovation and Technology (EX) Task Force met Aug. 7 and took the following action: 1) adopted its 2019 Fall National Meeting minutes and July 23 minutes; 2) adopted its working group reports and heard a report on the activities of the Innovation and Technology State Contact Group; 3) discussed comments related to the Artificial Intelligence Principles (Principles) adopted by the Artificial Intelligence (EX) Working Group, accepted amendments and adopted the Principles (Attachment Two-A); 4) received an update from the Accelerated Underwriting (A) Working Group and heard presentations on use of algorithms in insurance and algorithmic auditing; 5) and heard an update on comments submitted related to the draft Unfair Trade Practices Act (#880) amended language pertaining to Section 4. H. specific to rebating and exposed language for another comment period ending Aug. 28.

The Artificial Intelligence (EX) Working Group met multiple times in 2020 and after publishing five draft principles and accepting comments from stakeholders, it adopted Artificial Intelligence Principles for the insurance industry during its June 30 meeting.

The Big Data (EX) Working Group met Aug. 4 and took the following action: 1) adopted its Dec. 7, 2019, minutes; 2) received an update from the Casualty Actuarial and Statistical (C) Task Force regarding its draft white paper on best practices for the review of predictive models and analytics filed by insurers to justify rates; 3) received an update on the work of the Accelerated Underwriting (A) Working Group; and 4) received an update on NAIC technical and nontechnical rate review trainings.

The Speed to Market (EX) Working Group met via conference call June 15, June 30 and July 15. During its June 15 meeting, the Working Group: 1) received an update on the SERFF Advisory Board and System for Electronic Rate and Form Filing (SERFF) metrics; 2) received an update from the Interstate Insurance Product Regulation Commission (Compact); 3) discussed SERFF state reports; and 4) adopted the suggestion to create a SERFF canned report for rate changes. During its June 30 meeting, the Working Group: 1) discussed suggestions for 2020 changes to the Life, Accident/Health, Annuity and Credit Uniform Product Coding Matrix (PCM) and Uniform Transmittal Document (UTD) effective Jan. 1, 2021. Two of the suggested changes were adopted: a) change the term “implementation date” to “effective date” on the UTD within the SERFF system general information area on the disposition letter; and b) add a sub-type of insurance (TOI) for expatriate plans under H15G and H15I. The description would be expatriate plans that are not required to comply with all state or federal mandates for health benefits. During its July 15 meeting, the Working Group: 1) adopted its June 15 minutes; 2) discussed suggestions for 2020 changes to the Property and Casualty PCM and UTD effective Jan. 1, 2021. None of the suggested changes were adopted; and 3) discussed plans for its next meeting, which will take place Aug. 27 to discuss the SERFF canned report in more detail and other topics related to the Working Group’s charges.

Long-Term Care Insurance (EX) Task Force—The Long-Term Care Insurance (EX) Task Force met Aug. 7 and took the following action: 1) adopted its July 2 minutes, which includes the following action: a) adopted its 2019 Fall National Meeting minutes; and b) received progress reports on the activities of its six workstreams; 2) adopted the formation of three subgroups and related charges (Attachment Two-B); 3) received a progress report on the activities of two of the Task Force’s workstreams: a) the rate review practices workstream has made progress developing a multi-state rate review process, which includes...
coordination with states and collaboration with the Compact; and b) the reduced benefit options (RBO) and consumer notices workstream developed and exposed for public comment a draft RBO Principles document that is intended to assist in providing guidance to state insurance regulators when evaluating RBO offerings by insurers; and 4) heard from consumer and industry representatives on their comments on the draft RBO Principles document.
National Association of Insurance Commissioners (NAIC) Principles on Artificial Intelligence (AI)

**RECOMMENDS** that insurance companies and all persons or entities facilitating the business of insurance that play an active role in the AI system life cycle, including third parties such as rating, data providers and advisory organizations (hereafter referred to as “AI actors”) promote, consider, monitor and uphold the following principles according to their respective roles; and

**THIS DOCUMENT** is intended to establish consistent high-level guiding principles for AI actors. These principles are guidance and do not carry the weight of law or impose any legal liability. This guidance can serve to inform and establish general expectations for AI actors and systems emphasizing the importance of accountability, compliance, transparency, and safe, secure, fair and robust outputs.

Further, **THIS DOCUMENT**

Should be used to assist regulators and NAIC committees addressing insurance-specific AI applications. The level of regulatory oversight may vary based on the risk and impact to the consumer. These principles should be interpreted and applied in a manner that accommodates the nature and pace of change in the use of AI by the insurance industry and promotes innovation, while protecting the consumer.

**Fair and Ethical**

a. AI actors should respect the rule of law throughout the AI life cycle. This includes, but is not limited to, insurance laws and regulations, such as those relating to trade practices, unfair discrimination, access to insurance, underwriting, privacy, consumer protection and eligibility practices, ratemaking standards, advertising decisions, claims practices, and solvency.

b. Consistent with the risk-based foundation of insurance, AI actors should proactively engage in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and to avoid proxy discrimination against protected classes. AI systems should not be designed to harm or deceive people and should be implemented in a manner that avoids harmful or unintended consequences and corrects and remediates for such consequences when they occur.
Accountable
a. AI actors should be accountable for ensuring that AI systems operate in compliance with these principles consistent with the actors’ roles, within the appropriate context and evolving technologies. Any AI system should be compliant with legal requirements governing its use of data and algorithms during its phase of the insurance life cycle. Data supporting the final outcome of an AI application should be retained and be able to be produced in accordance with applicable insurance laws and regulations in each jurisdiction. AI actors should be responsible for the creation, implementation and impacts of any AI system, even if the impacts are unintended. AI actors should implement mechanisms and safeguards consistent with the degree and nature of the risks posed by AI to ensure all applicable laws and regulations are followed, including ongoing (human or otherwise) monitoring and, when appropriate, human intervention.

Compliant
a. AI actors must have the knowledge and resources in place to comply with all applicable insurance laws and regulations. AI actors must recognize that insurance is primarily regulated by the individual states and territories of the United States as well as by the federal government, and that AI systems must comply with the insurance laws and regulations within each individual jurisdiction. Compliance is required whether the violation is intentional or unintentional. Compliance with legal requirements is an ongoing process. Thus, any AI system that is deployed must be consistent with applicable laws and safeguards against outcomes that are either unfairly discriminatory or otherwise violate legal standards, including privacy and data security laws and regulations.

Transparent
a. For the purpose of improving the public’s confidence in AI, AI actors should commit to transparency and responsible disclosures regarding AI systems to relevant stakeholders. AI actors must have the ability to protect confidentiality of proprietary algorithms, provided adherence to individual state law and regulations in all states where AI is deployed can be demonstrated. These proactive disclosures include revealing the kind of data being used, the purpose of the data in the AI system and consequences for all stakeholders.

b. Consistent with applicable laws and regulations, stakeholders (which includes regulators and consumers) should have a way to inquire about, review and seek recourse for AI-driven insurance decisions. This information should be easy-to-understand and describe the factors that lead to the prediction, recommendation or decision. This information may be presented differently and should be appropriate for applicable stakeholders.
Secure, Safe and Robust

a. AI systems should be robust, secure and safe throughout the entire life cycle so that in conditions of normal or reasonably foreseeable use, or adverse conditions, they can function in compliance with applicable laws and regulations. To this end, AI actors should ensure a reasonable level of traceability in relation to datasets, processes and decisions made during the AI system life cycle. AI actors should enable analysis of the AI system’s outcomes, responses and other insurance-related inquiries, as appropriate in keeping with applicable industry best practices and legal requirements.

b. AI actors should, based on their roles, the situational context and their ability to act, apply a systematic risk management approach to each phase of the AI system life cycle on a continuous basis to address risks related to AI systems, including privacy, digital security and unfair discrimination as defined by applicable laws and regulations.
Proposed Charges:

The **LTCI Multistate Rate Review (EX) Subgroup** will:

Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The Subgroup should complete its charges by the 2021 Summer National Meeting.

- **Chair**: Commissioner Michael Conway (CO)
- **Consolidation of workstream 1—Multi-state Rate Review Practices and workstream 5—Non-Actuarial Variance Among the States**
- **Open Sessions or Regulator Only Sessions, pursuant to open meetings policy #3 – discussion of companies, entities or individuals**

The **LTCI Reduced Benefit Options (EX) Subgroup** will:

Identify options and develop recommendations for the rate review approach that provides consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases. The Subgroup should complete its charges by Dec. 31, 2020.

- **Chair**: Commissioner Jessica K. Altman (PA)
- **Former workstream 3—Reduced Benefit Options and Consumer Notices**
- **Open Sessions**

The **LTCI Financial Solvency (EX) Subgroup** will:

a. Explore restructuring options and techniques to address potential inequities between policyholders in different states; and techniques to mitigate policyholders’ risk to state guaranty fund benefit limits including states’ pre-rehabilitation planning options. Evaluate the work of the consultant and report on the work to the Task Force
b. Evaluate the results of consultants’ work on the completion of a data call and report on the work to the Task Force
c. Monitor work performed by other NAIC solvency working groups and assist in the timely multi-state coordination/communication of the review of the financial condition of LTC insurers

The Subgroup should complete its charges by the 2021 Summer National Meeting.

- **Co-Chairs**: Doug Slape (TX) and Fred Andersen (MN)
- **Consolidation of workstream 2—Restructuring Techniques, workstream 4—Valuation of Long-Term Care Insurance (LTCI) Reserves and workstream 6—Data Call Design and Oversight**
- **Regulator Only Sessions, pursuant to open meetings policy #3 – discussion of companies, entities or individuals**
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:

   Receivership Law (E) Working Group

2. NAIC staff support contact information:

   Jane Koenigsman
   jkoenigsman@naic.org
   816-783-8145

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

   - **Insurance Holding Company System Regulatory Act (#440)**
   - **Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)**

   In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

   The Financial Stability Board’s (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

   - The **Insurance Holding Company System Model Act (#440)** requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The **Insurance Holding Company System Model Regulation (#450)**, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
   - The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

   However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

   One potential solution is to revise the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.
The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450
The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450. Consistency with any revisions to Model 440

4. Does the model law meet the Model Law Criteria? ❑ Yes or ❑ No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

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

If yes, please explain why:

While this change is being made in connection with the NAICs Macro Prudential Initiative, most important is that such changes are needed to address the challenges receivers continue to encounter in the area of continuation services which often result in significant additional legal and administrative expenses to the receivership estate and all members of the Task Force supported this request.

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

❑ Yes or ❑ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

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

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary: See previous discussion.
7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

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

The Insurance Holding Company System Model Act (#440) is an Accreditation Standard but the task force has not yet considered whether this should become part of the required elements of that specific standard. However, given the potential the changes have in reducing the cost of regulation under receiverships, a national standard is likely appropriate.

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

No.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:

   Financial Stability (EX) Task Force

2. NAIC staff support contact information:

   Todd Sells
tsells@naic.org
   816-783-8403

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

   - Insurance Holding Company System Regulatory Act (#440)
   - Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

   Background & Description
   One of the key deliverables of the Financial Stability (EX) Task Force is to implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the State Ahead initiative. The most significant of the deliverables from the MPI includes the development of a liquidity stress test for the largest life insurers.

   Scope of the Proposed Revisions to Model #440 and Model #450
   The scope of the request is limited to addressing the issue of establishing regulatory authority to require stress testing and disclosures related to liquidity risk and establish, in statute, the confidentiality of those disclosures as appropriate. The Financial Stability (EX) Task Force would complete the review and recommend proposed draft revisions to Model #440 and Model #450. It is anticipated that these revisions will need to reference liquidity stress testing framework documents that will need to be able to be modified annually without opening up the models themselves (e.g., directions regarding the liquidity stress test, reporting templates, and specific requirements of the stress scenarios). Revisions may be necessary to the following sections of Model #440 and Model #450, including, but not limited to:

   Model #440 Section 1. Definitions
   Model #440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
   Model #440 Section 8. Confidential Treatment
   Model #450: Consistency with any revisions to Model #440

4. Does the model law meet the Model Law Criteria? □ Yes or □ No (Check one)

   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? □ Yes or □ No (Check one)
If yes, please explain why:

While this change is being made in connection with the NAIC’s MPI, most important is that such changes are needed for confidentiality protections for those who would be filing this stress test, which includes the largest life insurers that are operating in all of the states.

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

☐ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood
Low Likelihood

Explanation, if necessary:

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

☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood
Low Likelihood

Explanation, if necessary:

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

☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood
Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple; the Task Force believes that such changes will be widely supported.

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

The Model #440 is an accreditation standard, but the Task Force has not yet considered whether this should become part of the required elements of that specific standard.

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

No.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

1. Name of group to be responsible for drafting the model:
   Life Actuarial (A) Task Force

2. NAIC staff support contact information:
   Reggie Mazyck

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

   The Standard Nonforfeiture Law for Individual Deferred Annuities (#805) sets the floor for the nonforfeiture interest rate at 1 percent. The current low interest rate environment necessitates lowering the nonforfeiture interest rate to 0 percent to allow companies to support the nonforfeiture guarantees in their deferred annuity contracts. The Life Actuarial (A) Task Force proposal seeks to amend Section 4B(3) of #805 to lower the 1 percent interest rate floor to 0 percent.

4. Does the model law meet the Model Law Criteria? □ Yes or □ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states?
      □ Yes or □ No (Check one)
      If yes, please explain why
   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      □ Yes or □ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?
   □ 1 □ 2 □ 3 □ 4 □ 5 (Check one)
   High Likelihood Low Likelihood
   Explanation, if necessary:
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

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Explanation, if necessary:

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

No

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

No
To: Members of the NAIC Executive Committee  
From: Superintendent Beth Dwyer, Rhode Island Department of Business Regulation Insurance Division  
Chair, NAIC Insurance Regulator Professional Designation Program Advisory Board  
Date: August 13, 2020  
Subject: 2019 Annual Report of NAIC Designation Program Advisory Board Activities

In October of 2006, the NAIC launched the Insurance Regulator Professional Designation Program ("Designation Program"), a formal credentialing program designed for regulators, by regulators to establish structured training and development paths for insurance department employees. In that same year, the Internal Administration (EX1) Subcommittee directed the program’s Advisory Board to present a brief annual report of program benchmarks and board activities. This memorandum, with its supplemental charts, sets forth an account of the program’s year in review.

**Program Enrollments**
We continued our outreach to states and have seen increased interest and enrollments across the board. In 2019, the NAIC Education & Training Department processed over 350 Designation Program enrollments, bringing the total number of enrollments since 2006 to 2,392.

We awarded 235 new designations in 2019. By year-end, earned designation totals were as follows: 943 APIR designees, 343 PIR designees, 22 SPIR designees, and 2 IPIR designees.

With the continuation of the State Ahead Strategic Plan, we expect a continuing increase in enrollments in 2020. Goal III of State Ahead speaks to Superior Member Services and Resources, which includes the initiative to “continue to increase regulator participation in the NAIC Insurance Regulator Professional Designation Program.”

**Program Updates**
Goal I of State Ahead speaks to providing regulators with the data, training and tools required to support a collaborative regulatory environment which, in part, includes utilizing cloud capabilities. The NAIC Designation Program cloud-based enrollment system was released at the end of 2017 to allow regulators to enroll, pay, apply for the designation, renew and keep their transcripts in the site. Work is underway to enhance functionality and expand support for participants as the program continues to grow.

**The Designation Program Mentoring Network**
States have been encouraged to appoint a “mentor” that can serve as a liaison between the Department and the NAIC’s Education & Training Department as a means of disseminating information about the program to interested regulators, and to assist candidates as they have questions. All but one territory has individuals active in this role. Most mentors have earned an NAIC Designation or are currently working toward one.

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The Annual Designation Program Advisory Board Meeting
The Designation Program Advisory Board met regularly throughout 2019 via conference call to discuss policy matters and other issues. The annual in-person board meeting was held May 6 in Kansas City. Discussion items included policy recommendations and promotion of the program in conjunction with the State Ahead goals.

2020 Accomplishments
Several significant accomplishments have occurred in 2020, including:
- Replacing the program’s enrollment site with a new program management system (Certemy) to streamline and automate many of the processes done manually today, which will provide a better user experience for program participants. Onboarding to the Certemy system began July 1 for an October implementation.
- Created and implemented a new course for the APIR level, “Introduction to Financial Regulation for Non-Financial Regulators.”
- Updated program policies in response to program participant needs and requests (waiving first retake fee, removing tenure requirements for APIR and PIR, and allowing courses to be taken “out of sequence”).
- Granted a 1-year extension on all Designation renewal dates.

About the Insurance Regulator Professional Designation Program Advisory Board
The 2019 Advisory Board was composed of Mary Mealer, Life and Health Manager, Market Regulation Division, Missouri Department of Insurance; Pat McNaughton, Chief Financial Examiner, Washington Office of the Insurance Commissioner; Rachel Chester, Chief of Consumer and Licensing Services, Rhode Island Department of Business Regulation Insurance Division and Scott Sanders, Supervisor of Insurance and Financial Oversight, Georgia Office of Insurance.

North Dakota Commissioner Jon Godfread chaired the 2019 Advisory Board.

In addition to overseeing Designation Program policy and advising NAIC Education Department staff on designation program policy administration, the board members work on outreach to regulators during NAIC Zone Meetings and other regulatory meetings. Additional information about the Designation Program can be found by visiting the NAIC website: http://naic.org/education_designation.htm
TOTAL ENROLLMENTS - 2392
Designation Participation by Zone
As of December 31, 2019

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State Ahead Status Reporting - July 2020

Projects by Strategic Themes
- Theme I: 21
- Theme II: 27

Projects by Strategic Goals
- Goal 1: 21
- Goal 2: 27
- Goal 3: 38
- Goal 4: 8

Projects by Strategic Objectives
- Objective A.12
- Objective B.19
- Objective C.16
- Objective D.5
- Objective E.6
- Objective F.6
- Objective G.6

Current Status of Active Projects
- 100% - 99%
- 60% - 66%
- 30% - 33%
- 1% - 33%

Progress on Active Projects
- On Schedule
- At Risk
- At Significant Risk

Projects by Strategic Goals
- Goal 1: 21
- Goal 2: 27
- Goal 3: 38
- Goal 4: 8

Projects by Strategic Objectives
- Objective A.12
- Objective B.19
- Objective C.16
- Objective D.5
- Objective E.6
- Objective F.6
- Objective G.6

Current Status of Active Projects
- 100% - 99%
- 60% - 66%
- 30% - 33%
- 1% - 33%

Ready to release 8/13/20

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Draft: 7/31/20

Model Law Development Report

Amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA); therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. At the 2015 Fall National Meeting, the Regulatory Framework (B) Task Force discussed the proposed revisions to this model. The Task Force met Feb. 11, 2016, and appointed the Accident and Sickness Insurance Minimum Standards (B) Subgroup to work on revisions to this model. The Subgroup has been meeting on a regular basis since the 2016 Spring National Meeting, and it plans to continue meeting via conference call until it completes its work. During its meetings, the Subgroup has discussed several issues, including its approach for revising the model’s disability income insurance coverage provisions, and decided preliminarily to review the Interstate Insurance Product Regulation Commission’s (Compact’s) approach. After pausing its work due to the ACA’s potential repeal, replacement or modification—and the possible impact on the provisions of this model, as well as the Subgroup’s preliminary proposed revisions to the model—the Subgroup began meeting again via conference call in May 2018. Revisions to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) were adopted by the full NAIC membership at the 2019 Spring National Meeting. The Subgroup has been meeting via conference call to consider revisions to Model #171 for consistency with the revised Model #170 since the 2019 Summer National Meeting discussion on comments received on Sections 1–5 of Model #171. In December 2019, the Subgroup set a public comment period ending Feb. 7 to receive comments on Section 6 and Section 7 of Model #171. Due to the COVID-19 health emergency, the Subgroup has not scheduled any meetings. Any future meetings will depend on when a new co-chair is appointed and the duration of the COVID-19 health emergency. As requested, the Subgroup received comments from stakeholders on Section 6 and Section 7 of Model #171. Whenever the Subgroup meets next, the Subgroup will: 1) complete its discussion of the comments received on Sections 1–5 of Model #171; and 2) begin discussion of the comments received on Section 6 and Section 7 of Model #171. The Subgroup would like to complete its work by the end of 2020.

Amendments to the Annuity Disclosure Model Regulation (#245)—The Executive (EX) Committee met June 19, 2017, and approved a Request for NAIC Model Law Development to amend Model #245. The amendments will revise Section 6—Standards for Illustrations. The purpose of the revision is to address issues identified by the Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee related to innovations in annuity products that are not addressed, or not addressed adequately, in the current standards. Revisions addressing participating income annuities were adopted by the Life Insurance and Annuities (A) Committee during its July 19, 2018, conference call and held pending the resolution of the Working Group’s discussions regarding illustrating indexes in existence for less than 10 years. The Working Group continues to discuss additional revisions on the index issue. The Working Group made progress during discussions via conference calls in late 2019 and early 2020, and it received an extension from the Life Insurance and Annuities (A) Committee at the 2020 Summer National Meeting to finish its work.

Amendments to the Health Maintenance Organization Model Act (#430)—The Executive (EX) Committee approved the Request for NAIC Model Law Development to amend Model #430 at the 2019 Summer National Meeting. The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force is drafting the amendments to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520). Following the 2019 Summer National Meeting, the Working Group met via conference call to consider recommendations from the Virginia Insurance Bureau on revising Model #430 consistent with its charge. During its Nov. 21, 2019, conference call, the Working Group decided to move forward with revising Model #430 based on recommendations from the Maine Bureau of Insurance (BOI). It is anticipated that the Subgroup will meet via conference call sometime after the 2019 Fall National Meeting to review an initial draft of revisions to Model #430 based on the Maine BOI’s recommendations. The Subgroup adopted the revisions to Model #430 on July 13. The Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee will consider adoption of the revisions after the 2020 Summer National Meeting.

Amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)—The Executive (EX) Committee approved the Requests for NAIC Model Law Development for amendments to Model #440 and Model #450 at the 2019 Fall National Meeting. The Working Group recently exposed proposed changes to Model #440 for a second round of comments while also exposing proposed changes to Model #450 for a first round of comments. The Working Group is still striving to adopt the calculation before the end of 2020.
Amendments to the Life Insurance Disclosure Model Regulation (#580)—The Executive (EX) Committee met June 19, 2017, and approved the Request for NAIC Model Law Development to incorporate a policy overview document requirement into Model #580 and the Life Insurance Illustrations Model Regulation (#582) in order to improve the understandability of the life insurance policy summary and narrative summary already required by Section 5A(2) of Model #580 and Section 7B of Model #582. While the Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee was originally planning to revise both Model #580 and Model #582, it will now revise only Model #580. The Working Group has been meeting via conference call to develop language to add a requirement for a one- to two-page consumer-oriented policy overview. The Working Group continued to make progress during conference calls in late 2019 and early 2020, and it received an extension from the Life Insurance and Annuities (A) Committee at the 2020 Summer National Meeting to continue its work.

Amendments to the Mortgage Guaranty Insurance Model Act (#630)—The Executive (EX) Committee and Plenary approved the Request for NAIC Model Law Development to amend Model #630 on July 26, 2013. The Mortgage Guaranty Insurance (E) Working Group of the Financial Condition (E) Committee developed substantial changes to the model, but it continues to discuss those changes. COVID-19 has prevented the Working Group from working on Model #630, for which in February the Financial Condition (E) Committee adopted an extension until the 2020 Fall National Meeting.

Amendments to the Unfair Trade Practices Act (#880)—The Executive (EX) Committee approved the Request for NAIC Model Law Development to amend Model #880 at the 2019 Fall National Meeting. The Innovation and Technology (EX) Task Force will draft amendments to Model #880, focusing on Section 4H, to clarify what is considered a “rebate” or “inducement.” A drafting group was formed, led by Superintendent Elizabeth Kelleher Dwyer (RI), to develop language for exposure. The drafting group held its first call on Jan. 27, 2020, followed by three more calls. In all, five drafts were discussed, the drafting group disbanded on June 17, 2020, and the draft coming out of that work was distributed and posted to the NAIC website for comment. The Innovation and Technology (EX) Task Force continues to deliberate regarding the language, and it will discuss it during its meeting on Aug. 7, 2020.

New Model: Real Property Lender-Placed Insurance Model Act—The Executive (EX) Committee approved the Request for NAIC Model Law Development, submitted by the Property and Casualty Insurance (C) Committee, to draft the new Real Property Lender-Placed Insurance Model Act at the 2017 Summer National Meeting. The Lender-Placed Insurance Model Act (C) Working Group of the Property and Casualty Insurance (C) Committee exposed a draft of this proposed new model focusing on lender-placed insurance related to mortgage loans for a public comment period ending Oct. 31, 2018. At the 2020 Summer National Meeting, the Working Group received an extension of time to continue drafting the new model.

New Model: Pet Insurance Model Law—The Executive (EX) Committee approved the Request for NAIC Model Law Development at the 2019 Summer National Meeting. The Pet Insurance (C) Working Group is holding conference calls to draft the model law to define a regulatory structure for pet insurance and address issues, such as: producer licensing; policy terms; coverages; claims handling; premium taxes; disclosures; arbitration; and preexisting conditions.

New Model: [State] Pharmacy Benefit Manager Licensure and Regulation Model Act—The Executive (EX) Committee approved the Request for NAIC Model Law Development at the 2019 Summer National Meeting to draft a new model law addressing the licensure or registration of pharmacy benefit managers (PBMs). The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force is drafting the model as a result of discussions that began during the Health Insurance and Managed Care (B) Committee’s work to revise the Health Carrier Prescription Drug Benefit Management Model Act (#22). Following the 2019 Summer National Meeting, the Working Group held several information-gathering sessions to assist it in working on its charge. The Working Group met via conference call in regulator-to-regulator session to discuss its next steps. The Working Group formed an ad hoc drafting group to develop an initial draft regulating PBMs. The Subgroup met via conference call July 16 to discuss a draft of establishing a PBM licensing requirement and other PBM provisions, including a gag clause provision. The Subgroup exposed the draft for a public comment period ending Sept. 1, 2020.
The Financial Stability (EX) Task Force met via conference call. The following Task Force members participated: Marlene Caride, Chair (NJ); Eric A. Cioppa, Vice Chair (ME); Alan McClain represented by Mel Anderson (AK); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima Woods represented by Philip Barlow (DC); David Altmaier represented by Susanne Murphy (FL); Doug Ommen (IA); Robert H. Muriel represented by Vincent Tsang and Kevin Fry (IL); Gary Anderson (MA); Chlora Lindley-Myers represented by John Rehagen (MO); Bruce R. Range represented by Justin Schrader (NE); Linda A. Lacewell represented by Martha Lees (NY); Jessica Altman (PA); and Kent Sullivan represented by Mike Boerner and James Kennedy (TX).

1. Adopted its Feb. 26, 2020, and 2019 Fall National Meeting Minutes

The Task Force met Feb. 26, 2020, and Dec. 9, 2019. During its Feb. 26 meeting, the Task Force took the following action: 1) announced reappointment of the Liquidity Assessment (EX) Subgroup; 2) discussed comments received on the draft 2019 liquidity stress test framework; and 3) discussed comments received on a request to join the Financial Condition (E) Committee in opening holding company models.


2. Heard an Update on FSOC Developments

Superintendent Cioppa reported that since the 2019 Fall National Meeting, the Financial Stability Oversight Council (FSOC) has met three times with a primary focus on the COVID-19 pandemic and the related economic crisis. On March 26, the FSOC met in executive session to discuss COVID-19 and non-bank mortgage origination and in open session to discuss developments related to COVID-19. He added that during the open session, he reported on the work of state insurance regulators in response to the crisis, noting that the insurance sector remains strong but that the impact of the low interest rate environment on life and annuity writers, as well as the issues surrounding business interruption coverage, are being monitored. On May 14, the FSOC met in closed session to discuss regulators’ response to COVID-19 and received an update on the work of the Nonbank Mortgage Liquidity Task Force. Finally, the FSOC met July 14 to hear an update on an activities-based review of the secondary mortgage market and to receive an update on the Federal Reserve’s stress tests, including additional COVID-19 focused analysis.

3. Received an Update from the Liquidity Assessment (EX) Subgroup on Progress in Achieving its Deliverables related to Liquidity Stress Testing

Mr. Schrader reported that via an e-vote effective April 17, the Task Force adopted a motion to pause the work on the 2019 Liquidity Stress Test (LST) and instead adopted a new 2020 charge for the Subgroup to address an American Council of Life Insurer’s (ACLI) proposal to focus on macroprudential information regarding how the insurance sector is navigating market conditions due to the economic impact of the pandemic. The Subgroup’s study group has established a scope of 23 companies for a quantitative and qualitative data collection with respect to liquidity. He added that the data collection consists of Phase I, which is qualitative data based on first-quarter financials, and Phase II, which is qualitative and quantitative data on second-quarter financials. He said that the deadline for Phase I was July 15, and the deadline for Phase II is Aug. 31. Mr. Schrader noted that results from both phases will be used to refine the study group’s prior work of developing the 2019 LST. He said that a pandemic in conjunction with an economic stress will now be considered for the postponed LST.

4. Received an Update from the Receivership and Insolvency (E) Task Force on its Work to Address the Financial Stability (EX) Task Force’s Referral Letter to Undertake Analysis Relevant to the MPI

Mr. Kennedy reported that the Receivership and Insolvency (E) Task Force continues to work to address the Financial Stability (EX) Task Force’s referral letter to undertake an analysis of resolution and recovery concerns important to financial stability as part of the Macroprudential Initiative (MPI) but with some delay due to the impact of COVID-19. The Receivership and Insolvency (E) Task Force will request comments and further consider key provisions that states should adopt into states’ receivership and guaranty fund laws and regulations. He added that earlier this year, the Receivership and Insolvency (E) Task Force and Financial Condition (E) Committee adopted a Request for NAIC Model Law Development, which, if adopted by...
the Executive (EX) Committee, the Receivership Law (E) Working Group will develop recommendations within the Insurance Holding Company System Regulatory Act (¶440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (¶450) to ensure the continuation of essential services to an insurer in receivership by affiliated entities in a group.

Mr. Kennedy reported that the Receivership and Insolvency (E) Task Force found that a bridge institution might be useful in a receivership to address early termination on qualified financial contracts (QFCs) but would require the use of a temporary stay on termination rights, which is prohibited in many states. Therefore, a possible solution is to explore if a bridge can be established under regulatory oversight before receivership to address early termination of QFCs.

Mr. Kennedy added that at the 2019 Fall National Meeting, the Executive (EX) Committee and Plenary adopted revisions to the Guideline for Stay on Termination of Netting Arrangements and Qualified Financial Contracts (¶1556) and at this Summer National Meeting, the Receivership and Insolvency (E) Task Force plans to adopt amendments to the Receiver’s Handbook to address federal taxes and federal releases. He also reported that the International Association of Insurance Supervisors (IAIS) will be meeting virtually in September to finalize the Application Paper on Resolution Planning.

5. Heard an Update on Collateralized Loan Obligation (CLO) Stress Tests

Eric Kolchinsky (NAIC) reported that equity markets continue to stabilize and have staged a comeback with year-to-date (YTD) return on nonaffiliated publicly traded common stocks being down by about 15% as of June 30. He added that the negative performance is driven primarily by insurer holdings of energy stocks. He also reported that the amount of bonds that have been downgraded to below investment grade has been minimal. He added that total NAIC 1 and NAIC 2 designation holdings have only decreased from approximately 95% to 93% from year-end 2019 to June 2020. Mr. Kolchinsky said that collateralized loan obligations (CLOs) continue to be a growing asset class for U.S. insurers, increasing 18% from $130 billion at year-end 2018 to $158 billion at year-end 2019. He noted that the NAIC was able to model $119 billion in several stress test scenarios. He concluded that NAIC CLO stress tests have determined that COVID-related scenarios will have a minor impact on the vast bulk of CLO-holding insurers. However, he cautioned that significant CLO exposures relative to capital and surplus, and concentrated exposures to atypical securities, are potential risks (particularly in a stressed environment) for several medium to small insurers.

6. Heard an Update on the IAIS

Tim Nauheimer (NAIC) reported that the IAIS has adopted a framework for a holistic approach to assessing and mitigating systemic risk, which recognizes that systemic risk can arise both from sector-wide trends with regard to specific activities and exposures, as well as from a concentration of these activities and exposures in individual insurers. He added that the IAIS Macroprudential Monitoring Working Group (MMWG) oversees many of the holistic initiatives, including the global monitoring exercise (GME) that consists of individual insurer monitoring (IIM) and sector-wide monitoring (SWM).

Mr. Nauheimer reported that the IAIS launched its eighth annual IIM exercise in March, but the exercise was reduced to a targeted COVID-19 data collection with both a quantitative section and a qualitative section. He added that there are 58 insurers participating worldwide, including 16 U.S. insurers that are submitting data quarterly on a best effort basis. He also reported that the IAIS launched its annual SWM exercise in March, but the exercise was also reduced to a targeted COVID-19 data collection with both a quantitative and qualitative section. He added that the NAIC has been providing quarterly SWM data to the IAIS. He said that the IAIS, in consultation with the Financial Stability Board (FSB), agreed that reporting to the FSB on the outcomes of the 2020 GME will be postponed by one year to October 2021. He concluded that common themes from the GME include: 1) the potential materialization of credit risk in insurers’ investment portfolio; 2) the impact of the low interest rate environment; 3) insurance sector interconnectedness; 4) business interruption; 5) operational resilience; and 6) cyber risk. He added that the IAIS is also developing a global risk dashboard with data from the GME.

Mr. Nauheimer also reported that the Macro-prudential Supervision Working Group (MSWG) has completed and exposed the application paper on liquidity risk management and is preparing for a second public consultation in November. Additionally, MSWG began drafting the Macroprudential Supervision Application Paper to provide guidance on Insurance Core Principle (ICP) 24. He added that the IAIS is also conducting a baseline assessment questionnaire for the implementation of the holistic framework, which focuses on ICPs and IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) standards adopted in November 2019. He said that the proposed NAIC staff survey responses were forwarded to Financial Stability (EX) Task Force members and interested regulators for review on July 27 and will be submitted jointly with the Federal Reserve and the Federal Insurance Office (FIO) to the IAIS.
He said that some of the work of the NAIC’s MPI has been delayed in order to provide relief to industry and members. He added that while the NAIC continues to work on a U.S. risk dashboard, the work has been paused to establish interim COVID risk dashboards for the property, life and health sectors, which will assist regulators in prioritizing the myriad of COVID issues that were occurring rapidly in April.

7. **Heard an Update on LIBOR**

Mr. Nauheimer reported that the Task Force monitors London Interbank Offered Rate (LIBOR)-related matters to assess if there are any issues that may significantly affect financial stability. He added that NAIC staff are also ex officio members of the Alternative Reference Rates Committee (ARRC), which is a group of private-market participants convened by the Federal Reserve Board and the Federal Reserve Bank of New York to help ensure a successful transition from U.S. dollar LIBOR to the secured overnight financing rate (SOFR). He identified several issues:

- Insurers were looking for safe harbor language from the NAIC and states to hold basis swaps in their derivatives portfolio. In response, the Financial Condition (E) Committee issued a letter on June 12 alerting insurers of its support of those swaps being deemed permissible derivative investments up to one year past the cutover.
- Some life reserving and accounting issues need to be addressed by the NAIC but pose no threat to financial stability.

8. **Discussed Exposure Comments for the Draft Revisions to Model #440**

Todd Sells (NAIC) reported that two comment letters were received by the Subgroup for the draft revisions to Model #440:

- The Texas Department of Insurance’s (DOI) comment letter suggests: 1) to incorporate the separate confidentiality section 8.2 into the original section 8 of Model #440 as occurred for the Group Capital Calculation; 2) to consider the Liquidity Stress Test an additional type of enterprise risk filing; 3) to define scope criteria in the definitions section; and 4) to ensure the NAIC Liquidity Stress Test Framework for a given year is completed in advance enough to allow states to adopt it and for insurers in scope to meet the requirements.
- The ACLI’s comment letter suggests modifications to the draft confidentiality provisions, but recognized their specific edits may not be valid if the Texas DOI’s recommendation to collapse the draft section 8.2 into the original section 8 of Model #440.

Mr. Sells concluded that the Subgroup intends to address these comments and provide a set of proposed revisions to Model #440 for the Task Force to expose and finalize.

Having no further business, the Financial Stability (EX) Task Force adjourned.

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GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council did not meet at the Summer National Meeting.
The Innovation and Technology (EX) Task Force met Aug. 7, 2020. The following Task Force members participated: Jon Godfread, Chair, and Chris Aufenthie (ND); Elizabeth Kelleher Dwyer, Vice Chair (RI); Lori K. Wing-Heier represented by Chris Murray (AK); Jim L. Ridling represented by Jerry Workman and Gina Hunt (AL); Alan McClain and Letty Hardee (AR); Elizabeth Perri (AS); Evan G. Daniels and Erin Klug (AZ); Ricardo Lara and Lucy Jabourian (CA); Michael Conway (CO); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmaier (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Dean L. Cameron (ID); Robert H. Muriel (IL); Stephen W. Robertson represented by Jerry Ehlers (IN); Vicki Schmidt represented by LeAnn Crow (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa represented by Ben Yardley (ME); Anita G. Fox (MI); Steve Kelly represented by Tammy Lohmann, Grace Arnold and Phil Vigliaturo (MN); Chlora Lindley-Myers and Cynthia Amann (MO); Mike Chaney and Andy Case (MS); Matthew Rosendale represented by Steve Matthews and Jeannie Keller (MT); Mike Causey represented by Tracy Biehn (NC); Bruce R. Ramge (NE); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Mark McGill and Carl Sorenson (NJ); Barbara D. Richardson (NV); Jillian Froment (OH); Glen Mulready represented by Cuc Nguyen (OK); Andrew R. Stolfi (OR); Jessica K. Altman and Michael Humphreys (PA); Raymond G. Farmer (SC); Larry D. Deiter (SD); Hodgen Mainda (TN); Kent Sullivan represented by Doug Sape and Michael Nored (TX); Scott A. White and Rebecca Nichols (VA); Michael S. Pieciak represented by Anna Van Fleet (VT); Mike Kreidler and Molly Nollette (WA); Mark Afable (WI); and James A. Dodrill (WV). Also participating was: My Chi To (NY).

1. **Adopted its July 23, 2020, and 2019 Fall National Meeting Minutes**

Commissioner Altman made a motion, seconded by Ms. Biehn, to adopt the Task Force’s July 23, 2020 (Attachment Five) and Dec. 6, 2019 (see NAIC Proceedings – Fall 2019, Innovation and Technology (EX) Task Force) minutes. The motion was unanimously adopted.

2. **Adopted its Working Group Reports**

Commissioner Godfread asked for reports from the Task Force’s working groups.

   a. **Big Data (EX) Working Group**

Commissioner Ommen said the Big Data (EX) Working Group met Aug. 4 and adopted its 2019 Fall National Meeting minutes and received an update from the Casualty Actuarial and Statistical (C) Task Force (CASTF). He said the CASTF is drafting a white paper, *Regulatory Review of Predictive Models*, to provide best practices for the review of predictive models and analytics filed by insurers to justify rates.

Commissioner Ommen said state insurance regulators have the responsibility to review and evaluate the advancing uses of technology, modeling techniques and the application of models in insurance and the priority question being addressed is whether state insurance regulators can determine whether predictive models, as used in rate filings, are compliant with state laws and regulations. He said the white paper includes an update on the development of the best practices for evaluating the use of variables and predictive modeling, noting the four best practices for regulatory review outlined in the white paper are to: 1) ensure compliance with state rating laws; 2) review all aspects of a model (data assumptions, adjustments, variables, inputs and outputs); 3) evaluate how a model interacts with and improves the rating plan; and 4) enable competition and innovation.

Commissioner Ommen said the white paper references the concept of “rational explanation” that refers to a plausible narrative connecting the variable and/or treatment in question with real-world circumstances or behaviors that contribute to the risk of insurance loss in a manner that is readily understandable to a consumer or other educated layperson. He said the white paper indicates that a “rational explanation” does not require strict proof of causality but should establish a sufficient degree of confidence that the variable and/or treatment selected are not obscure, irrelevant, or arbitrary.

Commissioner Ommen said the latest draft of the white paper was exposed June 12 and the CASTF is now reviewing the latest round of comments and plans to present the white paper to the Property and Casualty Insurance (C) Committee in September.
Commissioner Ommen noted that the white paper has been prepared more in the context of generalized linear models (GLMs) and similar systems that could be described as “static” models or algorithms, which are now more commonly found in insurance rate filings, although the best practices would also apply to models that also involve artificial intelligence. He said the “NAIC Principles for artificial intelligence (AI)” (AI Principles), which will be considered by the Innovation and Technology (EX) Task Force later in this meeting, more narrowly apply to a subset of developing innovative modeling that could be described as “more dynamic” due to the addition of AI to the modeling.

Commissioner Ommen said the Big Data (EX) Working Group also received an update from the Accelerated Underwriting (A) Working Group, noting that another important workstream initiated by the Big Data (EX) Working Group is the NAIC technical and nontechnical rate review trainings. These trainings started Nov. 13, 2019, and ended in June 2020. He said state insurance regulators received technical training in exploratory data analysis and statistical techniques insurers are using to develop property and casualty risk classification and rating plans and the training also covered specific advanced statistical techniques including GLMs, generalized additive models (GAMs), gradient boosted trees, random forest ensembles and decision tree models. He said that in addition to the more advanced technical training, the NAIC sponsored two non-theoretical, practical webinars, designated as “nontechnical webinars.” Moving forward, the NAIC plans to provide training targeted specifically to market conduct examiners.

Ms. Nichols reported that the Speed to Market (EX) Working Group met July 15, June 30 and June 15 via conference call. During its June 15 conference call, the Working Group heard updates regarding the NAIC System for Electronic Rates and Forms Filing (SERFF) Advisory Board and SERFF metrics, as well as an update from the Interstate Insurance Product Regulation Commission (Compact.)

Ms. Nichols said, in addition to hearing updates, the Working Group discussed the suggestion to create a SERFF canned report for rate changes. She said that after hearing comments from Working Group members, interested regulators and interested parties, the Working Group adopted the suggestion, noting that the parameters for this report will be discussed during the Working Group’s Aug. 27 conference call. She said the last item discussed during the June 15 conference call was the SERFF State Reports document, noting that any suggested revisions or additions will be discussed during a future call.

Ms. Nichols said the Working Group discussed changes to the Life, Accident/Health, Annuity and Credit Uniform Product Coding Matrix (PCM) and Uniform Transmittal Document on its June 30 conference call, noting that two of the suggested changes were adopted. She said the first was to change the term “implementation date” to “effective date” on the Uniform Transmittal Document within the SERFF “General Information” area and on the disposition letter; the second was to add a sub-type of insurance (TOI) for “expatriate plans” under H15G and H15I, which are the TOIs used for group health and individual health plans for hospital/surgical/medical expense. She said the description for this new sub-TOI would be: “expatriate plans that are not required to comply with all state or federal mandates for health benefits,” noting that these changes will be effective Jan. 1, 2021.

Ms. Nichols said that during its July 15 call, the Working Group, interested regulators and interested parties discussed the suggestions for changes to the Uniform Property & Casualty PCM and Uniform Transmittal Document, but the Working Group did not adopt any of the suggested changes. She said the Working Group adopted its June 30 and July 15 minutes via e-vote.

Commissioner Godfread provided the report of the Artificial Intelligence (EX) Working Group. He said the Working Group met during the 2019 Fall National Meeting and discussed comments related to how to start the process for developing the AI Principles for the insurance industry. He said the decision was to use the Organisation of Economic Co-operation and Development (OECD) principles as a basis and a draft was exposed for a public comment period ending in January 2020, followed by conference calls held June 30, June 3, May 5, Feb. 19 and Feb. 4. Numerous suggestions from many different stakeholders were discussed and many incorporated into the AI Principles, where was ultimately adopted during the Working Group’s June 30 conference call. He said the Task Force will be considering the AI Principles later in this meeting.
Commissioner Godfread asked if there were any questions regarding any of the Working Group reports. Hearing none, Commissioner Mais made a motion, seconded by Commissioner Conway, to adopt the following reports: 1) Big Data (EX) Working Group, including its Aug. 4 minutes (Attachment One); 2) Speed to Market (EX) Working Group, including its July 31, July 15, June 30 and June 15 minutes (Attachment Two); and 3) Artificial Intelligence (EX) Working Group, including its June 30, June 3, May 5, Feb. 19 and Feb. 4 minutes (Attachment Three). The motion passed unanimously.

3. Heard an Update on the Innovation and Technology State Contacts Group

Denise Matthews (NAIC) provided an update on the activities of the Innovation and Technology State Contacts group. She said the group has not been as active as in 2019 given other priorities, but it does continue to meet. She noted the following:

- The state contact names and contact information is posted on the NAIC website, so if a state has a change regarding that position, send the changes to Ms. Matthews so they can be updated.
- The group held three webinars in June. They were:
  - AAIS: Livraria/Kira workflow tool (June 2).
  - Verisk: Mozart workflow tool (June 4).
  - Theta Lake’s Compliance AI tool (June 8).
- There will be a contacts roundtable meeting Sept. 16 during the NAIC/NIPR Insurance Summit.

Ms. Matthews said one topic the group will consider is to identify what digital or other types innovations deployed or that experienced accelerated deployment as a result of COVID-19, will likely continue and what, if any, related regulatory implications would be of interest to discuss. She said she would be reaching out to industry trade groups and other interested parties to share experiences to help further that discussion.

4. Adopted the AI Principles

Commissioner Godfread said the next agenda item is to discuss the AI Principles document, which was adopted by the Artificial Intelligence (EX) Working Group during its June 30 conference call. He said he previously provided a brief recap regarding the work of the Working Group and an overview of the process, noting that there has been a great deal of discussion since the first draft of the AI Principles was exposed in January 2020. He said there were four calls specific to the draft, as well as new drafts issued as that work progressed. He said the June 30 version of the AI Principles was exposed by the Task Force for a public comment period and those comments were discussed during the Task Force’s July 23 meeting.

Commissioner Godfread thanked the stakeholders who participated throughout the process and said the issues are on the table and decisions now need to be made by the Task Force members regarding each. He said in order to expedite that process, he, working with Commissioner Afable, Superintendent Dwyer and staff, put together a “decisions” document that was sent July 28 to Task Force members, interested regulators and interested parties. He said he would be taking this section by section and would request a vote at the end of each section discussion, but would be taking the proxy discrimination issue separately and then ending with a vote on the overall AI Principles as amended during the process.

a. Amendments to the Introductory, Preamble Section

Commissioner Godfread began by introducing the outstanding issues related to the introductory language. He said there is a suggestion to add “data providers” to the opening paragraph, add the word “fair” after the word “secure” in the second paragraph, a request to further define “AI actors” and remove the words “from harm” in the last sentence of the third paragraph.

Commissioner Mais said he supports Commissioner Godfread’s suggestions that “data providers” and “fair” be added, “AI actors” not be further defined and “from harm” be removed.

Commissioner Godfread further clarified that he does not consider that adding “data providers” to this document implies that state insurance regulators would be regulating third-party data providers but that adding the language essentially draws their attention to this document that is intended for use within the insurance industry. He said it should put data providers on notice that these are the principles for use within the insurance industry.

Superintendent Toal made a motion, seconded by Superintendent Dwyer, to add “data providers,” “fair” and remove “from harm” from the introductory language. The motion was unanimously adopted.
b. Amendments to the Fair and Ethical Section Not Related to the Proxy Discrimination Issue

Commissioner Godfread said there is a suggestion regarding changing the word “unfair” to “unlawful” under the Fair and Ethical section. He said he would be opposed to making that change and asked for discussion.

Commissioner Conway said he would be opposed to that change, as well. He said the term “unfair discrimination” is used throughout the statutory structure and to change “unfair” to “unlawful” would cause confusion and lead to problems.

Commissioner Ommen agreed with Commissioner Conway and said the two principles of unfair discrimination are that similar risks are to be treated the same and protected class data is not to be used in the rating process. As such, if the concept of unlawfulness it introduced, it would lead to 56 jurisdiction interpretational differences.

Commissioner Mainda agreed and said changing “unfair” to “unlawful” brings about the thought of rule of law and that is not the direction of this document, which is more of a guidance document. He said he would support leaving it as “unfair.”

Commissioner Godfread said there did not seem to be support for this change, but asked if anyone would like to make a motion to adopt this change. Hearing none, he continued.

c. Suggested Language Related to the Proxy Discrimination Issue in the Fair and Ethical Section

Commissioner Godfread drew the Task Force member’s attention to the document provided and asked if the members wanted to make any changes to the proxy discrimination language in the draft. He said the discussion document outlines a summary of the language suggested to the Task Force via the comment letters. He said there three options are provided. He said the suggested language is a nod to understanding insurance is built on a cost- or risk-based foundation and he opened it up for discussion.

Commissioner Mais said he was in favor of leaving the language as-is in the draft, but the second option, including the words “Consistent with the cost-based foundation of insurance” does accomplish the intended purpose and reassures everyone that it is recognized that this is a cost-based industry, so he would support that language.

Ms. Nollette said Washington state supports the amended language and believes it is appropriate.

Commissioner Ommen said he supports the amended language but asked if it should be “cost-based” or “risk-based.” He asked if “risk-based” was discussed by the drafters, as it is typically the term he has heard used.

Commissioner Godfread said it was discussed and the intention was to use the broader term and to encompass more than ratemaking, but said he would be open to either term. He said it should be reflected in the minutes that it is intended to be the broader term that encompasses the entirety of the foundation of insurance.

Commissioner Ommen said in part it has to do with the context, and rating systems deal with losses and expenses and traditional factors tied to risk, but part of this deals with issues associated with other aspects of insurance such as marketing, fraud detection and others. He said he would be agreeable to “cost-based,” given the more general application of AI.

Commissioner Clark asked if consideration should be given to just saying, “Consistent with the foundation of insurance.”

Commissioner Godfread said the drafters did not discuss that but would be open to discussion by the Task Force members.

Commissioner Afaile said this issue was discussed by the drafters, noting that he believes “risk-based” is the broader term, but one of the two terms should be in the AI Principles and is important to clarify the intent.

Commissioner Godfread said the minutes will reflect the intention is that it is to be applied broadly.

Mr. Keen said the Option Two language is appropriate and he generally believes “risk-based” to be the broader term.

Commissioner Anderson agreed with Mr. Keen and said it may also capture what Commissioner Clark was talking about, as well, so he would support that language.

Commissioner Conway made a motion, seconded by Commissioner Ommen, to add the proposed language and change the word “cost-based” to “risk-based,” so it would read, “Consistent with the risk-based foundation of insurance…..”
Superintendent Dwyer asked for clarification that the intention is for this language to include claims, as well as rating. Commissioner Godfread said that it does and, hearing no further discussion, called the for the vote on the motion. The motion was unanimously adopted.

d. Amendments to the Accountable Section

Commissioner Godfread said there is a request to remove the last sentence in the Accountable section. He said it was added to provide some type of a “safe harbor” for the good actors in this space who do everything the right way and with good intentions, acknowledging there will be some grace given if mistakes are made, recognizing this is new technology and is being used in new ways which can result in unanticipated mistakes. He said that was the thinking behind adding that sentence. He said it may be a bit repetitive, as state insurance regulators consistently consider the entirety of the situation before acting.

Commissioner Mais said his concern is two-fold, the first being that this is a guidance document and is intended to convey expectations regarding the need to correct or compensate for consequences when they occur and we understand there will be some that may be harmful. He said state insurance regulators have the responsibility to look at the situation and act within the context, responding accordingly; however, this document should not limit or put restrictions on the authority of state insurance regulators. He said the last sentence in the Accountable and Compliant sections both are strongly directed at state insurance regulators and they do not belong in this type of document. He said the thought behind the suggested change in the Fair and Ethical section to add “and corrects and compensates such consequences when they occur” is intended to address that. He said he strongly believes AI can be a positive force and if he thought not having this language would stunt the growth of AI, he would be opposed to removing it; however, those two “safe harbor” sentences at the end of the Accountable and Compliant sections do not need to be there.

Commissioner Godfread asked Commissioner Mais to confirm that it is his preference to remove this language and go back and address this under the Fair and Ethical section. Commissioner Mais confirmed that to be correct.

Superintendent Dwyer agreed with Commissioner Mais and said she does not like the sentence, as negligence means there is a duty and a breach of that duty, and it is unclear what this language does. She said it tries to create a “safe harbor” but she does not believe it accomplishes that, so she would agree to go back to the Fair and Ethical section and add language suggested by Director Ramge.

Commissioner Conway said if there needs to be a statement like this, it belongs in the Accountable section. He said if the concept is to say that a good actor will not be hit with penalties, it seems like it should be incorporated into the Accountable section.

Commissioner Godfread said he could go either way. He said he leans toward putting it in the Accountable section, but he believes it fits in either place.

Commissioner Ommen said part of the issue is this is a guidance document and this seems to be mixing in a requirement for companies and data providers to comply with the law and additional responsibility in terms of fair and ethical behaviors that may go beyond current law. He said part of the problem is negligence is not the issue, but trying to avoid an algorithm or AI that contains inherent bias or that perpetuates or makes worse bias. He said the duty is to avoid that, but there is not currently a law related to it, so he said he agrees with Commissioner Mais, as this a guidance document and not a regulation.

Commissioner Anderson said he understands the concern, but said this happens and the aim is to remediate so if that can be captured in the Fair and Ethical section, like suggested, it would be the best way to capture this.

Ms. To said she would echo those comments, adding that she supports Commissioner Mais’ suggestion to delete the sentence. She said these are guiding principles and the difficult work lies ahead to implement and operationalize them. She said it will take everyone coming to the table with an open mind and a lot of trust. She said she understands the importance but does not believe this type of language is needed.

Commissioner Mais made a motion, seconded by Superintendent Dwyer, to delete the last sentence in the Accountable section and add language to the Fair and Ethical section part b, replacing the word “compensates” with “remediates” to read, “AI systems should not be designed to harm or deceive people and should be implemented in a manner that avoids harmful or unintended consequences and corrects and remedies for such consequences when they occur.” The motion was unanimously adopted.
e. Amendments to the Compliant Section

Commissioner Godfread said there is a suggestion to delete the last sentence in the Compliant section.

Superintendent Dwyer said she would propose replacing it with, “Use of AI does not create or change any existing statutory or regulatory requirements.” Commissioner Mais said that is the aim of that language, so he would support the new language.

Commissioner Conway asked if this language would impact some type of regulatory structure specific to AI created after these AI Principles are adopted. Superintendent Dwyer said the intent is that nothing changes that exists today, but it is not intended to impact anything that might be passed in the future specific to AI. Commissioner Conway said he was fine with that explanation.

Superintendent Toal said he has concerns with the language, as well, as this seems to be a broad statement and it is entirely possible there will be new regulatory requirements as a result of AI.

Superintendent Dwyer said an alternative is simply to delete the last sentence. She said AI will change regulatory requirements and the intent is not to alter that.

Commissioner Conway agreed that deletion of the sentence would be preferable.

Commissioner Conway made a motion, seconded by Superintendent Toal, to delete the last sentence. Hearing no further discussion, Commissioner Godfread called the vote. The motion was unanimously adopted.

f. Amendments to the Transparent Section

Commissioner Godfread said there were some suggestions made by Connecticut that clean up some of the language in this section.

Commissioner Mais said the suggestions were mostly technical edits and he proposed taking out the words “including consumers,” as they were the only stakeholder group identified. He said he understands wanting to be sure consumers are included but, on balance, the language is better without that, as consumers do not need to be called out specifically and it may cause questions or confusion to do so.

Commissioner Mais made a motion, seconded by Director Ramge, to adopt the edits suggested by Connecticut, including removing the words “including consumers” and changing the second sentence to read, “AI actors must have the ability to protect confidentiality of proprietary algorithms, provided adherence to individual state law and regulations in all states where AI is deployed can be demonstrated.” The motion was unanimously adopted.

g. Other Amendments

Superintendent Dwyer said Tom Considine (National Conference of Insurance Legislators—NCOIL) sent a text message to her indicating that NCOIL would like to comment on the introductory language. She said Mr. Considine said NCOIL suggests deleting the words “emphasizing the importance of accountability, compliance, transparency, and safe, secure, fair and robust outputs” from the end of the second paragraph in the introductory language. She said NCOIL is concerned those words make this more of a “practices” as opposed to a “principles” document.

Commissioner Conway said he struggles with that concern, because it says clearly that these principles are guidance and do not carry the weight of law or impose any legal liability.

Commissioner Ommen said he would support the change because just mentioning “outputs” is narrow, and state insurance regulators are interested in the inputs, as well as the outputs. He made a motion to change the word “outputs” to “systems.”

Superintendent Dwyer asked if Commissioner Ommen would prefer to end the sentence after “transparency,” as NCOIL’s suggestion is to end it after “systems.”

Commissioner Ommen said his intent is to leave in the change previously suggested by Connecticut and adopted by the Task Force to add the word “fair” and so that would be a problem with ending the sentence after “transparency.”
Director Ramge asked if the word “outcomes” as opposed to “outputs” would work, but Commissioner Ommen said it does not. He said maybe saying “systems” again is redundant.

Commissioner Godfread said ending the sentence at “systems” does not change the intent, so he does not have a problem with doing that.

Mr. Considine said this paragraph makes clear this is a principles document that does not carry the weight of law, but despite that sentence, everything after “systems” detracts from that intent.

Ms. Jabourian recommended the sentence stay in because it is important to emphasize paying attention to the outputs, as well.

Indiana State Rep. Matt Lehman (R-Berne) said the concern is the word “however,” because that implies there is a list of things that would be more guiding issues as opposed to principles, so taking out that language does not change the document but makes the “however” not as strong.

Mr. Keen suggested removing the word “however” and leaving the sentence in. Commissioner Mais agreed with that suggestion. Commissioner Mainda agreed with Mr. Keen and Commissioner Mais.

Superintendent Dwyer said she understands the concern and agreed that Mr. Keen’s suggestion may resolve the issue.

Rep. Lehman said he was fine with that and, even though the language may be redundant, removing the “however” resolves the concern.

Superintendent Dwyer made a motion, seconded by Commissioner Altman, to remove the word “however.” The motion was unanimously adopted.

Superintendent Toal made a motion, seconded by Commissioner Conway, to adopt the “NAIC Principles on Artificial Intelligence (AI)” (see NAIC Proceedings – Summer 2020, Executive (EX) Committee and Plenary, Attachment One) as amended during the meeting. The motion was unanimously adopted.

5. Heard an Update from the Accelerated Underwriting (A) Working Group and Presentations on Algorithmic Auditing

Commissioner Godfread asked Director Muriel to provide an update regarding what the Accelerated Underwriting (A) Working Group has been working on over the past months, noting that it ties closely to issues the AI Principles serve to inform and potentially guide. He said the AI Principles are guideposts to the industry and, while they do not carry the weight of law, they will inform other workstreams where decisions, definitions and potentially regulations may need to be developed to monitor and oversee this space. He said, therefore, it is important for the Task Force to be informed and aptly coordinating these efforts to ensure that there is consistency and the AI Principles are appropriately embedded in those work products.

a. Accelerated Underwriting (A) Working Group Update

Director Muriel reviewed the charge and the work plan of the Accelerated Underwriting (A) Working Group and the presentations that have been made to the Working Group. He said the Working Group appointed two subgroups: 1) Ad Hoc NAIC Liaison Subgroup; and 2) Ad Hoc Drafting Subgroup. He reviewed the key questions the Working Group is seeking to answer, the input data for accelerated underwriting, how behavioral data is being used and existing legislation that plays a role, such as the federal Fair Credit Reporting Act, and outlined potential consumer concerns. Director Muriel then discussed the timeline for the Working Group deliverables.

b. Algorithm Auditing in Life

Chris Stehno (Deloitte) provided an update on algorithm auditing considerations in life insurance underwriting. He said using historical decision data to build an algorithm will teach it to make similar decisions in the future, and if past decisions included bias, then the algorithm will reproduce that bias. Mr. Stehno said disproportional representation of protected groups in available data can be equally harmful for protected classes, noting that model performance in the real world is never identical to performance on an initial training set. He said algorithms need to be comprehensively audited for fairness, explainability and robustness, noting that automated code checks and comprehensive methodology should be used to detect and correct hidden risks.
c. **Accelerated Underwriting and Evaluating the Risks**

Patricia Matson (Risk and Regulatory Consulting—RRC) discussed traditional methods for life underwriting and the features of accelerated underwriting. She talked about the data elements used in accelerated underwriting now and what they would be in 10 years, as well as inherent risks related to accelerated underwriting. Ms. Matson provided an overview of how a company can test for these risks.

6. **Discussed Anti-Rebating Amendments to Model #880**

Commissioner Godfread asked Superintendent Dwyer to review the status of the work on Section 4H of the *Unfair Trade Practices Act* (#880) amendments related to anti-rebating.

Superintendent Dwyer said 21 comment letters were received on the language exposed by the drafting group. She said based on those comments, several changes were made to the draft (Attachment Four) to hopefully accommodate issues that appeared to be something the group would want to change. She provided an overview of some of the changes made, as well as some requested changes that were not included in the most recent draft.

Superintendent Dwyer said comments were received saying the words “value-added” introduced lack of clarity, so they were removed throughout the revised language, and the word “non-cash” was substituted, as it was recognized that nowhere in the document did it indicate that giving cash would not be allowed. She said it was suggested the word “specified” be changed to “provided,” noting that she would be interested in feedback on that suggestion. She said some changes were requested that were not made, including one related to unregulated third parties, keeping the insurer responsible, redrafting the section so the subsections are part of Section 1, and a suggestion that the word “related” was not specific enough, as there was no better suggested language provided. She said she is open to discussion related to these items. She said no change was made to require the product be added within the policy terms.

Superintendent Dwyer said there were comments related to the use of the words “primarily intended,” but the drafting group discussed that at length and when Rep. Lehman said NCOIL had discussed that at length and preferred “primarily intended,” that was chosen for the draft but she said, again, that she is open to alternative language.

Superintendent Dwyer said “loss mitigation” was added to Section 4H(2)(e)(1)(b)(1) and Section 4H(2)(e)(1)(b)(8) was rewritten. She said there were suggestions that Section 4H(2)(e)(1) through Section 4H(2)(e)(8) be limited to certain lines of insurance, but a line of insurance can mean different things in different states, so it may not be appropriate to do that; however, she said she is willing to discuss additional comments on that. She said the term “group” was requested in several of the comment letters, but it was not included in the most recent draft because of concerns in regard to abuses seen in the lender-placed and title insurance space, and the group did not want to create a situation like that again. She said Section 4H(2)(e)(3), Section 4H(2)(e)(4) and Section 4H(2)(e)(5) were written in an attempt to accommodate many of the comment letter suggestions, so she would ask the Task Force members to take a look at those, as well. She said there were comments related to using the term “policyholders,” so it was replaced with “clients” and that term is defined in the new draft language. She said she would welcome comments on that change. She said the new draft does not include a safe harbor for health insurers, as that did not seem warranted.

Superintendent Dwyer said Section 4H(2)(f)(1) was also rewritten and a drafting note added, as suggesting what the limits might be in terms of a static number appears problematic. She said it was suggested that charitable donations be put in a separate section, but no language was provided, so that has not yet been done. She said a subsection relating to things offered for “free” was added and there was agreement that offering insurance in connection with another policy would not be appropriate.

Superintendent Dwyer said this draft will be exposed for a public comment period ending Aug. 28 and then discussed during a future Task Force meeting.

7. **Discussed the Privacy Protections (D) Working Group**

Commissioner Godfread said the planned update from the Privacy Protections (D) Working Group would be provided during the next meeting of the Task Force.

Having no further business, the Innovation and Technology (EX) Task Force adjourned.
The Big Data (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call Aug. 4, 2020. The following Working Group members participated: Doug Ommen, Chair (IA); Elizabeth Kelleher Dwyer, Vice Chair, (RI); Lori K. Wing-Heier (AK); Daniel Davis (AL); Ken Allen (CA); Andrew N. Mais and George Bradner (CT); Sharon Shipp (DC); Frank Pyle (DE); Sandra Starnes (FL); Robert H. Muriel (IL); Rich Piazza (LA); Kathleen A. Birrane (MD); Benjamin Yardley (ME); Karen Dennis (MI); Phil Vigliaturo (MN); Brent Kabler (MO); Christian Citarella (NH); Carl Sornson (NJ); Gennady Stolyarov (NV); Jillian Froment (OH); Andrew R. Stolfi (OR); Michael McKenney and Shannen Logue (PA); Michael Wise (SC); Rachel Cloyd and J’ne Byckovski (TX); Todd E. Kiser, Tanji Northrup and Reed Stringham (UT); Kevin Gaffney and Christina Rouleau (VT); Molly Nollette (WA); and James A. Dodrill (WV).

1. **Adopted its 2019 Fall National Meeting Minutes**

   Mr. Vigliaturo made a motion, seconded by Mr. Bradner, to adopt the Working Group’s Dec. 7, 2019, minutes (see *NAIC Proceedings – Fall 2019, Innovation and Technology (EX) Task Force, Attachment One*). The motion passed unanimously.

2. **Received an Update on the Work of the Casualty Actuarial and Statistical (C) Task Force**

   Mr. Piazza said the Casualty Actuarial and Statistical (C) Task Force is working on two charges. The first charge is to draft and propose changes to the *Product Filing Review Handbook* to include best practices for the review of predictive models and analytics filed by insurers to justify rates. The second charge is to draft and propose state guidance for rate filings that are based on complex predictive models.

   Mr. Piazza said state insurance regulators are trying to determine if a rating plan and model included in a rating plan are compliant with state laws and regulations. Mr. Piazza said there are four best practices for regulatory review based upon regulatory expertise in the review of generalized linear models (GLMs) used in private passenger automobile insurance. The first is to ensure compliance with rating laws by reviewing the overall rate level impact of the proposed revisions and determine that individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk. The second practice is to obtain a clear understanding of the data used to build and validate the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output. The third practice is to evaluate how the model interacts with and improves the rating plan. The fourth practice is to enable competition and innovation. Mr. Piazza said states insurance regulators should assist in getting products to the market and ensure the public receives the benefit of models and more sophisticated rating plans.

   Mr. Piazza said Appendix B of the white paper identifies information a regulator may want to know to meet the objectives of the best practices. There are 79 informational elements referenced in Appendix B, which a state insurance regulator may find helpful in reviewing a GLM. Mr. Piazza said a regulator may need to access a large amount of information to understand how a model was built and how the model is used. Mr. Piazza said the 79 informational elements are organized in three categories of regulatory interest: 1) selecting model input; 2) building the model; and 3) the filed rating plan.

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   Mr. Piazza said the white paper addresses the concept of rational explanation, which is a somewhat controversial topic. Mr. Piazza said that a variable may be correlated to loss frequency, but the variable’s correlation to loss frequency may not make sense. Because of this, a state insurance regulator may ask the filer to provide a rational explanation of the correlation. Mr. Piazza said confidentiality of models remains a concern for industry. Mr. Piazza said the white paper recognizes confidentiality of models and that confidentiality protections are dependent upon state law.

   Mr. Piazza said the last draft of the white paper was circulated in June, and the Casualty Actuarial and Statistical (C) Task Force will review the nine comments submitted on the draft. The Task Force hopes to present the white paper to the Property and Casualty Insurance (C) Committee by the end of September.
Mr. Ommen said the Big Data (EX) Working Group’s focus is on whether state laws and regulations provide the framework to effectively regulate models and data being used. In response to Commissioner Ommen’s question about the concept of rational relationship and the Casualty Actuarial and Statistical (C) Task Force’s discussion about causation, Mr. Piazza said there were state insurance regulators who thought correlation alone may not be sufficient, and some states use the term “reasonable relationship” in statute. Mr. Piazza said a state insurance regulator may ask about the rational relationship a variable has to the cost of insurance if a correlation does not make sense to a regulator or a consumer would be unlikely to understand the importance of a variable.

Mr. Stolyarov said the white paper encapsulates longstanding practices of regulators and should not be misinterpreted as imposing new requirements for the review of GLMs. Mr. Stolyarov said state insurance regulators have considered the concept of rational relationship for decades since state insurance regulators must understand why a variable has a correlation to risk of loss. Mr. Stolyarov said a correlation may be spurious. Mr. Davis agreed and said actuaries in Alabama ask for an intuitive and plausible connection between predictor variables and the target variable. Mr. Davis said companies should be able to explain connection since there may be a correlation but no plausible explanation.

Commissioner Ommen said the Artificial Intelligence (EX) Working Group is addressing the impact of artificial intelligence (AI) on protected classes. Commissioner Ommen said the work of the Casualty Actuarial and Statistical (C) Task Force is being completed in the context of the current legal framework and addresses how the prohibition of using factors related to race affects the review of current models.

3. **Received an Update on the Work of the Accelerated Underwriting (A) Working Group**

Director Muriel said the Life Insurance and Annuities (A) Committee appointed the Accelerated Underwriting (A) Working Group at the 2019 Summer National Meeting and is charged to: “Consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, drafting guidance for the states.” Director Muriel said the Working Group has three phases of work: 1) information gathering; 2) identifying issues and work product; and 3) developing a work product. Director Muriel said the Working Group has met 16 times since October 2019 to receive presentations from actuarial consulting firms, life insurance companies, consumer advocates, law firms and a machine learning assurance company. Director Muriel said the Working Group is forming a liaison subgroup to coordinate activities with other NAIC working groups and a drafting subgroup to begin drafting a white paper. Director Muriel said the Accelerated Underwriting (A) Working Group plans to expose the first draft of the white paper by the end of 2020 and present a final work product to the Life Insurance and Annuities (A) Committee by the 2021 Summer National Meeting.

4. **Received an Update on NAIC Technical and Nontechnical Rate Review Trainings**

Kris DeFrain (NAIC) said the NAIC offered trainings from November 2019 to June 2020. Ms. DeFrain said state insurance regulators received technical training in exploratory data analysis and statistical techniques insurers are using to develop property/casualty (P/C) risk classifications and rating plans. A consulting actuary presented the theoretical development of statistical techniques and how to apply the theory to real-world datasets using R Programming Language. Ms. DeFrain said the initial sessions focused on exploratory data analysis to familiarize participants with approaches to inspect data irregularities in model data that can undermine the validity of models. The next phase of training was devoted to advanced statistical techniques, including GLMs, generalized additive models (GAMs), gradient boosted trees, random forest ensembles and decision tree models. Ms. DeFrain said the NAIC also offered two non-theoretical webinars, which were classified as nontechnical webinars. The NAIC plans to provide training in October targeted specifically to market conduct examiners. This training is being designed to assist market conduct examiners in identifying priority modeling issues in not only rate models, but also models used in underwriting, claims and marketing.

Ms. DeFrain said the NAIC presented new tools in February for states that contract with the NAIC to receive technical assistance in reviewing P/C rate models. Ms. DeFrain said state insurance regulators will be able to share information through a confidential model database and obtain NAIC technical assistance when reviewing a specific company’s model. Ms. DeFrain emphasized the NAIC is providing technical assistance in response to requests from state insurance regulators. Birny Birnbaum (Center for Economic Justice—CEJ) asked for more information about the functionality of the System for Electronic Rate and Form Filing (SERFF) to enhance the review of models and share information among state insurance regulators. Ms. DeFrain
said the NAIC has implemented the use of a SharePoint for state insurance regulators to share documents and is providing technical assistance to assist state insurance regulators in identifying whether information is missing in a rate filing. In response to Mr. Birnbaum’s question about whether there are written procedures regarding NAIC assistance, Ms. DeFrain said there are currently no written procedures and no direct connection of SharePoint to SERFF. Ms. DeFrain said these are two items still being developed.

Commissioner Ommen said he believes the Speed to Market (EX) Working Group has some responsibility regarding the functionality of SERFF and that SERFF needs to be updated so state insurance regulators are able to access and share information on models. Commissioner Ommen said he agrees written procedures are needed.

Having no further business, the Big Data (EX) Working Group adjourned.
The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force conducted an e-vote that concluded July 31, 2020. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Wally Thomas (AK); Jerry Workman (AL); William Lacy (AR); Frank Pyle (DE); Dean L. Cameron (ID); Heather Droge (KS); Tammy Lohmann (MN); Mark Rabauliman (MP); Jon Godfread (ND); Frank Cardamone (NH); Russell Toal (NM); Cuc Nguyen (OK); Mark Worman (TX); Tanji Northrup (UT); Lichiou Lee (WA); and Barry Haney (WI).

1. **Adopted its July 15 minutes**

The Working Group met July 15 (Attachment Two-A) and took the following actions: 1) adopted its June 15 minutes; 2) discussed suggestions for 2020 changes to the Property and Casualty PCM and Uniform Transmittal Document effective Jan. 1, 2021. None of the suggested changes were adopted; and 3) discussed plans for the next call, which will take place Aug. 27, to discuss the SERFF canned report in more detail and other topics related to the Working Group’s charges.

2. **Adopted its June 30 minutes**

The Working Group met June 30 (Attachment Two-B) and took discussed suggestions for 2020 changes to the Life, Accident/Health, Annuity and Credit Uniform Product Coding Matrix (PCM) and Uniform Transmittal Document effective Jan. 1, 2021. Two of the suggested changes were adopted: 1) change the term “implementation date” to “effective date” on the Uniform Transmittal Document within the System for Electronic Rate and Form Filing (SERFF) system general information area on the disposition letter; and 2) add a sub-type of insurance (TOI) for expatriate plans under H15G and H15I. The description would be expatriate plans that are not required to comply with all state or federal mandates for health benefits.

Having no further business, the Speed to Market (EX) Working Group adjourned.
The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call July 15, 2020. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Wally Thomas (AK); Jerry Workman (AL); William Lacy (AR); Shirley Taylor represented by Donna Archuleta (CO); Heather Droge (KS); Tammy Lohmann (MN); Camille Anderson-Weddle and LeAnn Cox (MO); Ted Hamby represented by Timothy Johnson (NC); Chrystal Bartuska (ND); Frank Cardamone (NH); Russell Toal represented by Leatrice Geckler (NM); Cuc Nguyen (OK); Mark Worman and Sharalyn Taylor-Hargrove (TX); Tanji Northrup (UT); Gail Jones and Lichiou Lee (WA); and Barry Haney (WI).

1. Adopted its June 15 minutes

The Working Group met June 15 and took the following action: 1) received an update on the SERFF Advisory Board and System for Electronic Rate and Form Filing (SERFF) metrics; 2) received an update from the Interstate Insurance Product Regulation Commission (Compact); 3) adopted the suggestion to create a SERFF canned report for rate changes; and 4) discussed SERFF state reports.

Ms. Droge made a motion, seconded by Mr. Thomas, to adopt the Working Group’s June 15 minutes (Attachment Two-A1). The motion passed unanimously.

2. Reviewed Suggestions and Made Changes to the Property and Casualty Uniform PCM and Uniform Transmittal Document effective Jan. 1, 2021

   a. The first suggestion discussed was to either change the “effective date of last rate revision” located on page four of the paper document and the rate/rule schedule of SERFF to the “renewal effective date of last rate revision” or add a field and capture both new and renewal effective dates for last rate revision. The other suggestion that aligned with this and was discussed simultaneously was to add a field to the rate/rule schedule showing the SERFF tracking number for the last rate revision. The reason for these suggestions is that they would be helpful since the state suggesting it limits rate changes during a renewal cycle. Ms. Motter noted that every state looks at these fields a little differently. She asked if it would be helpful to add instructions to the state general instructions and/or use the objection process with quick text to request that these fields be updated with a post submission update. Quick text could also be used at disposition to explain which type of date is being approved.

   Ms. Lohmann believed adding a field to the rate/rule schedule showing the SERFF tracking number for the last rate revision would be useful. Ms. Geckler believed both suggestions would be helpful. Ms. Archuleta noted that Colorado’s preference is to leave this section as it is and make no changes.

   Ms. Motter asked if changing the name of what is currently there would cause data integrity issues for filings previously submitted. Brandy Woltkamp (NAIC) noted that the previously submitted data may not reflect the new labeling if labels were changed. Ms. Motter asked if adding two new fields would be best. Ms. Woltkamp noted that this would be the best option for data integrity purposes. Ms. Droge noted that Kansas would not need these fields, but it is not opposed to adding them. Ms. Archuleta noted that Colorado also does not need these fields. Ms. Nguyen and Mr. Cardamone noted that quick text would be the best solution for the states that want these fields.

   Ms. Droge made a motion, seconded by Ms. Nguyen, to not adopt the suggestions to change the effective date of last rate revision or add a field to the rate/rule schedule showing the SERFF tracking number for the last rate revisions at this time. The motion passed unanimously.
b. The next suggestion discussed was regarding type of insurance (TOI) number 28. The suggestion was to update the instructions on force-placed business to force-placed or lender-placed business. It stated that this differs from the NAIC Annual Statement where force-placed business is filed on the same pre-defined lines of business as business placed by borrower or creditor for the same coverage. The reason provided for this suggestion is that this language would further clarify where the product should be reported on the annual statements.

Ms. Motter noted that there is already a footnote in the product coding matrix (PCM) that explains to report the business in the annual statement line. There is an asterisk placed next to TOI number 28 to draw attention to this explanation, which is located on the final page of the PCM. The existing note indicates that there is a difference between the PCM TOI and the annual statement reporting and to report the business in the appropriate annual statement line.

Mr. Thomas made a motion, seconded by Ms. Lohmann, not to further update the instructions on force-placed business under TOI number 28. The motion passed unanimously.

c. The next suggestion discussed was to add a TOI for Certificates of Insurance with the following Sub-TOIs: Personal/Commercial Certificate of Insurance Filings, Personal Certificate of Insurance Filings, and Commercial Certificate of Insurance Filings with the description, “Certificates are used to show proof that an organization or person has insurance coverage.” Ms. Motter noted that it may be appropriate to submit this under TOI number 33.0 (Other Lines of Business) or under the individual line of business these belong under. For example, if there was a filing submission for Commercial General Liability that would include the certificate of insurance used, it would be part of the filing submission and not be separated out. In this case, it would have the same TOI and be in the same filing submission as the remainder of the product.

Ms. Jones noted that Washington’s analysts are not in favor of implementing this suggestion. The analysts did not believe a certificate is a TOI, but it is more of a policy type; TOIs are supposed to be about the coverage involved. The analysts believe a new filing type is more appropriate than a new TOI. Ms. Droge noted that Kansas does not need this additional TOI. Mr. Worman noted that in Texas, these are filed separately, and they have their own statute and their own separate filing requirements. Ms. Bartuska noted that North Dakota also has a separate statute that dictates the certificates, and it uses filing labels for this. She noted that typically they come in with a larger policy, and she agrees that this is not needed, as it is more of a specific administrative form used by industry and agents and not a policy itself. Mr. Lacy noted that he is not in favor of creating a new TOI just for a certificate that already applies to an existing product and would require the filer to file under the appropriate TOI. Ms. Nguyen agreed.

Ms. Nguyen made a motion, seconded by Ms. Bartuska, to not add a new TOI for Certificates of Insurance. The motion passed unanimously.

d. The next suggestion discussed was to separate the TOIs for commercial umbrella and excess to the following: excess liability, umbrella liability, excess umbrella, and combination umbrella and excess. The reason provided for this suggestion is that some states consider these excess lines as separate lines of insurance. Ms. Motter noted that Ohio does not have different requirements for these lines. Ms. Jones noted that Washington’s staff is not in favor of making these changes, as the current TOI is working fine for Washington. She also expressed concern with how the data integrity of past filings would be affected if the current TOI were separated out.

Theresa Boyce (ACE Group) noted that she is only aware of two states where this information must be broken out, and it has not been a problem to use the current TOI in most states. Ms. Motter noted that states that need this information broken out can use filing labels.

Mr. Cardamone made a motion, seconded by Ms. Droge, to not separate out the TOIs for commercial umbrella and excess. The motion passed unanimously.
e. The last suggestion discussed was to add a field for advisory affiliations to the general information tab for specific TOIs/sub-TOI combinations. The reason for this suggestion is that they would like to create a method for the company to indicate, for state exceptions and compliance related issues, whether they are affiliated with and use an advisory affiliation such as Insurance Services Office (ISO), Association Insurance Services Inc. (AIS), The Mutual Service Office Inc. (MSO), Association for Cooperative Operations Research and Development (ACORD), ODEN Insurance Services Inc., Administrative Services Organization (ASO), etc.

Ms. Motter noted that state specific fields can be utilized for this request. Ms. Boyce noted that this request could be confusing because the reference number field for the advisory organization is not filled out unless they are adopting an ISO filing. She explained that it would need to be clarified if placed on the general information screen for a good understanding of exactly what has been requested. Ms. Jones agreed with this because if reference organization, reference number and reference title are already there, and then a new entity is added, it would need to be more descriptive; consequently, since a state specific field is utilized, everyone that fills out the filing would have to answer that question. She noted that she is concerned that the reference organization and advisory organization could get placed in the wrong field for the filing due to confusion on this request. Ms. Motter explained that this suggestion appears to ask for various compliance related exception information for various things, such as cancellations notice forms, fraud language, etc., all in one field, which could be difficult to interpret.

Mr. Cardamone made a motion, seconded by Ms. Droge, to not add a field for advisory affiliations to the general information tab for specific TOIs/sub-TOIs. The motion passed unanimously.

3. Discussed Other Matters

Ms. Nichols noted that another call will be scheduled at the end of August to discuss the SERFF canned report and a couple of other topics related to the Working Group’s charges.

Having no further business, the Speed to Market (EX) Working Group adjourned.
Draft: 7/7/20

Speed to Market (EX) Working Group
Conference Call
June 15, 2020

The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call June 15, 2020. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Joanne Bennett and Wally Thomas (AK); Jerry Workman (AL); William Lacy (AR); Shirley Taylor (CO); Frank Pyle (DE); Heather Droge (KS); Tammy Lohmann (MN); LeAnn Cox (MO); Ted Hamby (NC); Chrystal Bartuska (ND); Frank Cardamone (NH); Russell Toal (NM); Cuc Nguyen (OK); Sharalyn Taylor and Mark Worman (TX); Tanji Northrup (UT); Lichiou Lee (WA); and Barry Haney (WI). Also participating was: Maria Ailor (AZ); and George Bradner (CT).

1. Received an Update on the SERFF Advisory Board and SERFF Metrics

Joy E. Morrison (NAIC) noted that the System for Electronic Rate and Form Filing (SERFF) Advisory Board did not meet at the Spring National Meeting, but it will meet at the Summer National Meeting. She noted the new board members that joined in March. She stated that the SERFF data hosting project is complete, and it included some additional work to the state data retention feature, which is also complete. Both projects were finished under the projected budget. The other project discussed was a SERFF billing enhancement. Previously, industry customers were buying a block of filing transactions in advance. The blocks are being removed, and now states will be charged on transactions when the transactions occur. In the same way that they would put their state fees on a filing, the transactions fee will be added to the filing, and when the customer submits a transaction fee will be initiated at the same time. It is a four-piece project: 1) a self-service interface for the centralized e-commerce initiative; 2) a credit card payment method being added for infrequent filers; 3) removal of the filing block; and 4) a separate project for the SERFF filing review. A fee will be put in place to offset the cost of the vendor payments. There will be an analysis fee on filings that are submitted to Texas with an attachment on the forms schedule, which will help offset the cost of licensing for the vendor product that is being used for that pilot. That piece of work will be done as part of the billing project, and it is being reported separately in a separate fiscal project report.

The last project wrapping up is the SERFF Assessment. This involved bringing in an outside group to review SERFF and figure out what needs to happen for SERFF to meet existing and future needs of the stakeholders. About 100 stakeholder interviews took place as part of this process. A survey was also distributed to collect information from additional stakeholders. A final draft of the report was completed in May. Phases of the billing project will be put in to place this summer and fall. The SERFF Assessment project will be distributed to some of the members in July, and a fiscal request will probably be sent in the fall.

Birny Birnbaum (Center for Economic Justice—CEJ) noted that at each SERFF Advisory Board meeting for the last four to five years, the issue of SERFF filing access functionality was discussed. Many states use the SERFF filing access to provide the public access to rate and form filings. The public has access only to the public information, so if a filing has some sort of confidential information that a company marks trade secret for example, then those documents are not included in the public document that a member of the public can access. There is no disclosure when you go to SERFF filing access that any document has been withheld or the reason it has been withheld. This can be problematic as it may conflict with state laws, as the state may not refuse to provide a member of the public a document unless they disclose what document has been withheld and the reason for withholding that document. The CEJ has been asking for several years to include this SERFF filing access functionality to identify what documents are being withheld from public disclosure and the reason. The CEJ believes that some states may be out of compliance with their public information laws by not having SERFF provide that additional functionality.

Theresa Boyce (Chubb) noted that if you prepay the SERFF filing block now, the fee is a lot less than if you do not. She asked whether there would be an adjustment to the fee when the change is made to remove prepayments for filing blocks. Ms. Morrison noted that they do not intend to change the pricing based on whether it is or is not a block. They are trying to put everyone in the same rate group that they are currently in. Ms. Morrison noted that this is not being done to generate revenue, but to simplify things for both industry users and NAIC staff who manage the filing blocks. Ms. Boyce explained that her understanding then is that if a company typically buys a block then they will not have to prepay going forward to get the lower fee, they will just be charged the lower fee. Ms. Morrison noted that they would stay in that category through 2021. The block expiration is March 2022. In late 2021, pricing is expected to be based on usage. Most people should fall into the same bucket because a block is bought that is used within two years, and that is what is keeping a company in that rate band. Ms. Morrison noted that very little fluctuation is expected. Ms. Boyce asked how they would be billed. Ms. Morrison noted that they will not
be billed because the transaction fee will be taken by Automated Clearing House (ACH) debit, the same way the state fee is paid. She noted that additional details on this matter will be provided in early July.

2. Received an Update on SERFF Metrics

Ms. Morrison noted that the SERFF team generally looks at transaction volume, and it tries to determine if there are any kind of trends or changes that may occur in a state and how it handles a particular line of business that would affect the transaction volumes that come through the system. This helps the SERFF team predict and provide performance and support as well as a tracking revenue budget. The submissions are static from year to year. Generally, there are 550,000 to 565,000 transactions, not filings. If you are in a state where filings can be submitted on behalf of multiple companies, each company is counted as a transaction. If one filing is submitted on behalf of four companies, that is four transactions. This is what SERFF metrics are based on and what is used to generate the Speed to Market Assessment report that is provided to the individual states and the Commissioners at Roundtable in the national meetings. Mr. Bradner noted that from a reporting and workload standpoint, Connecticut only looks at the example provided as one transaction. The SERFF report he gets from his examiners shows four transactions, when they only reviewed one transaction. Mr. Bradner believes that this is a reporting metric that needs to be looked at because a company could be filing the product in four companies, but the examiner only reviews that one filing. He believes it should not be tracked in SERFF as a metric in workload management as four transactions, and it should just be one. He asked if there is a way that the states can change that to reflect how they measure workload. Ms. Morrison noted that she did not think the report could be modified in that way. Brandy Woltkamp (NAIC) noted that the way the reports are currently, they are based on transactions solely, which came from the direction of the Working Group. Ms. Morrison noted that this could be changed at the direction of the Working Group, and this was decided when metrics were reviewed. Mr. Bradner noted that it could be discussed in the future. Mr. Worman noted that Texas was having this issue as well, and someone on the SERFF team helped them come up with a way to address this concern so that the workload management is more reflective of what the reviewers are looking at. Mr. Lacy noted that the data they receive from SERFF can be used in many ways, and he discussed how they review the data in Arkansas. Ms. Morrison noted that they are looking at ways to make the data provided from SERFF easier to understand as part of the assessment.

3. Received an Update from the Compact

Karen Schutter (NAIC) noted that the Insurance Compact Compass, a three-year strategic plan with three priorities, nine objectives, and 28 action items, has been adopted. There is a webpage devoted to the strategic planning initiative. The link can be located on the Interstate Insurance Product Regulation Commission’s (Compact’s) website, insurancecompact.org. There are various tools available, including a dashboard, tracker and navigator. The navigator breaks down the action items by steps and timeframe. The timeframes will be reviewed due to the COVID-19 situation.

Last fall, the Compact’s Product Standards Committee (PSC) recommended amendments to two individual life uniform standard benefit features that had been in place for 10 years: a waiver of premium and a waiver of monthly deductions. The Committee is also working on a recommended new standard for a waiver of surrender charges for life products. These amendments and the uniform standard add qualifying benefit triggers. They are not long-term care (LTC); they just trigger upon the insured having a qualifying event. These amendments were done at the direction of the Management Committee. A gap analysis was completed in 2018, and this was on the list. The PSC met for the first time this year in mid-May, and it is working on these amendments and the new standard. The Committee is also working on the first action item under the strategic plan, which is providing wider and easier to follow notices and steps with respect to the development of uniform standards. The Committee will be looking for feedback from the states and consumer and industry representatives.

The Rulemaking Committee is actively working on its strategic plan action items, including whether to expand the group standards that are in place for term life, annuities and disability income to include more group types than just the employer groups. It is also working on a survey for companies and state insurance regulators to gather comprehensive information on how group types are filed, reviewed, approved, used and marketed. In addition, the Committee is reviewing notices to state insurance regulators and legislators regarding notice and their rights in terms of adoption and opting out of uniform standards. Work plans for the PSC rulemaking and published call summaries are available on the About page of the Compact website.

Committee drafting calls are now open to all state insurance regulators starting this year. The members of the Committee are still the only ones who will vote on any recommendations before they go up to the Compact. Upcoming calls will take place this summer.
The Compact has developed a COVID-19 resource page, which answers frequently asked questions (FAQ) about what type of questions a company can ask on an application with respect to COVID-19. The uniform standards regarding application questions are carefully drafted, and they must be in a certain format and require that any question be related to receiving a diagnosis from a member of the medical profession. State insurance regulators looking for guidance should review the resource page, and they are encouraged to reach out to the Compact office.

A website survey was previously conducted, and focus groups for state insurance regulator, industry, and consumer state legislators are being created. Each group will provide feedback on its perspective for enhancing the website, then a public call will take place to bring all the groups together to review the recommendations.

The Colorado Supreme Court has issued an opinion in a third-party litigation case. It was not the deciding court, but its opinion does affect Colorado and the Compact. It said that the uniform standards operate more as regulation, and a regulation cannot override a conflicting state statute. The membership has been looking at that, and they are working to put together a comparison, a state statute, and provisions of uniform standards. The initial feedback is that there are not a lot of situations where the uniform standards would differ from a state statute. The conflict in the Colorado case is that a two-year suicide clause was followed, and Colorado is one of three states that follow a one-year clause. There is a governance review committee that was created this year. It is looking at this case and kicking off two major projects for the Compact. One is a governance review to ensuring that best practices are being followed and benchmarking against comparable organizations. The other is a business assessment to look at the organization and ensure that it is sustainable over the next five to 10 years. Both projects came out of the strategic planning process. The selection process is currently taking place and responses came in earlier this month. The Governance Review Committee is reviewing those, and it will make selections and recommendations at the Summer National Meeting for the Compact to review and discuss.

4. Discussed the Suggestion to Create a SERFF Canned Report for Rate Changes

Brandy Woltkamp (NAIC) noted that the suggestion to create a SERFF Canned Report for rate changes came from the yearly request for Speed to Market suggestions that is sent out annually. The reason for this suggestion is that rate changes are important to every state insurance regulator, and allowing the state insurance regulators an easy way to see what was requested and in turn what was approved in one report would help the reviewers and state consumer help lines in reporting differences of rate information.

Mr. Bradner asked if this is for all lines of business or just specific lines of business and if it would include block cost filings. Ms. Ailor noted that this request is from one state, but that if there is a lot of interest in this suggestion, then the details regarding lines of business and types of insurance (TOIs) would need to be discussed further. Mr. Bradner noted that Connecticut is interested in this report, as he does a report each year for multiple lines of business regarding how many rate filings they received and what the overall rate the company was taking. For Auto and Homeowners, he reviews what the overall statewide impact of that change is and looks at commercial lines of business as well. Ms. Droge is also interested, and she noted that Kansas does a similar report. Mr. Toal, Ms. Taylor, Ms. Nguyen, Mr. Haney and Mr. Lacy also expressed interest in this report.

Ms. Taylor asked if this would encompass anything within a date parameter provided so it can provide several different filings in the same report. Ms. Motter said that is correct. She noted that it would be helpful if the states that currently create a report like this on their own or people that have an idea of what they would want out of this report can provide feedback and requests to the Working Group about what fields would be helpful. She asked that the feedback and requests be sent to Ms. Woltkamp.

Ms. Lee made a motion, seconded by Mr. Toal, to create a SERFF Canned Report for rate changes. The motion passed unanimously.

Lisa Brown (American Property Casualty Insurance Association—APCIA) asked if this information can be pulled from existing filings in SERFF, and she wanted to clarify that this is not a discussion about companies having to provide additional information. Mr. Bradner noted that this report would not be seeking additional information. It would look at what a company filed and then what was ultimately approved by the state. Ms. Nichols asked that any thoughts on this be sent to Ms. Woltkamp or Leana Massey (NAIC) so that information can be compiled and discussed in greater detail on a future call.
5. **Discussed SERFF State Reports**

Ms. Motter noted that a year or two ago, a meeting took place that centered around the Canned Reports, and feedback was sought as to which SERFF State Reports state insurance regulators were using. It was apparent in the meeting that people were not using the Canned Reports, and a lot of the reason was that it was not intuitive and people were unclear as to what data was being provided or not provided and what the fields represented. An attachment that outlines the existing Canned Reports and what fields are captured both in criteria selection and display was sent out with the agenda, and it is also posted to the Speed to Market webpage. Ms. Motter asked that everyone review the SERFF State Reports document to get a good understanding of the information currently provided and what the reports can capture and produce. Any suggested revisions or additions to the report going forward will be discussed in more detail on a future call.

Having no further business, the Speed to Market (EX) Working Group adjourned.
The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call June 30, 2020. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Joanne Bennett and Wally Thomas (AK); Yada Horace for Jerry Workman (AL); William Lacy (AR); Shirley Taylor (CO); Dean L. Cameron (ID); Heather Droge (KS); Tammy Lohmann (MN); Camille Anderson-Weddle (MO); Chrystal Bartuska (ND); Russell Toal (NM); Cuc Nguyen (OK); Sharalyn Taylor (TX); Tanji Northrup (UT); Gail Jones and Lichiou Lee (WA); and Barry Haney (WI). Also participating was: Bob Grissom (VA).

1. Reviewed Suggestions and Made Changes to the Life, Accident/Health, Annuity and Credit Uniform PCM and Uniform Transmittal Document effective Jan. 1, 2021

   a. The first suggestion discussed was to change the term “implementation date” to “effective date” on the filing and disposition letter, which is part of the transmittal document. For the paper filings, this would affect the transmittal document; and if the change is agreed upon, it would affect the System for Electronic Rate and Form Filing (SERFF), and changes would be made in SERFF as well. Reasons for this suggestion were discussed.

      Ms. Motter noted that a possible solution is to change the label to “effective/implementation date” with state instructions upon request to indicate how the state is viewing the date. Quick Text for the disposition could also be utilized to indicate what the date means. Ms. Jones noted that she believes using “effective date” is a better idea than using “effective/implementation date” because it stays consistent with the property and casualty line. She asked what would happen to filings that have the old implementation date if this change is made. Ms. Motter noted that it would not change the data previously stored. Ms. Taylor agreed with changing the wording as suggested, as did Superintendent Toal.

      Mr. Thomas made a motion, seconded by Ms. Lee, to change the term from “implementation date” to “effective date” on the Uniform Transmittal Document within the SERFF system general information area and on the disposition letter. The motion passed unanimously.

   b. The next suggestion discussed was to create an additional sub-type of insurance (TOI) for expatriate plans within the H15 TOI. Expatriate plans are exempt for the federal Affordable Care Act (ACA), and the recommendation is that they have a separate sub-TOI for identification and ease of locating. The recommendation is that the code be similar to the one created for short-term limited-duration (STLD) plans.

      Ms. Motter noted that something to consider is whether a TOI would need to be created for H15G, which is for health group, and H15I, which is for health individual. Ms. Jones noted that Washington’s actuarial staff has stated that expatriate coverage is only applicable to groups, and it supports adding a TOI for H15G. Ms. Motter noted that this would add H15G.005 for expatriate plans if this change is implemented. Mr. Thomas noted that Alaska’s analysis indicates that it would need this for individual sub-TOIs. Ms. Motter noted that this could be accommodated in a similar manner as stated previously. Ms. Jones noted that Alaska has filings coming in for expatriate plans, so it would use these suggested sub-TOIs.

      Mr. Thomas made a motion, seconded by Superintendent Toal, to add a sub-TOI for expatriate plans under H15G and H15I. The description would be expatriate plans that are not required to comply with all state or federal mandates for health benefits. The motion passed unanimously.

   c. The next suggestion was to either create a new TOI of A09I for Individual Annuities Registered Index-Linked with three sub-TOIs of A09I.001 for Interim Value based on fair value, A09I.002 for Interim Value based on proxy value, and A09I.003 for Interim Value based on other approach, or to create a new sub-TOI of A07I.004 for Registered Index-Linked. The reason for this suggestion was discussed.
Ms. Motter noted that things to consider are whether this would be applicable to group and individual, and whether an alternate solution could be the addition of one or two new TOIs of A07I and/or A07G and using filing labels for additional product granularity since state insurance regulators can search on filing labels. Ms. Jones noted that she prefers the alternate suggestion of adding a sub-TOI, but she stated that Washington would not be using these new TOIs. Superintendent Toal noted that New Mexico has not received these types of filings. Ms. Taylor noted that Colorado does not require any Life annuity rate or form filings, so it would not use these codes. Ms. Bartuska noted that North Dakota would also not use these new TOIs.

Ms. Nguyen made a motion, seconded by Ms. Bennett, to table this recommendation for future discussion and use other tools if needed for identifying these types of filings due. The motion passed unanimously.

d. The next suggestion discussed was to include a sub-TOI for “Group Medicare Part D Supplement” under H17G, Group Health – Prescription Drug. This would be used for plans sold to retiree groups to supplement the benefits provided by Medicare Part D. The reason for this suggestion is that Medicare Part D supplemental filings are not received often, but they have unique characteristics and requirements. It would be helpful to be able to identify these filings separately from other filings.

Ms. Taylor and Ms. Jones noted that it would be helpful to have a sub-TOI for this. Ms. Lee noted that Washington prefers having a separate TOI and sub-TOI under H17G for non-Medicare Part D supplemental or any other prescription. Ms. Motter asked if the filing labels would be a solution since most states are not in need of this change. Ms. Jones confirmed that they could use the labels. Ms. Taylor noted that she believes the filing labels would work for them as well. Ms. Nguyen noted that Oklahoma uses the filing labels a lot and finds them very helpful.

Ms. Nguyen made a motion, seconded by Ms. Bennett, to not create a new sub-TOI under H17G, but rather utilize the filing labels capability feature in SERFF in order to identify Group Medicare Part D Supplemental Filings. The motion passed unanimously.

e. The next suggestion was to include a new TOI and sub-TOI for “Group Retiree Health” to be used for plans designed to provide health insurance coverage to retirees of an employer. The reason for this suggestion was discussed. Ms. Lee noted that based on the current filing requirements for Washington, it is concerned that this change would confuse carriers, and it would prefer using filing labels for this.

Superintendent Toal made a motion, seconded by Ms. Bartuska, to not create a new TOI and sub-TOI, but rather utilize the filing label feature in SERFF to identify filing submissions for Group Retiree Health.

f. The next suggestion was to include a new TOI for combined dental and vision products with a sub-TOI for dental/vision with hearing benefits and a sub-TOI for dental/vision without hearing benefits. The reason for this suggestion was discussed. Ms. Lee noted that in Washington, these suggested TOIs could not be used due to its statutes for these coverages. The Working Group did not have an interest in making this suggested change.

Ms. Bennett made a motion, seconded by Superintendent Toal, to not create a new TOI for combined dental and vision products with sub-TOIs of dental/vision with and without hearing benefits, but rather continue utilizing the existing TOIs for these types of products, including filing labels and/or additional benefits fields where needed. The motion passed unanimously.

g. The next suggestion was to include a new TOI for “H# Multi-line – Other” to be used for forms with multiple products that are all health coverages. The reason for this suggestion was discussed. Ms. Motter asked if the TOI of H21 for Health Other could be used for these types of filings. Ms. Jones, Ms. Bartuska and Superintendent Toal thought that would be appropriate. Ms. Taylor noted that in Colorado, the carriers are required to complete separate filings for each type of product. The Working Group did not have an interest in making this suggested change.

Superintendent Toal made a motion, seconded by Ms. Taylor, to not make a change to the Product Coding Matrix (PCM) for a new TOI of “H# Multi-line – Other,” but rather recommend using H21 for Health Other for these types of filings. The motion passed unanimously.
Ms. Taylor noted that Colorado has seen carriers submitting 10 different types of products on an application; one included Life. She asked if any other states allow Life forms and rates to be included with other types of health coverages on the application. Superintendent Toal and Ms. Bartuska noted that New Mexico and North Dakota are not allowing that. Ms. Taylor confirmed that Colorado is making them take it off, as they are different products, and she wanted to confirm that other states were handling that in a similar manner.

h. The final suggestion discussed was adding sub-categories for reports in certain areas. The TOI with the most pressing concern is Long-Term Care (LTC). The suggestion also included a request for reports related to Medicare Supplements, Life Illustrations, Group Credit and Network Adequacy. The reason for this suggestion was discussed. Ms. Motter noted that many states are using a filing type of “Reports” for this item and filing labels for more granularity. Ms. Jones noted that using the filing type of “Reports” and connecting it to the sub-TOI the carrier deems fitting is appropriate. Ms. Taylor noted that Colorado uses annual certification on all of its reports. Colorado has created and uses state specific codes that specify each one of the LTC reports and Medicare Supplement reports. The Working Group did not have an interest in making this suggested change.

Ms. Taylor made motion, seconded by Ms. Anderson-Weddle, to not create additional sub-TOIs, but rather utilize filing types or state TOIs to assist in the acceptance of filing submissions for LTC, Medicare Supplements, Life Illustrations, Group Credit, and Network Adequacy. The motion passed unanimously.

Having no further business, the Speed to Market (EX) Working Group adjourned.
The Artificial Intelligence (EX) Working Group met via conference call June 30, 2020. The following Working Group members participated: Jon Godfread, Chair, Chris Aufenthie, Chrystal Bartuska and John Arnold (ND); Mark Afable, Vice Chair, Timothy Cornelius, Jody Ullman, Mark Prodoehl, Nathan Houdek, Barbara Belling, and Mary Kay Rodriguez (WI); Jerry Workman and Gina Hunt (AL); Erin Klug, Vanessa Darrah and Tom Zuppan (AZ); Lucy Jabourian and Pam O’Connell (CA); Michael Conway, Jason Lapham and Peg Brown (CO); Andrew N. Mais and George Bradner (CT); David Altmaier, Rebecca Smid, and Nicole Altieri Crockett (FL); Doug Ommen and Travis Grassel (IA); Bruce Sartain, Jeff Varga, CJ Metcalf and Vincent Tsang (IL); Amy Beard and Karl Knable (IN); Rich Piazza and Tom Travis (LA); Kathleen A. Brrane, Ron Coleman and Robert Baron (MD); Grace Arnold, Tammy Lohmann and Phil Vigliaturo (MN); Chlora Lindley-Myers and Cynthia Amann (MO); Kathy Shortt (NC); Christian Citarella (NH); Barbara D. Richardson (NV); Ron Kreiter (OK); Jessica K. Altman, Michael McKenney and Shannen Logue (PA); Alison May and Rachel Jade-Rice (TN); and Christina Rouleau (VT). Also participating were: Dean L. Cameron and Jo McGill (ID); Brenda Johnson and Tate Flott (KS); Robert Wake and Sandra Darby (ME); Troy Smith (MT); Randall Currier (NJ); Mark McLeod (NY); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer and Michael Wise (SC); Mike Boerner (TX); and David Hippen (WA).

1. **Adopted its June 3 Minutes**

The Working Group met June 3 and took the following action: 1) adopted its May 5 minutes; 2) continued reviewing the draft Principles on Artificial Intelligence (Principles); and 3) reviewed a proposed timeline for adoption of the AI Principles.

Commissioner Ommen made a motion, seconded by Commissioner Afable, to adopt the Working Group’s June 3 minutes (Attachment Three-C). The motion passed unanimously.

2. **Reviewed Draft AI Principles Version 5**

Commissioner Godfread reviewed the process for adopting the Principles once they have been adopted by the Working Group. He said the changes in Version 5 of the AI Principles, posted to the Working Group’s webpage since June 15, should reflect the discussion on the Working Group’s June 3 conference call. He reviewed those changes.

3. **Discussed Comments Related to Introductory Language, Legal Liability and Proxy Discrimination**

Commissioner Godfread said the APCIA recommended changes get us to a point where we are speaking consistently regarding what the Principles are intended to be; i.e., an internal, aspirational, guiding document for the NAIC. He said the language offered by the APCIA clarifies and adds weight to that purpose.

Ms. Jabourian asked why the word “aspire” is included. She said the entire document is aspirational. She said the word weakens the overall concept. Ms. Gleason said these are high level guiding principles, and that is why the word “aspire” was included. Ms. Jabourian said if the word was removed, it would not change that intent. Ms. Gleason said removing it would be agreeable if the rest of the language remains. Mr. McKenney said he would support removing the word “aspire” as well because the previous version recommends that AI actors “adhere” to the AI Principles, and changing that to the word “aspire” does seem to weaken the intent.
William D. Latza (Lemonade) asked if the word “aspire” is anywhere else in the Principles and whether anything else characterizes the Principles as aspirational if the word “aspire” is removed from the introductory language. Commissioner Godfread said he does not believe so but adding the word “aspire” does not change that this is aspirational; therefore, it is not necessary. Ms. Jabourian added that these are high level guiding principles, and they do not carry the weight of law or any legal liability. She said including the word “aspire” is simply not needed, and if included, it weakens the intent. Ms. Gleason asked if the minutes could reflect that the intent of the document is to be “aspirational.” Commissioner Godfread said yes, the minutes can reflect that point.

Binny Birnbaum (Center for Economic Justice—CEJ) said the CEJ submitted a comment that directly addresses this issue. He said the CEJ has some concerns with the APCIA language specific to so many references to compliance with legal requirements. He said it is the CEJ’s view that people do not need to be reminded that they must comply with the law. He said it is not an “aspirational” thing to comply with the law; this is an emerging area, and current legal requirements do not address everything. He said the CEJ suggested the addition of language that calls on AI actors to not simply seek to comply with legal requirements but to act according to the AI Principles in the absence of specific legal requirements and go beyond mere compliance when such actions would better meet the Principles. He said this gets to the aspirational part and drives home the point that the whole area of AI is uncharted ground for a lot of regulatory insurer actions. He said the CEJ has a real concern with the “level of regulatory oversight” language proposed by the APCIA, stating that the level of regulatory oversight will vary based on the risk and impact to the consumer. He said the Principles should be interpreted and applied in a manner that accommodates the nature and pace of change in the use of AI by the insurance industry and promotes innovation, while protecting the consumer from harm. He said this language introduces a lot of new terms that would be open to interpretation and could lead to stakeholders interpreting them to mean whatever they want, and the language does not really add anything useful.

Commissioner Mais said he agrees with deleting the word “aspire,” but regarding the “level of regulatory oversight” language, that just brings out the idea of proportionality that is fundamental to regulation. Commissioner Godfread said he agrees, noting that the entirety of this process is an attempt to get to balance in what is uncharted areas, while acknowledging and avoiding inherent risks. He said he believes this language does that and sets the right tone for other committees that will continue to have discussions about the level of regulatory oversight in the area of AI going forward.

Mr. Citarella said the word “will” in that sentence might be changed to “should” or “ought” to be more suggestive and not tie the hands of the state insurance regulator. Commissioner Mais suggested changing the word to “may.” Commissioner Afable and Commissioner Birrane agreed that it is a good change. Commissioner Ommen agreed that the document is intended to be guiding principles, and it does not have to be specific in all areas. He said he agrees with what is proposed.

Commissioner Godfread said the word “aspire” would be removed and the word “will” would be changed to “may” in the sentence about the level of regulatory oversight being based on the risk and impact to the consumer. Commissioner Richardson made a motion, seconded by Commissioner Altman, to adopt the APCIA language with the two suggested changes. The motion passed unanimously.

Commissioner Godfread asked the Working Group to turn its attention to the language under the Fair and Ethical section that says “AI actors should proactively engage in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and to avoid proxy discrimination against protected classes.” He said on a recent member call, this language was discussed and had overwhelming support. He said the risk of embedded bias in the use and creation of an algorithm is a recognized issue, and the members are committed to not allowing it. He said this has been front of mind since the creation of this Working Group, and this language is not only warranted but necessary at this point. He said a work product that does not address proxy discrimination would leave a gaping hole in terms of our intentions. He asked Mr. Aufenthie to talk about the North Dakota DOI’s suggested language. Mr. Aufenthie said a minor edit for clarification was offered. He said it was not the intent to make it confusing or equate the use of proxy variables with proxy discrimination, but quite the opposite. He said the feedback on the Version 5 language was that it could be interpreted to mean that proxy variables would never be allowed, but the proposed language is intended to say they would not be allowed to be used to unfairly or unlawfully discriminate against protected classes. He added that AI actors should proactively avoid AI systems that use variables or bad data that would make discrimination somehow legal, but at the same time, use of proxy variables would be allowed if there is a legitimate and acceptable business purpose.

Commissioner Ommen said he continues to have concerns about phrases such as “proxy variables” that are not well understood. He said discrimination in terms of education and employment is not unfair discrimination in the business of insurance. Commissioner Mais said he does think proxy discrimination has to be in the document, and disparate impact is a recognized
term. He said the proxy variable is a separate thing and having the two together does tend to unnecessarily confuse the issue. Commissioner Afable said he agrees that the North Dakota language helps clarify the points we are trying to make and gives direction to AI actors. He said it may not be perfect, but it is directionally correct. Ms. Lohmann said Minnesota would be in favor of the proxy discrimination language over the proxy variable, which seems directional, but the purpose of the proxy discrimination language is to capture the unintentional. Therefore, to Commissioner Ommen’s point, Ms. Lohmann said this is aspirational, and considering all things that might proxy a prohibited variable should be included. Commissioner Conway said the proxy discrimination language is needed. He asked whether it is necessary to call this out specifically in this document if there are truly legitimate business purposes in play that do not lead to proxy discrimination. He did say this is directionally headed in the right way. Commissioner Altman said the inclusion of the proxy discrimination language is critical in terms of thinking about this as an aspirational document and recognizing the risk.

J. Bruce Ferguson (American Council of Life Insurers—ACLI) said the ACLI believes that racial discrimination in any form, direct or indirect, is wrong; therefore, the ACLI would support the goal of the AI Principles and the Working Group’s desire to move forward with them. He said the ACLI would agree to including, at this point, a reference to proxy discrimination. He said the concept of proxy discrimination is somewhat new, and it was just introduced into the guiding Principles on June 3. He said that in looking at a number of comment letters, and as Commissioner Ommen pointed out, they all seem to differ somewhat regarding what is meant by the concept of proxy discrimination. He said that for the ACLI and within the life insurance context, it really means that AI should not be used to make underwriting decisions that would otherwise be prohibited by life insurance unfair trade practices laws as unfair discrimination. He said these guiding Principles are really intended to inform the work of other NAIC initiatives and for that matter individual state actions, so it is important to reach a common understanding among all the stakeholders as to what proxy discrimination means. He said he thinks this can be accomplished without delaying the progress made on the Principles.

Commissioner Godfread said he has reviewed many AI Principles documents, and this document is one of the most balanced in terms of recognizing that there will be some challenges as we move into utilizing this technology, but not having perfect definitions is expected, as this is an evolving space. He said this is a directional document for the NAIC, and there will need to be discussions regarding what is acceptable and what is unacceptable; that may need to happen at the different committees as these issues come forward. He said it is important to keep moving forward. Mr. Latza expressed support for Mr. Birnbaum’s concept regarding proxy discrimination, but the reason we are having the debate is because of failing to differentiate between these concepts. He said rather than wed the AI Principles to a particular legal construct, the Working Group should focus on the goal that insurance decisions should not be made solely on the basis of constitutionally protected classes, which is not to say there cannot be discrimination on an actuarial basis. He said if this principle is phrased in such a way so as to get away from the means and what we are trying to achieve, we can come up with something better.

Commissioner Ommen said the ACLI perspective is helpful. He said one must understand causation. He said one of the most emotional subjects is law enforcement, and data clearly supports the idea that there has been discrimination in a number of different ways that is clearly racially connected. He said you must be able to separate out what is flawed and what is good, actuarially supported data. He said it appears that a lot of the information being used is flawed because it unfairly selects based on race. He said he values this AI Principles document as a guidance, and the Working Group needs to have honest conversations about variables that are being used, but it cannot use unintentional disparate impact to conclude that something is wrong with the insurance model. He said using the term proxy discrimination may draw some people to conclude that we are talking about disparate impact, and he does not believe that we should.

Commissioner Conway said he is not so sure that it should just be accepted that societal problems and issues is a part of our insurance regulatory system. He said we need robust conversation about that, and he is not convinced that this should not be part of the discussion at this time. Commissioner Ommen said he agrees, and a lot of things are unequal and unjust; some of those factors are part of a rate making system. He said our eyes must be open as we discuss this because you cannot automatically conclude that the ratemaking process is improper. He said there are inequities that have been in our country for a long time that are being addressed and should be in the discussion. Commissioner Conway said the insurance industry should not be perpetuating those problems, and we should be discussing how to stop those activities. Commissioner Godfread said the current version of the Principles has language about absent negligence saying that if something is wrong, it simply needs to be corrected and does not call for punitive penalties. He said this is a balancing act.

Mr. Birnbaum said characterizing proxy discrimination as something vague and just a legal term is quite depressing. He said state insurance regulators have been looking for proxy discrimination forever, and when rating factors are filed that do not make sense, state insurance regulators have always looked to see if it is some kind of proxy for something else. He said the idea that the concept is untested or unknown is wrong, as it has been around as a legal concept in the fair housing act for over.
40 years and in insurance for decades. He said the language in the proposal is clear, and it does not need any embellishment by adding the term “proxy variables.” He said the high-level Principles are there to say insurers should be proactive because of the much greater risk of discrimination with AI algorithms. He said the language is sufficient, and discussion regarding proxy variables should be part of the model law development.

Ms. Gleason said this is an important conversation. She said the term “proxy discrimination” raises concerns, and she would recommend replacing it with “prohibited discrimination.” She said that would keep the conversation moving.

Andrew R. Pauley (National Association of Mutual Insurance Companies—NAMIC) said NAMIC cannot support the proxy discrimination language, as it is not defined in the document. He said it goes against the high-level aspirations of the document by including a very nuanced legal determination concerning these issues. He said NAMIC does not support unfair discrimination or any type of intentional discrimination; however, any attempt to remove rating factors that are actuarially justified and improve the predictive value of rating plans would be a move away from risk-based pricing, and NAMIC supports risk-based pricing. He said NAMIC has significant concerns, and it cannot be said that this is just an internal document, as the NAIC is a standard-setting body by its own definition, so when this document is created with this terminology without definition or understanding of what we are talking about, it is going to create confusion, litigation risk and new duties out in the public once it is released. He said the lack of a definition is not going to provide any guidance to future work streams, and it can do more harm than good. He said NAMIC applauds the work of the Working Group and understands the intention, but this has been a rushed process and forcing the issue in this manner is disconcerting to say the least. Commissioner Godfread said he takes exception to characterizing this as having been rushed. He said documents about the use of ethical algorithms or AI generally have a section denoting ethical and fairness, including proxy discrimination, and to somehow assume the term is not understood is not factual and he could not agree to that. He said there is a firm understanding of what it is, and it will be further developed as state insurance regulations are flushed out. He said many insurer chief executive officers (CEOs) have made statements over the last six weeks about doing better and being a part of the solution. He said on the NAIC member call, Director Farmer said we are going to take proactive steps to address some of these top of mind issues.

Richard L. Bates (State Farm) said he has read a lot of the documents that talk about proxy discrimination and disparate impact, and one of the articles says that for underwriting purposes, geography would be considered a proxy for race. He asked if that would carry over to the rating variable because geography is an acceptable rating factor. He said State Farm is opposed to unfair discrimination, but it is waiting to see the legislation that says geography cannot be used as a rating factor based on the idea that it would be considered a proxy for a prohibited characteristic.

4. **Adopted the AI Principles**


5. **Discussed its Timeline and Next Steps**

Commissioner Godfread said the adopted version of the Principles will be distributed, posted on the Working Group’s webpage, and forwarded to the Innovation and Technology (EX) Task Force for consideration. He said comments will be accepted until July 20 and discussed on the Task Force call on July 23. He said comments and changes could continue to be discussed with the possibility of adoption during the Task Force’s meeting the week of Aug. 3.

Having no further business, the Artificial Intelligence (EX) Working Group adjourned.

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American Property Casualty Insurance Association (APCIA)
Introductory Language Amendments

North Dakota Insurance Department, Artificial Intelligence (AI) Principles
Suggested Introductory Language
May 18, 2020

RECOMMENDS that insurance companies and all persons or entities facilitating the business of insurance that play an active role in the AI system lifecycle, including third parties such as rating and advisory organizations (hereafter referred to as “AI actors”) adhere to these fundamental principles: aspire to promote, consider, monitor, and uphold the following principles according to their respective roles; and:

THIS DOCUMENT is intended to establish consistent high-level guiding principles and best practices for AI actors. Although these principles are guidance and do not carry the weight of law or impose any legal liability. However, they should serve to inform and establish general expectations for AI actors and systems emphasizing the importance of accountability, compliance, transparency, and safe, secure and robust outputs. ensuring both are accountable, compliant, transparent, safe, secure and robust and produce outputs that are fair and ethical.

Further, THIS DOCUMENT

Should be used to assist regulators and NAIC committees addressing insurance-specific AI applications. The level of regulatory oversight will vary based on the risk and impact to the consumer. These principles should be interpreted and applied in a manner that accommodates the nature and pace of change in the use of AI by the insurance industry and promotes innovation, while protecting the consumer from harm.

RECOMMENDS that insurance companies and all persons or entities facilitating the business of insurance that play an active role in the AI system lifecycle, including third parties such as rating and advisory organizations (hereafter referred to as “AI actors”) adhere to these fundamental principles.

CALLS ON all AI actors to promote, consider, and monitor, the following principles for responsible stewardship of trustworthy AI, according to their respective roles.

UNDERLINES that the following principles are complementary and should be considered as a whole in totality.

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National Association of Insurance Commissioners (NAIC) Principles on Artificial Intelligence (AI)

RECOMMENDS that insurance companies and all persons or entities facilitating the business of insurance that play an active role in the AI system life cycle, including third parties such as rating and advisory organizations (hereafter referred to as “AI actors”) promote, consider, monitor and uphold the following principles according to their respective roles; and

THIS DOCUMENT is intended to establish consistent high-level guiding principles for AI actors. These principles are guidance and do not carry the weight of law or impose any legal liability. However, this guidance can serve to inform and establish general expectations for AI actors and systems emphasizing the importance of accountability, compliance, transparency, and safe, secure and robust outputs.

Further, THIS DOCUMENT

Should be used to assist regulators and NAIC committees addressing insurance-specific AI applications. The level of regulatory oversight may vary based on the risk and impact to the consumer. These principles should be interpreted and applied in a manner that accommodates the nature and pace of change in the use of AI by the insurance industry and promotes innovation, while protecting the consumer from harm.

Fair and Ethical

a. AI actors should respect the rule of law throughout the AI life cycle. This includes, but is not limited to, insurance laws and regulations, such as those relating to trade practices, unfair discrimination, access to insurance, underwriting, privacy, consumer protection and eligibility practices, ratemaking standards, advertising decisions, claims practices, and solvency.

b. AI actors should proactively engage in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and to avoid proxy discrimination against protected classes. AI systems should not be designed to harm or deceive people and should be implemented in a manner that avoids harmful or unintended consequences.

Accountable

a. AI actors should be accountable for ensuring that AI systems operate in compliance with these principles consistent with the actors’ roles, within the appropriate context and evolving technologies. Any AI system should be compliant with legal requirements governing its use of data and algorithms during its phase of the insurance life cycle. Data supporting the final outcome of an AI application should be retained and be able to be produced in accordance with applicable insurance laws and regulations in each jurisdiction. AI actors should be responsible for the creation, implementation and impacts of any AI system, even if the impacts are unintended. AI actors should implement mechanisms and safeguards consistent with the degree and nature of the risks posed by AI to ensure all applicable laws and regulations are followed, including ongoing (human or otherwise) monitoring and, when appropriate, human intervention. However, absent negligence in the creation, implementation or monitoring of an AI system, the remedy of an impact that violates existing regulation should be correction of said impact.
Compliant

a. AI actors must have the knowledge and resources in place to comply with all applicable insurance laws and regulations. AI actors must recognize that insurance is primarily regulated by the individual states and territories of the United States as well as by the federal government, and that AI systems must comply with the insurance laws and regulations within each individual jurisdiction. Compliance is required whether the violation is intentional or unintentional. Compliance with legal requirements is an ongoing process. Thus, any AI system that is deployed must be consistent with applicable laws and safeguards against outcomes that are either unfairly discriminatory or otherwise violate legal standards, including privacy and data security laws and regulations. Any decision by an AI actor that utilizes an AI system in its creation shall not be held in violation of existing regulation, if that same decision would have been rendered without the use of an AI system.

Transparent

a. For the purpose of improving the public’s confidence in AI, AI actors should commit to transparency and responsible disclosures regarding AI systems to relevant stakeholders, including consumers. AI actors must have the ability to protect confidentiality of proprietary algorithms and adherence to individual state law and regulations in all states where AI is deployed. These proactive disclosures include revealing the kind of data being used, the purpose of the data in the AI system and consequences for all stakeholders.

b. Consistent with applicable laws and regulations, stakeholders (which includes regulators and consumers) should have a way to inquire about, review and seek recourse for AI-driven insurance decisions. This information should be easy-to-understand and describe the factors that lead to the prediction, recommendation or decision. This information may be presented differently and should be appropriate for applicable stakeholders.

Secure, Safe and Robust

a. AI systems should be robust, secure and safe throughout the entire life cycle so that in conditions of normal or reasonably foreseeable use, or adverse conditions, they can function in compliance with applicable laws and regulations. To this end, AI actors should ensure a reasonable level of traceability in relation to datasets, processes and decisions made during the AI system life cycle. AI actors should enable analysis of the AI system’s outcomes, responses and other insurance-related inquiries, as appropriate in keeping with applicable industry best practices and legal requirements.

b. AI actors should, based on their roles, the situational context and their ability to act, apply a systematic risk management approach to each phase of the AI system life cycle on a continuous basis to address risks related to AI systems, including privacy, digital security and unfair discrimination as defined by applicable laws and regulations.
The Artificial Intelligence (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call June 3, 2020. The following Working Group members participated: Jon Godfread, Chair, Chris Aufenthie, Chrystal Bartuska, John Arnold and Mike Andreing (ND); Mark Afable, Vice Chair, Timothy Cornelius, Jody Ullman, Mark Prodoehl, Nathan Houdek, Barbara Belling, Renee Fabry and Mary Kay Rodriguez (WI); Tom Zuppan and Vanessa Darrah (AZ); Lucy Jabourian (CA); Peg Brown (CO); George Bradner (CT); Rebecca Smid and Nicole Allieri Crockett (FL); Doug Ommen and Travis Grassel (IA); Judy Mottar (IL); Jerry Ehlers (IN); Ron Coleman (MD); Phil Vigliaturo (MN); Cynthia Amann (MO); Kathy Shortt (NC); Christian Citarella and Emily Doherty (NH); Barbara D. Richardson (NV); Tynesia Dorsey (OH); Michael McKenzie and Shannen Logue (PA); Rachel Jade-Rice (TN); and Christina Rouleau (VT). Also participating were: Brenda Johnson and Tate Flott (KS); Troy Smith (MT); and Randall Currier (NJ).

1. Adopted its May 5 Minutes

The Working Group met May 5 and took the following action: 1) adopted its Feb. 19 minutes; 2) continued reviewing the draft Principles on Artificial Intelligence (Principles); and 3) reviewed a proposed timeline for adoption of the AI Principles.

Commissioner Richardson made a motion, seconded by Ms. Brown, to adopt the Working Group’s May 5 minutes (Attachment Three-C1). The motion passed unanimously.

2. Reviewed Draft Principles Version 4

Commissioner Godfread said the goal is to review the changes to version 4 of the Principles draft agreed to during the Working Group’s last meeting and go over a few other items. He said the document posted to the website represents the changes accepted by the Working Group based on the comments provided, but as noted in that document, there are a couple of outstanding questions and few things to discuss.

Commissioner Godfread said changes noted represent some clean-up done by North Dakota and Wisconsin staff working with Denise Matthews (NAIC). He said changes represent suggestions for cleaner or more correct language as suggested by the NAIC editors but do not represent substantive changes. He said they are intended to improve and make the language more consistent. He asked if anyone had any concerns about those changes. Hearing none, he said that paragraph (b) under the Accountable section seemed to more appropriately belong in the Transparent section, so that change was made as well. He asked if there are any corrections or concerns about version 4 of the draft artificial intelligence (AI) Principles as posted. Ms. Jabourian said “according to applicable law” under the Accountable section (a) is not needed, and “federal and state” is not needed under the Compliant section (a). She also said moving the paragraph to the Transparent section is appropriate.

Birny Birnbaum (Center for Economic Justice—CEJ) said one of the core consumer protection issues with AI is the increased potential for unfair discrimination caused by the use of data that reflect historical discrimination against protected classes or discrimination by proxy. He said simply avoiding intentional discrimination is not enough and suggested the principles are missing this key issue of responsibility for AI developers and users to identify and minimize proxy discrimination against protected classes. He suggested adding “to avoid proxy discrimination against protected classes” to the end of the first sentence in the Fair and Ethical section part (b) to address that concern.

Ms. Jabourian asked if it would be appropriate to add “including unfair discrimination” to the end of the last sentence in the Fair and Ethical section (b) to address Mr. Birnbaum’s concern. Mr. Birnbaum said the term “proxy discrimination” needs to be added because most in the industry think “unfair discrimination” means “intentional,” and in this case, if there is an intent to address unintentional discrimination, it needs to be specifically stated.

Commissioner Ommen said this is a complex and difficult issue, and he is concerned about using language that is not well understood or well developed in a guidance document. Mr. Birnbaum said Commissioner Ommen seems to be saying there is a legal system in place that does not identify proxy discrimination, and it is an undefined term. He said when he talks to regulators, they say they have the authority to take action if they find a factor that has a discriminatory effect. Therefore, it
seems to be well understood. Commissioner Ommen said he does not think it is a good idea to use terms that are not uniformly understood in a guidance document.

Mr. Currier said he agrees with Ms. Jabourian’s suggestion as a way to address Mr. Birnbaum’s concern. Peter Kochenburger (University of Connecticut School of Law) said he prefers to have the “proxy discrimination” language in as well and that there are other terms in the document that could have different meanings in different states. Mr. Kochenburger suggested some language used in a Vatican document related to AI. Commissioner Godfread said he would be interested in seeing that language.

Scott Kosnoff (Faegre Drinker Biddle & Reath LLP—Faegre Drinker) said he agrees that these words sometimes are not well understood. He said he used to think unfair discrimination was broad enough to include proxies but now is not sure it is. He said the Big Data (D) Working Group asked NAIC staff to come up with a definition for unfair discrimination and what is prohibited in terms of rate making. He said the definition was focused on whether there are equitable differences in expected losses and expenses. He noted that in addition to unfair discrimination prohibitions, a number of states prohibit certain classifications from being considered. He said proxies for prohibited factors does not fit in with what is often thought to be unfair discrimination. Mr. Birnbaum asked if there is agreement that discriminating based on race is not permitted, then why would an algorithm that has the same effect be permitted. He said the only way to prevent that in an era of big data is to take a proactive approach to determine what can be done to recognize and minimize this type of unfair discrimination by proxy. He said there are two types of unfair discrimination, one based on prohibited factors and the other based on lack of a sound actuarial correlation, and the two types bleed into each other. He said that is why it is so important to recognize it in this AI document. Mr. Birnbaum said the words “and to avoid proxy discrimination against protected classes” should be added at the end of the first sentence in the Fair and Ethical section, item (b). He said the key message is to “proactively engage,” and it should be considered as an AI model is being developed.

Angela Gleason (American Property and Casualty Insurance Association—APCIA) said that consistent with what Commissioner Ommen said, this is guidance and for NAIC committees as the look at AI applications. She said that is where these conversations should take place, and they are not appropriate for this document. Commissioner Godfread said the argument to include something of this nature is persuasive. He said as has been pointed out, if proxy discrimination were to be discovered, we would expect to stamp it out and do our best to remove it. He added that this is a big concern with AI and something that has come up on every conference call. He said he would be inclined to include that language as a signal to the other groups that the bias brought about by these types of proxies will need to be addressed. Commissioner Afable agreed and said he would like to have an opportunity to look at this to see if there is a better definition of proxy discrimination. He said it does not necessarily lead to disparate impact but is a practice upon which regulators have consistently taken action. Mr. Bradner agreed there needs to be a statement in the Principles that guides regulators and Working Groups as they develop guidance and standards related to AI. Ms. Jabourian and Ms. Logue agreed. Commissioner Godfread said that if there are no objections from the Working Group, Mr. Birnbaum’s language would be taken under advisement and added for now as this issue continues to be considered. He said as these are aspirational principles, one of the larger aspirations would be missing if something is not included on this. Commissioner Ommen said he fully supports the exploration of this matter but because discrimination is systemic historically, even if there is correlation to risk, it is very difficult to determine what to do about it in insurance. William D. Latza (Lemonade) said he agrees with Mr. Birnbaum and that AI should not be a mechanism to perpetuate these problems. He said actuaries have a good idea of what unfair discrimination is, and there are laws that are fairly clear. He said AI can be a way to resolve this type of discrimination as well, and he would be willing to help to eliminate the noise related to this type of discrimination and work to try to develop language to resolve this very important issue.

Richard Bates (State Farm) agreed with Commissioner Ommen and said this needs to be studied more. He said the industry needs to be part of this discussion. He said there is a lot of litigation risk and not a lot of clarity. Mr. Bates said there may be a more appropriate time to discuss it, given current events, when cooler heads can prevail, and it can be done from a broader perspective. Commissioner Godfread said right now, it is just a placeholder for future discussion.

Commissioner Godfread asked the Working Group if there was any additional discussion on removing the “applicable law” and “state and federal” language previously brought up by Ms. Jabourian. He said hearing no objections, those words would be removed from the next version of the Principles.

Mr. Kochenburger said in the second line of the Transparent section related to consumers having a way to inquire about, review or seek resource for AI-driven insurance decisions, the word should be “and” as opposed to “or.” Commissioner Godfread said he agrees, and that change will be made.
Commissioner Godfread commented on the Accountable and the Compliant sections related to potential inadvertent or unforeseen impacts of AI, particularly when it is without negligence. He said he would not like to see use of AI stifled, especially in areas where it can benefit consumers and insurers, by potentially being punitive regarding unintended consequences. He said to that end, he suggests adding language to basically thread the needle between heavy-handed regulation and doing what is right for the consumer. He said he would like to add “However, absent negligence in the creation, implementation or monitoring of an AI system, the remedy of an impact that violates existing regulation should be correction of said impact” in the Accountable section right after the sentence ending in “human intervention.” He said he would also like to recommend, in the Compliant section, that the last sentence be: “Any decision by an AI actor that utilizes an AI system in its creation shall not be held in violation of existing regulation, if that same decision would have been rendered without the use of an AI system.” Commissioner Afable agreed with the suggested changes. Commissioner Godfread said that if an AI actor is a habitual violator of what is agreed to be inappropriate, other actions would be taken related, but if everything has been done appropriately and yet something adverse comes of it, the thought would be to take corrective action as the remedy. Commissioner Godfread said hearing no comments objecting to this language, it will be included in the next draft.

3. Discussed Comments Related to Introductory Language

Commissioner Godfread said for the discussion on the introductory language, he would draw everyone’s attention to a new document provided with the notice of the meeting and posted on the NAIC website regarding suggested language from the North Dakota Department of Insurance (DOI). He said the APCIA also offered language in its previously posted comments. He asked Mr. Aufenthie to present the North Dakota proposed language. Mr. Aufenthie said the language is intended to clarify that the Principles are intended to be guideposts and high-level guidance and do not necessarily carry the weight of law. Ms. Gleason said the APCIA offered some suggestions previously but would be happy to work with Mr. Aufenthie to make this language a little more robust as this is an important point. She said the APCIA will identify the objectives, to ensure consistency across the NAIC committees and to be clear these are only guidance and do not carry the weight of law. Mr. Latza asked where this document will live and who is actually giving these guidelines. Commissioner Godfread said it is the intention to send this to the Executive (EX) Committee and then to Plenary for adoption. Ms. Matthews confirmed that would be the process and said this document would be within the purview of the Innovation and Technology (EX) Task Force and as innovation and technology projects are worked on by other NAIC committees, this would be something it would review as it starts working on other applications of AI. Mr. Birnbaum said the CEJ likes the North Dakota language and appreciates the APCIA’s comments about this pertaining to NAIC committees and that would be a positive contribution. However, he said the other APCIA comments seem to water down the Principles such that they do not have an affect, so the CEJ would be opposed to that language.

4. Discussed its Timeline and Next Steps

Commissioner Godfread said the Working Group has stated from the beginning that it would like to complete this work expeditiously. He said the goal is for the Principles to be adopted by the Working Group’s parent committee, the Innovation and Technology (EX) Task Force, at the NAIC Summer National Meeting, making it possible for the Principles to be adopted by the full membership by the Fall National Meeting. He reviewed a timeline that would make that possible, including:

- Posting version 5 of the Principles, based on this meeting, by June 15.
- Holding another conference call of the Working Group the week of June 29, with the intention of adopting the Principles.
- Posting the adopted version of the Principles by the end of that week.
- Providing an exposure and comment period.
- Task Force consider adoption of the Principles during the Summer National Meeting.

Having no further business, the Artificial Intelligence (EX) Working Group adjourned.
The Artificial Intelligence (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call May 5, 2020. The following Working Group members participated: Jon Godfread, Chair, Chris Aufenthie, Chrystal Bartuska and Colton Schulz (ND); Mark Afable, Vice Chair, Timothy Cornelius, Barbara Belling, and Mary Kay Rodriguez (WI); Vincent Gosz (AZ); Lucy Jabourian (CA); Peg Brown (CO); George Bradner (CT); David Altmaier (FL); Doug Ommen and Andrea Seip (IA); Judy Mottar (IL); Rich Piazza (LA); Ron Coleman (MD); Phil Vigliaturo and Tammy Lohmann (MN); Cynthia Amann (MO); Kathy Shortt and Tracy Biern (NC); Christian Citarella and Emily Doherty (NH); Barbara D. Richardson (NV); Mark Hamlin (OH); Ron Kreiter (OK); Rachel Jade-Rice, David Combs and Bill Huddleston (TN); and Christina Rouleau and Kevin Gaffney (VT). Also participating were: Mark McGill and Randall Currier (NJ); Matt Homer (NY); Daniel Morris (SC); Maggie Dell and Travis Jordan (SD); Nancy Clark (TX); and Tracy Klausmeier (UT).

1. Adopted its Feb. 19 Minutes

The Working Group met Feb. 19 and took the following action: 1) adopted its Feb. 4 minutes; 2) continued reviewing the draft Principles on Artificial Intelligence (Principles); and 3) reviewed a proposed timeline for adoption of the Principles.

Mr. Kreiter made a motion, seconded by Commissioner Ommen, to adopt the Working Group’s Feb. 19 minutes (Attachment Three-C2). The motion passed unanimously.

2. Reviewed Draft Principles Version 3 Comment Letters

Commissioner Godfread asked for general comments related to version 3 of the Principles draft. Hearing none, he said he wants to begin the discussion by going section by section, deferring the reviewing of comments related to the introductory section until later.

Commissioner Godfread said the American Property Casualty Insurance Association (APCIA) offered suggested language to replace or revise the term “risk-based” to eliminate any confusion related to how the term is used within a rating context. He asked if any of the trade associations on the call would like to speak to it, but hearing no comments from those representatives, he asked Mr. Aufenthie if he would like to comment. Mr. Aufenthie said the APCIA suggested replacing the term “risk-based” with “appropriate,” which seems in line with what the Working Group is looking for. It would read “appropriate use of artificial intelligence,” not to be confused with how it is used within the context of rating. Mr. Aufenthie said he agrees with this change. Commissioner Richardson said she prefers that language as well. Denise Matthews (NAIC) also pointed out another place in the Accountable section where the sentence was modified to replace the term “risk-based” with “…appropriate mechanisms and safeguards consistent with the degree and nature of the risks posed by AI…” Ms. Jabourian asked how the word “appropriate” would be defined within this context. Mr. Aufenthie said given that this document is intended to be high level, the assumption is that it would be defined more specifically later, but he said he is open to suggestions regarding alternatives. Ms. Jabourian said she just wants to understand this better. Commissioner Godfread said these principles are intended to be a guiding framework and not a law or regulation. Commissioner Richardson said it will be easier to know what is inappropriate than appropriate, and you will not know until you see it.

Mr. Currier said he is not sure the word “appropriate” is even needed. Commissioner Godfread said the Working Group could discuss that when it gets back to the section by section review. He directed the Working Group member’s attention to the Fair and Ethical section of the Principles. He said he is comfortable with the American Council of Life Insurers’ (ACLI’s) suggested revisions to this section. Commissioner Afable agreed that the ACLI language is acceptable.

Commissioner Godfread asked if anyone had any additional comments on the Fair and Ethical section. Hearing none, he asked Mr. Aufenthie to walk through the changes to the Accountable section. Mr. Aufenthie said a few of the comments that were suggested limited the Principles to “regulated entities.” He asked if the Working Group wants it limited to regulated entities or applied to a broader group like third parties and other artificial intelligence (AI) actors. Mr. Bradner said third parties may be selling AI products to insurance carriers and state insurance regulators, so those parties should be included. Ms. Jabourian and
Ms. Brown (CO) agreed. Commissioner Richardson said her regulatory authority is limited to the regulated entity; therefore, she might disagree. Commissioner Godfread said he agrees with that statement in a practical sense, but this would send a signal to the third-party entities that they were expected to follow these principles, and there may be some value in doing that. Commissioner Richardson agreed.

Andrew R. Pauley (National Association of Mutual Insurance Companies—NAMIC) said NAMIC still has two significant concerns with the Principles, the first being its applicability even if the result is unintended, as it is not considered to be the current state of the law. He would ask that the last part of that sentence be stricken or at least the language “according to law” be added so that it is very clear. He also said NAMIC objects to the “right to seek recourse” language, suggesting that it could be written in other ways, and the ACLI has proposed some alternative language.

Commissioner Godfread asked if the Working Group members have any comments related to Mr. Pauley’s comments. Mr. Bradner said he thinks the language needed to be there, but he does not object to adding “according to law.” He believes companies should not be able to hide behind a contention that they did not know something was happening. He said that can be the outcome if the company is not doing due diligence and testing to be sure they are understanding how the AI is working. Ms. Jabourian agreed with Mr. Bradner. Mr. Aufenthie said he is okay with the language “according to law,” but when talking about AI, he thinks the unintentional phrase still needs to be there. Commissioner Godfread agreed, and he said the comments were valid regarding unintended outcomes and the guidance is intended to apply to the “unintended” as well. Mr. Currier asked for clarification regarding the language “according to current law” and whether that is referring to the law as of the date of this document or in the future as the law evolves. Commissioner Godfread said his intention was the current laws of the times, so it is not frozen as of the date of this document. Mr. Currier said the addition of the last sentence by the APCIA that states, “[t]he information may be presented to the regulator and consumer differently” is concerning. Lisa Brown (APCIA) said changing the word “current” to “applicable” might make this more of a living document, the intent behind the language related to presenting information differently to a consumer is to acknowledge the level of specificity, and detail may need to be greater for a state insurance regulator than a consumer. Peter Kochenburger (University of Connecticut School of Law) said the language, as is, would be preferable even with the addition of “applicable law” and “unintended” only implies that there is a responsibility to get it corrected. He said it does not necessarily speak to whether it would be a cause of action or a violation of any law. He said there must be some recourse for a problem, but this document is not saying what that must or should be, so both are well phrased as they are.

Scott Kosnoff (Faegre Drinker Biddle & Reath LLP—Faegre Drinker) said he encouraged state insurance regulators to consider where they want the laws to evolve to as opposed to where it exists today and to let that guide future efforts and NAIC workstreams. Commissioner Godfread said that is the intention, and he asked the Working Group members’ preference regarding the use of the term “current” versus “applicable” regarding laws and regulations. Mr. Kosnoff and Mr. Kochenburger both agreed that “applicable” is preferred. Commissioner Godfread agreed, and he said the ability to seek recourse needs to be there; he said that while the Principles do not carry the weight of law, there has to be recourse available to consumers. Commissioner Afable agreed that the language related to seeking recourse should stay in the Principles for the reasons already stated.

Commissioner Godfread asked about the suggestion from the APCIA that there be a different presentation of information to consumers than to state insurance regulators. Ms. Brown (APCIA) indicated that different levels of disclosure may be necessary for consumers versus state insurance regulators, not to minimize anything that needs to be disclosed to a consumer but to recognize that a state insurance regulator may need much more information than a consumer. Ms. Jabourian said if the intention behind a different presentation of information to consumers is to make it easier for the consumer to understand, she could agree with that, but not if that is intended to signify that it would be limited in scope.

Commissioner Godfread asked the Working Group members if they wanted to include any kind of language related to acknowledging that something may go wrong even when good, strong, best practices are followed. Mr. Bradner said this would come down to a case by case situation and trying to craft language to soften that is not appropriate. He said each case will have to be reviewed on its own merits. Mr. Aufenthie said the APCIA’s suggested language does try to address that concern, but the point of reviewing each case on its own merits makes sense. Commissioner Godfread agreed that adding language may muddy the waters. Mr. Currier said it gets into creating legal defenses; therefore, it is probably not appropriate. Mr. Kosnoff agreed, but it does raise an important point, as there will be mistakes, but the intention is for the carrier to be responsible in terms of what they do with AI. Mr. Citarella said it goes beyond the scope of the document, and it does not need to be included. Ms. Brown (APCIA) and Commissioner Richardson agreed. Commissioner Godfread agreed, and he said that while there is an
understanding, there will be mistakes and those will have to be navigated to ensure that the response is not too harsh; this gets too far into the weeds for this document.

Mr. Aufenthie reviewed the comments received on the Transparent section related to disclosure and whether it needs to be narrowed down to be more specific and protect proprietary information. Commissioner Afable said the Working Group continues to discuss whether this document should be narrowed down, but given that it has also repeatedly been said it is intended to be a guideline, it seems that it should stay broad; therefore, he said he would not favor the suggested narrowing language. Mr. Bradner agreed with Commissioner Afable. Mr. Pauley said NAMIC suggested including materiality language, and he said adding the word “relevant” to “stakeholders” would be helpful if the intention is to provide guidance to future workstreams. William D. Latza (Lemonade) said the last sentence of the Transparent section related to “proactive disclosures,” including the kind of data being used, the purpose in the AI, and consequences for stakeholders combined with the ability for consumers to change the information, is very prescriptive language and it could be an invitation to consumers to “game” the system or be fraudulent. He suggested changing the word “proactive” and inserting a particular purpose regarding disclosures that enable consumers to modify risky behavior or to correct misinformation. Mr. Aufenthie said he views this as similar to what is done related to credit scoring where the consumer knows where to go to correct their data. Mr. Latza said he agrees with that, but giving consumers a roadmap to manipulate the data is a bad idea. Ms. Jabourian said the language should be kept as is because a consumer has a right to know if information is being used and where the data is coming from, such as social media. She said to the degree that it has an adverse impact, the consumer has a right to know. Mr. Kochenburger agreed with Ms. Jabourian. Mr. Currier said the ACLI’s suggested language related to non-proprietary is a little concerning and not helpful. Commissioner Godfread said it would be left as is for now.

The language suggested by Shannen Logue (PA) was discussed. Commissioner Godfread said the language was intended to keep this more future thinking and the use of the term “applicable” as opposed to “current” again should cover that well. He also said there was no objection to adding “as defined by law and regulation,” as suggested by the ACLI.

3. Discussed Timeline and Next Steps

Commissioner Godfread said the Working Group will create a redline version of these changes and provide an opportunity for review. He said there will be another conference call to review introductory language and the new redline draft and cover the other sections and comments.

Having no further business, the Artificial Intelligence (EX) Working Group adjourned.
The Artificial Intelligence (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call on Feb. 19, 2020. The following Working Group members participated: Jon Godfread, Chair (ND); Vanessa Darrah (AZ); Lucy Jabourian (CA); David Altmaier and Rebecca Smid (FL); Andria Seip and Travis Grassel (IA); Judy Mottar (IL); Amy Beard (IN); Michelle Johnson (LA); Ron Coleman (MD); Phil Vigliaturo (MN); Cynthia Amann (MO); Christian Citarella (NH); Barbara D. Richardson (NV); Mark Hamlin (OH); Ron Kreiter (OK); Shannon Logue and Michael McKenney (PA); David Combs and Allison May (TN); and Christina Rouleau (VT). Also participating were: Michelle Scaccia (MT); Chris Aufenthie (ND); Randall Currier (NJ); Olivia Bumgardner (NY); G. Lee Hill, Jr. (SC); and Rachel Hemphill and Nancy Clark (TX).

1. Adopted its Feb. 4 Minutes

Commissioner Godfread said the Working Group met Feb. 4 to review the comments received on the Working Group’s artificial intelligence (AI) principles draft exposed at the 2019 Fall National Meeting.

Commissioner Richardson made a motion, seconded by Commissioner Altmaier, to adopt the Working Group’s Feb. 4 minutes (Attachment Three-C3). Mr. McKenney said the minutes reflect that he has concerns about potentially excluding third parties such as rating and advisory organizations. He said he provided that comment regarding the first paragraph in the draft starting with “Recommends.” He said he was suggesting language to that effect be included after the “…that play an active role in the AI system lifecycle” to make clear they would be included in the definition of “AI actors.” Commissioner Richardson and Commissioner Altmaier accepted the change as a friendly amendment to their motion and second to adopt the minutes. The motion passed unanimously.

2. Heard Introductory Remarks

Commissioner Godfread reiterated that the purpose of this document is to be a very high-level working document essentially providing guideposts for the NAIC and other workstreams touching on this area. He said it is not intended to be interpreted as a model law or regulation but rather is a principles-based document that state insurance regulators can use as they look at how AI affects the many different areas of insurance.

3. Reviewed its Draft Principles

Commissioner Godfread started with comments related to the Compliant section of the draft. He said a change was suggested for the first sentence to read: “AI actors must have resources in place to ensure compliance with all applicable federal and state insurance laws and regulations.” Angela Gleason (American Property and Casualty Insurance Association—APCIA) said the APCIA offered that language because it would be very difficult for one person to have specific knowledge of all laws and regulations. Mr. Citarella said he offered a similar suggestion in his comments to ensure the responsibility would not fall on the modelers themselves. He agreed that the language proposed by the APCIA would cover his concern. Ms. Jabourian emphasized that there are modelers getting licensed as producers and insurers are then using those modelers, so it is important that the modelers, who are AI actors, have knowledge of insurance laws and regulations. Mr. McKenney agreed that everyone involved needs to know the insurance laws and regulations. He said “specific knowledge” maybe too strong, but they should have the knowledge. Commissioner Godfread said he thinks that is the intention of the offered language and said he would be comfortable with it saying they must have “the knowledge and the resources.” He asked if the Working Group was good with: “AI actors must have the knowledge and the resources in place to ensure compliance with all applicable federal and state insurance laws and regulations.” There were no objections to that language.

Commissioner Godfread said the only comment on the second sentence under the Compliant section was to add the words “as well” as a grammar clean-up. He said there were comments to remove the third sentence altogether. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI recommends removing it because it is redundant and unnecessary. Ms. Gleason said the APCIA agrees and if it remains, it would hold the AI actor to a higher burden and level of compliance than is found in any other insurance law or practice. Commissioner Godfread said this sentence intends to make clear that regardless of the intent, the reality is the buck will stop with the insurer if there is a bad outcome. Mr. Currier said that makes sense but what might be missing from the sentence is the subject. Commissioner Godfread asked if that was resolved by adding the word
“violation” so the sentence would read: “Compliance is required whether the violation is intentional or unintentional.” Ms. Jabourian and Mr. Vigliaturo agreed with leaving the sentence in and the suggested change. Commissioner Godfread said there will likely be more discussion on this, but the sentence, with the change, will be left in for now.

Commissioner Godfread said that the APCIA recommended deleting the fourth sentence. Ms. Gleason said the APCIA does not disagree with the intent of this sentence but it is represented in the Accountable section, so it would be redundant. Commissioner Godfread agreed with that assertion and deleting the sentence from this section. He said it was suggested the words “cultural, social, and” be removed from the fifth sentence consistent with other areas of the draft. J.P. Weiske (American InsureTech Council—AITC) said the AITC agrees with that recommendation. Mr. Currier said the words “agreed upon” are not necessary as well, and he said he likes the recommendation to include the words “including privacy and data security” to the end of the sentence. Commissioner Godfread noted there is a recommendation to include “risk-based” in front of the words “monitoring for compliance,” so that will be added as well. He said the sentence will read: “Compliance with state and federal laws is an ongoing process, thus any AI system that is deployed must show consistent risk-based monitoring for compliance with laws and safeguards against outcomes that are either unfairly discriminatory or violate legal standards, including privacy and data security.” Commissioner Richardson said many states have specific “public policy” language in their statutes and asked if the Working Group thinks those will be picked up with the “legal standards” language in this sentence. Commissioner Godfread said he thinks it would.

Commissioner Godfread read the first sentence in the Transparent section and then recommended language proposed by New Hampshire. Mr. Currier said he likes the New Hampshire language as well, suggesting there needs to be “AI” added in front of “Actors.” Mr. Vigliaturo said he likes the language as well but recommended adding the words “laws and” in front of “regulations.” Mr. Godfread said the new language would read: “For the purpose of improving the public’s confidence in AI, AI actors must be transparent about how they use these systems. AI Actors should commit to transparency and responsible disclosures regarding AI systems to relevant stakeholders, including consumers, while maintaining the ability to protect confidentiality of proprietary algorithms and adherence to individual state laws and regulations in all states where AI is deployed. Among these proactive disclosures include revealing the kind of data being used, the purpose of the data in the AI system and consequences for all stakeholders.”

Ms. Gleason said the APCIA still has concerns about the disclosure being overly robust even though the APCIA supports transparency. She said this is a lot for this stage of the development of the AI process. Ms. Jabourian said this is important language. She said the word “consumer” could possibly be replaced with “regulators,” but transparency is very important to the state insurance regulators. Mr. McKenny said the word “stakeholders” should remain because the issue is broader than just state insurance regulators. Commissioner Godfread acknowledged the APCIA’s position but said those details will be determined as this moves forward and if those words were removed, it would be effectively gutting this section.

Commissioner Godfread reviewed the language for the first sentence in the Secure, Safe and Robust section. He suggested the language submitted by the APCIA without the first phrase, so the sentence would read: “AI systems should be robust, secure and safe throughout the entire life cycle so that, in conditions of normal use or reasonably foreseeable use, the AI system can function in compliance with existing laws and regulations.” Ms. Hemphill said she is concerned with taking out the words “or other adverse conditions.” Ms. Gleason said the APCIA was just trying to clean up the language. Scott Kosnoff (Faegre Drinker Biddle & Reath LLP—Faegre Drinker) said this language is in the Organisation for Economic Cooperation and Development (OECD) AI Principles and is intended to provide protection from things like hackers compromising how the AI works. Commissioner Godfread said he is comfortable with removing those words because that type of activity should be “reasonably foreseeable,” so it is covered. Ms. Hemphill stated she still thinks “other adverse conditions” should be left in because they may not be “reasonably foreseeable.” Commissioner Godfread said he understands her concern and said the “or other adverse conditions” language will remain for the next draft.

Ms. Gleason said the APCIA recommends removing the second sentence in the section because traceability is more of a transparency concept and, therefore, is already covered. Ms. Jabourian said it should be left in because traceability is more technical than just transparency. She said it makes sure every step is captured so the process is known, not just the outcome. Ms. Gleason said there should be some clarity and specificity around the level of traceability required because this is a technically difficult concept and could require more than what is possible. Mr. Bayerle said the ACLI recommends deleting this sentence as it has concerns about this creating new regulations for AI that would not apply to other programs companies have in place. He also said a lack of clarity may also be a concern. Commissioner Godfread asked if it would help to add a modifier such as “reasonable level” before “traceability.” Ms. Logue said adding “reasonable” is a good idea and since this is a principles-based document, it is not intended to get into the details of how it will work. Mr. Vigliaturo agreed this is a good compromise. Ms. Jabourian agreed as well. Commissioner Godfread said that will be added, and the sentence for the next draft
will read: “To this end, AI actors should ensure a reasonable level of traceability in relation to datasets, processes, and decisions made during the AI system lifecycle.”

Commissioner Godfread read the APCIA’s recommended changes to the next sentence. Mr. Currier asked if it would make sense to replace “state of the art technologies, methods or processes” with “best practices.” Mr. Vigliaturo said a difference between “best practices” and “state of the art technologies” is currency, as “best practices” could have been from 20 years ago as opposed to “state of the art” being current. Commissioner Godfread said the intent is to keep these principles broad, so he said he leans more toward “current industry best practices and as required by law.” He said the sentence would read: “AI actors should enable analysis of the AI system’s outcomes and responses to insurance related inquiries as appropriate to the context, and in keeping with current industry best practices and as required by law.”

He said the last sentence in that section received a couple of comments. He said it was suggested that “unfair bias” be replaced with “unfair discrimination.” The Working Group agreed with that language for the next draft of the AI Principles.

4. Discussed its Timeline and Next Steps

Commissioner Godfread said the Working Group will create and send out another redline version of the draft document. He said the goal will be to discuss it at the Spring National Meeting. He said the next draft will be sent out and published by Feb. 28, with a deadline for comments by March 13. He said stakeholders would have an opportunity to make public comments at the Working Group’s meeting at the Spring National Meeting.

Denise Matthews (NAIC) and Mr. Aufenthie noted there are still some issues to get resolved from the first conference call and that it will be the goal to get those incorporated into the next draft to the extent possible.

Having no further business, the Artificial Intelligence (EX) Working Group adjourned.
The Artificial Intelligence (EX) Working Group of the Innovation and Technology (EX) Task Force met via conference call on Feb. 4, 2020. The following Working Group members participated: Jon Godfread, Chair (ND); Mark Afable, Vice Chair, represented by Lauren Van Buren (WI); Vincent Gosz (AZ); Lucy Jabourian (CA); Mark Murphy (CT); Rebecca Smid (FL); Doug Ommen, Andria Seip and Travis Grassel (IA); Judy Mottar (IL); Amy Beard and Jerry Ehlers (IN); Rich Piazza and Tom Travis (LA); Ron Coleman (MD); Phil Vigliaturo and Tammy Lohmann (MN); Cynthia Amann (MO); Christian Citarella (NH); Barbara D. Richardson (NV); Mark Hamlin (OH); Ron Kreiter (OK); Shannen Logue and Michael McKenney (PA); David Combs and Allison May (TN); Mike Peterson and Eric Lowe (VA); and Christina Rouleau (VT). Also participating were: Chris Aufenthie and Colton Schulz (ND); Mark McGill and Randall Currier (NJ); Olivia Bumgardner and Marshal Bozzo (NY); Maggie Dell and Travis Jordan (SD); Rachel Hemphill (TX); and Barbara Belling, Sue Ezalarab, and Mary Kay Rodriguez (WI).

1. **Heard Introductory Remarks**

Commissioner Godfread said the comments submitted are very helpful. He said the intention behind these principles is to provide guiding principles for the NAIC and state insurance regulators across the country to use as the Working Group starts to look at the use of artificial intelligence (AI) in the insurance industry. He said the comments are not intended to be a model law or regulation; they are essentially an internal document to be used as while looking at other working groups and workstreams where AI may be used. He said some of the comments attempt to get more detailed, and the Working Group has been resistant to do that because these are higher level principles or guideposts to be used by state insurance regulators and industry. He said not defining terms is, in some cases, intentional.

2. **Reviewed Artificial Intelligence (EX) Working Group Draft Principles Comment Letters**

Commissioner Godfread started with comments related to the Preamble. He said that not being too specific with definitions is intended to respect that AI is an evolving space in technology and guidance of this sort is meant to be a high-level review. He said he is hesitant to limit the scope to marketing, distribution, underwriting, ratemaking and claims settlement, as he would hope these principles could be used more broadly, remembering that they do not carry the weight of law. Commissioner Richardson asked if the task could be approached in a piecemeal fashion, as it is difficult to get one’s arms around it when it is so broad. She said that it might allow progress to be made a little at a time. Commissioner Godfread asked if it would help to add “any other insurance related usages.”

Angela Gleason (American Property and Casualty Insurance Association—APCIA) said it would be helpful to memorialize the intention behind these principles—possibly in the preamble—in order to limit and take this one piece at a time, as suggested by Commissioner Richardson. She said this is a big issue; and in order to ensure that these principles have value, there needs to be an understanding of who the players are and to whom the expectations are related.

Commissioner Godfread said both the APCIA and the American Council of Life Insurers (ACLI) have proposed language that the Working Group can consider to see if some direction can be provided that does not necessarily limit the scope of these definitions. He said he could go either way and was open to feedback regarding the term “AI actors” not being defined and the suggestion that it be limited to a specific list of stakeholders. He said the intention is to keep it broad but related to the business of insurance, so it may be good to define it for those that play a role in insurance. Mr. McKenney said he has concerns about potentially excluding third parties since they may not necessarily facilitate the business of insurance. Commissioner Godfread said he was comfortable leaving it broad to ensure that no one is left out that is participating and expected to consider these principles.

Commissioner Godfread said that under the “Under Calls On” section, it was suggested that “implement” be changed to “consider.” He said he was fine with that. He said Pennsylvania provided a comment to add the word “monitor” as well, so that it would say “consider and monitor.” He said he would be open to that. Hearing no objections, he said the change would be made.
Commissioner Godfread said that under the “Fair and Ethical” section, the intent was to narrow the language to regulation only with respect to insurance. He said adding the word “unfair” in front of “discrimination” and removing “promotion of fair” would be acceptable to him. Commissioner Richardson asked if the verb “should” be “must [obey the law]” as it is normally expected that laws must be obeyed. Commissioner Godfread said “should” was consistent with the principles not carrying the weight of law, but he acknowledged Commissioner Richardson’s point. Commissioner Ommen said he appreciated the opening comments regarding the language not carrying the weight of law, which suggests to him that this is an aspirational document in some ways. He said that while he understands Commissioner Richardson’s concern, if it is not a law, then “should” better reflects the intent. He said, regarding the list of things this section and part would pertain to, he felt that “truthfulness” is an important aspiration, and protection of consumer privacy should be included, such as the principles of informed consent. Commissioner Godfread agreed that it would be good to add something about consumer privacy, consumer truthfulness and protection. Mr. Currier agreed with changing “should” to “must” and agreed with adding consumer privacy and protection language. Ms. Jabourian agreed that consumer privacy and protection should be added as well.

Mr. Coleman asked why it was necessary to insert the word “unfair” before “discrimination.” Commissioner Godfread said the concern is that without that word the language could be interpreted as going broader than current law in terms of unfair discrimination. He said such language should tie back to laws already in place for insurance today, like the Unfair Trade Practices Act (#880), which helps to guide this document. Commissioner Ommen said the word “discrimination” can unfortunately carry a negative connotation, but that is what risk-based pricing is designed to do. He said that it would be unfair if companies did not give equitable treatment to consumers with similar risks, but without an accepted understanding of what “unfair” means, it is unclear and therefore open to interpretation.

Commissioner Godfread reviewed suggested changes to the “Fair and Ethical” section under Item b. He said it was suggested that the phrases “and society,” “enhancing creativity while,” and “cultural, social, and” be removed and the word “must” be changed to “should.” He said he is comfortable with all these narrowing changes because they keep in line with the authority of insurance commissioners. Mr. Vigliaturo suggested adding the words “for consumers” at the end of the paragraph to make it clearer. Commissioner Ommen said he supports the changes because even though this is an aspirational document, part of the issue is that even with laws regarding fairness, this is even more vague; and since there is a system of laws, there needs to be some tie to that or it is really hard to define. He said state insurance regulators are not ethicists, so this must be kept in mind. Mr. Travis said he agreed with changing “must” to “should.”

Commissioner Godfread said the “Accountable” section received the most comments. He said, in summary, there was a request to remove “principles” from the first sentence. He said based on the suggestions that the new sentence would read, “AI actors should be accountable for ensuring that AI systems operate in compliance with all state principles, consistent with the actors’ roles, the risk-based situational context, and evolving technologies.” Ms. Gleason said the APCIA put forward some of this language and explained that changing “best practices” to “technologies” makes it more definitive and easier for companies to understand. She said “risk-based,” like privacy, is intended to clarify taking a risk-based approach regarding AI systems. Mr. Citarella asked what was meant by “risk-based” because this would not be specific to ratemaking. She said the term “risk-based” in this context does not pertain to ratemaking, but it is more along the lines of a cost and risk versus benefit analysis.

Commissioner Godfread read the proposed second sentence. He said based on the suggestions, the new sentence would read, “Any AI system should be compliant with laws and regulation governing its use of data and algorithms during its phase of the insurance lifecycle.” He said he thought these were good changes. Mr. Vigliaturo said he had concerns with inserting “existing laws and regulations” because this is attempting something that is more along the lines of establishing guiding principles, and the existing regulations may not be quite up to the standards needed to cover behaviors in this area. For that reason, he said he would be against making that change. Commissioner Godfread said the goal is to highlight the laws that might need to be changed, but state insurance regulators do not have the ability to go beyond the existing laws that are in place. He suggested making a new third sentence stating, “Data supporting the final outcome of an AI application should be retained and be able to be produced to the extent similar information is required in non-AI systems in accordance with applicable insurance laws in each jurisdiction.” He said this would address data privacy concerns and establish the expectation that the industry be able to readily produce the data that they are using. Ms. Gleason said this was added for transparency and an accountability issue. Ms. Jabourian said she is not sure about this being the same as non-AI applications, as much of this is unknown; therefore, she is not comfortable with this sentence. She said leaving the matter with the laws and regulations in the jurisdiction would make her more comfortable. Ms. Gleason said the APCIA assumes that these principles are not intending to create a higher burden for AI. Commissioner Godfread said one can get to the same point without highlighting the differences in application insurance
laws within each jurisdiction and the document reads cleaner without it. Ms. Jabourian agreed that they must comply with the laws in each jurisdiction.

Commissioner Godfread moved on to the next sentence and, based on the comments, suggested changing it to read, “AI actors are responsible for the creation, and implementation and impacts of any AI system, even if certain impacts are not foreseeable.” He asked for comments and there were none. He then moved on to the next sentence. He said it was suggested that the words “risk-based” be inserted before “human” and that the words “or otherwise” be inserted after the word “human.” He said he thought these were good additions. Hearing no objection, he moved on to the next sentence. Based on the suggested changes, he suggested that the sentence be re-worded to read, “Consistent with current requirements, stakeholders should have a way to inquire about, review or seek recourse of the AI-driven insurance decisions.” Ms. Jabourian agreed that consumers and state insurance regulators should have the ability to get access to this information, so leaving this in is important.

Commissioner Godfread read the last sentence in the “Accountable” section, and he said that there were requests to remove it from the section. He said it would be his preference to leave it in. Brian Bayerle (ACLI) said requirements already exist regarding having the right to correctability; therefore it is redundant. Ms. Jabourian said the matter is important from a state insurance regulator’s perspective, and it is not redundant. She said it provides clarity and recommended that it not be removed. Mr. Vigliaturo agreed with Ms. Jabourian, as did Peter Kochenburger (University of Connecticut Law School), and he said the issue has come up in the past and should be left in. Mr. Currier noted that in the previous sentence New Hampshire and Louisiana suggested language defining “stakeholders” that is interesting and should be considered regarding the inclusion of consumers and potential policyholders. Commissioner Godfread asked if putting “which includes regulators and consumers” in parentheses following the word “stakeholders” would make that better. Mr. Currier agreed that it would.

3. **Discussed Timeline and Next Steps**

Commissioner Godfread said the Working Group will create a redline version of these changes and provide an opportunity to review it. He said there will be another conference call to review the new redline draft and cover the other sections.

Having no further business, the Artificial Intelligence (EX) Working Group adjourned.
Section 4(H) of NAIC Model Unfair Trade Practices Act

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

H. Rebates.

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

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

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

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

(c) Reducing the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or


(e)(1) The offer or provision by insurers or producers, by or through employees, affiliates or third party representatives, of value-added non-cash products or services at no or reduced costs when such products or services are not specified provided in the policy of insurance if the product or service:
   (a) Relates to the insurance coverage and
   (b) Is primarily intended to satisfy one or more of the following:
      (1) Provide loss mitigation or loss control;
      (2) Reduce claims costs or claim settlement costs;
      (3) Educate about risk of loss to persons or property;
      (4) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
      (5) Enhance health or financial wellness;
      (6) Provide post-loss services;
      (7) Incent behavioral changes that improve the health or reduce the risk of death of the insured; or
(8) Assists in the administration of underlying employee or retiree benefit policies or with compliance with a state of federal law or regulatory requirement.

(2) The insurer or producer making the offer must clarify that the product or service is not part of the insurance policy and must provide information regarding the assistance, if any, that the insurer will provide should the consumer have an issue with the product or service.

(2.3) The Commissioner may adopt regulations when implementing the permitted practices set forth in (2)(e)(1) this regulation, the Commissioner may adopt regulations for the purpose of ensuring consumer protection. Issues include: Such regulations may address, but are not limited to among others, consumer data protections and privacy, especially instances where third party vendors require policyholder data as a condition of receiving the value added product or service, consumer disclosure and unfair discrimination consistent with applicable law.

(3.4) If the product or service is not made available to all policyholders or applicants clients (defined as policyholders, potential policyholders, certificate holders, potential certificate holders, insureds, potential insureds or applicants), its availability must be based on written objective criteria and offered in a fair and nondiscriminatory manner that is fair and not unfairly discriminatory including, by example, offering the product or service based on risk characteristics of a client.

(5) If an insurer does not have such objective criteria sufficient evidence that the product or service is cost effective or has a material correlation to risk, but has a good-faith belief that the product or service meets the criteria in (H)(e)(1) may mitigate, assess or identify sources of risk of loss or claims, the insurer or producer may provide the product or service in a fair and not unfairly discriminatory manner as part of a pilot or testing program for a reasonable period of time upon approval of the Commissioner.

(4.6) The cost to the insurer or producer offering the product or service to any given policyholder client should be reasonable in comparison to the average that policyholder’s client’s premiums or the insurance coverage without the provided product or service.

(5) Gifts or offers of gifts in connection with marketing for the sale or retention of contracts of insurance is considered de minimus and not in violation of this statute as long as the cost does not exceed [two hundred and fifty dollars] per person per year; Drafting Note: States may wish to alter the financial limitations set forth in this section depending upon each state’s economic environment.

(f) Notwithstanding any other provision, an insurer or a producer may:

(1) Offer or give non-cash promotional or advertising items or meals to or charitable donations on behalf of to a personal lines policyholder or potential policyholder client, as long as the total fair market value actual cost of the non-cash promotion or advertising items and/or meals or charitable donations, for all named or additional insureds in the policy in total, does not exceed an amount set in regulation reasonably determined by the Commissioner per calendar policy year per person and no purchase or renewal of an insurance policy is either expressly or impliedly not required. The offer must be made in a fair and not unfairly discriminatory manner and may not be contingent on the purchase, continued purchase or renewal of a policy;

Drafting note – The committee would suggest that, at the time of the drafting of this model, the lesser of 5% of the current or projected policyholder premium or $250 would be an appropriate limit.

(2) Offer or give gifts or value added services to commercial or institutional insureds clients in connection with marketing for the sale or retention of contracts of insurance, as long as the cost is reasonable in light of the relationship between the parties premium or proposed premium and the cost of the gift or service is not included in any amounts charged to another person or entity; and/or

Drafting note – The committee would suggest that, at the time of the drafting of this model, the lesser of 5% of the current or projected policyholder premium or $250 would be an appropriate limit.
(3) conduct raffles or drawings to the extent permitted by state law, as long as there is no participation cost to entrants, the drawing or raffle does not expressly or impliedly obligate participants to purchase insurance and the prizes are not valued in excess of five hundred dollars a reasonable amount determined by the Commissioner and the drawing or raffle is open to the public. The raffle or drawing must be fair and not unfairly discriminatory and may not be contingent on the purchase, continued purchase or renewal of a policy.

Drafting Note: States may wish to alter the financial limitations set forth in this section depending upon each state’s economic environment.

(g) An insurer, producer or representative of either may not offer or provide insurance as an inducement to or interdependent with the purchase of another policy or give or offer to give “free” insurance or otherwise use the word “free” in any offer.

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

Drafting Note: Each state may wish to examine its rating laws to assure that they contain sufficient provision against rebating. If they do not, this section might be expanded to cover all lines of insurance.
Draft: 8/20/20

Innovation and Technology (EX) Task Force
Conference Call
July 23, 2020

The Innovation and Technology (EX) Task Force met via conference call July 23, 2020. The following Working Group members participated: Jon Godfread, Chair, and Chris Aufenthie (ND); Elizabeth Kelleher Dwyer, Vice Chair (RI); Lori K. Wing-Heier represented by Chris Murray and Anna Latham (AK); Jim L. Ridling represented by Gina Hunt (AL); Alan McClain and Letty Hardee (AR); Elizabeth Perri (AS); Evan G. Daniels and Erin Klug (AZ); Ricardo Lara represented by Lucy Jabourian (CA); Michael Conway (CO); Andrew N. Mais (CT); David Altmaier (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Dean L. Cameron (ID); Robert H. Muriel represented by Judy Mottar (IL); Stephen W. Robertson represented by Jerry Ehlers (IN); Vicki Schmidt represented by LeAnn Crow (KS); Sharon P. Clark (KY); James J. Donelon and Tom Travis (LA); Gary Anderson (MA); Kathleen A. Birrane (MD); Anita G. Fox represented by Chad Arnold (MI); Steve Kelly, Grace Arnold and Tammy Lohmann (MN); Chlora Lindley-Myers represented by Cynthia Amann (MO); Mike Causey represented by Tracy Bieln and Kathy Shortt (NC); Bruce R. Ramge (NE); Chris Nicolopoulos represented by Christie Rice (NH); Barbara D. Richardson (NV); Jillian Froment represented by Rich Campbell (OH); Andrew R. Stolfi (OR); Jessica K. Altman and Michael Humphreys (PA); Raymond G. Farmer (SC); Larry D. Deiter (SD); Hodgen Mainda represented by Rachel Jade-Rice (TN); Kent Sullivan represented by Doug Slape and Michael Nored (TX); Scott A. White represented by Trish Todd (VA); Michael S. Pieciak represented by Emily Brown (VT); Mike Kreidler represented by John Haworth and Michael Bryant (WA); Mark Afable represented by Nathan Houdek (WI); and James A. Dodrill represented by Joylynn Fix (WV). Also participating: Joana Lucasukh (NY).

1. Discussed AI Principles as Adopted by the Artificial Intelligence (EX) Working Group

Commissioner Godfread said NAIC members made the decision to form the Artificial Intelligence (EX) Working Group during last year’s Mid-Year meeting. He said members heard a presentation and spent time discussing artificial intelligence (AI), how it is being driven by the availability of vast amounts of data and ever expanding computing power, and how important it would be to expediently develop guidance in this area for the insurance industry. He said that was the genesis of the Artificial Intelligence (EX) Working Group last June 2019. He reviewed the charge to the Working Group established by the Innovation and Technology (EX) Task Force during its meeting at the NAIC 2019 Summer National Meeting in New York, NY. He said the Working Group has been able to stay on track, holding its first meeting on Sept. 5, 2019, hearing an overview on AI, and covering AI principles generally and the Organisation for Economic Co-operation and Development’s (OECD’s) AI principles, which have been adopted by 42 countries, including the U.S. He said he and Commissioner Afable discussed how to approach developing principles for the insurance industry and using the OECD Principles as a basis for developing AI principles for the insurance industry with the Working Group members who agreed that it is an appropriate approach. He said an AI Principles (Principles) draft was first exposed for comment in January 2020 and the Working Group held calls on Feb. 4 and Feb. 19. Then, after a delay due to the COVID-19 pandemic, the Working Group got back to work holding calls on May 5 and June 3. Commissioner Godfread said the Working Group recently met on June 30 where the work was finalized, and the Principles were adopted and again exposed for comment. He said the Principles before the Task Force represent AI “FACTS” for the insurance industry, establishing expectations around its development and use of AI including sections titled, Fair and Ethical, Accountable, Compliant, Transparent and Secure/Safe/Robust. He said these are the key tenets of the Principles.

Commissioner Godfread highlighted a couple of key points related to the Principles. First, he said the industry has been adamant about being clear that these Principles represent “guideposts” and do not carry the weight of law; to that end, specific introductory language was added. He said there have also been sensitivities related to anything that might create new burdens related to adverse consumer impact, given that AI and everything associated with it in terms of big data and algorithms is fairly nascent, and there may be inadvertent or unintentional missteps as we all explore the vast potential of AI and benefits it can bring consumers and the industry, even as we consider and work to mitigate potential risk of harm. He said the Working Group’s proposed Principles have “threaded that needle” in a way that can work for everyone.

Secondly, Commissioner Godfread said most have heard a lot about “proxy discrimination” lately, and the potential AI has to use proxies to perpetuate unfair discrimination or fail to identify and eradicate embedded bias against protected classes. The Working Group was sensitive to that issue, and there has been a lot of discussion around this, not only at the Working Group level but with the full membership on more than one occasion.
Commissioner Godfread opened it up to discussion by the Task Force members. Commissioner Mais presented points from his comment letter. He said the comments were straightforward, and he reviewed them, including the inclusion of data providers in the first paragraph. He said he would also suggest adding the word “fair” in the introductory paragraph beginning with “This Document,” prior to “safe, secure and robust outputs.” He said he also suggests deleting the word “or” between the words “harmful” and “unintended” in the Fair and Ethical section and adding “and corrects and compensates for such consequences when they occur.” He said there will be failures, and this spells out the consequences which is to “correct and compensate.” He said in the next two sections, he will discuss the last sentences as one. He said he has a concern regarding the last sentences in the Accountable and Compliant sections. He said this should be a guiding document, not a regulatory guidance document, and those two sentences represent regulatory guidance. Therefore, he said this is not the place for that, and it could be interpreted as tying the hands of state insurance regulators. He said there needs to be fairness, openness and trust, and he does not think this document should be telling state insurance regulators what they should and should not be doing. Lastly, he said specifically mentioning “consumers” in the Transparent section is concerning because by only mentioning consumers, it might make others think they were not meant to be included, and it would leave out relevant stakeholders.

Commissioner Godfread said he has no concerns with the preamble changes and adding the word “fair” as suggested. He said in regard to the language in the Fair and Ethical section stating, “and corrects and compensates for such consequences when they occur,” that is covered in Part A of the Accountable section, and that shows some balance in terms of what we are trying to do. He said there may be a difference of opinion in terms of how this gets accomplished. He said he does not believe the language ties the hands of state insurance regulators because this is a guiding document. He said the last sentence in both the Accountable and Compliant sections give a nod to the creation of or discussion around a safe harbor and the good actors in this space saying that if you do everything right and follow proper procedures, there will be some regulatory flexibility within the regulatory community. He said it the language recognizes that mistakes are going to happen with new technology, especially of this caliber, and there will be unexpected outcomes even with the best intentions. He said the last sentence in the Accountable section covers that, and it allows for a remedy that makes the consumer whole again.

Ms. Jabourian said California agrees with Commissioner Godfread’s comments, but it does have concerns with the proposed language under Subsection b of the Fair and Ethical section. She said there is no need to add that because it is covered under the Accountable section.

Commissioner Godfread asked if any member of the Task Force wished to offer the Connecticut proposed language as an amendment to the Principles. Commissioner Anderson asked if it would be appropriate to take this and comments just recently received under consideration and discuss them during the next meeting of the Task Force. Commissioner Godfread said another exposure draft could be put together and discussed during the next meeting. He asked the Task Force members what might be included in that next draft. Commissioner Anderson said it would be easier to gather the feedback and determine how they might be woven into the document. He said it is difficult to determine the impact of these comments, having not had time to give them more thought. Commissioner Birrane agreed, and she said it would be good to hear the reasoning, but she is not ready to vote on a motion at this point. Mr. Nored agreed that it would be helpful to see another exposure draft on this. Commissioner Godfread said that could be done. Commissioner Conway suggested that the Task Force push hard to vote during the next meeting; endless amounts of time could be spent tweaking and reworking the language and it would still not be perfect, so it is important to recognize the work already done, and it is time to take that next step. Commissioner Godfread said that is the goal, as it does not appear the members are ready to vote on it today. Commissioner Anderson said the delay is not to take away from the good work already done, but just to try to take into consideration the comment letters before taking a vote. Commissioner Oommen said he agrees with thinking this through, and he supports some of Commissioner Mais’ suggestions. He said he wants to propose that the Task Force consider the North Dakota language raised at the Working Group level having to do with proxy discrimination that recognizes avoiding proxy discrimination does not preclude the use of proxy variables for legitimate and acceptable business purposes. Commissioner Oommen provided the example of the correlation between hypertension and race, and he attributes it to various correlations between diet, nutrition and smoking, and to some extent geography and other factors. He said the relationship between hypertension and mortality is based on science, and he expects that there is also a correlation between race and premium as a result of this, but the premium is not the causation of the disparity. He said he thinks the North Dakota language recognizes that there are inequities that need to be carefully looked at and examined, but at the same time the science and the cause need to be addressed without turning the premium rate into a causation. He said he would support the North Dakota language because it ably explains this and captures one of the challenges state insurance regulators will face when dealing with these disparities in society.
Commissioner Godfread said this will be offered as possible language in the next draft of the Principles. He said he would open the discussion to interested parties. Paul S. Graham (American Council of Life Insurers—ACLI) said the ACLI supports the Principles as adopted by the Artificial Intelligence (EX) Working Group. He talked about how life insurers use AI and how important it is today in the marketplace. He said the ACLI supports the wording at the end of the Accountable section, as having a safe harbor is important for new and innovative ideas to come into play. He said the ACLI supports including a reference to proxy discrimination, and it looks forward to working with stakeholders regarding the concept of proxy discrimination in the insurance context, what it means exactly, and how processes and oversight can be put into place to prevent AI from doing what would otherwise not be allowed by regulation or law. He said the ACLI supports the adoption of the Principles as written, and it supports the amendment offered by the North Dakota Department of Insurance (DOI) as being very helpful in framing the concept of proxy discrimination in the insurance context.

Bob Ridgeway (America’s Health Insurance Plans—AHIP) said AHIP believes it would be better and easier to define if the focus on proxy discrimination was narrowed by changing the word “unfair” to “unlawful.” He also said AHIP suggests that in some cases, AI might result in unintentional proxy discrimination, and it would be helpful to include the word “unlawful” again before the words “proxy discrimination” making it easier to regulate.

Angela Gleason (American Property Casualty Insurance Association—APCIA) offered a few additional considerations, saying the APCIA is fully committed to the strict enforcement of discrimination laws and practices, and it understands that the goal is to stress the importance of processes and procedures being in place to proactively engage in responsible stewardship of AI. She said as you look at proxy discrimination, it is important to balance that with ensuring that regulatory objectives, such as consumer protections, are adhered to as well as sound insurance principles grounded in financial solvency. She said the APCIA suggests that terms such as “beneficial outcomes” and “harmful” are subjective and can be removed without changing the intent. She said the APCIA suggests some additional introductory language to provide more clarity, stating that the Principles are not intended to expand current law or create additional laws and last. She said the APCIA suggests the addition of the words “willful and wonton” in front of “negligence,” protecting employees working on these issues.

Commissioner Godfread asked if the anyone from the Consumer Data Industry Association (CDIA) wished to present their comments. Hearing none, Andrew R. Pauley (National Association of Mutual Insurance Companies—NAMIC) said NAMIC provided written comments. He said NAMIC respects the NAIC’s response to race discrimination in insurance, and it adamantly opposes discrimination in general, but it is strongly supportive of risk-based pricing in insurance. He asked that if the term proxy discrimination remains in the Principles that it be paired with some statement supporting risk-based pricing as a general concept. He said NAMIC believes that the North Dakota language is very important in term of approaching an understanding of the concerns listed, and it concurs with the comments made by Commissioner Ommen. He said not much time has been spent discussing the positive aspects of AI in terms of transforming the consumer experience in many positive ways, and he hopes there are not any unintended consequences from the Principles that would have a negative impact on that.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CEJ supports the Connecticut proposals. He said proxy discrimination is clear and appropriate for these principles, and the CEJ opposes the proposed North Dakota language, as it introduces an unrelated concept—proxy variables—that confuses the basic principle. He said he also takes issue with Commissioner Ommen’s suggestion that it is at odds with cost-based pricing, saying that it improves cost-based pricing, and the CEJ provided an example of that in its comments. He said minimizing proxy discrimination does not mean you cannot use a particular variable as you can to the extent that variable is or those variables are, predictive of the outcome but not to the extent they are correlated with a particular class. He said the role of proxy discrimination versus cost-based pricing is also not addressed by the North Dakota language. He said the CEJ opposes using the word “unlawful” versus “unfair” because current law does not envision any action or prohibition against proxy discrimination, and that is what the CEJ wants to see enshrined in these principles. He said the CEJ supports the Connecticut proposals, particularly regarding supposed “safe harbors” in the Accountable and Transparent sections.

b. Discussed Next Steps for the Adoption of the AI Principles

Commissioner Godfread said the next steps are to provide a summary document to the Task Force members with options that may lead to some amendments to the Principles to be discussed during the next Task Force meeting.
2. **Discussed Anti-Rebating Draft Model Law Amendments**

   a. **Discussed Comments Related to the Anti-Rebating Draft Model Law Amendments**

Superintendent Dwyer provided background on the rebating issue. She said most states have language consistent with the *Unfair Trade Practices Act (8880)*, but there is inconsistent application. To clarify that, many bulletins have been issued to explain the intent, creating angst as to what can and cannot be done. Superintendent Dwyer said this has gone on for a long time, so there was a desire to get to some language that allows the consumer benefits to be offered. She said a drafting group was formed to get pen to paper, including eight state insurance regulators, five trade associations, one insurtech startup, one industry representative, a consumer representative, and representation by the National Council of Insurance Legislators (NCOIL). She said the work began on Jan. 27 working with a chair’s draft, followed by several conference calls to discuss and revise the draft. She said the drafting group disbanded after its June 3 meeting after creating five drafts and putting the last one out for comment (Attachment Five-A). She said 23 comment letters were received; all were and will continue to be considered, and she reviewed some common themes including:

- **H. 2. (e)(1):** Some commenters wanted expanded and some wanted more restrictive language, as well as comments requesting additional language to avoid unfair discrimination.
- **H. 2. (e)(2):** There were comments indicating confusion as to what the language meant and requests to change it to allow the commissioner to create regulations.
- **H. 2. (e)(3):** Comments requesting more clarity and specificity as to what a pilot and test program would be and limiting the duration to one year.
- **H. 2. (e)(4):** Comments saying the language is a bit vague and requests to change to be more specific.
- **H. 2. (e)(5):** There were a number of comments saying that (e)(5) and (f)(1) are talking about the same thing and yet are in two different sections; therefore, recommendations to move it to (f)(1). Comments about what the amount should be or be set by the commissioner, and yet, in another part it stipulates it as [two hundred and fifty dollars], and some suggested that it should be $500. Again, some comments suggested that the language should be expanded to allow more and others saying it should be more restrictive.
- **H. 2. (f)(2):** There was a suggestion to add the word “group” in addition to what is there. Superintendent Dwyer noted that the use of that term might bring up issues regarding rebating issues related to commercial insureds in the lender-placed area, and that may be of concern. She said the commenters suggesting that might want to look at that again to see how it could be considered while not creating a situation in which commercial is preferred and people paying the premium are adversely affected.
- **H. 2. (f)(3):** There were comments that the “five hundred dollars” should be bracketed, and some mention that language in the section is vague.

Superintendent Dwyer then opened it up for comment from the Task Force members. Mr. Murray said Alaska just wants to show support for the draft. Commissioner Mais said Connecticut provided a technical edit. Regarding the specified amounts being set in regulation, he said in some states it is a difficult and time consuming process to change, and it does not offer the flexibility needed, so the suggestion is to add “or otherwise reasonably determined by the commissioner.” Superintendent Dwyer asked if putting those amounts in brackets would help. Commissioner Mais said he would prefer to not be locked into a number because it can stay locked in for many years and get woefully out of date. He said he preferred something to the effect of “reasonably determined by the commissioner.”

Ms. Lucashuk said she had no additional comments to offer beyond what was provided in writing. Mr. Humphreys said he did not have much to add to Pennsylvania’s comment letter either, but he said the specificity was appreciated and he would suggest deleting some of it and providing more of a general approach to rebates not tied to the risk and not having a predetermined amount dictated to the states, allowing them to determine what may be appropriate in their markets. He said it is important to note that in COVID-19 filings they received, carriers were making the COVID-19 benefits contingent on continued purchase or renewals, so it is important to clarify that.

Mr. Bryant said Washington made 13 comments in its letter that covered three areas that are: 1) providing a more direct link with the type of value added benefit of the underlying coverages; 2) suggesting changing terms like “mental state” and “good faith belief” to a more empirical standard; and 3) committing to giving the commissioner regulatory authority over consumer protection issues that arise from this.
Director Ramge said he supports the model, as it strikes a good balance, and he suggested that the drafting note include brief but appropriate comments to remind that there are provisions within the Real Estate Settlement Procedures Act (RESPA) and the Federal Crop Insurance Corporation (FCIC) that might affect the ability to provide rebates. Superintendent Dwyer asked Director Ramge if he could provide language to address that issue, and he said yes.

Ms. Lohmann said the only thing Minnesota would comment on not already mentioned is the concern regarding third parties, regarding whether anyone has any liability or obligation there since they are not licensed and therefore the commissioner would not be giving approval for these services, and most carriers say they have no liability for them. She said there may need to be something addressing that issue in the model. Superintendent Dwyer asked if Minnesota could provide language to that effect, and Ms. Lohmann said yes.

Mr. Ridgeway said the summary of issues provided earlier in the meeting did not mention some of AHIP’s comments. Superintendent Dwyer clarified that it was just a general summary, but all letters and comments will be considered.

b. Discussed Next Steps for Completing the Development of Amended Model Law Language

Superintendent Dwyer said the intention is to go through the comment letters carefully and come up with summaries and possibly another draft for discussion during the Task Force meeting on Aug. 7.

3. Discussed its Timeline and Next Steps

Commissioner Godfread said the plan is to create summaries for the comments and continue the discussion during the Task Force meeting on Aug. 7.

Ms. Jabourian said she would like to go on record as stating that California does not agree with changing the word “unfair” to “unlawful” in the Principles.

Commissioner Anderson asked for clarification regarding the timeline for completing the Principles. Commissioner Godfread said they were to be created by the Summer National Meeting. He said significant discussion has taken place both at the Working Group level and on member calls. He said he thinks it is very close, it just needs the final touches and then it will be ready to move forward. He said there has been a lot of discussion in an open and transparent setting; they are guiding level principles for the NAIC, and they will become more defined as related work transpires in other workstreams. He said the Principles do not represent a model law or regulation, but they serve as guideposts that will be considered in terms of guiding that discussion.

Commissioner Altman said she supports the timeline and pushing forward. She said much conversation has already taken place and could continue, but in recognition of all the work and discussion that has already taken place, it is important to move this forward. She said she fully supports doing everything possible to get this wrapped up at the Summer National Meeting.

Having no further business, the Innovation and Technology (EX) Task Force adjourned.
Section 4(H) of NAIC Model Unfair Trade Practices Act

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

H. Rebates.

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

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

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

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

(c) Redistributing the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or


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

(a) Relates to the insurance coverage and

(b) Is primarily intended to satisfy one or more of the following:

(1) Provide loss control;

(2) Reduce claims costs or claim settlement costs;

(3) Educate about risk of loss to persons or property;

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

(5) Enhance health or financial wellness;

(6) Provide post-loss services.

(7) Incent behavioral changes that improve the health or reduce the risk of death of the insured; or
(8) Assists in the administration of employee or retiree benefit policies.

(2) The Commissioner may adopt regulations when implementing the permitted practices set forth in (2)(e)(1) to ensure consumer protection. Issues include, but are not limited to, consumer data protections, especially instances where third party vendors require policyholder data as a condition of receiving the value added product or service, consumer disclosure, unfair discrimination consistent with applicable law.

(3) If the product or service is not made available to all policyholders or applicants its availability must be based on written objective criteria and offered in a fair and nondiscriminatory manner. If an insurer does not have sufficient evidence that the product or service is cost effective or has a material correlation to risk, but has a good-faith belief that the product or service may mitigate, assess or identify sources of risk of loss or claims, the insurer or producer may provide the product or service as part of a pilot or testing program for a reasonable period of time upon approval of the Commissioner.

(4) The cost to the insurer or producer of providing the product or service to any given policyholder should be reasonable in comparison to the average policy premiums or the insurance coverage.

(5) Gifts or offers of gifts in connection with marketing for the sale or retention of contracts of insurance is considered de minimus and not in violation of this statute as long as the cost does not exceed [two hundred and fifty dollars] per person per year;

Drafting Note: States may wish to alter the financial limitations set forth in this section depending upon each state’s economic environment.

(f) Notwithstanding any other provision, an insurer or a producer may:

(1) offer or give promotional or advertising items or meals or charitable donations on behalf of to a personal lines policyholder or potential policyholder, as long as the total fair market value of the promotion or advertising items and/or meals does not exceed an amount set in regulation by the Commissioner per calendar year per person and no purchase or renewal of an insurance policy is either expressly or impliedly required;

(2) offer or give gifts or value added services to commercial or institutional insureds in connection with marketing for the sale or retention of contracts of insurance, as long as the cost is reasonable in light of the relationship between the parties; or

(3) conduct raffles or drawings to the extent permitted by state law, as long as there is no participation cost to entrants, the drawing or raffle does not expressly or impliedly obligate participants to purchase insurance and the prizes are not valued in excess of five hundred dollars.

Drafting Note: States may wish to alter the financial limitations set forth in this section depending upon each state’s economic environment.

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

Drafting Note: Each state may wish to examine its rating laws to assure that they contain sufficient provision against rebating. If they do not, this section might be expanded to cover all lines of insurance.

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LONG-TERM CARE INSURANCE (EX) TASK FORCE

Long-Term Care Insurance (EX) Task Force Aug. 7, 2020, Minutes.....................................................................................4-86
Long-Term Care Insurance (EX) Task Force July 2, 2020, Minutes (Attachment One) .................................................4-89
Reduced Benefit Options Associated with Long-Term Care Insurance Rate Increases,
Principles and Issues (RBO Principles Document), July 2, 2020 Draft (Attachment One-A) ..........................4-92
2020 Proposed Charges for Newly Appointed Subgroups (Attachment One-B) .....................................................4-94
The Long-Term Care Insurance (EX) Task Force met via conference call Aug. 7, 2020. The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain represented by Carroll Astin (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Bryant Henley (CA); Karima M. Woods (DC); Trinidad Navarro (DE); David Altmairer represented by John Reilly (FL); Colin M. Hayashida represented by Paul Yuen (HI); Doug Ommen (IA); Dean L. Cameron (ID); Robert H. Muriel (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary Anderson (MA); Anita G. Fox represented by Karen Dennis (MI); Steve Kelley represented by Fred Andersen and Grace Arnold (MN); Chlora Lindley-Myers (MO); Matthew Rosendale represented by Bob Biskupiak (MT); Mike Causey represented by David Yetter (NC); Jon Godfread (ND); Bruce R. Ramge (NE); Marlene Caride (NJ); Russell Toal represented by Anna Krylova (NM); Glen Mulready represented by Andy Schallhorn and Cuc Nguyen (OK); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry D. Deiter (SD); Hodgen Mainda (TN); Kent Sullivan (TX); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude represented by Linda Johnson (WY).

1. **Adopted its July 2 Minutes**

Commissioner White said the Task Force met July 2 and took the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) received progress reports on the current activities of its six workstreams; 3) exposed a draft reduced benefit option (RBO) principles document for a 30-day public comment period ending Aug. 3; and 4) exposed draft 2020 charges for its newly appointed subgroups for a 14-day public comment period ending July 17.

Commissioner Donelon made a motion, seconded by Commissioner Altman, to adopt the Task Force’s July 2 minutes (Attachment One). The motion passed unanimously.

2. **Adopted 2020 Charges for its Newly Appointed Subgroups**

Commissioner White said the Task Force exposed the charges for its three new appointed subgroups for public comment. No comments were received. The subgroups are a consolidation of the Task Force’s six workstreams, and the charges are a delegation of Task Force charges. The existing workstream memberships will be rolled into each subgroup, and existing interested parties of the Task Force will be listed as interested parties for each of the subgroups. If any state insurance regulator wishes to be added or removed as a member or interested regulator or if interested parties wish to be added to the distribution list, please notify NAIC staff.

Director Ramge made a motion, seconded by Commissioner Atman, to appoint the three new subgroups—the Long-Term Care Insurance (LTCI) Multistate Rate Review (EX) Subgroup, the LTCI Reduced Benefit Options (EX) Subgroup and the LTCI Financial Solvency (EX) Subgroup—and related 2020 charges (Attachment One-B). The motion passed unanimously.

3. **Received a Progress Report on Activities of the Task Force**

   a. **Multistate Rate Review Practice**

Commissioner Conway said the multistate rate review workstream remains the centerpiece work of the Task Force, and it is intended to develop a consistent state-based approach for reviewing LTCI rate increase filings. The goal is to have the result be an actuarially justified rate increase process that is timely and eliminates cross-state rate subsidization. He said the multistate actuarial review group is overseen by himself and Commissioner White, and it has involved state department actuaries from Connecticut, Minnesota, Nebraska, Texas and Utah. The multistate actuarial team considers the experience and expectations filed by the requesting company, as well as other actuarial matters that have been discussed by the Long-Term Care Pricing (B) Subgroup the past several years, including the handling of shrinking blocks and not allowing inappropriate inclusion of past losses in remaining policyholders’ rates.
Commissioner Conway said collaboration is also occurring between the multistate team and the Interstate Insurance Product Regulation Commission (Compact) for rate filings submitted to the Compact. The infrastructure of the Compact is also used for efficiency and coordination. The pilot project is underway and reviewing several rate filings. The multistate team will be working with the Task Force to determine the final work product. The intent is for state insurance departments to be able to rely on the work of the multistate team in their review and granting of LTCI rate increase filings. However, each state will ultimately be responsible for approving, partially approving or denying a rate increase filing in their state.

Birny Birnbaum (Center for Economic Justice—CEJ) asked how, in evaluating rate inequality between states’ policyholders under the work of the consultant performing the data call, the Task Force will assess the quality of the rate reviews performed to-date by individual states. He asked whether rate inequality, if it exists, is due to differing assumptions by the states as to who is responsible—policyholders or shareholders—or pricing errors.

Commissioner Conway said part of the multistate review process has been to look at the rate increases that have been granted. This is a discussion that the Task Force is having. The multistate team is focused on the actuarial rate review processes used by Minnesota and Texas, both of which consider the concerns Mr. Birnbaum has raised.

Mr. Birnbaum asked if the data call submissions would be made publicly available to consumer stakeholders. If not, he inquired as to why, as the information seems like it would be the same information available in public rate filings. Additionally, he asked why the information is confidential.

Commissioner White said the data call was conducted under confidentiality laws. He said the data has not yet been reviewed by the Task Force; therefore, no final decisions have been made, but the Task Force will evaluate if any information can be shared.

Jan M. Graeber (American Council of Life Insurers—ACLI) said the insurance carriers that participated in the data call provided the information with the understanding that it would remain confidential. While carriers have access to their own information, they do not have access to other company information.

Commissioner Conway said the Task Force will be as transparent as possible, but it must weigh confidentiality issues. He said the Task Force will have more discussions that can be made public.

Ms. Graeber asked when industry and interested parties would be included in any of the work of the multistate rate review workstream. Commissioner Conway said the Task Force is just beginning to review an initial work product. He said the goal is to have the process in place by the end of the year, so he hopes to engage industry and interested parties within the next couple months.

Commissioner Donelon asked if the report of the multistate review team will be released in confidential regulator-only format or if will it be publicly released. Commissioner White said the Task Force will discuss this on a future call.

Commissioner Donelon asked if there is a pool of funds available industrywide to LTCI insurers. Mr. Andersen said each company holds reserves that will fund future policyholder claims, and he is not aware of any other funds.

b. **RBO and Consumer Notices**

Commissioner Altman said the RBO and Consumer Notices workstream developed a principles document to provide guidance to state insurance regulators when evaluating RBO offerings by insurers. The document is offered to assist the Task Force in completing its charge to “[i]dentify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.” The principles and issues outlined in the document are:

- Fairness and equity for policyholders that elect an RBO.
- Fairness and equity for policyholders that choose to accept rate increases and continue LTCI coverage at their current benefit level.
- Clarity of communication with policyholders eligible for an RBO.
- Consideration of encouragement or requirement for a company to offer certain RBOs.
- Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible.
Commissioner Altman said the workstream released an RBO Principles document for public comment and received comments from interested parties. She said the new subgroup will meet after the national meeting to discuss comments in more depth. She said the subgroup will also begin developing a principles document for consumer notices.

4. Received Comments on the RBO Principles Document

Bonnie Burns (California Health Advocates—CHA) said CHA’s comment letter included concerns with how RBOs are presented and portrayed to policyholders, how they are offered, if policyholders have an understanding of the relationship between the RBOs and their potential premiums, how the rates are affected by the RBO decisions policyholders make, and the fairness of the rates. She said some consumer notices include language that there may be additional rate increases. She said standards for format and how information is presented in consumer notices will be important. She said she has done a lot of work in California with consumers. She wants to ensure that the RBOs are fair to the insured and that consumer notices are understandable for policyholders of different ages and financial and care-giving situations to make the best decision.

Commissioner Altman said input from the consumer representatives will be important to the development of the consumer notices principles document. She said while they have not yet answered the questions around rates and the impact of RBOs, she is discussing with Commissioner Conway how the two subgroups will work together in bringing the review and pricing of RBOs into the multistate rate review process.

Ms. Graeber said the ACLI provided comments on the RBO principles document. She said the ACLI wants to be a partner with state insurance regulators and other stakeholders on a goal in providing policyholders meaningful options for the rate increase on LTCI coverage. She said the ACLI is supportive of developing principles to guide state insurance regulators in the review of RBOs facing an increase on the LTCI policy. She said it is important to recognize the characteristics of the block of business and how those characteristics affect the choices that are provided to consumers.

Ms. Graeber said the ACLI identified three overarching principles supporting a review: 1) no policyholder or carrier should be required to modify a contract that has been entered into; 2) any offer made should consider the impact on remaining policyholders; and 3) offers should ensure that there is no unfair discrimination among policyholders. Providing fair and meaningful options to consumers starts with recognizing all aspects of LTCI policies, as not all LTCI products are the same and have evolved over time. Insurers have LTCI blocks with variations.

Ms. Graeber said a policyholder’s decisions may not be just based on affordability, but also based on their personal situation, so there is no one-size-fits-all for RBOs. Fairness and equity can be achieved by clear communication of the options available and insurers encouraging policyholders to base decisions on the appropriateness of that option for their individual situation and benefit level. She said a main point is to balance communication with the policyholders—what is reasonable and fair—while still allowing insurers the flexibility to identify what options make sense for their block of business.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.

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The Long-Term Care Insurance (EX) Task Force met via conference call July 2, 2020. The following Task Force members participated: Scott A. White, Chair, and Doug Stolte (VA); Michael Conway, Vice Chair (CO); Jim L. Ridling (AL); Alan McClain represented by William Lacy (AR); Christina Corieri represented by Vincent Gosz (AZ); Ricardo Lara represented by Susan Bernard (CA); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro (DE); David Altmaier represented by Carolyn Morgan (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Eric Anderson (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon (LA); Eric A. Cioppa (ME); Anita G. Fox represented by Karen Dennis (MI); Steve Kelley represented by Fred Andersen (MN); Matthew Rosendale represented by Regan Hess (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Bruce R. Range represented by Rhonda Ahrens (NE); Marlene Caride (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson (NV); Glen Murlie represented by Andrew Schallhorn (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Raymond G. Farmer (SC); Larry D. Deiter represented by Jill Kruger (SD); Hodgen Mainda represented by Rachel Jade-Rice (TN); Kent Sullivan and Doug Slape (TX); Todd E. Kiser (UT); Michael S. Pieciak represented by Emily Brown (VT); Mike Kreidler (WA); Mark Afable represented by Richard Wicka (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. **Adopted its 2019 Fall National Meeting Minutes**

Commissioner Ridling made a motion, seconded by Commissioner Caride, to adopt the Task Force’s Dec. 9, 2019, minutes (see NAIC Proceedings – Fall 2019, Long-Term Care Insurance (EX) Task Force). The motion passed unanimously.

Commissioner White said the Task Force also met June 30 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss workstream planning.

2. **Received a Progress Report on Activities of the Task Force and Exposed a Draft Principles Document for Public Comment**

   a. **Multistate Rate Review Practice**

Commissioner Conway said the multistate rate review workstream is the center-piece work of the Task Force. He said the workstream is intended to develop a consistent state-based approach for reviewing long-term care insurance (LTCI) rate increase filings that culminate actuarially appropriate increases granted by the participating state insurance departments. The rate review process will be timely and eliminate cross-state rate subsidization to the extent that it exists.

Commissioner Conway said the multistate actuarial review group will perform an actuarial review of a rate increase filing that can be relied upon by the state insurance departments. Member actuaries from Connecticut, Minnesota, Nebraska, Texas and Utah are leading this work. The multistate actuarial team will consider the experience and expectations filed by the requesting company. The review will also consider actuarial matters that have been discussed by the Long-Term Care Pricing (B) Subgroup the past several years, including the handling of shrinking blocks and not allowing inappropriate inclusion of past losses in remaining policyholders’ rates.

The multistate actuarial team will collaborate with the Interstate Insurance Product Regulation Commission (Compact) for rate filings submitted to the Compact. The infrastructure of the Compact may be used for efficiency and coordination. The team is currently reviewing several rate filings, and it is learning lessons as progress is made through those rate filings. The team will work with the Task Force on how the coordination of a rate review analysis will be designed.
b. **Non-Actuarial Variances Among the States**

Commissioner Kreidler said the non-actuarial variance among the states workstream was focused on evaluating the differences among the states in the application of non-actuarial factors and reviewing considerations in evaluating rate increase requests. The workstream was tasked with developing a model set of recommendations for non-actuarial practices. On June 24, the workstream adopted its recommendations that address caps, phase-in periods, and solvency impact, as well as other concepts, such as waiting periods, size of the block, and age of the policyholders. These are topics that may need to be viewed from both the actuarial and non-actuarial perspective. This workstream recognizes the need for the multistate rate review workstream to consider these recommendations, as the topics correspond with the actuarial development process. As the Task Force is aware, these recommendations were formerly referred to the multistate rate review workstream to be incorporated into their development process for the overall rate review methodology and framework.

Mr. Knable said he would like to emphasize that the Task Force discusses the multistate rate review and non-actuarial workstreams’ recommendations with each individual state, and that each state will still be responsible for the final approval of the rate increase in their state, so that this process is not confused with a complete national approach to LTCI rate increases.

Commissioner White said the non-actuarial considerations were referred to the multistate rate review workstream, and there will be an opportunity for further discussion by commissioners as they are incorporated into that development process.

c. **Restructuring Techniques**

Mr. Slape said the restructuring techniques workstream was formed to evaluate restructuring options. The workstream has developed a scope of work that would direct a legal consultant to evaluate restricting options and provide a report to the Task Force. The scope of work and listing of qualifications for a consultant have been adopted by the Task Force. Mr. Slape anticipates that the NAIC will consider and issue a request for proposal (RFP). Any law firms that may be interested in bidding on such a project and would like to be on a distribution list for an RFP may contact Dan Daveline (NAIC). If the RFP is issued, and once bids are received, before initiating the project, the Executive (EX) Committee would determine if a Budget and Fiscal Impact Statement (BFIS) should be adopted by the NAIC.

d. **Reduced Benefit Options and Consumer Notices**

Commissioner Altman said the workstream has been looking at the options that companies make available to consumers as alternative choices to accepting rate increases when rate increases are necessary. The workstream has also been focused on sharing information across the states on practices currently in use and opportunities to be more aligned strategically. The workstream developed the Reduced Benefit Options (RBO) Principles document to provide guidance to state insurance regulators when evaluating RBO offerings by insurers. The principles and issues outlined in the document are:

- Fairness and equity for policyholders that elect an RBO.
- Fairness and equity for policyholders that choose to accept rate increases and continue LTCI coverage at their current benefit level.
- Clarity of communication with policyholders eligible for an RBO.
- Consideration of encouragement or requirement for a company to offer certain RBOs.
- Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible.

Commissioner Altman said the draft RBO Principles document is ready for public comment. She recommends a 30-day public comment period with comments submitted to Eric King (NAIC) by Aug. 3. The workstream plans to engage with stakeholders going forward. The workstream will schedule a conference call shortly after the Summer National Meeting to discuss comments received on the draft and next steps for collaboration. One additional charge of the workstream is to focus on the consumer notices to make sure the information provided to consumers about RBOs is clear and robust.

Commissioner White said the draft RBO Principles document (Attachment One-A) will be exposed for a 30-day public comment period ending Aug. 3.
e. Valuation of LTCI Reserves

Mr. Andersen said the valuation workstream’s goal is to coordinate valuation and rating issues affecting reserves, which tend to be the same issues, including morbidity, policyholder behavior and investment returns. There continues to be uncertainty in older-age morbidity and COVID-19. Older-age morbidity experience is continuing to develop. Recently, issues related to COVID-19 have affected LTCI. The current and future nursing home impacts and the market impact due to the declining interest rates could be offsetting in some areas. These issues will be a focus in upcoming months and years if consumers’ attitudes over elders entering long-term care (LTC) facilities changes over time. Also, as part of the workstream’s scope, a document was developed to help ensure that states’ LTCI rate review and reserve teams are coordinating. The Task Force released this document for feedback from state insurance regulators only.

f. Data Call Design and Oversight

Mr. Stolte said the data call design and oversight workstream was organized to perform two functions: 1) define a scope of work for a data call for certain LTCI carriers in order to accumulate and analyze the current level of LTCI rate inequity among the states’ policyholders; and 2) review the work of a consultant performing such a data call for communication to the Task Force. Prior to the 2019 Fall National Meeting, the workstream was focused on developing that data call, as well as developing a scope of work for a consultant. In November 2019, the NAIC released an RFP to several actuarial consulting firms; subsequently, the Executive (EX) Committee adopted a BFIS in February. Soon after, the NAIC announced that it had hired LTCG Actuarial Consulting Group (LTCG) as the NAIC’s consultant on this project. Subsequently, the workstream met with the consultant to provide it with direction, and under Virginia state law, it directed 19 insurers to complete the data call overseen by LTCG. Most of the insurers have now completed that data call, and LTCG is analyzing the data. The workstream has met on three calls to review the data.

Bonnie Burns (California Health Advocates—CHA) asked when the documents and reports discussed by the workstreams would be made available to the public. Jeffrey C. Johnston (NAIC) said the data call RFP was posted to the NAIC website last fall, and it was removed once the NAIC administrative process was completed. Commissioner Conway said the multistate rate review workstream has not reached the point where information can be made public yet. Once that point is reached, information will be made available for public discussion.

Birny Birnbaum (Center for Economic Justice—CEJ) said the data call information will be of great interest to stakeholders, he and asked if the data call information will be made public and in what time frame. Mr. Stolte said the data was collected confidentially under Virginia state law. He said a report will be made available when the analysis is complete. Mr. Johnston said the data analysis is still in process, and the Task Force may know a time frame by the Summer National Meeting.

3. Exposed 2020 Proposed Subgroup Charges for Public Comment

Commissioner White said the next steps for the Task Force include moving more discussions about the rate review methodology, reduced benefit options, and consumer notices into the public realm. An administrative plan is to consolidate the six workstreams into three NAIC subgroups. This organizational step will help to ensure that the Task Force properly accounts for the views of the consumer representatives, industry and other stakeholders. The Task Force chose to appoint subgroups, as these groups are largely intended to be temporary NAIC groups. The subgroup charges include a delegation of the Task Force charges a new LTCI Multistate Rate Review (EX) Subgroup and a new LTCI Reduced Benefit Options (EX) Subgroup. The new LTCI Multistate Rate Review (EX) Subgroup will be the consolidation of the multistate rate review and non-actuarial variances workstreams, which will be chaired by Colorado. The new LTCI Reduced Benefit Options (EX) Subgroup will be the RBO and consumer notices workstream, which will be chaired by Pennsylvania. The new LTCI Financial Solvency (EX) Subgroup will be a consolidation of the restructuring techniques, valuation of LTCI reserves, and data call design and oversight workstreams. It is intended to address the confidential work of those three workstreams. It is co-chaired by Minnesota and Texas.

The Task Force exposed proposed charges for its three new subgroups for a 14-day public comment period ending July 17 (Attachment One-B). Comments should be sent to Jane Koenigsman (NAIC). The Task Force will plan to address any comments and consider the charges for adoption at the Summer National Meeting.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.
REduced benefit options associated with long-term care insurance (LTCI) rate increases –
request for public comment -

Drafted by the Reduced Benefit Options Workstream (#3) of the Long-Term Care Insurance (EX) Task Force

INTRODUCTION

The Reduced Benefit Options (RBO) Workstream is composed of regulators from 17 state insurance
departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the
following charge:

Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI)
contract benefits where policies are no longer affordable due to rate increases.

The Workstream regulators have developed a list of RBO principles in order to provide guidance for evaluating
RBO offerings.

PRINCIPLES AND ISSUES, INCLUDING THOSE WITH PARTICULAR NEED FOR STAKEHOLDER INPUT, INCLUDE:

1. Related to fairness and equity for policyholders that elect an RBO:
   - Are all policyholders facing a rate increase being offered an RBO?
   - Do the RBOs provide reasonable value?

2. Related to fairness and equity for policyholders that choose to accept rate increases and continue LTCI
   coverage at their current benefit level:
   - To what extent could anti-selection take place, placing the financial stability of the remaining block of
     business at further risk?

3. Related to clarity of communication with policyholders eligible for an RBO:
   - What are recommendations for ensuring policyholders have maximized opportunity to make decisions
     in their best interest?
   - Should regulators, in some cases, encourage a company to offer fewer options in order to reduce the
     complication in decisions policyholders will face?

4. Related to consideration of encouragement or requirement for a company to offer certain RBOs:
   - Evaluate legal constraints, impact on remaining policyholders and company finances, and impact on
     Medicaid budgets if regulators are driving reduced LTCI benefits.
5. Related to exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:

- Identify pros and cons of rate increases being tied into insurers offering, e.g., hand railings for fall prevention in high-risk homes.

WIDELY ESTABLISHED RBOs IN LIEU OF RATE INCREASES

a. Reduce inflation protection going forward, while preserving accumulated inflation protection
b. Reduce Daily Benefit
c. Decrease Benefit Period/Maximum Benefit Pool
d. Increase Elimination Period
e. Contingent Nonforfeiture
   i. Claim amount can be sum of past premiums paid
   ii. Only receive that benefit if the policyholder qualifies for a claim

LESS COMMON RBOs FOR POTENTIAL DISCUSSION

a. Cash buyout
b. Co-pay percentage on benefits
Proposed Charges:

The **LTCI Multistate Rate Review (EX) Subgroup** will:

Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The Subgroup should complete its charges by the 2021 Summer National Meeting.

- *Chair: Commissioner Michael Conway (CO)*
- *Consolidation of workstream 1—Multi-state Rate Review Practices and workstream 5—Non-Actuarial Variance Among the States*
- *Open Sessions or Regulator Only Sessions, pursuant to open meetings policy #3 – discussion of companies, entities or individuals*

The **LTCI Reduced Benefit Options (EX) Subgroup** will:

Identify options and develop recommendations for the rate review approach that provides consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases. The Subgroup should complete its charges by Dec. 31, 2020.

- *Chair: Commissioner Jessica K. Altman (PA)*
- *Former workstream 3—Reduced Benefit Options and Consumer Notices*
- *Open Sessions*

The **LTCI Financial Solvency (EX) Subgroup** will:

a. Explore restructuring options and techniques to address potential inequities between policyholders in different states; and techniques to mitigate policyholders’ risk to state guaranty fund benefit limits including states’ pre-rehabilitation planning options. Evaluate the work of the consultant and report on the work to the Task Force.
b. Evaluate the results of consultants’ work on the completion of a data call and report on the work to the Task Force.
c. Monitor work performed by other NAIC solvency working groups and assist in the timely multi-state coordination/communication of the review of the financial condition of LTC insurers.

The Subgroup should complete its charges by the 2021 Summer National Meeting.

- *Co-Chairs: Doug Slape (TX) and Fred Andersen (MN)*
- *Consolidation of workstream 2—Restructuring Techniques, workstream 4—Valuation of Long-Term Care Insurance (LTCI) Reserves and workstream 6—Data Call Design and Oversight*
- *Regulator Only Sessions, pursuant to open meetings policy #3 – discussion of companies, entities or individuals*
The Information Systems (EX1) Task Force met via conference call Aug. 5, 2020. The following Task Force members participated: Kathleen A. Birrane, Chair, represented by Paula Keen (MD); Ricardo Lara, Vice Chair, represented by David Noronha (CA); Lori K. Wing-Heier (AK); Alan McClain represented by Letty Hardee (AR); Robert H. Muriel represented by Judy Mottar (IL); Vicki Schmidt represented by Shannon Lloyd (KS); Sharon P. Clark represented by Russell Hamblen (KY); Steve Kelley represented by Matthew Vatter (MN); Chlora Lindley-Myers represented by Cynthia Amann (MO); Barbara D. Richardson (NV); Jillian Froment represented by Tynesia Dorsey (OH); Kent Sullivan represented by Nancy Clark (TX); and Scott A. White represented by Vicki Ayers (VA). Also participating were: Chris Murray and Katrina Kelly (AK); Blase Abreo (AL); Bud Leiner, Vanessa Darrah and Cheryl Hawley (AZ); Charlene Ferguson, Stephanie Wong and Henry Tam (CA); Lady Mendoza (CT); Gordon I. Ito, Mio Shimamura and Melanie Fujiwara (HI); Doug Ommen and Kim Cross (IA); Lauren Peters and Cindy Anderson (IL); Jennifer Groth (IN); Timothy Schott and Pamela Roybal (ME); Christine Peters and Adam Goldhammer (MN); Kathy Shortt and Tracy Biehn (NC); Johnny Palsgraaf (ND); Russell Toal and Myra Morris (NM); Eileen Fox, Nellie Rosin and Leigh Solomon (NY); Ben Anderson, Lori Barron and Michelle Brugh Rafeld (OH); Ron Kreiter, Cuc Nguyen and Michael Parrott (OK); Tashia Sizemore, Brian Fordham and Kirsten Anderson (OR); David Kelly (PA); Matt Gendron (RI); David Muckerheide (TX); Trish Todd, Richard Tozer and Andrea Baytop (VA); Randy Fong, John Haworth and Molly Nollette (WA); Timothy Cornelius (WI); and Bryan Stevens (WY).

1. **Adopted its 2019 Fall National Meeting Minutes**

Director Wing-Heier made a motion, seconded by Ms. Amann, to adopt the Task Force’s Dec. 6, 2019, minutes (see NAIC Proceedings – Fall 2019, Information Systems (EX1) Task Force). The motion passed unanimously.

2. **Adopted its 2021 Proposed Charges**

Mr. Noronha made a motion, seconded by Mr. Hamblen, to adopt the Task Force’s 2021 proposed charges, which remain consistent with 2020 (Attachment One). The motion passed unanimously.

3. **Received an IT Operational Summary Report**

Scott Morris (NAIC) highlighted several sections included in the Information Technology (IT) Operational Report received by the Task Force members. The report provides updates on technology initiatives at the NAIC, upcoming improvements, impacts to state technology, new offerings from the NAIC, and general updates on the activities of the NAIC technology team.

   a. **Product Highlights**

   The Iowa and State Based Systems (SBS) teams successfully transitioned Iowa from legacy SBS to the new platform. This milestone was the first virtual transition due to the COVID-19 work environment. The final two states moving to the new platform this year are Tennessee (September) and North Carolina (November). Connecticut is currently licensed and in queue for its new implementation in 2021 and Hawaii for a 2022 implementation.

   In mid-March, the NAIC swiftly moved into a work-from-home mode, given the COVID-19 pandemic. The NAIC team realigned priorities to support state insurance departments’ needs around COVID-19. Some of the COVID-19 work and activities included:

   - Creating a regulator-only collaboration website for sharing COVID-19 related information.
   - Supporting members with SBS needs, such as extension of licenses, temporary license setup, continuing education (CE) waivers, certificate of authority emailing, etc.
   - Helping several states move to electronic payments using the NAIC Online Premium Tax for Insurance (OPTins) platform.
   - Completing the property/casualty data collection for business interruption insurance and supporting the life data collection.
   - Supporting virtual meetings, such as the 2,900-attendee COVID-19 special event.
   - Creating a new SharePoint document portal as an iPad alternative for commissioners and senior staff to access meeting artifacts.

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A request for proposal (RFP) process was completed in the fourth quarter of 2019, and Deloitte was selected to complete an assessment of the NAIC System for Electronic Rate and Form Filing (SERFF). Deloitte started the assessment in January and completed interviews with more than 100 stakeholders. Essentially, Deloitte found that the platform has performed well for the states to help improve the rate and form filing process, but foundational improvements are needed. The report recommends a phased approach to the SERFF redesign, with a pilot phase and three implementation phases. That assessment was shared with the Executive (EX) Committee at the mid-year meeting, and it will be also be shared during Roundtable at the Summer National Meeting, after which next steps will be determined.

OPTins is used by 28 states to process premium and surplus lines tax forms and fees. It also allows taxes to be collected electronically, and some can be very large. The NAIC is working to reduce transactional risk by modifying OPTins to delay the settlement to states to reduce the number of failed payments. Prior to moving forward with this enhancement, the NAIC solicited feedback from the states on this change. Based on that input, the system enhancement will move forward, and it will be released in December, ahead of the 2020 annual filing deadline for most states.

b. **Innovation and Technology**

The NAIC continues to explore technology to provide secure, reliable and flexible options for its members. Creating an NAIC data cloud platform is one key area of focus, and many pieces are now in place and being configured. The NAIC is starting to test a proof of concept using a new data warehouse technology called Snowflake as the access point for a safe and secure way for the states to connect to NAIC datasets. The solution will provide access to read-only data, and it is being piloted with two states. Feedback from those participants will help shape the solution to best meet member needs as we move forward with building the platform.

Cloud migrations of the applications that the NAIC builds and supports for state insurance regulators are underway. Applications are being migrated to multiple test and development environments first. Once proven, the production systems that state insurance regulators use will be moved. Third and fourth quarters will also include database upgrades and migrations. The NAIC is targeting to be complete by the end of the year, with these migrations with full cut-over most likely occurring in the first quarter of 2021.

c. **Service and Support**

Overall NAIC service request volume remains steady at around 11,000 to 13,700 inquiries per month. In March, volume had increased by approximately 10%. This increase in volume was related to the COVID-19 pandemic, and the NAIC continues to receive calls related to this event. Overall, most of call drivers during the second quarter were primarily made up of industry users requesting assistance while accessing NAIC products and services to accomplish regulatory filing deadlines for annual financial statements (internet filing), premium and surplus lines tax filings (OPTins), product and rate filings (SERFF), annual corporate updates (Uniform Certificate of Authority Application—UCAA), and licensing transactions (SBS).

4. **Received a Portfolio Update and Project Status Reports**

Cheryl McGee (NAIC) reported on the project portfolio. As of July, the NAIC’s technical project portfolio includes 23 active technical projects, 17 of which are projects of the State Head strategic plan. Two projects have been completed since the last report.

5. **Discussed Other Matters**

Ms. Keen said the Task Force will meet Sept. 25 via conference call in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to review documents for new 2021 financial impact statements that are considered technical projects.

Having no further business, the Information Systems (EX1) Task Force adjourned into regulator-to-regulator session pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
The mission of the Information Systems (EX1) Task Force is to: 1) provide regulator-based technology expertise to the Internal Administration (EX1) Subcommittee; and 2) support committee activities and objectives by monitoring projects that provide technical services or systems for state-based insurance regulation, as prioritized by the Executive (EX) Committee.

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Cheryl McGee/Sherry Stevens

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LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

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The Life Insurance and Annuities (A) Committee met via conference call Aug. 11, 2020. The following Committee members participated: Jillian Froment, Chair, and Peter Weber (OH); Marlene Caride, Vice Chair, represented by Philip Gennace (NJ); Jim L. Ridling and Steve Ostlund (AL); Trinidad Navarro (DE); Doug Ommen and Mike Yanacheak (IA); Dean L. Cameron (ID); James J. Donelon (LA); Jon Godfread (ND); Bruce R. Ramge (NE); Chris Nicolopoulos represented by Roni Karnis (NH); Barbara D. Richardson (NV); Linda A. Lacewell represented by Bill Carmello (NY); and Mark Afable and Richard Wicka (WI). Also participating were: David Altmaier (FL); Robert H. Muriel (IL); Sharon P. Clark (KY); Eric A. Cioppa (ME); Chlora Lindley-Myers (MO); Mike Causey (NC); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); and Raymond G. Farmer (SC).

1. **Adopted its July 10 Minutes**

The Committee met July 10 and took the following action: 1) adopted its Dec. 30, 2019, and Dec. 8, 2019, minutes; 2) adopted technical revisions to *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48)*; 3) adopted *Valuation Manual* amendments; and 4) adopted *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49-A)*.

Commissioner Donelon made a motion, seconded by Commissioner Godfread, to adopt the Committee’s July 10 minutes (Attachment One). The motion passed unanimously.

2. **Adopted the Reports of its Working Groups and Task Force**

   a. **Accelerated Underwriting (A) Working Group**

   Director Muriel said the Accelerated Underwriting (A) Working Group met July 31. During its meeting, the Working Group took the following action: 1) adopted its March 12, Feb. 20, Feb. 2, Jan. 23 and 2019 Fall National Meeting minutes; and 2) heard an update presentation, including a summary of the process that has been followed, some of the lessons learned, and the timeline for completion of its charge.

   b. **Annuity Disclosure (A) Working Group**

   Mr. Yanacheak said the Annuity Disclosure (A) Working Group met March 13. He said the Working Group has not met since March because Working Group members have been focused on issues related to the pandemic in their own states. He said during its March 13 meeting, the Working Group took the following action: 1) continued to discuss revisions to the *Annuity Disclosure Model Regulation (#245)*; 2) adopted revised language clarifying what financial instruments are included in an index, each of which has to have been in existence for at least 15 years; and 3) identified a few additional issues that it wants to address prior to bringing the revisions to the Committee.

   First, the Working Group would like to include some plain language revisions to the disclosure requirement in Section 6G. The second and third issues revolve around whether the Working Group wants to make recommendations to the Committee related to whether there is a need for product approval standards for proprietary indices and whether there needs to be standards surrounding the relationship between the hedging provider and the index provider.

   Mr. Yanacheak said the Working Group is close to finishing the revisions to Model #245, and it requested an extension of the Request for NAIC Model Law Development in order for the Working Group to finish its work by the Fall National Meeting.

   Commissioner Ommen spoke in support of giving the Working Group additional time. He made a motion, seconded by Commissioner Godfread, to extend the Request for NAIC Model Law Development until the Fall National Meeting.
c. **Annuity Suitability (A) Working Group**

Commissioner Ommen said the Annuity Suitability (A) Working Group met July 29. During this meeting, the Working Group took the following action: 1) adopted its 2019 Fall National Meeting minutes and Dec. 19, 2019, minutes; and 2) heard an update from Idaho, Iowa, Kentucky, Ohio and Rhode Island on their efforts to adopt the revised *Suitability in Annuity Transactions Model Regulation* (#275), including any issues they had encountered.

Commissioner Ommen said the Working Group discussed its work for 2020 and agreed to develop a frequently asked questions (FAQ) document to assist the states as they move forward with adopting the revised Model #275 and implementing its provisions in fulfillment of the second part of its charge to “consider how to promote greater uniformity across NAIC-member jurisdictions.” He said the Working Group decided a draft FAQ document would be developed and exposed for a 30-day public comment period to solicit any additional questions to add to the document. He said the Working Group plans to meet via conference call in September to discuss any comments received.

d. **Life Insurance and Illustration Issues (A) Working Group**

Mr. Wicka said the Life Insurance Illustration Issues (A) Working Group met July 24, after not having met since before the 2019 Fall National Meeting. He explained that, like everyone else, the Working Group member’s attention was focused on addressing pandemic-related issues in their home states. He said that during its July 24 meeting, the Working Group reviewed two alternate versions of revisions to the *Life Insurance Disclosure Model Regulation* (#580). He said one version retains the current time frame for delivery of the policy overview at the same time as the buyer’s guide (either at the time of application or at the time of policy delivery if there is a free-look period). The other version has the policy overview delivered at the time of application.

Mr. Wicka said the Working Group also reviewed two alternative versions of the sample policy overview for term life insurance policies. One version shows the sample pre-underwriting; the other, after underwriting. He said the Working Group exposed the sample policy overview for a public comment period ending Aug. 28. He said the Working Group plans to meet via conference call to discuss any comments received and make any adjustments to the sample policy overview. He said the Working Group plans to develop sample policy overview documents for whole life and universal life, which will be exposed for public comment in the future.

Mr. Wicka said he believes the Working Group is making good progress, and he would like to request an extension of the Request for NAIC Model Law Development, so the Working Group can finish up its work.

e. **Life Actuarial (A) Task Force**

Mr. Weber said the Life Actuarial (A) Task Force met Aug. 6, Aug. 4 and Aug. 3. He said during these meetings, the Task Force adopted its June 25, June 18, June 11, June 4, May 28, May 21, May 14 and May 7 minutes, which included the following action: 1) adopted its Feb. 27, Feb. 20, Feb. 13, Feb. 6, Jan. 30 and Jan. 23 minutes; 2) adopted changes to the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805); 3) adopted amendment proposal 2020-05, which modifies the net premium reserve (NPR) to reflect continuous deaths and immediate payment of claims; 4) adopted *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold After November 25, 2020* (AG 49-A); 5) adopted amendment proposal 2020-06, which establishes a process for replacing the London Interbank Offered Rate (LIBOR); and 6) adopted amendment proposal 2020-07, which modifies VM-02, Minimum Nonforfeiture Mortality and Interest of the *Valuation Manual* by replacing the fixed 4% floor for the life minimum nonforfeiture interest rate with a reference to the rate used to determine the minimum funding for the cash value accumulation test in Internal Revenue Code § 7702 that will serve as the floor, as previously intended, but it will change as appropriate if this § 7702 rate changes.

Mr. Weber said the Task Force heard an update on the results of the yearly renewable term (YRT) field test modeling and range of interpretation survey from the American Academy of Actuaries (Academy) YRT Field Test Project Oversight Work Group, Oliver Wyman and NAIC staff. He said the Task Force also discussed proposed changes to the Model #805 nonforfeiture interest rate floor. The Task Force agreed to expose Section 4B of Model #805 with various nonforfeiture rate floor options between one-half of one percent (0.5%) and zero percent (0%), inclusive.

Mr. Weber said the Task Force heard an update from the Academy Annuity Reserves Work Group (ARWG) on the proposed timeline and approach for the development of a principle-based reserving (PBR) framework for non-variable annuities; and it adopted the report of the VM-22 (A) Subgroup, including its July 15, July 1, June 11 and May 20 minutes. He said the Task...
Force also heard an update from the Interstate Insurance Product Regulation Commission (Compact); and adopted the reports of the Longevity Risk (E/A) Subgroup, the Guaranteed Issue (GI) Life Valuation (A) Subgroup, the Experience Reporting (A) Subgroup, and the Indexed Universal Life (IUL) Illustration (A) Subgroup, including its June 2 and May 26 minutes.

Mr. Weber said the Task Force exposed the following amendment proposals: 1) 2019-33, which provides for the application of PBR requirements for group life insurance contracts with individual risk selection criteria issued under insurance certificates; 2) 2020-03, which clarifies that exact calculations for the NPR are allowed; and 3) 2019-34, which affirms that policies subject to the Standard Valuation Law (#820), prior to becoming parties to modified coinsurance (mod-co) agreements, are still subject to Model #820 after entering the mod-co agreements, and it provides guidance related to the actuarial opinion and asset adequacy analysis.

Mr. Weber said the Task Force exposed the 2021 Generally Recognized Expense Table (GRET) recommendation and heard an update from the Society of Actuaries (SOA) on research and education. He said the SOA update of 2020 Life Mortality Improvement Factors was exposed, and the Task Force heard updates from the Academy PBR Governance Work Group and Council on Professionalism.

Commissioner Donelon made a motion, seconded by Director Ramge, to adopt the following reports: Accelerated Underwriting (A) Working Group (Attachment Two); Annuity Disclosure (A) Working Group (Attachment Three), including an extension of the Request for NAIC Model Law Development; Annuity Suitability (A) Working Group (Attachment Four); Life Insurance Illustration Issues Working Group, including an extension of the Request for NAIC Model Law Development; and Life Actuarial (A) Task Force. The motion passed unanimously.

3. **Discussed Next Steps for the Life Insurance Online Guide (A) Working Group**

Director Froment reminded the Committee of the genesis of the Life Insurance Online Guide (A) Working Group. She explained that the Working Group came out of the work of the Life Insurance Buyer’s Guide (A) Working Group. That Working Group developed a two-page guide to life insurance. But the Working Group also recognized that there is a lot more information about life insurance that would be useful for consumers to know than what made sense to include in a two-page Life Insurance Buyer’s Guide. Director Froment said there was also information at that time on the NAIC website, under Insure U. This led to the Committee appointing the Life Insurance Online Guide (A) Working Group with the charge to “[d]evelop an online resource on life insurance, including the evaluation of existing content on the NAIC website, to be published digitally for the benefit of the public.”

Director Froment said this Working Group was originally chaired by Mary Mealer (MO), and it is currently chaired by Sarah Neil (RI). Director Froment said that while this Working Group has made progress in identifying topics and developing language, the number of Working Group members has declined and the Working Group has encountered difficulty making progress on the design and function of the buyer’s guide in an online format. Director Froment said the most likely explanation for this is that online design and computer applications are not the areas of expertise of the participants on this Working Group.

Director Froment said she has spoken Ms. Neil about taking a bifurcated approach to moving this project forward. She said first, she would like for the Working Group to focus on finishing the substance of the online guide. Next, she said she would like for the Working Group to enlist the expertise of the NAIC Communications Division, which is currently working on a rebranding of the NAIC website. She said Jennifer Cook (NAIC) has had conversations with NAIC Communications Director Laura Kane, who has expressed her willingness to assist with the project. She said Ms. Cook, in the coming weeks, will send an email to Committee members describing its work plan going forward and to seek additional state insurance regulator members to be on the Working Group.

4. **Discussed Next Steps for the Retirement Security (A) Working Group**

Director Froment said she would like to see the Retirement Security (A) Working Group make significant progress in the coming months. She said our recent experiences with the pandemic have only highlighted the critical importance of retirement security. She reminded the Working Group that during the latter part of 2019, Commissioner Taylor had—before leaving the District of Columbia Department of Insurance, Securities and Banking—heard presentations from a number of groups that were active in the area of retirement security, to learn about what they were doing. He also had requested comments on a draft work plan and received significant feedback.
Director Froment said, in order to move forward, this Working Group needs a chair and some additional members. She said she has reviewed the comments on the work plan, and suggests revising it in response to those comments to: 1) narrowly focus on areas where the NAIC and insurance regulators have expertise; and 2) leverage the extensive work of our many partners on this topic. She said she does not anticipate that this project will be overly burdensome, especially once a final work plan is in place. She said she would like to receive comments from regulators and interested parties on a revised work plan, as well as provide an opportunity for additional volunteers to join this Working Group. She said she does not anticipate that this project will be overly burdensome, especially once a final work plan is in place. She said if there are no volunteers to chair the group, Ohio is willing, but she would be happy to step aside if another state is interested in chairing this effort.

She asked Committee members, or members of their staff, to email David Torian (NAIC) with their interest to chair or be a member of this Working Group. She said Mr. Torian would be sending an email to Committee members in the coming weeks that will include a revised work plan with a deadline to submit comments.

5. **Discussed Reviewing the Design and Guidance for Life Insurance and Annuities Illustrations**

Director Froment explained that this topic is on the Committee agenda because of the conversations that occurred on the Committee’s July 10 conference call. She said part of the discussion that preceded the adoption of AG 49-A revolved around issues raised in a comment letter submitted by Birny Birnbaum (Center for Economic Justice—CEJ). She said Mr. Birnbaum’s comment letter is posted on the Committee page on the NAIC website in the materials for the July 10 conference call. She said Mr. Birnbaum also submitted a comment letter to the Executive (EX) Committee and Plenary, as AG 49-A is being considered for adoption at the upcoming meeting of the Executive (EX) Committee and Plenary. She mentioned that Mr. Birnbaum inquired whether this Committee would reconsider its adoption of AG 49-A; however, that is not procedurally possible. She explained that AG 49-A is now before the Executive (EX) Committee and Plenary for its consideration, noting that they are the appropriate groups to consider the issues raised by Mr. Birnbaum in his submitted comment letter.

Director Froment said the adoption of AG 49-A is an important first step in addressing some concerns with IUL illustrations involving multipliers. The Committee agreed to discuss the larger issues raised in the CEJ comment letter regarding all illustrations, as well as discuss perhaps having a new charge. She explained that the regulatory framework has evolved over time and naturally has evolved as state insurance regulators have addressed specific issues or concerns. She said state insurance regulators must react to new concerns or products by trying to adapt the existing framework to the issue before them. She said this can sometimes cause unintended consequences or leave gaps in the guidance.

Director Froment said she would like to reiterate her suggestion from the Committee’s July 10 conference call, that there may be a need to look closely at the current design and regulation framework for life insurance and annuity illustrations and determine what, if any, changes or additions may be needed. She said she does not have a charge to suggest at this time, but would like to take this first more formal step of placing the issue on the agenda and starting the discussion. Because the virtual meeting format does not allow for input from audience members, Director Froment said she would schedule a follow-up call in the near future to discuss a possible charge in more detail, including where that charge most likely belongs.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
The Life Insurance and Annuities (A) Committee met via conference call July 10, 2020. The following Committee members participated: Jillian Froment, Chair, Tynesia Dorsey and Peter Weber (OH); Marlene Caride, Vice Chair (NJ); Jim L. Ridling, Yada Horace and Steve Ostlund (AL); Alan McClain represented by Vincent Gosz and Vanessa Darrah (AR); Doug Ommen, Mike Yanacheak, Lindsay Bates and Kevin Clark (IA); Dean L. Cameron and Michele Mackenzie (ID); Vicki Schmidt represented by Julie Holmes, Tate Flott, Nicole Boyd, Craig Van Aalst, Barbara Torkelson and Brenda Johnson (KS); James J. Donelon represented by Rich Piazza, Frank Opelka and Tom Travis (LA); Jon Godfread (ND); Bruce R. Ramge and Martin Swanson (NE); Chris Nicoloopoulos represented by Roni Karnis (NH); Barbara D. Richardson (NV); Linda A. Lacewell represented by Mark McLeod, Victor Agbu and Bill Carmello (NY); and Mark Afable (WI). Also participating were: Russ Galbraith (AR); Jodi Lerner, and Perry Kupferman (CA); Eric Unger and Rolf Kaumann (CO); David Altmaier, Chris Struk and Carolyn Diggis (FL); Fred Andersen and John Robinson (MN); Cynthia Amann and Marjorie Thompson (MO); Steve Boston (PA); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Mike Boerner, Rachel Hemphill Raja Malkani and David McElroy (TX); Tanji Northrup and Tomasz Serbinowski (UT); Craig Chupp (VA); and Lichiou Lee and John Haworth (WA).

1. **Adopted its Dec. 30, 2019, and 2019 Fall National Meeting Minutes**

Commissioner Ridling made a motion, seconded by Commissioner Caride, to adopt the Committee’s Dec. 8, 2019 (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee) and Dec. 30, 2019 (Attachment One-A) minutes. The motion passed unanimously.

Director Froment said since the adoption of the *Suitability in Annuity Transactions Model Regulation (#275)* via conference call Dec. 30, 2019, questions have come up in the states regarding implementation of the model. She explained that given the second part of the Annuity Suitability (A) Working Group’s charge to “[c]onsider how to promote greater uniformity across NAIC-member jurisdictions” and after speaking with Commissioner Ommen, they agreed that it would be helpful for the Working Group to continue to try to develop guidance for the states as they implement the revised model. Director Froment said Commissioner Ommen has graciously agreed to chair this effort. Director Froment said the Working Group is scheduled to meet on July 29 as part of the virtual NAIC Summer National Meeting.

Director Range said the Market Conduct Examination Standards (D) Working Group plans to revise the Market Regulation Handbook in accordance with the revised Model #275. He asked whether the Working Group should postpone its work until after the Annuity Suitability (A) Working Group finishes its guidance. Commissioner Ommen agreed that it makes sense for the Market Conduct Examination Standards (D) Working Group to hold off for just a few months.

2. **Approved the Request for NAIC Model Law Development for Model #805**

Mr. Boerner explained that the Request for NAIC Model Law Development for the *Standard Nonforfeiture Law for Individual Deferred Annuities (#805)* arises out of concern with the 1% minimum nonforfeiture accumulation rate, which may be difficult for insurers to achieve in the current very low interest rate environment. He said this Request for NAIC Model Law Development is to revise Model #805 to address this minimum nonforfeiture rate.

Mr. Carmello said he would like to expand the Request for NAIC Model Law Development to address the current cap in Model #805. He explained that while this is not an issue at the moment, during a high interest rate environment in the future, the 3% cap currently in Model #805 could become a problem. He said it makes sense to address both of these issues at this time.

Mr. Gendron said he would like for Life Actuarial (A) Task Force to consider whether the minimum nonforfeiture rate should be something other than 0%, like 0.5%. Mr. Boerner said under the Request for NAIC Model Law Development, the Task Force could also consider other alternatives between 0% and 1%. He clarified that the move to 0% does not mean a company is prohibited from guaranteeing more than that.
Director Froment suggested that the Committee vote on the current Request for NAIC Model Law Development, which is responding to the current situation in the marketplace. She suggested that the Task Force discuss the additional issues raised by Mr. Carmello and Mr. Serbinowski and report back to the Committee with any suggestions regarding additional modifications to Model #805. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI would be supportive of having the Task Force look at the cap, but the current Request for NAIC Model Law Development is responding to an urgent need and the cap is not likely to be an issue in the near term. Liz Pujolas (Insured Retirement Institute—IRI) agreed with Mr. Bayerle that revisiting the cap could occur down the road.

Commissioner Richardson made a motion, seconded by Commissioner Caride, to approve the Request for Model Law Development with respect to Model #805. The motion passed unanimously.

3. ** Adopted Technical Revisions to AG 48**

Mr. Boerner said a couple of edits were made to *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48)* that were already made to the *Term and Universal Life Insurance Reserve Financing Model Regulation (#787)*. He said one was a reference change to the Credit for Reinsurance Model Law (#785) and another was a reference change to the Credit for Reinsurance Model Regulation (#786). He said AG 48 needs to remain similar to Model #787, as there are situations in which both are needed for some period of time to cover their portion of XXX financing arrangements.

Mr. Ostlund made a motion, seconded by Director Ramge, to adopt technical revisions to AG 48 (see *NAIC Proceedings – Summer 2020, Executive (EX) Committee and Plenary – Attachment Three*) The motion passed unanimously.

4. ** Adopted Valuation Manual Amendments**

Mr. Boerner said there were seven *Valuation Manual* amendments for the Committee to consider. He said they are primarily technical in nature. He said one example involves a reference to the London Interbank Offered Rate (LIBOR), which is scheduled to go away in 2021. He said *Valuation Manual* amendment 2020-06 revises the *Valuation Manual* to be with when LIBOR is scheduled to go away. He said another example is *Valuation Manual* amendment 2020-07, which replaces the 4% floor for the minimum nonforfeiture interest rates with a reference to Internal Revenue Service (IRS) §7702 with which it was originally intended to coordinate. Director Ramge asked if there are any references to LIBOR in any of the NAIC models. Mr. Boerner said he does not know, but the question could be researched.

Commissioner Ommen made a motion, seconded by Commissioner Caride, to adopt the *Valuation Manual* amendments (see *NAIC Proceedings – Summer 2020, Executive (EX) Committee and Plenary – Attachment Four*). The motion passed unanimously.

5. ** Adopted AG 49-A**

Mr. Andersen explained the background behind the development of AG 49-A, which starts with the *Life Insurance Illustrations Model Regulation (#582)*. Model #582 specifies the requirements for life insurance illustrations. Mr. Andersen said insurance companies favor illustrations because they allow the demonstration to consumers of both guaranteed and non-guaranteed elements of life insurance policies. He said an example of a non-guaranteed element is the credited rate on a policy’s account value in a given year. He said, for some policies in some products, this credited interest rate is determined at the beginning of a policy year, dependent on the market interest rate and market factors at that time. He said for indexed universal life (IUL) insurance policies, the credited interest rate plays out during a policy year. He said in many cases, it depends on the movement of a stock market index during that year. He explained that if Standard & Poor’s 500 index (S&P 500) has a good year, there will be a higher credited interest rate; but if the S&P 500 has a bad year, the credited interest rate might be zero. He said the account might not lose money due to that movement, but it does not gain money in a bad stock market scenario either. He said the question is how these credited interest rates should be illustrated.

Mr. Andersen explained that the Model #582 contemplates constraints on illustrations based on what has recently happened. He said for indexed products, there were concerning practices taking place involving illustrations of what has recently happened, which led to *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49)* being developed in 2015. He said an extreme example of what AG 49 was trying to prevent is risky international stock funds that had a good five-year run being the baseline for an illustration that projects the next 30 years.
Mr. Andersen explained that in 2018, commissioners became aware of product innovations that were leading to the illustration of even higher credited rates than was contemplated when AG 49 was being developed. The biggest innovation was the multiplier. He said the multiplier results in more downside and more upside than related indexed products seen before. He said in 2018, the Committee charged the Life Actuarial (A) Task Force, which formed the IUL Illustration (A) Subgroup, to address any concerns with these products. Throughout 2019, there were a number of open in-person meetings and conference calls, and key decisions were made. Mr. Andersen said the first decision by the Task Force was to reject a proposal from a coalition of active IUL writers suggesting that adding disclosures would be a sufficient way to address the charge. The Task Force instead decided to take a more conservative approach and place additional constraints on the illustrated credited rates. The second decision by the Task Force was to reject a proposal by a large contingency of companies that suggested that products with multipliers should illustrate more favorably than products without multipliers. The Task Force instead decided to allow products with multipliers to illustrate no more favorably than products without multipliers. The third decision was to add more conservatism in the illustration of policy loans, cutting in half the illustrated benefit of borrowing at a certain rate and illustrating at a rate that was up to 1% higher and under Task Force adoption would now be 0.5% higher.

Mr. Andersen said the general concept behind these issues is selecting a point on the spectrum of allowing innovation on one side preventing loopholes on the other side. He acknowledged that on the Task Force, there were many differing opinions about where on the spectrum of allowing innovation verses preventing loopholes the Task Force should land. He said AG 49-A lands somewhere in the middle, but it is significantly more conservative than AG 49.

Commissioner Ommen spoke in support of AG 49-A. He said this project is critically needed at this time and reflects the knowledge and diligence of the Task Force members. He said AG 49-A is a big step forward for consumers.

Scott R. Harrison (IUL Coalition) said the outcome, while not perfect, does successfully resolve the concerns raised by state insurance regulators. He said that the IUL Coalition still supports disclosures, and there is opportunity to work on enhanced disclosures for innovative products. Mr. Bayerle is supportive of AG 49-A. He said it addresses the issues at hand without stifling innovation. He said that while not perfect, it will be a positive outcome for consumers.

Birny Birnbaum (Center for Economic Justice—CEJ) cautioned the Committee to keep in mind that the purpose of this effort is to reign in unrealistic and deceptive IUL illustrations and prevent insurers from using product designs to juice accumulation values with no real benefits to consumers. He said these are faux innovations. He said this resulted in an approach to setting maximum crediting rates that is overly complex, untethered to reality and virtually impossible for regulatory or consumer accountability.

Mr. Birnbaum said AG 49-A was developed under a flawed process orchestrated by industry. He said AG 49-A reflects policy decisions that are fundamentally anti-consumer, and they should have been made by the Committee instead of the Task Force actuaries. He said a high-level task force should be created to address the inherent deceptiveness and over-complexity of current illustrations. He said AG 49-A is too complex to permit any accountability of insurers to consumers or state insurance regulators, and it still creates opportunities to game the guideline.

Mr. Birnbaum identified four major areas of concern:

1) The flawed process used to develop AG 49-A was the result of an inappropriate request by the Task Force for the ACLI to coordinate industry to come up with a proposal, effectively giving ownership of the AG 49 rewrite to the very insurers whose practices were causing the problems the Task Force was charged with stopping. Mr. Birnbaum said this resulted in an approach to setting maximum crediting rates that is overly complex, untethered to reality and virtually impossible for regulatory or consumer accountability.

2) The Task Force should be directed to work with the Independent Proposal, which was drafted by independent experts who have expertise in the design and sale of IUL and other life insurance products, who have no financial interest in the outcome. Mr. Birnbaum said the Independent Proposal establishes a simpler, more effective and more accountable approach to establishing crediting rates for IUL illustrations.
3) The application of any revised protections should apply to all illustrations whether for new policies or for new illustrations on in-force policies regardless of date of issue. Mr. Birnbaum said if the purpose for revising AG 49 is to stop unrealistic illustrations and provide consumers with better information and expectations about how the IUL product will operate and perform, logic dictates that the consumer protections in a revised AG 49 should be available to all consumers.

4) The revised AG 49-A must eliminate loan arbitrage that permits illustrations to show premium and finance policy loans as a risk-free way to make money. Mr. Birnbaum said the current AG 49 and proposed AG 49-A permit policy loans to be illustrated with a policy loan interest rate less than the crediting rate for illustrating account value accumulation. He said this is an example of illustrating riskless arbitrage—the consumer can borrow money at one rate and earn a higher rate of return without any risk. He said this allows IUL illustrations to present future loans on the policy as cash disbursements that never need to be paid back because the policy is continuing to earn the constant better-than-loan-interest-rate returns.

Bonnie Burns (California Health Advocates) said she was shocked by the complexity of the illustration that Mr. Birnbaum attached to his comment letter. She said that a person would need to take a class to be able to understand this document.

Director Froment said she has been actively engaged with Mr. Boerner and Mr. Andersen throughout the development of AG 49-A. She said it is clear to her that they have made incredible progress that will have an immediate positive impact on consumers. She said the longer action is delayed, the longer these illustrations will continue the way that they are. She said she recognizes that there is a broader question, and she would like to discuss at the Summer National Meeting the possibility of a new charge to thoroughly review the design and regulation of illustrations and determine what changes, if any, might be needed and what group might be best able to handle the charge.

Mr. Carmello said New York would support taking a fresh look. Commissioner Ommen said he supports moving forward with AG 49-A because there is a need for immediate action. However, he recognizes that a state insurance regulator’s work is never done, and he would support further review of illustrations broadly and the Task Force’s consideration of aspects of the Independent Proposal, to the extent that they were not considered before.

Commissioner Ommen made a motion, seconded by Commissioner Ridling, to adopt AG 49-A amendments (see NAIC Proceedings – Summer 2020, Executive (EX) Committee and Plenary – Attachment Five). The motion passed unanimously.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
The Life Insurance and Annuities (A) Committee met via conference call Dec. 30, 2019. The following Committee members participated: Doug Ommen, Chair, (IA); Stephen C. Taylor, Vice Chair (DC); Jim L. Ridling represented by Steve Ostlund (AL); Keith Schraad represented by Vincent Gosz (AZ); Trinidad Navarro represented by Fleur McKendell (DE); Dean L. Cameron (ID); James J. Donelon (LA); Bruce R. Ramge (NE); Barbara R. Richardson (NV); Linda A. Lacewell represented by Mark McLeod (NY); Jillian Froment (OH); Hodgen Mainda represented by Brian Hoffmeister and Rachel Jade-Rice (TN); and Mark Afable represented by Richard Wicka (WI). Also participating were: Jodi Lerner and Perry Kupferman (CA); Jason Lapham (CO); Jim Walker (FL); Teresa Winer (GA); Amy Beard (IN); Tate Flott and Julie Holmes (KS); Al DeRemigis (MD); Lindsay Laxon (ME); Renee Campbell (MI); Cynthia Amann (MO); Keith Nyhan and Denise Lamy (NH); Jeffrey Rohaly (PA); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Andrew Dvorine (SC); Mike Boerner, Doug Danzeiser and Phil Reyna (TX); Tomasz Serbinowski (UT); and Michael Gerachis (VA).

1. **Adopted Revisions to Model #275**

Commissioner Ommen explained that during the Committee’s meeting at the Fall National Meeting, the Committee directed the Annuity Suitability (A) Working Group to review and consider revisions to the proposed draft appendices to the *Suitability in Annuity Transactions Model Regulation* (Model #275). He said the Working Group met Dec. 19 via conference call and revised the draft appendices (see NAIC Proceedings – Summer 2020, Life Insurance and Annuities (A) Committee, Attachment Four-A).

Commissioner Ommen said that prior to this conference call, NAIC staff distributed a draft of proposed revisions to Model #275 reflecting the Working Group’s revisions to the appendices during its Dec. 19 call and additional revisions he is suggesting as Committee chair. He suggested that the Committee review the draft and discuss his suggested revisions. There was no objection.

Commissioner Ommen discussed the suggested revisions to Section 6A(2)—Disclosure Obligation. He explained that the suggested revisions are being made for consistency with the proposed language for Appendix A. He requested comments. There were no comments.

Commissioner Ommen discussed the suggested revisions to Section 6A(4)—Documentation Obligation. He explained that the suggested revisions to this provision reflect the discussion during the Working Group’s Dec. 19 conference call to add an Appendix C.

Commissioner Ommen explained the suggested revision to Section 6A(5)—Application of the Best Interest Obligation to add the word “direct” for clarity. He said that during its discussions of the proposed revisions to Model #275, the Working Group extensively discussed Section 6A(5) and its intent to apply the proposed best interest standard of conduct to any producer who exercises material control or influence in the making of a recommendation and who receives direct compensation as a result of the recommendation or sale. He requested comments. There were no comments.

Commissioner Ommen next discussed the proposed drafting note for Section 6C(2)(h)—Supervision System. He explained that the Utah Insurance Department suggested the drafting note to clarify the intent of Section 6C(2)(h).

Director Cameron asked about the provision’s intent. Commissioner Ommen explained that Section 6C(2)(h) is intended to require insurers to eliminate certain types of incentives targeted at specific annuities within a limited period. He said Section 6C(2)(h) does not prohibit general incentives regarding sales of a company’s products with no emphasis on any particular product. He said the proposed drafting note is consistent with this intent.

Gary Sanders (National Association of Insurance and Financial Advisors—NAIFA) suggested the Committee consider amending the drafting note to more closely track the language in Section 6C(2)(h) by deleting the words “that promote” and replacing those words with “based on.”

Mr. Serbinowski said Utah has no objection to the suggested revision. After discussion, the Committee accepted Mr. Sanders’ suggested revision.
Commissioner Ommen next discussed the suggested revisions for Section 6E—Safe Harbor. He said the suggested revisions to Section 6E are the result, in part, of his discussions with NAIC staff and the U.S. Department of Labor (DOL) staff, particularly with respect to language in Section 6E concerning fiduciaries. He explained that the suggested revision to Section 6E(1) clarifies the general scope of the safe harbor. He said the suggested revisions to Section 6E(4)(b) clarify the scope of the safe harbor with respect to investment adviser representatives. He said the suggested revision to Section 6E(4)(c) to change the statutory citation from Section 4975(f)(8)(J)(i) of the Internal Revenue Code (IRC) to Section 4975(e)(3) of the IRC also is clarifying. He explained that the initial IRC citation was not wrong, but, as explained by the DOL staff, it was not broad enough to be consistent with Section 3(21) of the federal Employee Retirement Income Security Act of 1974 (ERISA).

Director Ramge suggesting adding the language “and any amendments or successor statutes thereto” to Section 6E(4)(c) for consistency with the language in Section 6E(5)(c). There was no objection to his suggestion.

Commissioner Ommen discussed the suggested revisions to the drafting note for Section 6E(5)(b). He said the suggested revisions are clarifying. There was no objection to the suggested revisions. He discussed the suggested revisions to Section 6E(5)(c), which also are a result of his discussion with the DOL staff. He explained that under some provisions in federal law describing fiduciaries, a fiduciary may not have fiduciary duties. He said the suggested revisions address this issue. There was no objection to the suggested revisions.

The Committee next discussed proposed Appendix A—Agent (Producer) Disclosure for Annuities. Commissioner Ommen said Appendix A is based on and was developed by the Working Group to provide guidance on the information to be provided to consumers in accordance with Section 6A(2)—Disclosure Obligation.

Director Froment acknowledged and expressed appreciation for the comments received on Appendix A. She said that in reading the comments, she believes many of the suggested revisions have already been extensively discussed, and many are outside the scope of the proposed revisions to Model #275. She reiterated that the Working Group developed the appendices to provide guidance and clarity of expectations for producers. She said the appendices were not meant to be buyer’s guides for consumers.

Commissioner Ommen walked the Committee through the provisions of Appendix A, beginning with its proposed title. Director Froment said she could support the Fixed Annuity Consumer Choice Campaign’s (FACC) suggestion to add the word “insurance” to the title for consistency with the next section in the appendix. There was no objection to her suggestion.

Commissioner Ommen discussed next the section in the appendix describing the information the insurance producer is to provide in the form. He explained that the Working Group’s revisions to Appendix A included an “Additional Information” section, which required the inclusion of the producer’s national producer number (NPN). He said that as part of the Committee chair’s suggested revisions to Appendix A, he has deleted the “Additional Information” section because the information that was to be provided under that section was outside the scope of the proposed revisions to Model #275. He suggested including the NPN in this section. There was no objection to his suggestion.

Commissioner Ommen next discussed the “What Types of Products Can I Sell You?” section.

Director Froment said the Working Group extensively discussed this section. She said the purpose of this section is to provide meaningful information to consumers without overwhelming them with too much information and making it lose its meaning. She said she believes the proposed language for this section strikes a good balance.

Commissioner Taylor and Commissioner Donelon expressed support for Director Froment’s comments. No revisions were made to this section.

Commissioner Ommen next discussed the section “How I’m Paid for My Work.” He said he is suggesting alternative language to what the Working Group developed for this section, which he believes is more consumer friendly. He asked for comments.

Director Froment expressed support for Commissioner Ommen’s alternative language with some minor revisions. There was no objection to substituting Commissioner Ommen’s alternative language for this section for the Working Group’s language.
Director Froment suggested deleting “or third parties such as independent marketing organizations” and replacing it with “other sources” and requiring the producer to further describe the other sources of compensation. She said she suggests this revision because consumers typically will not know what an “independent marketing organization” is. She also suggested deleting the word “cash” in the box and replacing it with “above” for clarity. There was no objection to her suggested revisions.

Commissioner Ommen reiterated his reasons for deleting the “Additional Information” section because the information to be included in this section was outside the scope of the proposed revisions to Model #275. There was no objection to deleting the section.

The Committee next discussed proposed Appendix B—Consumer Refusal to Provide Information. No changes were made to this appendix.

The Committee next discussed proposed Appendix C—Consumer Decision to Purchase an Annuity NOT Based on a Recommendation.

Director Froment explained that during the Working Group’s Dec. 19 conference call, the Working Group decided it was appropriate to split Appendix B into two appendices, with Appendix C being the second appendix because the appendices address the two different situations described in Section 6A(4)—Documentation Obligation.

Commissioner Ommen asked for comments from the Committee on the appendices.

Commissioner Richardson asked if it was the Working Group’s intent to restrict the appendices, if possible, to one page. Commissioner Ommen said for Appendix A, he believes it could be one page, but there was no specific intent to make it one page.

Commissioner Richardson explained that she has seen issues with forms having the acknowledgement and signature on a separate page removed from the substantive language in the form. She suggested adding a drafting note above the acknowledgement and signature lines to instruct insurers that the acknowledgement and signature should be in immediate proximity to the disclosure language. There was no objection to her suggestion.

Director Froment made a motion, seconded by Commissioner Taylor, to adopt the revisions to Model #275 (see NAIC Proceedings – Summer 2020, Executive (EX) Committee and Plenary, Attachment Two-A). Alabama, Arizona, Delaware, District of Columbia, Iowa, Louisiana, Nebraska, Nevada, Ohio, Tennessee and Wisconsin voted in favor of the motion. New York voted against the motion. The motion passed.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
Accelerated Underwriting (A) Working Group  
Virtual Summer National Meeting  
July 31, 2020

1. Adopted its March 12, Feb. 20, Feb. 6, Jan. 23, and 2019 Fall National Meeting Minutes


2. Heard an Update Presentation on the Work of the Working Group

Director Muriel said the rest of this meeting is going to be an update presentation on the progress of the Working Group. He said he is going to review the process the Working Group is following, and Mr. Tsang will review some of the highlights of the information shared with the Working Group.

Director Muriel explained that the Working Group was formed by the Life Insurance and Annuities (A) Committee at the 2019 Summer National Meeting. He said the Working Group was charged to “[c]onsider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, drafting guidance for the states.” He said there are 12 members on the Working Group: himself as chair, Ms. Arnold as vice chair, Colorado, Iowa, Louisiana, Missouri, Nebraska, North Dakota, Ohio, Rhode Island, Washington and Wisconsin.

Director Muriel said the Working Group held its first coordinating conference call Oct. 2, 2019, and it developed a three-phase work plan. He explained that the first phase is information gathering, the second phase will focus on identifying the issues and deciding on a work product, and the last phase will focus on putting pen to paper. He said the Working Group hopes to have a first draft of its work product by the end of this year, with a final product to the Life Insurance and Annuities (A) Committee by the 2021 Summer National Meeting.

Director Muriel said the Working Group has met 16 times, including its current meeting. He said six of those meetings were held in regulator-to-regulator session pursuant to paragraph 3 of the NAIC Policy Statement on Open Meetings (specific companies, entities of individuals) when requests were made to share information involving particular companies or company-specific proprietary intellectual property. He said the Working Group’s goal is to maintain as open a process as possible, and it even held both open and regulator-to-regulator session with the same presenters.

Director Muriel said the Working Group has heard presentations from: 1) insurance companies about their accelerated underwriting programs and practices; 2) consulting firms about their experience in assisting companies to build and review accelerated underwriting programs (Deloitte, Risk & Regulatory Consulting LLC, and Milliman); 3) a consumer advocate about consumer concerns regarding the use of accelerated underwriting from a fairness perspective (Center for Economic Justice—CEJ); 4) the American Academy of Actuaries (Academy) about accelerated underwriting from an actuarial perspective; 5) lawyers from two Illinois law firms about data collection and privacy from a legal standpoint (Foley & Lardner LLP and Edelson PC); and 6) a machine learning assurance company about its experience in assisting companies to establish controls and audits for artificial intelligence (AI) (Monitaur).
Director Muriel explained the next steps that the Working Group plans to follow. He said the Working Group plans to form two ad hoc subgroups. He said one is called the Ad Hoc Liaison Subgroup, which will focus on coordinating with the all the other NAIC groups that are looking at related issues; and the other is called the Ad Hoc Drafting Subgroup, which will focus on synthesizing information and making a recommendation to the Working Group on a work product.

Mr. Tsang explained that accelerated underwriting is an emerging platform; and traditional underwriting is still the norm for most applications. He said companies are pursuing accelerated underwriting because it offers many attractive business incentives, such as the potential to save on underwriting expenses, especially for low premium policies like term life insurance, where it can take companies several years to break even. Accelerated underwriting is also attractive to companies because when underwriting takes less time, companies can underwrite more policies. Life insurance applicants also benefit from accelerated underwriting because the process can be accomplished entirely online without any invasive blood tests.

Mr. Tsang mentioned that companies may give up important medical information in using accelerated underwriting, which may lead to higher mortality risk. He said, unlike traditional underwriting, which is based on the current underwriting manual, accelerated underwriting relies on the reasonableness of its algorithm. He said accelerated underwriting also requires companies to implement additional controls and documentation responsibilities, including disclosures to applicants who receive an adverse underwriting decision.

Mr. Tsang said with respect to the data used in accelerated underwriting, insurers have the sole responsibility to collect, scrutinize and analyze the input data to ensure that it is accurate. He said some companies, with the help of reinsurers, use third parties to collect data and provide an initial risk analysis. He said some accelerated underwriting programs “triage” applications into separate groups. He explained that under some accelerated underwriting programs, when an applicant is triaged as someone who should go through the remaining accelerated underwriting steps, the algorithm then assigns the applicant a risk score and recommends a risk class. He said a human underwriter reviews that recommendation and may request a blood or urine test even when the accelerated underwriting program recommends otherwise.

Mr. Tsang said the data collected for accelerated underwriting is normally a subset of traditional underwriting data, and it includes a mix of medical and behavioral data, such as: 1) data provided in the life application; 2) an attending physician statement; 3) prescription drug history; and 4) Medical Information Bureau (MIB) info. He said it is important to note that accelerated underwriting programs and its algorithms are assisting, not replacing, human underwriters by collecting data and performing an initial risk analysis.

Mr. Tsang explained that traditional underwriting is considered the “gold standard,” and each company expects its accelerated underwriting program to replicate the gold standard via back-testing. He said the interactions between the accelerated underwriting program and the human underwriter enable the algorithm to learn from its mistakes and improve via the machine learning process. He explained that back-testing may also identify isolated prior underwriting errors and provide valuable feedback to the human underwriter.

Mr. Tsang explained that accelerated underwriting algorithms are not static. He said most are on their second- or third-generation algorithm, and they continue to change through machine learning processes. He said insurers develop controls and documentation for the first-generation algorithms, but they sometimes place less emphasis on the controls and documentations for later generations. He said it is important that companies continue to perform the checks and balances on all generations of their accelerated underwriting programs. Besides medical data, some companies believe that behavioral data can also provide...
important information about an individual’s risk profile, especially for younger people. Some examples of the behavioral data collected are gym membership, profession, marital status, family size, shopping habits, wearables and credit scores.

Mr. Tsang said if behavioral data is not properly scrutinized, association may be confused with causation and lead to unfair adverse underwriting decisions. For example, a high-income individual is perceived as someone who has excellent medical care. However, a high-income individual may also have the resources for illegal drug use, or a healthy young couple may not have the dispensable income to join a gym but exercise on their own. In that case, lack of a gym membership should not indicate an increased mortality risk. He cautioned that behavioral data could lead to incorrect conclusions or unintended discrimination.

Mr. Tsang said the Working Group has spoken with only a few major life insurers about their current accelerated underwriting practices, so its findings are not conclusive. He said, generally, larger companies have resources to develop their own accelerated underwriting programs. Accelerated underwriting programs require plenty of resources, and they can be expensive.

Mr. Tsang said compliance with laws and regulations is the responsibility of a company’s chief risk officer (CRO), general counsel, and enterprise risk management committee. Smaller companies may not have the required resources to develop their own programs and rely on external consulting firms to monitor and build controls for their accelerated underwriting programs.

Mr. Tsang said insurers have high expectations for accelerated underwriting programs because of their potential to reduce human errors in data processing and allow human underwriters to spend more time on high value activities. He said the potential for savings is significant for low premium products, such as term insurance. The companies expect that the expense savings, along with the ability to issue more policies, compensates for the potentially higher mortality cost.

Mr. Tsang said based on a 2019 Society of Actuaries (SOA) “Accelerated Underwriting Practices Survey,” companies rely mostly on data in the application form and other medical-related data. Some companies also rely on other data such as motor vehicle records, criminal history, credit scores and financial data. Very few companies use data such as electronic health records, wearables and social media usage. Mr. Tsang said companies are currently using back-testing, random holdouts, post-issue monitoring and other techniques to examine the accuracy of accelerated underwriting programs. He said peer reviews are also used to test a program’s compliance with applicable laws and regulations.

Mr. Tsang said there are several federal laws that may affect accelerated underwriting programs, such as the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which protects medical data privacy. There is the federal Fair Credit Reporting Act (FCRA), which protects credit data privacy and prohibits illegal use of credit data. Most recently, at the state level, there is the NY Circular Letter No. 1 issued in January 2019, which outlines the key compliance issues for accelerated underwriting; i.e., integrity of input data, transparency of algorithm, and adequate disclosure). There is also Florida House Bill 1189, which is the first state law that prohibits insurers from using genetic data for underwriting and pricing of life, disability and retirement products.

Mr. Tsang said credit data is not widely used in accelerated underwriting programs today, but that is likely to change over the next decade. He said credit data is popular among the companies that use it, like employers and banks, because it covers most Americans and the data is updated frequently. A few life insurers currently use credit data as an input item for their AU programs. Mr. Tsang said those companies have performed actuarial studies to justify its soundness, actuarially. He said a typical credit report contains about 800 attributes, which include a consumer’s employment history, mortgage payment history and rental payment history, among other things. Insurers only use about 50 out of the 800 attributes because many of these attributes are correlated with one another.

Mr. Tsang said using credit score data is controversial, as the distributions of credit scores are quite different among ethnic groups and there is not a lot of information on how companies document their monitoring and control processes for unlawful discrimination. He said the selected attributes are perceived as variables that explain the consumer’s behavior. He said the mortality hypothesis is that individuals with high credit scores are expected to have lower mortality risk profiles; but the correlation between mortality and credit score is not absolute. For example, having a high credit score does not shield a person from illness.

Mr. Tsang said it is easy to confuse association with causation. He said two items that behave in similar patterns does not mean that one is causing the other. He said while some companies consider credit score as a valuable input to explain mortality risk, some groups challenge this view due to the potential confusion of association with causation. He said credit scores should not be used in isolation, and checks and balances must be employed to minimize the occurrence of unintended discrimination.
against protected classes. He suggested that one possibility is to use credit data as a supplemental data point rather than a key input variable in order to use it as a check for a negative rather than a check for a positive.

Mr. Tsang said the FCRA protects consumers from illegal uses of their credit scores, and it allows consumers to see their data and challenge the data’s validity; however, the scope of FCRA is limited, and it does not cover personal information such as credit card purchases, social media usage and wearables. Consumers do not have an avenue to challenge the validity of non-FCRA data or any adverse decisions that may arise as a consequence. Currently, few companies use non-FCRA data, but this may change over time.

Mr. Tsang highlighted a few questions that state insurance regulators may want to consider, such as whether insurance regulations should be updated to disallow the use of non-FCRA covered data or to provide avenues for customers to challenge the validity of non-FCRA data and its adverse effects.

Mr. Tsang said Birny Birnbaum (CEJ) gave a presentation where he raised a number of concerns regarding the potential for adverse underwriting decisions to unfairly affect minorities. Mr. Birnbaum said: 1) the regulatory framework has failed to keep pace with the market in terms of using big data and AI; 2) the input data used by insurers may have inherited biases, which should be removed or controlled; 3) regulations should promote fairness, and underwriting decisions should not be justified solely on actuarial soundness; and 4) the life industry should promote availability and affordability of insurance products to protected classes and curtail any unlawful discrimination. Mr. Tsang said Mr. Birnbaum also provided some other suggestions, including requiring companies using accelerated underwriting to file their accelerated underwriting programs with state insurance regulators for review, which is consistent with the accelerated underwriting programs for auto and property insurance. Mr. Birnbaum also suggested extending FCRA-type protections to all input data for accelerated underwriting.

Ms. Shepherd asked whether companies are using accelerated underwriting currently. Mr. Tsang said there are large companies developing and using their own accelerated underwriting programs, and smaller companies are working with consultants or reinsurers to develop a template to modify and use. He said right now, about 10% of applications go through accelerated underwriting, but he expects that to increase to around 40% within the next decade.

Mr. Birnbaum asked about how the Ad Hoc Liaison Subgroup and the Ad Hoc Drafting Subgroup would be formed and report their work. Director Muriel said the membership for the subgroups is just getting established, but he assured Mr. Birnbaum that the subgroups would hold open meetings to discuss how to develop and report their work to the Committee.

Peter Kochenburger (University of Connecticut School of Law) asked how important it is for accelerated underwriting modelers to be able to plausibly provide a causation analysis as well as a correlation. Mr. Tsang said it is important that there be some reasoning and rationale provided for why one variable would be causing another, above and beyond observing a pattern or correlation between two variables.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
Accelerated Underwriting (A) Working Group
Conference Call
March 12, 2020

The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call March 12, 2020. The following Working Group members participated: Robert H. Muriel, Chair, Mike Chrysler, Bruce Sartain, Fred Moore, Vincent Tsang and Lita Mavrothalasitis (IL); Grace Arnold, Vice Chair, Fred Andersen and John Robinson (MN); Jason Lapham (CO); Russ Gibson and Lindsay Bates (IA); Rich Piazza (LA); Chris Aufenthie and Ross Hartley (ND); Sarah Neil (RI); Lichiou Lee and David Hippen (WA); and Mark Afable, Barbara Belling, Susan Ezalarab, Diane Dambach, Rebecca Rebholz, Mary Kay Rodriguez, Renee Fabry and Richard Wicka (WI). Also participating were: Katherine Hrouda, Perry Kupferman and Pam O’Connell (CA); Wanchin Chou (CT); Jo McGill (ID); Karl Knaale (IN) Brenda Johnson and Barbara Torkelson (KS); Renee Campbell (MI); Denise Lamy, Roni Karnis and Karen McCallister (NH); Peter Dumar and Todd Cafarelli (NY); Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed Next Steps

Director Muriel reminded the Working Group and interested parties that the Spring National Meeting is cancelled and plans for having meetings via conference call are underway. He said he has been considering the best way for the Working Group to commence with the next phases of its work plan. He said one idea is to appoint two subgroups: 1) a drafting subgroup; and 2) an NAIC Liaison Subgroup.

Director Muriel explained that the drafting subgroup would focus on synthesizing the information received in the presentations and making a recommendation to this Working Group about the type of work product to develop. He said the drafting subgroup could also propose a process for accomplishing the work product. He said the NAIC Liaison Subgroup could focus on ensuring that this Working Group is aware of the work undertaken by all other NAIC groups, past and present, that might be useful. He asked that people with feedback on the subgroups or interest in participating in either subgroup email Jennifer R. Cook (NAIC).

2. Heard Presentations

Director Muriel said the Working Group today would hear presentations from two Illinois law firms: 1) Edelson PC; and 2) Foley & Lardner LLP.

a. Accelerated Underwriting: Potential Data Collection Methods and Concerns

Director Muriel introduced Shawn Davis (Edelson PC) as the director of digital forensics with Edelson PC and an adjunct industry professor with the Illinois Institute of Technology. Mr. Davis said he was going to focus his presentation on: 1) how consumer data is collected and users are tracked online; 2) issues that may be of concern with accelerated underwriting going forward; and 3) suggestions for possible guidelines or regulations.

Mr. Davis said there are two main types of data collection mechanisms: 1) active data collection; and 2) passive data collection. He said active data collection occurs when a consumer knowingly gives information, usually filling out a survey, web registration forms or social media postings. Passive data collection is running in the background, and it tracks consumers’ activity through the use of cookies, IP addresses or MAC addresses, geolocation, browsers and http headers. He said every time someone clicks on a website, third parties are automatically notified. He explained that his firm uses a network interception proxy to see background network traffic. He gave an example where, in 2018, he went to four websites and clicked on one link on each website, and 192 third parties were contacted by clicking on one link on four sites. He conducted this same test two and a half years later, and 347 third parties were notified.

Mr. Davis said there is a lot of information being collected and transmitted to third parties in which consumers have no idea. Almost all websites have third-party software code built in, like Google code, Facebook code or Adobe code. Each website will place a cookie on your computer to identify you, or it will read that cookie to see if it is you when you are looking at a site. Whatever pages you click on, the third parties know based on the cookies. Companies also track geolocation, and they are able to do so with a great deal of specificity so they can tell where you are and what you have looked at. This is collected from an app.
Mr. Davis said geolocation is also collected from people’s devices. For example, if someone turns on Google maps, Google sees everywhere you have gone. Apple phones also track geolocation, but they do not send the information back to Apple. Facebook also collects information, which is personally linked to the individual. Educational platforms also collect massive amounts of information in order to implement adaptive learning programs. Health information is another category of information that is collected and shared with third parties. For example, GoodRx provides discounts for prescription drugs, and it sends names of drugs selected for coupons to Facebook. Mr. Davis said some telehealth apps also disclose medical information to third parties. Financial data is another category of data that is collected. Data is collected every time someone swipes their credit card or uses a mobile payment application. Then, there are financial transaction data aggregators like Yodlee and Mint. Mr. Davis said these companies provide a service that allows consumers to log on to their accounts and pull transactional data into a single application. Yodlee then sends “de-identified” data to clients to determine risk.

Mr. Davis explained that consumers cannot always trust that their data has been truly de-identified, and he explained that there is a difference between “de-identified” data and “anonymized” data. He explained that data can often easily be “re-identified.” He explained that there are direct identifiers, like name, Social Security number, driver’s license number, phone number or email address. There are also indirect identifiers that do not identify someone on their own, but they may when combined; e.g., ZIP code, age and race. If data has been de-identified, all direct and indirect identifiers are removed from the data, but it contains a unique identifier. The original data collector has a link between the identifier and the identity of the people. The data purchaser does not have the link, and it cannot re-identify people. On the other hand, data is anonymized when all direct and indirect identifiers are removed, and there is no way for either the collector or the buyer to re-identify it.

Mr. Davis said there is a false narrative that once information is de-identified, it cannot be used to identify people; however, companies often remove direct identifiers but indirect identifiers may remain. He said 87% of people in the U.S can be re-identified with only date of birth, gender and ZIP code. He said re-identification of 90% of the people in the U.S. is possible with only four transactional data points from purchases, noting that both passive and active collectors often collect passive information, such as geolocation. He said an address can be determined from geolocation and a person can be identified.

Mr. Davis said the data is collected by data brokers, and Acxiom is the largest data broker. As of 2018, Acxiom collects more than 5,000 data points across 700 million consumers worldwide. He shared some examples of the data points collected: socioeconomic status; economic stability; one of nearly 200 ethnic codes; religion; health interests; alcohol and tobacco interests; casino gaming and lottery interests; details about someone’s home; whether someone is planning to have a baby; details about banking and insurance policies; media usage; credit card purchases; activities; relationship status; age; gender; education; employment; and number of children.

Mr. Davis said life insurers are starting to look at using data from data brokers to identify risky clients. He said insurers are starting to test mined data from shopping history, social media and magazine subscriptions to identify risky clients. He showed a slide used by a consulting company illustrating how marketing data can be used by life insurers to indicate eligibility for a preferred policy as opposed to additional underwriting. According to the consulting company’s infographic titled, “Can Marketing Data Predict Life Span?,” a sample potential customer “Sarah” is profiled. Sarah reads travel magazines, has good finances, bikes and runs, eats healthy food, and does not watch a whole lot of TV. Based on this profile, Sarah should be actively pursued for new business and retention, and the insurer should quickly issue her a preferred policy without additional underwriting. In contrast, a sample potential customer “Beth” is also profiled. Beth has a long commute, has had a bankruptcy, frequently eats at McDonalds, bought a treadmill, and watches a lot of TV. Based on this information, the recommendation is not to send Beth any offers, not to pursue aggressive retention efforts, and to collect more information to review before offering Beth a policy. Mr. Davis said another area is mailing lists. Mailing lists can be bought based on specific information. A purchase can sort for certain information, such as religion, ethnicity and income level, to generate a leads list.

Mr. Davis discussed potential concerns with using this data. He explained that the federal Fair Credit Reporting Act (FCRA) has jurisdiction over consumer reporting agencies’ (CRAs) use of data. CRAs are companies whose primary purpose is to collect consumer information and provide reports. Under the FCRA, people have the right to be told if information in a consumer report is used against them in order to deny an application for insurance. Under the FCRA, consumers have the ability to request the data that a CRA possesses, including credit reports, and it provides consumers with the ability to dispute incorrect information. Under the FCRA, consumers are able to see everyone who has accessed their credit report. The FCRA has jurisdiction over 400+ CRAs, including credit bureaus and companies that screen tenants. However, FCRA requirements do not apply to companies that are not CRAs. The new types of data that insurance companies are looking to use in accelerated underwriting—such as purchase data, web history data, geolocation from mobile apps, driver data from apps, facial and behavioral analytics, social media data, fitness data from wearables, electronic health records, and genetic data—are not
covered under the FCRA. Consumers do not have the right to be advised of any adverse action taken in reliance on this data, nor is there a mechanism to dispute potential inaccuracies.

Mr. Davis also said it is difficult for insurance companies to know if this data is accurate. He gave several examples of the potential for non-FCRA data to be inaccurate. For example, he said an individual who purchases alcohol for clients in a sales job could incorrectly be added to an “alcoholic” profile in a data broker list. Another example is facial analytics that scans people faces to detect medical conditions or whether someone might be a smoker. Facial analytics may not detect plastic surgery, which could improve approvals for wealthy individuals or the facial analytics algorithm may incorrectly categorize a person as a smoker due to crow’s feet and under eye bags when they may be stressed or tired. Wearable devices may inaccurately sense heart rate or oxygen levels and falsely categorize someone as a potential heart attack risk. Web use inaccuracies may result from search data or social media. Mr. Davis gave the example of a wife researching her husband’s cancer or joining a network cancer group, resulting in the wife being added to a data broker cancer risk profile. Another example is mobile applications flagging an individual who frequently drives near medical offices as a risk due to mobile app geolocation data. Another example is posting a happy hour on Facebook and getting flagged as a potential alcohol abuser.

Mr. Davis said another concern is discrimination. He explained that insurance by nature discriminates based on things such as health, age and gender. However, insurance should not discriminate based on an individual’s race, religion or beliefs, national origin, employer, sexual orientation, geography or disability. It is possible that algorithms may inadvertently be causing additional medical underwriting at a higher rate for protected classes of people. Artificial intelligence (AI) and machine learning may make unintended decisions or adapt models without an insurance company realizing. Some examples of this include an algorithm that may inadvertently evaluate skin tone during facial analytics and flag race; or, an algorithm may flag minorities or LGBTQ persons due to the types of magazines they read or TV shows and movies they watched. An algorithm might also flag individuals as a risk due to geolocation data for an area that is tied predominantly to a particular race or national origin.

Based on the potential for inaccurate conclusions and inadvertent discrimination to be based on non-FCRA data, Mr. Davis suggests that state insurance regulators consider guidance or regulations for: 1) transparency of risk algorithms used to state insurance departments; 2) prohibiting the use of non-FCRA data or requiring similar adverse action reports as required under the FCRA; 3) transparency to consumers when non-FCRA data is used; 4) auditing or evaluating new technologies, such as facial analytics and wearables, for accuracy; and 5) ensuring that re-identification methods are not used for purchased data where consumers were originally told data was de-identified or anonymized.

b. Changing Legal Landscape: Privacy Developments

Jennifer Urban Rathburn (Foley & Lardner LLP) gave a presentation on privacy developments affecting the insurance industry. She explained that the current debate focuses on the merits of a comprehensive legal privacy regime versus allowing industry and companies to self-regulate. She said there is a strong trend towards more sweeping privacy legislation at the international, federal and state levels. Some examples include New York’s cybersecurity regulation for financial services companies (23 NYCRR 500), the European Union (EU) General Data Protection Regulation (GDPR), Nevada’s privacy law and the California Consumer Privacy Act (CCPA), which have all been enacted in the past five years.

Ms. Rathburn said her presentation is based on providing guidance to companies to address the privacy laws that are emerging. She said her presentation describes how companies can best comply with new legal requirements. She said there is a lot of focus on how different privacy laws affect the insurance industry and how companies can comply with all these varying regulations. She said companies should look at things from a policy and competitive perspective. Separate from the laws that are being enacted, consumers are becoming increasingly concerned about how their information is being accessed and used. She said companies want to be responsive to these concerns and transparent regarding how they use data.

Ms. Rathburn said companies can gain a competitive edge by having robust privacy programs in place. She said a recent study showed that companies enjoy significant returns on their investments in privacy systems. She said as new legal regimes emerge, there are best practices that companies can put into place to prepare for compliance. She said companies need to make it a priority to know the data they are using and to have processes and mechanisms in place to respond to individual rights, whether an individual wants to access, correct or delete information.

Ms. Rathburn said having a privacy notice that complies with the legal requirements that are in place for such notices in a state is critical. She said companies should regularly review and update their privacy practices, privacy notices, as well as regularly update any third-party contracts in which protected information is shared. She said part of knowing their data is staying up to date on legal developments and classifying data based on its sensitivity in regard to the applicable legal requirements. She said
companies should develop procedures for processing an individual’s rights under the legal regime, including developing model consents and training employees on how to handle requests within the required deadlines.

Ms. Rathburn said when state insurance regulators are looking to develop models, they need to keep in mind not only what they are most concerned about, but also how the insurance company is using data and their continued operations.

Mr. Sartain asked about transparency and whether Ms. Rathburn was aware of any laws addressing how authorizations should specify where data is being collected from.

Ms. Rathburn explained that authorizations usually address a company’s use and subsequent disclosure of information. She said a company’s privacy practices should list what data a company is collecting.

Mr. Davis said a few states have laws covering transparency; but in the majority of cases, consumers are not aware of what information is being collected and used. He said he anticipates that laws will be drafted to cover this issue, noting that he expects nationwide laws addressing the use of data collection to be enacted.

Director Muriel asked Mr. Davis if it is his understanding that life insurance companies are currently using non-FCRA data.

Mr. Davis said that his understanding, based on white papers, is that insurers are not using non-FCRA data currently to deny applications, but they may use the data to decide who to market to or whether to refer an application for additional underwriting. He said his impression is that companies are hesitant to use non-FCRA data, but they are very interested in doing so in the future.

Peter Kochenburger (University of Connecticut School of Law) asked what changes companies may be contemplating to improve how they obtain consumer consent. He said online disclosures are generally problematic, and consent, practically speaking, is often a fiction because few people actually read and understand consent forms or privacy notices.

Ms. Rathburn said, in her opinion, the consent process and privacy notices are just getting more confusing, but companies are trying to address this issue. She said some companies are developing summaries that outline a company’s general data use principles. She said layered notices are also common where checkboxes are utilized to verify that a consumer has read a notice, but there is not a standard, consistent practice. She said things are still in flux, but companies are hoping to develop shorter summary notices that consumers will be better able to understand.

Ms. Mavrothalasitis followed up on Mr. Sartain’s question and asked how to make consumers aware that information from their phones or social media accounts may be used by insurers when they apply for a policy. For example, she said social media accounts or applications on iPhones have consents, and she discussed whether a third party with shared information should also have to obtain consent, or at least highlight to a consumer where they are getting their data from.

Mr. Davis said an application will often prominently state that they will not disclose data to third parties, but the fine print says they will share “de-identified” or “anonymized” data, which, in some cases, can be “re-identified.”

Ari Scharg (Edelson) said when a company gets consent to use data for a specific purpose, this needs to be articulated and identified in its privacy policy. He said this type of usage of data would have to be identified in the privacy policy.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Feb. 20, 2020. The following Working Group members participated: Robert H. Muriel, Chair (IL); Grace Arnold, Vice Chair (MN); Jason Lapham (CO); Russ Gibson (IA); Rich Piazza (LA); Cynthia Amann (MO); Chris Aufenthie (ND); Matt Holman (NE); Jillian Froment and Mark Hamlin (OH); Elizabeth Kelleher Dwyer represented Sarah Neil (RI); David Hippen (WA); and Mark Afable represented by Sue Ezalarab (WI). Also participating was: Wanchin Chou (CT).

1. **Heard a Presentation from the CEJ**

Director Muriel said the purpose of the Working Group’s call is to hear a presentation from the Center for Economic Justice (CEJ), but before the presentation, he wanted to discuss the Working Group’s next steps. He said he understands that some states have reached out to Deloitte to seek their comments on the reviewing, auditing and testing of a life insurer’s accelerated underwriting program. He explained that as discussed during the Working Group’s Feb. 6 conference call, the Working Group has scheduled a few more companies, law firms, the American Academy of Actuaries (Academy), and other speakers to present during future Working Group conference calls on actual company accelerated underwriting practices, legal, and compliance issues. He said the Working Group’s objective is to provide state insurance regulators with a more in-depth understanding of, not just a theory, but the practical aspects of accelerated underwriting. He said following that discussion, the Working Group would discuss the auditing, reviewing and testing issues related to accelerated underwriting. He said the Working Group plans to reach out to Deloitte to have it present to the Working Group during its April 2 conference call on topics such as the auditing, reviewing and testing of a life insurance accelerated underwriting program, as well as its experience related to these topics. He urged Working Group members to contact him or the Working Group’s vice chair if anyone has any questions about the Working Group’s next steps and its objectives.

Birny Birnbaum (CEJ) discussed consumer protection issues related to accelerated underwriting in life insurance (AUW) and regulatory actions needed to address them. He said accelerated underwriting is the application of big data analytics (BDA) in insurance based on the data mining of massive databases with consumer information coupled with predictive modeling, and it has been used by property/casualty (P/C) insurers since the early 1990s. He said that given this, there is a lot of information and experience available to state insurance regulators to review related to BDA and its use with respect to AUW.

Mr. Birnbaum described what types of consumer data are used for certain types of BDA applications. He also discussed the historical and current regulatory oversight over the data and the algorithms used by insurers, explaining why insurers’ use of BDA represents a challenge to state insurance regulation and consumer protection. He said insurers’ use of BDA has a huge potential to benefit consumers and insurers, but it also has huge implications for fairness, access and affordability of insurance and for state insurance regulators’ ability to keep up with the changes and protect consumers from unfair practices. He said the current insurance regulatory framework generally does not provide state insurance regulators with the tools and resources to effectively respond to insurers’ use of big data. He noted that “free-market competition” alone cannot and will not protect consumers from unfair insurer practices. Regulatory modernization is needed to protect consumers, which is even more important for AUW because state insurance regulators do not even have the tools that have been developed for P/C insurance.

Mr. Birnbaum said insurers are using and have used BDA for more than predicting claims, such as fraud detection, price optimization and personalization. He provided a historical background on such use beginning in 2005 with Allstate using BDA algorithms with credit scoring. He described the current regulatory framework and how it has been challenged in the era of BDA. He detailed the regulatory structure in place from its beginnings as the old school era of big data and how that framework has moved to the new school era of big data with limited regulatory oversight and the ability of state insurance regulators to address certain issues, such as disparate impact issues.

Mr. Birnbaum described how BDA models are developed by comparing historical univariate analysis versus modern multivariate analysis, explaining their strengths, limitations and challenges. He said understanding the difference between historical univariate analysis and modern multivariate analysis is essential to understand consumer protection issues, and he needed regulatory response to insurers’ use of BDA. He discussed algorithmic bias and its causes and remedies. He said insurers’ use of BDA increases the potential for proxy discrimination and disparate impact. He highlighted the New York Department of Financial Services’ Circular Letter to insurers on the use of external consumer data and information sources in
underwriting for life insurance and a provision from the NAIC’s *Market Regulation Handbook* on the issue of disparate impact on protected classes. He discussed changes needed to modernize the current regulatory framework to address these issues by providing state insurance regulators with the necessary regulatory tools, resources and techniques to examine disparate impact. He said such modernization needs to generally include new or revised NAIC models, particularly for life insurance that: 1) establish principles and values for insurers’ use of BDA; 2) require routine reporting by insurers and publication by state insurance regulators of types, sources and uses of data by insurers; 3) require advisory organization oversight of vendors providing algorithms for marketing, pricing and claims settlement; 4) require filing and regulatory review of underwriting guidelines and/or tier placement factors, rating plans and algorithms; and 5) provide explicit recognition of disparate impact against protected classes as unfair discrimination in marketing, pricing and claims settlement with safe harbors for practices that assess and minimize disparate impact without compromising cost-based pricing.

Mr. Gibson asked Mr. Birnbaum about disparate impact and disparate intent. Mr. Birnbaum explained the differences between the two. He said disparate intent occurred in the past when insurers intentionally discriminated against consumers with their use of race-based pricing and underwriting. He said disparate impact refers to unintentional discrimination or proxy discrimination, such as the use of criminal history in pricing and underwriting. He said the issue, particularly in this era of multivariate analysis is to recognize the possibility of disparate impact, identify it, and minimize it. Mr. Hippen asked Mr. Birnbaum if he had any recommendations to help to ensure that state insurance regulators stay abreast of what is going on in the marketplace with AUW. He said the first step is for state insurance regulators to establish their values and principles for using BDA. The second step is to make sure the state’s laws are current with respect to the regulatory authority needed to meet the established values and principles. He said the last step is ensuring that the state department of insurance (DOI) has the necessary regulatory resources, such as DOI employee skill sets, needed to analyze multivariate analyses and algorithms to help ensure that insurers are complying with the state’s values and principles for using BDA.

Mr. Chou discussed what has been occurring on the P/C insurance side with respect to BDA and its application to the life insurance side. He also asked how state DOIs can address the issue of limited regulatory resources. Mr. Birnbaum reiterated some of the suggestions that he offered for regulatory modernization to address issues in the new era of AUW. He suggested that state insurance regulators may want to leverage the Interstate Insurance Product Regulation Commission (Compact) to address the limited regulatory resources issue.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Feb. 6, 2019. The following Working Group members participated: Robert H. Muriel, Chair, Patrick Hyde, Erica Weyhenmeyer, Vincent Tsang and Bruce Sartain (IL); Grace Arnold, Vice Chair, Fred Andersen and John Robinson (MN); Jason Lapham (CO); Russ Gibson and Lindsay Bates (IA); Rich Piazza (LA); Cynthia Amann, William Leung and Camille Anderson-Weddle (MO); Chris Aufenthie and Ross Hartley (ND); Jillian Froment, Peter Weber and Mark Hamlin (OH); Sarah Neil (RI); and Rebecca Rebholz and Lauren Van Buren (WI). Also participating were: Perry Kupferman, Katherina Hrouda and Pam O’Connell (CA); Wanchin Chou and Andrew Greenhalgh (CT); Michele MacKenzie (ID); Karl Knable (IN); Barbara Torkelson and Tate Flott (KS); Maile Campbell (NV); Mark McLeod and Peter Dumar (NY); Cuc Nguyen (OK); Tracy Bixler (PA); Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed its Work Plan

Director Muriel asked for feedback on the focus of the Working Group’s efforts so far. He reminded the Working Group that Deloitte Consulting gave a presentation during the Working Group’s Jan. 23 conference call. He said he is working on scheduling presentations for the coming weeks with another consulting firm, a consumer advocate, two life insurance companies and a law firm.

Ms. Arnold said she has found the presentations helpful in understanding how accelerated underwriting (AUW) fits in a broader context.

Director Muriel said that some presenters have proprietary and confidential information to share and would like to do so in a regulator-to-regulator session. He explained that in keeping with the NAIC Policy Statement on Open Meetings, the Working Group is able to grant these requests on a case-by-case basis if they involve particular companies and company-specific proprietary intellectual property. He said he wants everyone to know that the Working Group plans to keep presentations in open session as much as possible and will strive to meet in regulator-to-regulator session when necessary to protect proprietary and confidential information.

Director Muriel clarified the Working Group will not be delving into the actuarial aspects of AUW. He explained that the Working Group’s charge contemplates coordination with the Life Actuarial (A) Task Force, noting that the Working Group will not be duplicating their work. He said the Working Group plans to focus on unlawful discrimination, privacy, transparency and disclosure in the context of AUW. He said the intention is for this focus to lead to an end product that satisfies the concerns of consumers, state insurance regulators and the industry alike.

Birny Birnbaum (Center for Economic Justice—CEJ) said he agrees with the Working Group’s stated focus and suggested adding a presentation about state efforts in this area, like the Illinois Biometric Protection Act (BIPA) and the genetic discrimination legislation in Florida.

Mr. Tsang said he would ask the law firms he has been in contact with to address these topics in their presentations.

Ms. Hemphill said it is not possible to completely separate topics like unfair discrimination from actuarial issues and suggested that the Society of Actuaries (SOA) has resources that would be helpful to the Working Group.

Mr. Leung suggested that the Working Group review the Casualty Actuarial and Statistical (C) Task Force’s Regulatory Review of Predictive Models white paper.

Mr. Robinson asked whether genetic testing information is part of the AUW process and if it is an issue within the scope of the Working Group.

Mr. Sartain said he had the same question. He said it is not clear what types of external data insurers are using and whether it may include data from Ancestry and/or 23andMe.

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David Leifer (American Council of Life Insurers—ACLI) said the decision of whether to tackle this topic in this Working Group is up to the state insurance regulators, but he said that life insurers do not use data from Ancestry or 23andMe. He said any genetic information would be found in an individual’s medical file. He said that a ban on the use of all genetic information is stunningly controversial. He suggested focusing on transparency and disclosure. He said that genetic information and credit score data is being dealt with elsewhere.

Mr. Birnbaum said he hopes that the Working Group will develop principles and approaches to deal with AUW, regardless of the data source, in a uniform way across the country.

Brendan Bridgeland (Center for Insurance Research—CIR) said that consumers are not sure what data is being accessed when they apply for life insurance. He said the presentations have mentioned the types of data used, but also include an “other data” catch-all category. He said he understands the desire to protect proprietary information about a specific algorithm, but, from a transparency perspective, this is important information for consumers to have. He said that to the extent that genetic information is increasingly available, it is important to consider it, along with everything else that may be available and accessed.

Director Muriel said the Working Group would continue to consider and discuss this issue. He summarized the topics he would like future presentations to address: 1) data sources, their legitimacy, privacy and embedded biases of the data, if any; 2) transparency and development of the algorithm; 3) accuracy versus fairness; 4) disclosure of AUW results to consumers; 5) implementation issues; and 6) controls, governance and data warehousing.

Director Muriel said two law firms have been contacted to present to the Working Group. He said one will be talking about discrimination from a legal perspective, and the second will cover cybersecurity. He said the Working Group will plan to coordinate with the NAIC working groups that are also working on related issues. He said he wants to make sure the different workstreams are coordinating.

Director Muriel asked for feedback on what the Working Group’s work product should be. He said the default seems to be a white paper that would be for state insurance regulators, the industry and consumers.

Ms. Neil suggested that the Working Group revisit what was going on in the Big Data (EX) Working Group that precipitated the referral to the Life Insurance and Annuities (A) Committee.

Jennifer Cook (NAIC) said she would circulate excerpts from the minutes of the Big Data (EX) Working Group.

Director Muriel asked the Working Group to think about what work product the Working Group should develop.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.

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The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Jan. 23, 2020. The following Working Group members participated: Robert H. Muriel, Chair, Mike Chrysler, Linda Bryant, Vincent Tsang and Bruce Sartain (IL); Grace Arnold, Vice Chair, and John Robinson (MN); Jason Lapham (CO); Russ Gibson and Lindsay Bates (IA); Rich Piazza (LA); Cynthia Amann, William Leung and Camille Anderson-Weddle (MO); Ross hartley (ND); Matt Holman (NE); Jillian Froment and Mark Hamlin (OH); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); David Hippen (WA); and Diane Dambach; Mary Kay Rodriguez, Sue Ezalarab, Rebecca Rebholz and Lauren Van Buren (WI). Also participating were: Jacob Lauten (AK); Perry Kupferman, Katherina Hrouda and Pam O’Connell (CA); Andrew Greenhalgh (CT); Karl Knable (IN); Barbara Torkelson and Tate Flott (KS); Denise Lamy, and Karen McCallister (NH); Seong-min Eom (NJ); Annette James (NV); Cuc Nguyen (OK); Mark McLeod and Bill Carmello (NY); Brian Hoffmeister (TN); Mike Boerner (TX); Tomasz Serbinowski (UT); and James Young (VA).

1. **Heard a Presentation from Deloitte Consulting**

Director Muriel reminded the Working Group that the work plan contemplates the Accelerated Underwriting (A) Working Group progressing through three phases in order to complete its charge by the 2020 Fall National Meeting. The first phase is the information-gathering phase, which started with a presentation at the 2019 Fall National Meeting from Patrick L. Brockett (The University of Texas at Austin).

Director Muriel said this phase is scheduled to continue until the 2020 Spring National Meeting, noting that he is in the process of scheduling additional presentations for every other Thursday to explore this topic from different perspectives. He said Chris Stehno (Deloitte Consulting LLC) is giving the presentation on this conference call.

Mr. Stehno said Deloitte started helping clients with accelerated underwriting (AUW) in 2007. He explained that Deloitte called it “application triage” and that it came out of the realization that the number of people purchasing life insurance was declining. He said the number of individual life and annuity policies sold has dropped significantly, while the face amounts of the policies sold has increased—indicating that just the wealthy are buying life insurance. He said the mechanism for selling life insurance—through agents earning a commission—has not evolved over the years. He said consumers’ buying preferences have changed and that the channels for selling insurance have not. He said agents cited the fact that the same number of hours is required to sell a policy, regardless of the size of the policy. He said it became clear that traditional sales methods, cumbersome and time-consuming risk assessment processes, and unacceptable commissions all have contributed to the declining numbers of middle-income people buying life insurance.

Mr. Stehno said Deloitte undertook protective value studies, where the company looked at whether paramedical exams and fluid collections are always necessary. He said Deloitte was trying to determine if there is a type of person that can be identified where there are diminishing returns for going through the paramedical exam and fluid collection. He explained that predictive analytics were being used to triage applications, identifying certain healthy applications for whom selected medical underwriting requirements can be waived. He said Deloitte determined that out of the individuals that apply for life insurance, 30% to 40% are able to go through AUW. Most companies use a binary rule (such as policy face amounts or the age of applicant) in combination with an algorithm to determine if they can be waived out of traditional underwriting.

Mr. Stehno explained the application triage process used to determine if an application can skip traditional underwriting. He said illustrative eligibility criteria, a detailed build chart and disqualifying major medical conditions criteria are applied in the initial step of identifying eligible and healthy applicants. He said if the application met this linear criteria, then the company will query third-party data sources—such as Medical Information Bureau (MIB) records, motor vehicle records (MVRs), prescription drug (Rx) records and electronic health records (EHRs)—and apply an underwriting filter to that information to determine if the applicant needs to go through traditional underwriting. If the application does not go to traditional underwriting at this point, the applicant will go through a telephone interview, at which time additional underwriting filters are applied. If the application is not kicked to traditional underwriting after the phone interview, the data collected to that point is processed by predictive model. He said each application then receives a health score and reason code. Then a policy is issued within 24 to 48 hours without going through medical underwriting. About 40% of policies applied for are issued without medical
underwriting. The remaining 60% of applications go through traditional underwriting. He said about 75% of the policies eligible for AUW are life insurance policies.

Mr. Stehno said Deloitte has found that transparent and open algorithmic solutions provide for a better agent/customer experience as “reason codes” can be easily developed to share algorithm details at the appropriate level to the appropriate person. He said that applying “application triage” using application data, MIB, MVR, Rx and other third-party data—together with underwriting rules established by the insurer—often provides results that are similar to fully underwritten decisions for a significant portion of the business, predominantly the higher-scoring segments. He explained that application triage does not result in an adverse action, because the applicant will either go through accelerated underwriting or traditional underwriting.

Mr. Stehno explained that most all large and mid-size companies have established data analytics practices. He said more than a dozen companies in the marketplace have some form of AUW. He said some reinsurers, data vendors and consulting firms are now offering “industry” algorithms and risk-scoring. He said electronic health records are complementary to AUW and are now widely used. He explained that there are many opportunities for expanding the use of data analytics in life insurance, such as use in producer optimization; product design and pricing; sales and marketing; new business and underwriting, in-force management; and claims and fraud.

Director Muriel asked Working Group members and interested regulators to reach out to the industry in their respective states to get feedback on their expectations for this Working Group.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
Annuity Disclosure (A) Working Group
Conference Call
March 13, 2020

The Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call March 13, 2020. The following Working Group members participated: Mike Yanacheak, Chair, and Kim Cross (IA); Chris Struk (FL); Julie Holmes, Craig Van Aalst and Shannon Lloyd (KS); Nour Benchaboun (MD); John Robinson (MN); Andrew Schallhorn and Cuc Nguyen (OK); Matt Gendron and Sarah Neil (RI); and Doug Danzeiser, Sandra Dodson and Lynn Pazdral (TX). Also participating were: Steve Ostlund (AL); Dave Lathrop (AZ); Carrie Couch and Marjorie Thompson (MO); Denise Lamy (NH); Andrew Dvorine (SC); David Hippen (WA); and Susan Ezalarab (WI).

1. **Adopted a Revision to Section 6F(9)(b)(i) of Model #245**

Mr. Yanacheak said that because the in-person Spring National Meeting has been postponed due to COVID-19, the Working Group finds itself with additional time to address any outstanding issues. He said that most of the Working Group members he has spoken with over the past few days think that the language in the Jan. 24 draft revisions to the Annuity Disclosure Model Regulation (#245) could be improved (Attachment Three-A).

The American Council of Life Insurers (ACLI) submitted a comment letter on this draft. Robbie Meyer (ACLI) summarized the ACLI comment letter. She said the ACLI remains concerned with the language of Section 6F(9)(b)(i) in the draft, which states: “The index is a combination of indices, made up of stocks, bonds, futures, commodities, interest rates, or exchange traded funds, each of which has been in existence for at least fifteen (15) years.”

Ms. Meyer said ACLI is concerned that this language would inadvertently undercut robust and understandable disclosures for consumers. She said the language is ambiguous as to whether each listed component needs to have been in existence for 15 years and whether each of the listed components needs to be an index. She said this requirement would prohibit illustration of many nontraditional indices of fixed indexed annuities that have been approved for sale and in the market and that are constructed from financial components, such as exchange-traded funds (ETFs) or futures, that are not indices.

Ms. Meyer said the ACLI suggests the following revision: “The index is comprised of indices, stocks, bonds, futures, commodities, interest rates or exchange traded funds, each of which has been in existence for at least fifteen (15) years.”

The Working Group discussed the ACLI’s suggested revision to Section 6F(9)(b)(i). Mr. Robinson said he has discussed this issue with the ACLI, as has Mr. Benchaboun and Mr. Van Aalst. They all said they would support the ACLI language. Ms. Neil said she struggles with what steps are taken by companies to ensure that a consumer understands what goes into these indices. She said fixed indexed annuities (FIAs) typically attract a more traditional investor, but these types of indices contain elements that require a higher level of sophistication than a typical FIA.

Mr. Robinson agreed that this is an issue and that maybe the Working Group should discuss how to tell the consumer about what makes up an index. However, he said he does not consider that question to be affected by the language change being discussed.

Mr. Schallhorn pointed out that there is a requirement to illustrate a high 10 years and a low 10 years, so consumers will be shown a possible upside and a downside. Ms. Neil explained that, in her view, if the suggested language opens up what financial products can comprise an index, she wants to be sure that proper steps are taken to ensure that consumers understand these financial products that comprise the index.

Birny Birnbaum (Center for Economic Justice—CEJ) followed up on Ms. Neil’s concerns and said the ACLI’s proposed revisions do more than simply say what financial products can be part of an index. He said this change allows the illustration of something that was not previously allowed to be illustrated because it had not been in existence for the requisite period of time. He said the biggest concern with this change is that it encourages data-mining for certain historical results to create products that illustrate well.

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Mr. Birnbaum said there is no consumer demand for products with indices that consumers have never heard of and do not understand. He said just because a product is already in the marketplace does not mean it is a good product that should be illustrated. He said this language creates a situation that amounts to an invitation to data mine recent historical experience to produce a favorable illustration for the past 15 years, but it is not likely to produce the same results going forward. He said that is inherently misleading.

Mr. Birnbaum also said that the revisions allow for gaming of the illustration. He shared the following example to illustrate his point. He said if there is an index that is comprised of five financial instruments and only one of the instruments has been in existence for only 15 years, while the rest have been in existence for 20 years, the illustration of the index will only look back 15 years. He said this allows for a company to create an index that limits the lookback to 15 years, when a lookback to years 16–20 would harm the illustration. Mr. Birnbaum suggested that Section 6F(9)(b)(i) should be revised to require each financial instrument to have been in existence for at least 20, but preferably 30, years.

Ms. Meyer said the ACLI believes that customers understand these products. She conceded that it is difficult to ensure understanding, but the more information consumers get, the more likely it is they will understand. She said prohibiting the illustration of a number of products that are already in the marketplace is in conflict with consumer education. She said that if a product has been approved, it should be able to be illustrated. She said if there are issues with these products that have been approved, this project addressing illustrations is not the most effective context to address those concerns.

Mr. Birnbaum said the ACLI says it is committed to consumer understanding, but he questioned that assertion based on the ACLI’s opposition to other provisions in the model that would require disclosure to consumers about how the index is calculated. He also said that the idea that more information is always better is false; i.e., more information does not equate to consumer understanding. He said consumers need information that will help them understand. He said illustrations are not needed to explain a product. He said illustrations create a false impression that past performance is an indication of future performance, which it is not. He said in this way, illustrations accomplish the opposite of consumer understanding. He said the goal is to stop misleading illustrations and force companies to explain their products in ways that consumers understand.

Mr. Birnbaum also said the ACLI’s suggested revision is incorrect when it states that “[t]he index is comprised of indices, stocks, bonds, futures, commodities, interest rates, or exchange traded funds…” He said an index is not comprised of components, it tracks the performance of something.

The Working Group discussed whether language that says “the index is an instrument that tracks the performance of indices, stocks, bonds, futures, commodities, interest rates or exchange traded funds…” is more accurate than saying the index is “comprised” of something.

Mr. Robinson said Mr. Birnbaum’s suggested language speaks to what an index does, which is not a definition. He said the language the ACLI suggested is an accurate way to describe an index; i.e., that the index is a weighted average of something, describes what it is, to say that it tracks something and describes what it does.

Mr. Gendron said Section 6F(9)(b)(i) refers to a “combination of indices,” and Section 6F(9)(b) (iii) refers to “any algorithm or other method of combining the indices,” which explains what it means to “combine” the indices. He conceded that these are not exactly definitions, but that is the practical effect, so he is OK with the language.

Mr. Benchaaboun pointed out that Section 6F(9)(b)(iv) states that the algorithm must be made available to insurance commissioners, which means that the insurance departments will have the ability to approve the algorithm at the time of the product filing.

Mr. Gendron said he is concerned with relying on the insurance commissioner’s ability to approve an algorithm at the time of filing. He said he is not aware of any insurance departments that have standards for reviewing indices. He said he asked the Interstate Insurance Product Regulation Commission (Compact), and he learned that it has form filing requirements but no vetting or standards by which indices are measured. He said this is not something that can be fixed quickly. He suggested that the Working Group could make a recommendation to the Life Insurance and Annuities (A) Committee that such standards should be developed, but they do not exist right now.

Mr. Struk said Florida is not a member of the Compact and does not have standards by which to judge whether an index is appropriate or inappropriate.
Ms. Neil said forms are reviewed to make sure they comply with state law. She said it is her opinion that this is the appropriate place for a discussion about how these products are going to be sold to the public.

Mr. Hippen said, when reviewing filings, Washington attempts to stop companies from using an index that it controls or that it can tell from its construction could be easily manipulated by the company. He said, however, the insurance department is limited by how much and what kind of information the company provides.

Mr. Birnbaum summarized his view of how the revised provisions in Model #245 allow for the creation of products that mislead consumers. He said, first, there are the provisions that allow data mining to create bespoke indices that will illustrate favorably over the previous 15-year period. If the company sees that an index is not preforming well, the model allows it to tweak the indices. The company is not required to disclose to the consumer how the index is calculated, and overwhelmed insurance departments do not provide a lot of accountability. He also pointed out that there is no requirement that the index company be separate from the company that is providing the hedging for the product based on the index. The index provider can change its rules as long as it is consistent with its own governance procedures, with no review of those rules.

Bryan Pinsky (American International Group Inc.—AIG) said AIG is supportive of consumer protection and making sure that illustrations and all the other materials provided to consumers at the point of sale are clear, understandable, fair and balanced. He said the purpose for revising Model #245 is to ensure that the regulation is pragmatic and usable, but does not create inappropriate loopholes. He said he appreciates Mr. Birnbaum’s underlying concerns, but some of his comments do not reflect the way the industry operates or the way the indices actually work. He said hedge costs do not assume a reversion to the mean. He said hedge costs are not affected by past performance of indices; they consider how fair markets would price based on a formula. He said whether an index performance is high or low does not affect the hedge costs for these indices.

Mr. Pinsky explained that a lot of information is provided to consumers by their financial advisor that augments an illustration, such as marketing materials and fact sheets, that describe how the indices work. He said the reason that companies do not support providing the underlying algorithm and rule book to consumers is because they are not owned by the company and are not the insurance company’s intellectual property. He said these indices are created and provided by third parties, and they continue to own the intellectual property. He said the rule book is not going to help consumers or financial advisors understand the index. He said that understanding is provided by the simplified, fair and balanced marketing materials, fact sheets provided by the index provider, and an understanding of how the index works within the indexed annuity that it is being purchased with, which is in the illustration.

Mr. Pinsky said it is important to realize that clients cannot lose money when they buy an indexed annuity. He said consumers are not investing in the index; they are investing in a product that references the index for the sole purpose of determining what interest credit will be provided to the client. He said that while the mechanisms supporting the index are important, the exact mathematical nuances of the index are not the most important pieces of information for the client to understand. He said the most important thing for consumers is diversification in choice in the product. He said the products were not developed to data-mine for indices that illustrate most favorably; they are intended to provide diversification in choice for clients. He said because of how independent third parties are able to create these indices, they are generally able to provide a more stable crediting rate that the insurance companies are able to provide. He said no consumer is forced to buy or stay in these. He said clients in all indexed annuities can reallocate across different strategies or indices if they do not like what they have for whatever reason, or as their crediting strategies mature, at no cost.

Mr. Pinsky said there are no facts to support the assertion that indices are changed to improve the look of performance. He said that sometimes indices are changed if there are new versions and that in new markets, environments may perform differently. He said that he is not sure of the reason for Mr. Birnbaum’s concern with the tie between index providers and hedging. He said there might be a circumstance where there is an arm of an investment bank that provides hedging assets to insurance companies and may also have another arm that creates indices. But he said that ultimately, the insurance company is accountable for ensuring that it is setting an appropriate option budget for its clients on indices that are available within the products provided to its clients.

Mr. Yanacheak identified three issues the Working Group’s discussion brought to light. The first is whether the Working Group should raise with the Life Insurance and Annuities (A) Committee the issue of the need for standards for product oversight in the states and with the Compact in the area of indexed annuities. He said the second issue involves the relationship between an index provider and the hedging provider. Iowa asked about this relationship in its product review and would like the Working Group to consider whether a referral to further consider this issue might be appropriate. The final issue is to revise Section 6F(9)(b)(i).
Mr. Van Aalst made a motion, seconded by Mr. Robinson, to revise Section 6F(9)(b)(i) as follows: “The index is comprised of indices, stocks, bonds, futures, commodities, interest rates, or exchange traded funds, each of which has been in existence for at least fifteen (15) years.” Florida, Kansas, Maryland, Minnesota, Oklahoma and Texas voted in favor of the motion. Rhode Island voted against the motion. The motion passed.

Mr. Gendron said he has been working on some “plain language” modifications to the disclosure requirements in Section 6G that he would like the Working Group to consider before it forwards the proposed revisions to Model #245 to the Life Insurance and Annuities (A) Committee for consideration.

Mr. Kilcoyne said he also has language modifications to suggest for the language just adopted.

Mr. Robinson also said he has some wording changes he would like the Working Group to consider.

The Working Group agreed to wait to finalize its proposed revisions to Model #245 until after reviewing this revised language. Mr. Yanacheak asked for revisions to be emailed to his attention, with a copy to Jennifer Cook (NAIC). Mr. Yanacheak confirmed that if the American Academy of Actuaries (Academy) has any minor suggestions along the lines of what the Working Group members are discussing, it should submit them.

Having no further business, the Annuity Disclosure (A) Working Group adjourned.
ANNUITY DISCLOSURE MODEL REGULATION

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Appendix A. Annuity Illustration Example

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Section 5. Standards for the Disclosure Document and Buyer’s Guide

A. (1) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall at or before the time of application be given both the disclosure document described in Subsection B and the Buyer’s Guide, if any.

(2) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer’s Guide no later than five (5) business days after the completed application is received by the insurer.

(a) With respect to an application received as a result of a direct solicitation through the mail:

   (i) Providing a Buyer’s Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the Buyer’s Guide be provided no later than five (5) business days after receipt of the application.

   (ii) Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.

(b) With respect to an application received via the Internet:

   (i) Taking reasonable steps to make the Buyer’s Guide available for viewing and printing on the insurer’s website shall be deemed to satisfy the requirement that the Buyer’s Guide be provided no later than five (5) business day of receipt of the application.

   (ii) Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer’s website shall be deemed to satisfy the requirement that the disclosure document be provided no later than five (5) business days after receipt of the application.
(c) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurance department of the state for a free annuity Buyer’s Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity Buyer’s Guide.

(d) Where the Buyer’s Guide and disclosure document are not provided at or before the time of application, a free look period of no less than fifteen (15) days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under state law or regulation.

B. At a minimum, the following information shall be included in the disclosure document required to be provided under this regulation:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity;

(2) The insurer’s legal name, physical address, website address and telephone number;

(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate:

(a) The guaranteed and non-guaranteed elements of the contract, and their limitations, if any, including for fixed indexed annuities, the elements used to determine the index-based interest, such as the participation rates, caps or spread, and an explanation of how they operate;

(b) An explanation of the initial crediting rate, or for fixed indexed annuities, an explanation of how the index-based interest is determined, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(c) Periodic income options both on a guaranteed and non-guaranteed basis;

(d) Any value reductions caused by withdrawals from or surrender of the contract;

(e) How values in the contract can be accessed;

(f) The death benefit, if available and how it will be calculated;

(g) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(h) Impact of any rider, including, but not limited to, a guaranteed living benefit or long-term care rider;

(4) Specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply; and

(5) Information about the current guaranteed rate or indexed crediting rate formula, if applicable, for new contracts that contains a clear notice that the rate is subject to change.

C. Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.
Section 6. Standards for Annuity Illustrations

A. An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this section and:

(1) Clearly labeled as an illustration;

(2) Includes a statement referring consumers to the disclosure document and Buyer’s Guide provided to them at time of purchase for additional information about their annuity; and

(3) Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of illustrations.

B. An illustration furnished an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

C. The illustration shall not be provided unless accompanied by the disclosure document referenced in Section 5.

D. When using an illustration, the illustration shall not:

(1) Describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(2) State or imply that the payment or amount of non-guaranteed elements is guaranteed; or

(3) Be incomplete.

E. Costs and fees of any type shall be individually noted and explained.

F. An illustration shall conform to the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared;

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled “page 4 of 7 pages”);

(3) The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the contract is assumed to have been in force;

(5) The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

(6) Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;

(7) Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed;
The non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period.

In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent ten (10) calendar years; one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the least index value growth (the “low scenario”); one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the most index value growth (the “high scenario”). The following requirements apply:

(a) The most recent ten (10) calendar years and the last twenty (20) calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three (3) months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;

(b) If any index utilized in determination of an account value has not been in existence for at least ten (10) calendar years, indexed returns for that index shall not be illustrated, unless all of the following criteria are met:

(i) The index is a combination of indices, made up of stocks, bonds, futures, commodities, interest rates, or exchange traded funds, each of which has been in existence for at least fifteen (15) years;

(ii) The method of combination is such that a unique fifteen (15)-year history of the index can be constructed;

(iii) Any algorithm or other method of combining the indices shall be fixed from the creation of the index, except for changes made pursuant to the index provider’s established governance rules and procedures;

(iv) Any algorithm or other method that is supporting such an index and is included in the illustration shall be made available for inspection at the request of the commissioner; and

Drafting Note: States may want to consider making the algorithm available to consumers upon request.

(v) Indexed returns that are based on historical performance prior to the existence of the index are visually differentiated from indexed returns that are based on historical performance thereafter.

(vi) If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least ten (10) calendar years, the allocation to such indexed account(s) shall be assumed to be zero;

(c) If any index utilized in determination of an account value has been in existence for at least ten (10) calendar years but less than twenty (20) calendar years, the ten (10) calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

(d) If any index utilized in determination of an account value meets the criteria of Section 6.E.(9)(b) but has less than twenty (20) calendar years of history, the ten (10) calendar year
periods that define the low and high scenarios shall be chosen from the exact number of years of unique history, including history, constructed pursuant to 6.F.(9)(b)(ii);

(de) The non-guaranteed element(s), such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element(s);

(ef) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:

(i) The allocation used in the illustration shall be the same for all three scenarios; and

(ii) The ten (10) calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.

(gf) The geometric mean annual effective rate of the account value growth over the ten (10) calendar year period shall be shown for each scenario;

(gh) If the most recent ten (10) calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection H, the most recent ten (10) calendar year historical period experience of the index shall be used for each subsequent ten (10) calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

(hi) The low and high scenarios: (i) need not show surrender values (if different than account values); (ii) shall not extend beyond ten (10) calendar years (and therefore are not subject to the requirements of subsection H beyond subsection H(1)(a)); and (iii) may be shown on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the ten (10) calendar year period for the low scenario, the high scenario and the most recent ten (10) calendar year scenario; and

(ii) The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;

(10) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., “see page 1 for guaranteed elements”);

(11) The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

(12) The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;

(13) Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;
(14) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(a) The benefits and values are not guaranteed;

(b) The assumptions on which they are based are subject to change by the insurer; and

(c) Actual results may be higher or lower;

(15) Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps or spreads for fixed indexed annuities;

(16) The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;

(17) Illustrations shall be concise and easy to read;

(18) Key terms shall be defined and then used consistently throughout the illustration;

(19) Illustrations shall not depict values beyond the maximum annuitization age or date;

(20) Annuity income rate shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and

(21) Illustrations shall show both annuity income rates per $1000.00 and the dollar amounts of the periodic income payable.

G. An annuity illustration shall include a narrative summary that includes the following unless provided at the same time in a disclosure document:

(1) A brief description of any contract features, riders or options, guaranteed and/or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract;

(2) A brief description of any other optional benefits or features that are selected, but not shown in the illustration and the impact they have on the benefits and values of the contract;

(3) Identification and a brief definition of column headings and key terms used in the illustration;

(4) A statement containing in substance the following:

(a) For other than fixed indexed annuities:

(i) This illustration assumes the annuity’s current nonguaranteed elements will not change. It is likely that they will change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

(ii) The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer’s Guide provided with your Annuity Contract for more detailed information;
For fixed indexed annuities:

(i) This illustration assumes the index will repeat historical performance and that the annuity’s current non-guaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, will not change. It is likely that the index will not repeat historical performance, the non-guaranteed elements will change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

(ii) The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer’s Guide provided with your Annuity Contract for more detailed information.

(ii) For fixed indexed annuities where the index has not been in existence for fifteen (15) years, but the criteria in Section 6.F.(9)(b) have been met, the following additional statements:

(I) Indexed returns that are based on historical performance prior to the existence of the index are visually differentiated from indexed returns that are based on historical performance thereafter;

(II) Because the index has not been in existence for the entire time period used in the illustration, some of the values of the index shown are a weighted average of indices or other financial instruments that were in existence for that time period;

(III) Either the weights used in combining the indices or other financial instruments are constant over time, or the weights are based on an algorithm that is consistently applied over time but may produce different weights in different years; and

(IV) The consumer may request further explanation of the algorithm used to determine the weights;

(iii) For fixed indexed annuities where the index is a combination of indices or other financial instruments and has been in existence for fifteen (15) years, the following additional statements:

(I) Either the weights used in combining the indices are constant over time, or the weights are based on an algorithm that is consistently applied over time but may produce different weights in different years; and

(II) The consumer may request further explanation of the algorithm used to determine the weights;
Additional explanations as follows:

(a) Minimum guarantees shall be clearly explained;

(b) The effect on contract values of contract surrender prior to maturity shall be explained;

(c) Any conditions on the payment of bonuses shall be explained;

(d) For annuities sold as an IRA, qualified plan or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;

(e) For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur; and

(f) A brief description of the types of annuity income options available shall be explained, including:

   (i) The earliest or only maturity date for annuitization (as the term is defined in the contract);

   (ii) For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available based on the guaranteed rates in the contract, at the later of age seventy (70) or ten (10) years after issue, but in no case later than the maximum annuitization age or date in the contract;

   (iii) For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and

   (iv) The periodic income amount based on the currently available periodic income rates for the annuity income option in item (ii) or item (iii), if desired.

H. Following the narrative summary, an illustration shall include a numeric summary which shall include at minimum, numeric values at the following durations:

(1) (a) First ten (10) contract years; or

   (b) Surrender charge period if longer than ten (10) years, including any renewal surrender charge period(s);

(2) Every tenth contract year up to the later of thirty (30) years or age seventy (70); and

(3) (a) Required annuitization age; or

   (b) Required annuitization date.

I. If the annuity contains a market value adjustment, hereafter MVA, the following provisions apply to the illustration:

(1) The MVA shall be referred to as such throughout the illustration;

(2) The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender;

(3) The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit;
A statement, containing in substance the following, shall be included:

When you make a withdrawal the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount you receive. If interest rates go down, the MVA will likely increase the amount you receive.

Illustrations shall describe both the upside and the downside aspects of the contract features relating to the market value adjustment;

The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of a MVA;

Actual MVA floors and ceilings as listed in the contract shall be illustrated; and

If the MVA has significant characteristics not addressed by Paragraphs (1) – (6), the effect of such characteristics shall be shown in the illustration.

Drafting Note: Appendix A provides an example of an illustration of an annuity containing an MVA that addresses Paragraphs (1) – (6) above.

J. A narrative summary for a fixed indexed annuity illustration also shall include the following unless provided at the same time in a disclosure document:

An explanation, in simple terms, of the elements used to determine the index-based interest, including but not limited to, the following elements:

(a) The Index(es) which will be used to determine the index-based interest;
(b) The Indexing Method – such as point-to-point, daily averaging, monthly averaging;
(c) The Index Term – the period over which indexed-based interest is calculated;
(d) The Participation Rate, if applicable;
(e) The Cap, if applicable; and
(f) The Spread, if applicable;

The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;

The narrative shall include a brief description of the frequency with which the company can re-set the elements used to determine the index-based credits, including the participation rate, the cap, and the spread, if applicable; and

If the product allows the contract holder to make allocations to declared-rate segment, then the narrative shall include a brief description of:

(a) Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the indexed-based segments; and
(b) Differences in guarantees applicable to the declared-rate segment and the indexed-based segments.
K. A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:

(1) The assumed growth rate of the index in accordance with Subsection F(9);

(2) The assumed values for the participation rate, cap and spread, if applicable; and

(3) The assumed allocation between indexed-based segments and declared-rate segment, if applicable, in accordance with Subsection F(9).

L. If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that non-substantive changes, including, but not limited to changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to Section 1035 of the Internal Revenue Code, rollovers or transfers, which do not alter the key benefits and features of the annuity as applied for will not require a revised illustration unless requested by the applicant.

Section 7. Report to Contract Owners

For annuities in the payout period that include non-guaranteed elements, and for deferred annuities in the accumulation period, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

A. The beginning and end date of the current report period;

B. The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

C. The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

D. The amount of outstanding loans, if any, as of the end of the current report period.

Section 8. Penalties

In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of this regulation shall be guilty of a violation of Section [cite state’s unfair trade practices act].

Section 9. Separability

If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the regulation and its application to other persons or circumstances shall not be affected.

Section 10. [Optional] Recordkeeping

A. Insurers or insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information provided in the disclosure statement (including illustrations) for [insert number] years after the contract is delivered by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

Drafting Note: States should review their current record retention laws and specify a time period that is consistent with those laws.

B. Records required to be maintained by this regulation may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

Drafting Note: This section may be unnecessary in States that have a comprehensive recordkeeping law or regulation.
Section 11. Effective Date

This regulation shall become effective [insert effective date] and shall apply to contracts sold on or after the effective date.
Annuity Illustration Example
[The following illustration is an example only
And does not reflect specific characteristics of any actual product for sale by any company]

ABC Life Insurance Company

Company Product Name
Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)
An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy
(Contact us at Policyownerservice@ABCLife.com or 555-555-5555)

| Sex: Male                               | Initial Premium Payment: $100,000.00 |
| Age at Issue: 54                        | Planned Annual Premium Payments: None |
| Annuitant: John Doe                     | Tax Status: Nonqualified              |
| Oldest Age at Which Annuity Payments Can Begin: 95 | Withdrawals: None Illustrated |

Initial Interest Guarantee Period: 5 Years

Initial Guaranteed Interest Crediting Rates
First Year (reflects first year only interest bonus credit of 0.75%): 4.15%
Remainder of Initial Interest Guarantee Period: 3.40%

Market Value Adjustment Period: 5 Years
Minimum Guaranteed Interest Rate after Initial Interest Guarantee Period *: 3%

* After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

Annuity Income Options and Illustrated Monthly Income Values

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

Annuity income options include the following:
- Periodic payments for Annuitant’s life
- Periodic payments for Annuitant’s life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant’s life with payments continuing for the life of a survivor annuitant

Illustrated Annuity Income Option: Monthly payments for annuitant’s life with payments guaranteed for 10-year period.
Assumed Age When Payments Start: 70

<table>
<thead>
<tr>
<th>Account Value</th>
<th>Monthly Annuity Income Rate/$1,000 of Account Value *</th>
<th>Monthly Annuity Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on Rates Guaranteed in the Contract</td>
<td>$164,798</td>
<td>$5.00</td>
</tr>
<tr>
<td>Based on Rates Currently Offered by the Company</td>
<td>$171,976</td>
<td>$6.50</td>
</tr>
</tbody>
</table>

* If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.
### ABC Life Insurance Company

**Company Product Name**
Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

Contact us at Policyownerservice@ABCLife.com or 555-555-5555

<table>
<thead>
<tr>
<th>Contract Year/Age</th>
<th>Premium Payment</th>
<th>Interest Crediting Rate</th>
<th>Account Value After MVA</th>
<th>Minimum Cash Surrender Value After MVA</th>
<th>Interest Crediting Rate</th>
<th>Account Value Before and After MVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
<td>(7)</td>
</tr>
<tr>
<td>1 / 55</td>
<td>$ 100,000</td>
<td>4.15%</td>
<td>104,150</td>
<td>95,818</td>
<td>92,000</td>
<td>4.15%</td>
</tr>
<tr>
<td>2 / 56</td>
<td>0</td>
<td>3.40%</td>
<td>107,691</td>
<td>100,153</td>
<td>93,000</td>
<td>3.40%</td>
</tr>
<tr>
<td>3 / 57</td>
<td>0</td>
<td>3.40%</td>
<td>111,353</td>
<td>104,671</td>
<td>95,614</td>
<td>3.40%</td>
</tr>
<tr>
<td>4 / 58</td>
<td>0</td>
<td>3.40%</td>
<td>115,139</td>
<td>109,382</td>
<td>98,482</td>
<td>3.40%</td>
</tr>
<tr>
<td>5 / 59</td>
<td>0</td>
<td>3.40%</td>
<td>119,053</td>
<td>114,291</td>
<td>114,291</td>
<td>3.40%</td>
</tr>
<tr>
<td>6 / 60</td>
<td>0</td>
<td>3.00%</td>
<td>122,625</td>
<td>118,946</td>
<td>118,946</td>
<td>3.40%</td>
</tr>
<tr>
<td>7 / 61</td>
<td>0</td>
<td>3.00%</td>
<td>126,304</td>
<td>123,778</td>
<td>123,778</td>
<td>3.40%</td>
</tr>
<tr>
<td>8 / 62</td>
<td>0</td>
<td>3.00%</td>
<td>130,093</td>
<td>130,093</td>
<td>130,093</td>
<td>3.40%</td>
</tr>
<tr>
<td>9 / 63</td>
<td>0</td>
<td>3.00%</td>
<td>133,996</td>
<td>133,996</td>
<td>133,996</td>
<td>3.40%</td>
</tr>
<tr>
<td>10 / 64</td>
<td>0</td>
<td>3.00%</td>
<td>138,015</td>
<td>138,015</td>
<td>138,015</td>
<td>3.40%</td>
</tr>
<tr>
<td>11 / 65</td>
<td>0</td>
<td>3.00%</td>
<td>142,156</td>
<td>142,156</td>
<td>142,156</td>
<td>3.40%</td>
</tr>
<tr>
<td>16 / 70</td>
<td>0</td>
<td>3.00%</td>
<td>164,798</td>
<td>164,798</td>
<td>164,798</td>
<td>3.40%</td>
</tr>
<tr>
<td>21 / 75</td>
<td>0</td>
<td>3.00%</td>
<td>191,046</td>
<td>191,046</td>
<td>191,046</td>
<td>3.40%</td>
</tr>
<tr>
<td>26 / 80</td>
<td>0</td>
<td>3.00%</td>
<td>221,474</td>
<td>221,474</td>
<td>221,474</td>
<td>3.40%</td>
</tr>
<tr>
<td>31 / 85</td>
<td>0</td>
<td>3.00%</td>
<td>256,749</td>
<td>256,749</td>
<td>256,749</td>
<td>3.40%</td>
</tr>
<tr>
<td>36 / 90</td>
<td>0</td>
<td>3.00%</td>
<td>297,643</td>
<td>297,643</td>
<td>297,643</td>
<td>3.40%</td>
</tr>
<tr>
<td>41 / 95</td>
<td>0</td>
<td>3.00%</td>
<td>345,050</td>
<td>345,050</td>
<td>345,050</td>
<td>3.40%</td>
</tr>
</tbody>
</table>

For column descriptions, turn to page 245-14
Column Descriptions

(1) **Ages** shown are measured from the Annuitant's age at issue

(2) **Premium Payments** are assumed to be made at the beginning of the Contract Year shown

**Values Based on Guaranteed Rates**

(3) **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.

(4) **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.

(5) **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

<table>
<thead>
<tr>
<th>Years Measured from Premium Payment:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surrender Charges:</td>
<td>8%</td>
<td>7%</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

(6) **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your initial guaranteed interest rate, the MVA will DECREASE the amount you receive. Page 4 of this illustration provides additional information concerning the MVA.

**Values Based on Assumption that Initial Guaranteed Rates Continue**

(7) **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.

(8) **Account Value** is calculated the same way as column (4).

(9) **Cash Surrender Value Before and After MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

**Important Note:** This illustration assumes you will take no withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

This illustration assumes the annuity’s current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustration.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer’s guide.
MVA-adjusted Cash Surrender Values (CSVs) Under Sample Scenarios

The graphs below show MVA-adjusted Cash Surrender Values (CSVs) during the first five years of the contract, as illustrated on page 2 ($100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

**Graph #1** shows if the interest rate on new contracts is 3% LOWER than your Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (green line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

**Graph #2** shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column (6) on Page 2), which in this scenario limits the decrease for the first 2 years (yellow line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.
The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call July 29, 2020. The following Working Group members participated: Doug Ommen, Chair (IA); Jillian Froment, Vice Chair (OH); Steve Ostlund (AL); Jodi Lerner (CA); Tanisha Merced (DE); Dean L. Cameron (ID); Tate Flott (KS); Renee Campbell (MI); Bruce R. Range (NE); Keith Nyhan (NH); Cuc Nguyen (OK); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Rachel Jade-Rice (TN); and Richard Wicka (WI). Also participating was: Malinda Shepherd (KY).

1. **Adopted its Dec. 19, 2019, and 2019 Fall National Meeting Minutes**

The Working Group met Dec. 19, 2019, and Dec. 7, 2019. During its Dec. 19 meeting, the Working Group discussed comments received on appendices to the *Suitability in Annuity Transactions Model Regulation* (#275).

Superintendent Dwyer made a motion, seconded by Director Froment, to adopt the Working Group’s Dec. 19, 2019 (Attachment Four-A), and Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Life Insurance and Annuities (A) Committee, Attachment Two). The motion passed unanimously.

2. **Discussed State Activities to Adopt Revised Model #275**

Commissioner Ommen said the purpose of this agenda item is hear a discussion of activities some states have taken to adopt the 2020 revisions to Model #275, which added a best interest standard of conduct for insurers and producers. He said this discussion relates to the Working Group’s work in 2020 to complete the second part of its charge to “consider how to promote greater uniformity across NAIC-member jurisdictions.”

Commissioner Ommen said Iowa adopted the revisions to Model #275 through the adoption of an administrative rule in May with a Jan. 1, 2021, effective date.

Superintendent Dwyer discussed the steps Rhode Island has taken to move toward promulgating a rule to adopt the 2020 revisions. She asked Commissioner Ommen about Iowa’s experience in adopting the revisions to Model #275 and whether the Iowa Insurance Department (IID) had experienced pushback from stakeholders with respect to some of the provisions.

Commissioner Ommen said that prior to Iowa beginning its administrative rulemaking process, the IID had discussions with stakeholders. Some of the discussions related to issues included in the draft frequently asked questions (FAQ) guidance document the Working Group will discuss next. He said Iowa received widespread support from stakeholders on the new regulation. He detailed the process the IID used to adopt the regulation, which included going through an administrative rules committee of the Iowa Legislature, and through that process, the IID was able to explain the history and the process the NAIC used to develop the revisions to Model #275. He explained that Iowa’s administrative rulemaking process does not allow for the adoption of drafting notes within the text of a rule. He said stakeholders encouraged the IID to include the drafting notes found in the revisions to Model #275 in a bulletin, which insurers can use, together with the rule, to assist in their implementation.

Director Cameron said Idaho has submitted legislation related to the revisions to Model #275 for consideration during Idaho’s upcoming legislative session. He said the Idaho Department of Insurance has not received any comments yet suggesting changes to the language in the revisions to Model #275. He discussed legislation enacted during Idaho’s last legislative session imposing additional standards for indexed annuities. He discussed provisions in the legislation requiring clarification and provisions that caused concern among some stakeholders, such as the new surrender charge requirements and provisions requiring insurers to file before use of advertising materials and materials insurers provide to their producers.
Commissioner Ommen agreed the states could encounter additional issues other than those specifically related to the best interest standard of conduct during their process to adopt the revisions to Model #275.

Director Froment said Ohio is beginning its administrative process to adopt the revisions to Model #275. She said the Ohio Department of Insurance has had informal discussions with stakeholders and expects within the next few weeks to submit a legislation proposal implementing the revisions to Model #275 for executive branch review before submitting legislation to the Ohio legislature for its consideration. Director Froment said that during some of Ohio’s discussions with stakeholders, some questions have been raised about certain provisions in the revisions to Model #275 and the intent behind them. She said Ohio has expressed its commitment to stakeholders to develop a bulletin or a FAQ document to answer some of the questions, but is looking to use some of what the Working Group includes in its FAQ guidance document to assist Ohio in developing its own FAQ or bulletin. She said Ohio also is looking at a Jan. 1, 2021, implementation date.

Ms. Shepherd explained that Kentucky has a requirement to review adopted regulations every five years. She said that as part of this review process, the Kentucky Department of Insurance will be submitting revised annuity suitability regulations, which will include the revisions to Model #275, to the Kentucky Legislature in August.

Commissioner Ommen said Working Group members, NAIC staff and he are ready and available to assist the states as they move forward with adopting the revisions to Model #275. He said he believes the FAQ guidance document is part of this effort to provide assistance to the states, but he also urged states to reach out directly to the Working Group members if they have questions about the revisions to Model #275.

3. Exposed the Draft FAQ Guidance Document

Commissioner Ommen said that NAIC staff, along with others and himself, developed a draft FAQ document as one way for the Working Group to complete the second part of its charge to “consider how to promote greater uniformity across NAIC member jurisdictions.” He explained that this guidance document will assist the states as they move forward with adopting the revisions to Model #275 through either the administrative or legislative process.

Commissioner Ommen said the FAQ document included in the Working Group’s materials is a draft and, at the end of the discussion, he is going to suggest exposing it for a 30-day public comment period. He said the purpose of the 30-day comment period is for the Working Group to receive input from stakeholders on what issues should be addressed in the document. He explained that some of the initial questions included in the FAQ document are questions NAIC staff and others received to date from the states and other stakeholders as they have moved forward with adopting the revisions to Model #275.

After additional discussion, the Working Group agreed to expose the draft FAQ document for a 30-day public comment period. The Working Group directed NAIC staff to revise the draft to “clean up” the draft prior to distributing it for public comment.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
Annuity Suitability (A) Working Group Conference Call December 19, 2019

The Annuity Suitability (A) Working Group of the Life Insurance and Annuities (A) Committee met via conference call Dec. 19, 2019. The following Working Group members participated: Jillian Froment, Chair (OH); Doug Ommen, Vice Chair (IA); Jerry Workman and Steve Ostlund (AL); Jodi Lerner (CA); Fleur McKendell (DE); Dean L. Cameron (ID); Vicki Schmidt and Tate Flott (KS); Nour Benchaaboun (MD); Renee Campbell (MI); Bob Harkins (NE); Keith Nyhan (NH); Mark McLeod (NY); Elizabeth Kelleher Dwyer, Matt Gendron and Sarah Neil (RI); Patrick Merkel (TN); and Richard Wicka (WI).

1. Discussed Comments Received on Appendices to Model #275

Director Froment discussed the purpose of the call, reminding the Working Group that at the Fall National Meeting, the Life Insurance and Annuities (A) Committee directed the Working Group to discuss potential revisions to the appendices based on the comments received by the Nov. 26 public comment deadline and any supplemental comments received. She said the goal is to create consumer-friendly documents that provide guidance to producers and insurers in satisfying the disclosure and documentation obligations established in the proposed revisions to the Suitability in Annuity Transactions Model Regulation (#275). She said the Working Group would discuss the comments received section-by-section beginning with Appendix A.

Director Froment said the Center for Economic Justice (CEJ) submitted comments on Appendix A, suggesting that the title should be revised to reflect consumer-friendly terms such as “agent and broker” and the appendix’s scope, which is annuities. After discussion, the Working Group agreed to accept the suggested revision, but retained the word “producer” in in parentheses in the title because the state insurance departments license “producers.”

The Working Group next discussed the CEJ’s suggested revisions to the next section, “Insurance Agent Information,” which describes the information to be provided on the form concerning the insurance agent.

Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) asked what the reference to “company name” means and whether it refers to the name of the insurance company or the producer’s insurance agency. He said most consumers will assume “company” name means the insurance company.

The Working Group discussed whether to retain “company” or use another word. After discussion, the Working Group agreed to change the reference to “business/agency name.”

The Working Group discussed the next section, “Client Information,” which describes the information to be provided on the form concerning the consumer.

Mr. Bissett suggested changing the word “client” to “consumer.” After discussion, the Working Group agreed to accept Mr. Bissett’s suggested revision.

Birny Birnbaum (CEJ) explained that the CEJ’s suggested revisions to this section make it more consumer-friendly. He said the CEJ differs in its approach to this section from the Joint Trades’ approach because the CEJ believes this section should include other types of investment products a producer may be authorized to sell, not just annuities. He pointed out that both the CEJ and the Joint Trades agree that the product checklist should be deleted.

The Working Group discussed the two approaches and whether to delete the product checklist. After discussion, the Working Group agreed to change the section’s title to “What Types of Products Can I Sell You?” The Working Group also agreed to revise the section’s language to read as follows: “I am licensed to sell annuities to You in accordance with state law. If I recommend that You buy an annuity, it means I believe that it effectively meets Your financial situation, insurance needs, and...
financial objectives. Other financial products, such as life insurance or stocks, bonds and mutual funds, also may meet Your
needs.” The Working Group decided to retain the checklist of products the producer can offer or sell, including non-insurance
products, such as mutual funds, stocks and bonds, and certificates of deposit.

The Working Group discussed the provision in the appendix concerning whose insurance products a producer is authorized to
sell, such as products from one insurer or two or more insurers.

Director Froment said the Joint Trades and the CEJ both suggest in their comments that this provision be a distinct section in
the appendix. The Joint Trades suggests titling the section as “Whose Insurance Products Can I Sell to You?” The CEJ suggests
titling the section as “Whose Annuities Can I Sell to You?” Director Froment said the CEJ suggests additional revisions to
delete “contracted and appointed” and to revise other language to make it more consumer-friendly.

After discussion, the Working Group agreed to the CEJ’s suggested title and the other suggested revisions to this provision.
The Working Group also agreed to delete the language concerning “My Relationship with You” because of potential
consumer confusion.

The Working Group discussed the next section in the appendix, “My Compensation Structure.” Director Froment said the Joint
Trades and the CEJ both suggest revising the section’s title to “How I’m Paid for My Work.” She said the Joint Trades and the
CEJ differ on the language to be included in this section.

Jason Berkowitz (IRI) said the Joint Trades’ suggested revisions strive to avoid potential consumer confusion.

The Working Group discussed the Joint Trades and the CEJ’s suggested revisions. After discussion, the Working Group decided
to retain the checkbox compensation-related language and add the following introductory paragraph: “It’s important for You
to understand how I’m paid for my work. Depending on the particular annuity You purchase, I may be paid a commission or a
fee. Commissions are generally paid to Me by the insurance company while fees are generally paid to me by the consumer. If
You have questions about how I’m paid, please ask Me.”

The Working Group next discussed the CEJ’s suggested language for inclusion in the section “Additional Information.”

Mr. Birnbaum suggested the Working Group delete the requirement in section “Insurance Agent (Producer) Information” to
provide the producer’s license number and instead include in this section the requirement that the producer provide his or her
national producer number (NPN). After discussion, the Working Group agreed.

Mr. Berkowitz said the Joint Trades do not believe the information the CEJ suggests including in this section is necessary.

Mr. Gendron said he could support requiring the appendix to include the BrokerCheck website information.

Commissioner Ommen said he could support requiring the appendix to include the information about viewing an insurance
agent’s record by going on the appropriate state insurance department’s website.

After discussion, the Working Group agreed to add this additional language and the additional CEJ suggested language
requiring a producer to include his or her securities license number if the producer is licensed to sell securities.

The Working Group next discussed Appendix B—Consumer Refusal to Disclose All or Partial Consumer Profile Information
Form. Director Froment said the Joint Trades suggests dividing this form into two forms with one form titled “Consumer
Refusal to Provide Information” and the other form, to be Appendix C, titled “Consumer Decision to Purchase an Annuity
NOT Based on a Recommendation.” She asked if the Working Group supported this approach. The Working Group expressed
support for taking this approach.

Director Froment said the Joint Trades and the CEJ suggest revisions to Appendix B. She suggested using the Joint Trades’
suggested revisions as the starting point for Working Group discussion. The Working Group agreed to her suggestion.

Mr. Birnbaum said the CEJ’s suggested revisions are meant to make the appendix more meaningful and more consumer-
friendly.
Mr. Berkowitz said the Joint Trades’ suggested revisions are tailored to make sure consumers understand what they are doing when they refuse to provide information that the producer needs to help to ensure a recommended product effectively meets the consumer’s financial needs, objectives and situation.

The Working Group discussed the suggested revisions, with some Working Group members expressing concern that some of the suggested revisions could cause more consumer confusion.

Commissioner Ommen noted the purpose of the appendices, which is to provide guidance to insurers and producers for complying with the proposed disclosure and documentation obligations. He suggested that the Working Group include the Joint Trades’ suggested revisions for Appendix B and Appendix C in the next draft of proposed revisions to Model #275 and discuss the language and any additional comments received on the language at the Life Insurance and Annuities (A) Committee’s meeting at the Fall National Meeting. There was no objection to his suggestion.

Having no further business, the Annuity Suitability (A) Working Group adjourned.
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The Life Actuarial (A) Task Force met via conference call Aug. 3, Aug. 4 and Aug. 6, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain and Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA). Also participating was: Rachel Hemphill (TX).

1. **Adopted its June 25, June 18, June 11, June 4, May 28, May 21, May 14 and May 7 Minutes**

The Task Force met June 25, June 18, June 11, June 4, May 28, May 21, May 14 and May 7 and took the following action: 1) adopted its Feb. 27, Feb. 20, Feb. 13, Feb. 6, Jan. 30 and Jan. 23 minutes; 2) adopted changes to the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805); 3) adopted amendment proposal 2020-05, which modifies the net premium reserve (NPR) to reflect continuous deaths and immediate payment of claims; 4) adopted *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold After November 25, 2020* (AG 49-A); 5) adopted amendment proposal 2020-06, which establishes a process for replacing the London Interbank Offered Rate (LIBOR); 6) adopted amendment proposal 2020-07, which modifies VM-02, Minimum Nonforfeiture Mortality and Interest, of the *Valuation Manual* by replacing the fixed 4% floor for the nonforfeiture interest rate used to determine the minimum funding for the cash value accumulation test in Internal Revenue Code Section 7702.

Mr. Ostlund made a motion, seconded by Mr. Kupferman, to adopt the Task Force’s June 25 (Attachment One), June 18 (Attachment Two), June 11 (Attachment Three), June 4 (Attachment Four), May 28 (Attachment Five), May 21 (Attachment Six), May 14 (Attachment Seven) and May 7 (Attachment Eight) minutes. The motion passed unanimously.

2. **Heard an Update on the YRT Field Test**

Jason Kehrberg (American Academy of Actuaries—Academy) said the Academy initially commented in November 2017 on the potential occurrence of issues when projecting rates for yearly renewable term (YRT) reinsurance premiums under VM-20, *Requirements for Principle-Based Reserves for Life Products*, of the *Valuation Manual*. He said the letter noted the possibility of companies having differing interpretations of how to perform the modeling. He said the Task Force subsequently asked the Academy to conduct a field test on the different ways that companies might be modeling YRT reinsurance premiums. In response, the Academy put together a project oversight group (POG), comprising industry members and state insurance regulators. The POG established a design subgroup to develop instructions for testing different potential long-term solutions to the issue of projecting YRT premiums. Mr. Kehrberg said soon after the start of the design subgroup process, Oliver Wyman was engaged to put together a model office to provide oversight for the field testing of the potential YRT solutions.

Chris Whitney (Oliver Wyman) provided an overview of the YRT field test and interpretation survey presentation (Attachment Nine). He said a representative principle-based reserving (PBR) model was developed with the goal of providing early insights into the drivers for the variabilities and the impact that reinsurance has on PBR. He said initial insights from the model were shared last year while the industry field test and interpretation survey were being designed. He said the field test has since been conducted by the Academy. He said Oliver Wyman then partnered with the Academy and the NAIC to: 1) expand the granularity of the analysis dimensions and the model based on observations from field test participants; 2) use the PBR model to confirm and explain the results of the field test and perform some additional analysis based on responses to the interpretation survey; and 3) develop the report, including establishing some broad key takeaways and insights for the analysis. He said the report, in conjunction with the Academy report that summarizes the field test responses, provides additional clarity on the impact that the proposed solutions and interpretations of those solutions might have on company results. He noted that the PBR model is available for any additional analysis the Task Force may need to decide on a potential solution.
Jennifer Frasier (NAIC) provided a review of the proposed solutions in amendment proposal 2019-40, amendment proposal 2019-41, and amendment proposal 2019-42. She said the three proposals can respectively be associated with principles, best estimates and prescribed margins. Dylan Strother (Oliver Wyman) discussed the field test results and analysis. He said the field test instructions requested that participating companies submit point in time and projected reserve results for term or universal life with secondary guarantee (ULSG) products. Companies were required to submit results using a baseline scenario applying the interim solution (1/2 cL) and each of the three scenarios proposed in the amendment proposals. While numerous companies were invited to participate in the field test, the sophistication of the modeling, the extensive analysis, and some resource constraints limited the number of participants to 11 entities. Mr. Strother said the number was sufficient to do the required analysis and comparison to the representative PBR model. He noted that the distribution of companies in the field test was a good representation of company sizes, credibility assumptions and mortality assumptions across the industry. The field test submissions were used to refine the granularity in the places that were identified as the most significant drivers. Those drivers were the mortality, reserves and the properties of reinsurance. Mr. Strother said the biggest driver of the variation in results was the relationship between current scale of rates and anticipated mortality. He said two credibility scenarios for the representative model were also selected. He reviewed the results from each of the three amendment proposals under the baseline assumptions and the proposed action scenarios. Mr. Tsang asked if any of the participating companies expressed a preference for one of the three amendment proposals. Scott O’Neal (NAIC) said while no company expressed a preference for a specific proposal as the winning solution, some companies did note how they would implement a particular proposal or which actions may require additional work or potential model enhancements. Jeffrey L. Johnson (John Hancock) said a comment letter was submitted prior to commencement of the field test that stated a preference for amendment proposal 2019-42. Leonard Mangini (Academy) asked if the results of amendment proposal 2019-41 reflect a lack of understanding of the proposal. Mr. Strother said the proposals may require rewording. Mr. Jakielo asked why the baseline did not include mortality improvement. Mr. O’Neal said the observed company rates were more favorable than the rates reflecting mortality improvement. Alice Fontaine (Fontaine Consulting) said in amendment proposal 2019-40, Action C and Action D were suggestions of formulaic approaches representing how companies might decide when to change the rates in their model. She said using the formulaic approach was expected to be more informative than allowing a company to use only its judgment.

Mr. O’Neal said the range of interpretation survey, conducted by the Academy with support from Oliver Wyman, was designed to gather information on how companies would interpret the different proposed solutions for modeling non-guaranteed YRT reinsurance under PBR. The survey was intended to increase the level of participation above that observed in the field study and to use the additional responses to generalize across the industry. Mr. O’Neal said the survey was designed to capture most of the potential company responses and interpretations using predefined choices. For responses that were outside of the predefined choices, written descriptions could be provided in the “other” category. Companies were asked to complete a survey for each YRT treaty that had a separate modeling approach. Mr. O’Neal said 36 separate groups of direct writers and reinsurers submitted 51 separate survey responses. He discussed the slides, providing data on reinsurers’ actions taken in response to the various proposed options. He noted that if a company chose the “other” option and the survey reviewer felt the description of the company action was close to a predefined option category, the company would be asked to consider mapping the response to the predefined category. He discussed the results based on the three amendment proposals. He said all the models assume mid-year issue dates, a single neutral YRT scale developed from the field study, and a single high credibility mortality scenario. He noted that ULSG used a neutral rate scale with zero first year premium, followed by renewal premiums determined using a 95% factor applied to company best estimate mortality without any allowance for future mortality improvement. Mr. Boerner asked why the graph of the pre-reinsurance deterministic reserve for term insurance model of amendment proposal 2019-40 results shows a dip. Mr. Strother said it is possibly due with the discount rate and some of the asset mechanics related to revaluing. Mr. Whitney said they will check to confirm that that is the case. After reviewing the survey results for the three proposed amendment proposals, Mr. O’Neal directed participants to page 38 of the presentation for the list of key takeaways.

Katie van Ryn (Oliver Wyman) discussed the evaluation of the impact on the deterministic reserve under these different amendment proposals. She said no reinsurers participated in the field test. She said the range of interpretation survey was used to provide insight into how reinsurers would handle the various proposals and to investigate the total reserve impact between the ceding and assuming companies. The results from the five reinsurers that participated in the range of interpretation survey were the basis for the analysis. Ms. van Ryn said a key observation is that differing modeling approaches between the ceding and assuming companies can result in differences between the reserve credit and the assumed reserve. Mr. Strother said slide 45 provides the dimensions on which the field test results can be compared. He reiterated that the intent of the presentation is not to recommend a solution but to provide the dimensions on which the decision can hinge. Mr. Boerner said a follow up call will be scheduled to allow Oliver Wyman to respond to further questions.
2. **Exposed Revisions to Model #805**

On its June 11 call, the Task Force adopted a revision to Model #805 (Attachment Ten) that sets the floor for the interest rate used to determine minimum nonforfeiture to 0%. The revision was held by the Task Force in anticipation of the approval of a Request for NAIC Model Law Development for changes to Model #805. The Life Insurance and Annuities (A) Committee adopted the Request for NAIC Model Law Development July 10. The Executive (EX) Committee will consider adoption of the Request for NAIC Model Law Development Aug. 13. Mr. Boerner said on July 10, the Life Insurance and Annuities (A) Committee asked the Task Force to consider a minimum nonforfeiture rate between 0% and 1%. He said the Request for NAIC Model Law Development is written to allow consideration of the request. He said suggestions for removing the 3% cap applicable to the minimum nonforfeiture rate or revising the redetermination provision would be outside the scope of the Request for NAIC Model Law Development. Brian Bayerle (American Council of Life Insurers—ACLI) discussed the ACLI comment letter (Attachment Eleven) supporting the 0% floor for the minimum nonforfeiture interest rate. He said the rate on five-year U.S. Department of the Treasury (Treasury Department) notes and 10-year Treasury Department notes were respectively 21 basis points (bps) and 55 bps on July 31. He said the rates are historically low, making it difficult for companies to support a 1% guarantee. He said maintaining an unsupported rate is a risk to the continued availability of deferred annuity products for consumers. Liz Pujolas (Insured Retirement Institute—IRI) said the IRI comment letter (Attachment Twelve) concurs with the need for the 0% floor. She said IRI is willing to work to get the Model #805 changes adopted at the state level. Mr. Leung asked for information on the reasoning behind adoption of the 1% floor. Mr. Bayerle said he would do research and provide a response for the next Task Force discussion on the issue. Mr. Carmello said he recalls that at the time, a 1% floor was not a significant issue. He suggested that in the current economic situation, companies may not want to increase surrender charges to maintain profitability. Mr. Bayerle said companies have a limited number of options available in lieu of having a lower rate. Mr. Carmello said the New York Department of Financial Services favors a rate higher than 0%. He said the thought that a company could have a 0% crediting rate is not palatable. Mr. Bayerle said the minimum nonforfeiture rate floor affects only the guaranteed rate, not the crediting rate. He said competitive market pressures will keep the crediting rate above 0%, and it will drive rates up as the interest environment improves. Mr. Leung suggested that because the company credits interest on only 87.5% of the annuity premium, the minimum nonforfeiture rate floor might not need to be as low as 0%. Mr. Bayerle said the ACLI will consider that suggestion. Mr. Ostlund asked for examples of the minimum nonforfeiture values under various interest scenarios. Mr. Bayerle agreed to consider the request. Mr. Robinson asked what the implication might be for indexed annuities. Sheldon Summers (Claire Thinking Inc.) said the rates for indexed annuities still fall between the 1–3% range. He said there would be no immediate effect on indexed annuities. Janne Daharsh (Interstate Insurance Product Regulation Commission—Compact) said state adoption of a revised Model #805 is not required for filings under the Compact. She said the Compact Uniform Standard requires only NAIC adoption. Mr. Boerner asked what if a compacting state has a higher standard in their law. Ms. Daharsh said a state could opt out of the Uniform Standards, but that has never happened for annuities.

After the close of the session, the chair released an exposure of Model #805 that provided four options for the minimum nonforfeiture interest rate, 0.15%, 0.25%, 0.35% and 0.5% for a 21-day public comment period ending Aug. 25.

3. **Adopted the Minutes of the VM-22 (A) Subgroup**

Mr. Hendrick made a motion, seconded by Mr. Weber, to adopt the VM-22 (A) Subgroup’s July 15 (Attachment Thirteen), July 1 (Attachment Fourteen), June 11 (Attachment Fifteen) and May 20 (Attachment Sixteen) minutes. The motion passed unanimously.

4. **Heard an Update from the Academy ARWG**

Ben Slutsker (Academy Annuity Reserves Work Group—ARWG) introduced the ARWG presentation (Attachment Seventeen) on elements of the framework for fixed annuity PBR. He said the objective is to propose a new statutory reserve methodology for fixed annuities that uses an actuarial framework to determine reserves based on the level and type of risk inherent in the contract. The four main pillars of the ARWG objective are: 1) appropriate reflection of risk; 2) comprehensive accounting for all material risks; 3) consistent application across similar products; and 4) practicality and appropriateness of the methodology. Mr. Slutsker said the recent revisions to VM-21, Requirements for Principle-Based Reserves for Variable Annuities, will be the starting point for development of the new fixed annuity framework. The target effective date for the new framework is January 2023. Chris Conrad (ARWG) said the ARWG recommends that the framework scope cover both payout and deferred annuity contracts, for individual and group business. The scope for deferred annuities will include most of the account value-based annuities, such as single and flexible premium deferred annuities, multi-year guarantee annuities, fixed indexed annuities, two-tiered annuities, and riders on fixed annuity contracts. The scope for payout annuities will include single premium immediate annuities, deferred income annuities, pension risk transfer, and structured settlement contracts. Mr. Conrad said
guaranteed investment contracts, synthetic stable value contracts, and funding agreements are not be included in the scope of products covered by the new framework.

John Miller (ARWG) said exclusion tests will be developed to allow products with less risk to continue using the current requirements. He said the exclusion test calibration has not been set. He said field tests being conducted by Willis Towers Watson will help determine the appropriate ratio for the exclusion test. He said that use of the exclusion test will be voluntary.

Mr. Conrad said the ARWG recommendation is to have reinvestment assumptions consistent with the current VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, investment quality percentage allocation, which is reflective of industry experience. He said other asset assumptions should be consistent with VM-20 and VM-21, as appropriate. Mr. Miller said the ARWG recommends allowing aggregation across contracts consistent with the risks inherent in the products and how the risks are managed. He said consistent aggregation principles should be applied for stochastic processes and exclusion tests. Mr. Slutsker said the ARWG has discussed the question of application of the new framework to in force business. He said the ARWG believes that there is merit to applying the framework to all in force business regardless of issue date.

5. Adopted the VM-22 Subgroup Report

Mr. Sartain said half of the Subgroup calls were used to discuss the issues presented by the ARWG. He said the remaining time was spent talking about the standard projection amount. He said the thought is to use the VM-21 standard projection amount, appropriately modified for fixed annuities. He said discussion of whether the standard projection amount will be used as a floor will occur later. He said the Subgroup recommendations to the Task Force are to accept the scope proposed by the ARWG and to instruct the ARWG to continue working on an exclusion test. He said the Subgroup does not have a current recommendation on aggregation. Task Force members voiced no objection to the two recommendations. Mr. Carmello did state a preference for retaining the current requirements as a floor. Ms. Hemphill noted that as the exclusion test is developed, thought must be given to the relationship of the thresholds to company materiality standards. Mr. Sartain said the discussion of the application of the new framework to in force business was a low priority for the Subgroup. He said the Subgroup tabled its discussion of aggregation until the ARWG work is complete. He said the Subgroup has no recommendation on the reinvestment guardrails or the standard projection amount/floor issue.

Mr. Sartain made a motion, seconded by Ms. Ahrens, to adopt the report of the VM-22 (A) Subgroup. The motion passed unanimously.

6. Heard an Update from the Compact

Ms. Daharsh provided an update on the activities of the Compact. She said the officers of the Compact Commission and the Compact Management Committee will meet Aug. 14 to receive comments on and consider adoption of proposed guidelines on committee composition and application criteria for the Consumer Advisory Committee. She said the Compact Commission will hear the reports of the Governance Committee on two projects, governance review, and the business structure.

Ms. Daharsh said the Product Standards Committee began reviewing comments from the ACLI regarding amendments to the additional standards for waiver of premium and waiver of monthly deduction standards. The key purpose of the amendment is to expand the trigger for waiver benefits beyond total disability. The Committee is also working on an additional standard for a waiver of surrender charge for life insurance.

Ms. Daharsh said the Compact has received 690 filings through October, of which 656 have been approved. Those numbers are down 20% compared to last year. She said the average wait time for review of a filing is 20 days, compared to 33 days last year. The median number of states on a Compact filing is 43. The number of mix-and-match filings has continued to decrease and now comprises 26% of filings. She said 54% of the filings are for life products, 33% of the filings are for annuity products, and most of the remaining filings are for long-term care (LTC) and disability income. She said the newest uniform standard to become effective is the group annuity standards. Three group annuity filings have been received.

Ms. Daharsh said the Compact actuaries are monitoring Task Force activities related to Model #805. She noted that the Compact uniform standards for deferred annuities refer to any model and changes to the model as effective immediately and available for Compact filing once adopted by the NAIC. She said state adoption of the model is not required for Compact filings. Mr. Robinson asked for further information on why state adoption for Model #805 is not required. Mr. Weber said states joining the Compact agree to allow the Compact standards to supersede state requirements.
7. **Adopted the Report of the Longevity Risk (E/A) Subgroup**

Ms. Ahrens said the Subgroup has not met since the 2019 Fall National Meeting. She said the Life Risk-Based Capital (E) Working Group was finalizing plans to implement longevity risk factors for risk-based capital (RBC) C-2 risk. The plans have been delayed until an impact study can be completed. The impact study for the factors is planned for early next year. She said work is being done on longevity risk transactions that are unlike payout annuities. These transactions call for future premium collection, with the reinsurer absorbing the longevity risk. The ceding company holds zero reserves and the assuming company holds near zero reserves at inception, therefore, producing near zero longevity risk. She said only a few companies are engaging in these transactions. A regulator-only call will be planned to discuss those transactions.

Ms. Ahrens made a motion, seconded by Mr. Kupferman, to adopt the report of the Longevity Risk (E/A) Subgroup. The motion passed unanimously.

8. **Adopted the Report of the GI Life Valuation (A) Subgroup**

Ms. Ahrens said the Subgroup did not meet during the spring or summer. She said previous discussions favored developing a PBR approach for guaranteed issue (GI) mortality. She suggested that *Actuarial Guideline XLIV—Group Term Life Waiver of Premium Disabled Life Reserves* (AG 44) could provide guidance. She asked if the target date for completion of the Subgroup charge could be extended. Mr. Boerner said Ms. Ahrens should make a recommendation for a revised target date to the Task Force prior to the deadline for submitting 2021 charges.

Ms. Ahrens made a motion, seconded by Mr. Ostlund, to adopt the report of the GI Life Valuation (A) Subgroup. The motion passed unanimously.

9. **Adopted the Report of the Experience Reporting (A) Subgroup**

Mr. Andersen said an exposure of additional elements related to accelerated underwriting for VM-51, Experience Reporting Formats, will be considered after the initial transition of the NAIC becoming the statistical agent. He said the Subgroup plans to have calls during the next quarter regarding actuarial aspects of accelerated underwriting, specifically an update on how well accelerated underwriting is predicting mortality in comparison to traditional underwriting. He said the Subgroup will also look to study experience for variable annuities with guarantees.

Mr. Andersen made a motion, seconded by Ms. Ahrens, to adopt the report of the Experience Reporting (A) Subgroup. The motion passed unanimously.

10. **Adopted the Report of the IUL Illustration (A) Subgroup**

Mr. Weber made a motion, seconded by Mr. Chou, to adopt the IUL Illustration (A) Subgroup’s June 2 (Attachment Eighteen) and May 26 (Attachment Nineteen) minutes. The motion passed unanimously.

Mr. Andersen said the Life Insurance and Annuities (A) Committee adopted AG 49-A. The Executive (EX) Committee and Plenary will consider the guideline for adoption on Aug. 14. Mr. Andersen briefly summarized that in late 2018, the Life Insurance and Annuities (A) Committee became aware of index product innovations that were leading to illustrations with higher credited rates than contemplated when the original guideline was developed. He said one of the major innovations was the multiplier. The Task Force was charged with addressing the concerns regarding product features. The charge was assigned to the Subgroup. To address the concerns, the Task Force instructed the Subgroup to add conservatism to the constraints of illustrated credited rates instead of focusing solely on disclosures. The Subgroup was also told to allow products with multipliers to illustrate no more favorably than products without multipliers and to reduce by half the illustrated benefit of borrowing at a certain rate and illustrating at a higher rate. These decisions were reflected in the guideline that was adopted.

Mr. Andersen said a general concept behind these issues is selecting a point on the spectrum of allowing innovation and preventing loopholes. He said AG 49-A ended up somewhere in the middle. He said while it is significantly more conservative than the existing guideline, it still provides guidance aligned with the *Life Insurance Illustrations Model Regulation* (#582). He said if after observing the results and practices following adoption of AG 49-A, there remain substantial concerns about unrealistic illustrations, the Committee will need to consider changes to Model #582.

Mr. Andersen made a motion, seconded by Mr. Yanacheak, to adopt the report of the IUL Illustration (A) Subgroup’s. The motion passed unanimously.
11. **Exposed Amendment Proposal 2019-33**

Mr. Boerner said amendment proposal 2019-33 was previously exposed for public comment. He said the Academy Life Reserves Work Group (LRWG) has revised the proposal to respond to comments from the ACLI (Attachment Twenty), Mr. Chupp (Attachment Twenty-One) and Mr. Robinson (Attachment Twenty-Two). Mary Bahna-Nolan (LRWG) said the amendment proposes to bring into scope a group insurance product that has attributes of individualized products that should be subject to VM-20. She said because the product is usually filed under a group chassis, it is generally being excluded from VM-20 requirements. She said in response to the comment letters, the following changes were made: 1) the amendment was modified to more clearly define the policies it covers so that true group insurance business would not be swept in; 2) VM-51 was modified to accommodate a certificate number and add an individual/group indicator; and 3) a clarifying edit was made to the language format. She recommended that the Task Force proceed with the proposal. Mr. Weber asked if the premiums for these products are easily identified in the annual statement blank. Ms. Bahna-Nolan said the premiums are not separated, and a request to the Blanks (E) Working Group may be necessary. Mr. Robinson said a group contract number data element should also be added to VM-51. Ms. Bahna-Nolan agreed that the field should be added.

Mr. Leung made a motion, seconded by Mr. Robinson, to expose amendment proposal 2019-33 (Attachment Twenty-Three), including the suggested edits, for a 60-day public comment period ending Oct. 5. The motion passed unanimously.

12. **Exposed Amendment Proposal 2020-03**

Ms. Hemphill said amendment proposal 2020-03 clarifies that the NPR can be calculated using the mean or mid-terminal method, or it can also be calculated using a more direct method. She said since its previous exposure, the language in the proposal has been aligned with the language in the *Accounting Practices and Procedures Manual* (AP&P Manual).

Mr. Chou made a motion, seconded by Mr. Weber, to expose amendment proposal 2020-03 (Attachment Twenty-Four) for a 21-day public comment period ending Aug. 25. The motion passed unanimously.

13. **Exposed Amendment Proposal 2019-34**

Mr. Robinson said the amendment proposal seeks to clarify the asset adequacy requirements for modified coinsurance (mod-co) business. He said because the mod-co agreement is structured such that the ceding company holds the reserves while the assuming company is responsible for the liability, there are challenges in holding either company responsible for cash-flow testing. He said the amendment clarifies that cash-flow testing is the responsibility of the ceding company, regardless of whether the liability has been ceded to a reinsurer. Mr. Carmello suggested that the amendment should be expanded to include other forms of reinsurance, such as funds withheld.

Mr. Robinson made a motion, seconded by Ms. Ahrens, to expose amendment proposal 2019-34 (Attachment Twenty-Five) for a 45-day public comment period ending Sept. 18. The motion passed unanimously.

14. **Exposed the 2021 GRET**

Dale Hall (Society of Actuaries—SOA) discussed the 2021 Generally Recognized Expense Tables (GRET) presentation (Attachment Twenty-Six). He noted that the SOA has also supplied a letter (Attachment Twenty-Seven), which provides a deeper overview of the methodology. He said there are no material changes in the process as compared to past years. He said the methodology attempts to minimize large jumps from one year to the next. He noted that the number of companies in the study decreased from 326 to 292. He attributed the decrease to companies no longer meeting the criteria for inclusion.

Mr. Leung made a motion, seconded by Mr. Weber, to expose the 2021 GRET for a 21-day public comment period ending Aug. 25. The motion passed unanimously.

15. **Heard an Update on SOA Research and Education**

Mr. Hall provided a presentation (Attachment Twenty-Eight) identifying recent and upcoming topics of possible interest to state insurance regulators of life insurance. He said most of the SOA research team’s recent work is related to COVID-19 topics crossing all areas of practice. He said the pandemic has had an impact on claims, assets, interest rates, operational risk and underwriting. He listed a few COVID-19 related references available on the SOA website. He said studies are under way that will provide information on the COVID-19 impact on insured life claims. He specifically noted a group life claim study that will allow comparisons of 2020 group life death claims to group life death claims for 2018 and 2019. He said the study is not
limited to COVID-19 claims, and it will also include death trends, such as suicide and accidental deaths. He pointed out a few other life insurance studies focusing on how companies are looking at mortality, modeling, new business practices, and asset/liability management, considering the low interest environment.

16. Exposed the 2020 Life Mortality Improvement Scale Recommendation

Marianne Purushotham (Joint Academy/SOA Life Mortality Improvement Subgroup) discussed a presentation (Attachment Twenty-Nine) on the 2020 mortality improvement scale recommendation. She said the objective of the mortality improvement updates is to address the incorporation of mortality improvement allowed in VM–20 Section 9.C.3.g. She said the mortality improvement scale is based on an average of historical data and data based on forecasted expectations, which is then smoothed to yield the mortality improvement scale. She said for 2020, there has been much discussion of how shocks, like the COVID-19 pandemic, affect the historical mortality improvement scale. She said the Subgroup decided to treat shocks as capital planning events, as opposed to treating them as impacts to reserves. Among the considerations leading to the decision for 2020 are: 1) the lack of sufficient data to understand the COVID-19 shock; 2) that reflecting a shock is inconsistent with the goals of the mortality improvement goal updates; and 3) avoiding the setting of a precedent for other excess mortality events. She said while the 2020 mortality improvement will not include an impact for the pandemic, pandemic deaths will be included in historical average used in the 2022 mortality improvement scale; but its effect will be smoothed. She said COVID-19 issues to be considered in the future are whether its impact on the insured population will be similar to its impact on the general population and what, if any, will be its long-term impact on mortality improvement rates.

The Task Force agreed to expose the 2020 Life Mortality Improvement Scale Recommendation for a 21-day public comment period ending Aug. 25 without objection.

17. Heard an Update from the Academy PBR Governance Work Group

Donna Claire (Academy PBR Governance Work Group) gave a presentation (Attachment Thirty) on PBR resources available from the Academy. She said the Academy is surveying appointed actuaries to get information on the impact of COVID-19 on 2020 year-end asset adequacy testing, including assumptions for mortality, lapses, interest rates, and long-term care (LTC). The white paper generated from the survey is expected to be available in September. Ms. Claire said the Academy Variable Annuity Reserves and Capital Work Group released a VM-21 checklist on Aug. 3. The checklist details the items to consider when determining variable annuity reserves and capital. Ms. Claire said the Academy PBR practice page on the Academy website provides the PBR toolkit, Academy comments on PBR, links to NAIC PBR resources, and Academy publications on PBR. She noted that the Life Principle-Based Reserves Under VM-20 practice note has been updated to reflect the 2020 Valuation Manual. She also highlighted the PBR Qualification Standard on the webpage. She said the Boot Camp will be virtual. Information is available on the Academy website. Another publication referenced by Ms. Claire is the PBR analysis template.

18. Heard an Update from the Academy Council on Professionalism

Shawna Ackerman (Academy) said the Academy has COVID-19 resources available on its website, including links to federal rules and regulations, congressional resources, Academy resources, and the NAIC Coronavirus Resource Center. Kathy Riley (Academy) said the Actuarial Standards Board (ASB) met in June to review the second exposure draft of Actuarial Standard of Practice (ASOP) No. 2—Nonguaranteed Elements for Life Insurance and Annuity Products. The comment period closes on Nov. 13. Ms. Riley said the comment period for the second exposure draft for ASOP No. 22—Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers ends on Nov. 30. She said the comment period for the first exposure draft of ASOP No. 11—Financial Statement Treatment of Reinsurance Transactions Involving Life Insurance or Health Insurance ended June 30. Comments on ASOP No. 11 will be reviewed by the ASB in December. She said ASOP No. 56—Modeling has been released, and it is effective for work done on or after Oct. 1. Godfrey Perrott (Academy) said the Actuarial Board for Counseling and Discipline (ABCD) received 72 requests for guidance (RFG). He said one general RFG asked whether Precept 1, covering integrity and honesty, applies only to actuarial work or applies to all activities. He said the answer is that it applies to all activities. He said Precept 13 requires Academy members to report material violation of the code if they cannot correct it.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met via conference call June 25, 2020. The following Task Force members participated:
Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted Revisions to AG 49**

Mr. Andersen said AG 49-A, the proposed revision to *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49), will reflect the Task Force charge that products with multipliers, cap buy ups and other index-linked enhancements should not illustrate more favorably than products without those features. AG 49-A also provides additional limits on the illustration of policy loan leverage. He said that given the constraints of the *Life Insurance Illustrations Model Regulation (#582)*, AG 49-A strikes a balance between allowing product innovation and reducing potential loopholes without eliminating all index features. He recommended that if AG 49-A is adopted, the Task Force should observe market activities for first six to 12 months following the effective date to determine if Model #582, its associated illustrated scale and focus on historic returns make sense for the indexed universal life (IUL) product.

Mr. Andersen made a motion, seconded by Mr. Weber, to adopt AG 49-A, the revision to AG 49 effective for all policies issued after the AG 49-A effective date (Attachment One-A). The motion passed unanimously.

Mr. Boerner said, once AG 49-A is adopted by the Executive (EX) Committee and Plenary, and its effective date is set, the Task Force will consider exposure of a proposal to discontinue AG 49 for all policies issued after the effective date of AG 49-A.

2. **Adopted Amendment Proposal 2020-07**

Tom Kalmbach (Globe Life) discussed the Globe Life comment letter (Attachment One B) on amendment proposal 2020-07, which proposes to change the life nonforfeiture interest rate floor in VM-02, Minimum Nonforfeiture Mortality and Interest. He said the change will result in increases in cash values and higher premiums for consumers. He said higher premiums will make the products in the small face amount market less affordable. He said the only economic reason for the change is related to paid-up additions and in-kind benefits. He proposed allowing a lower interest rate to determine the amount of paid-up and in-kind benefits while retaining the current rate for calculation of the base cash value.

Mr. Serbinowski said that lowering the interest rate for paid-up values and in-kind benefits results in lower values for both. He said the proposal should not receive regulatory consideration.

Mr. Boerner said a change such as the one Mr. Kalmbach is proposing should not be pursued in the *Valuation Manual*. He said that type of modification should be addressed through a model law change.

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment One-C) responds to companies’ concerns about whether adoption of the proposal should be deferred to allow more time to prepare for the change. He said deferring the change to the 2022 *Valuation Manual* would provide companies less time to address the matter. He pointed out that if the change is adopted for the 2021 *Valuation Manual*, companies will have 18 months to comply with the change. He said it is important that the nonforfeiture rate link to Section 7702 of the Internal Revenue Code (IRC) be maintained.
Elizabeth Brill (New York Life) said the comment letter (Attachment One-D), jointly submitted with three other companies, supports amendment proposal 2020-07. She said it is important that policyowners who surrender their policies receive equitable value in line with the intent of the standard nonforfeiture law. She said that in this low interest rate environment, retaining a 4% nonforfeiture interest rate floor potentially hurts consumers.

Mr. Weber made a motion, seconded by Mr. Yanacheak, to adopt amendment proposal 2020-07 (Attachment One-E). The motion passed, with Nebraska dissenting.

3. Adopted Amendment Proposal 2020-06

Mr. Boerner said Task Force members will consider whether the option for companies to produce their own swap spread curves should remain in amendment proposal 2020-06. He said if the Task Force chooses to remove the company option from the amendment proposal, it will result in the removal of the word “calculated,” the restoration of the word “prescribed” and the removal of the language requiring the VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, disclosures.

Mr. Bayerle said the ACLI comment letter encourages the Task Force to adopt the amendment proposal in its entirety. He said the amendment proposal was initiated because of the noted differences between the rates produced by the NAIC and the rates observed in the marketplace. He said allowing companies to use their market observable rates helps align their rates used in valuation with the rates used in their other internal processes. He said that with the disclosure provisions in the proposal providing a safety net, the risks are minimal. He said the disclosure would easily allow the NAIC to discover issues and quickly resolve them through discussion with the company.

Mr. Ostlund asked if a Valuation Manual change will be required to implement the replacement of the London Interbank Offered Rate (LIBOR).

Pat Allison (NAIC) said adoption of the amendment proposal gives the Task Force the authority to adopt and implement a LIBOR replacement without further changes to the Valuation Manual. She said once the LIBOR replacement has been implemented, a Valuation Manual amendment proposal could be submitted to capture the identity of the new data source for the sake of clarity.

Mr. Carmello made a motion, seconded by Mr. Robinson, to adopt amendment proposal 2020-06, with the “company may elect ...” paragraph deleted, the word “calculated” removed, the word “prescribed” restored and the proposed revisions to VM-31 Section 3.D.6.v and Section 3.F.4.h deleted (Attachment One-F). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for in-force illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective as follows: for all new business and in force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption*],

1.1 Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

1.2 Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

1.3 Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:
i. The policy is subject to Model #582.

ii. Interest credits are linked to an external index or indices.

ii. The policy offers Indexed Credits.

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The credited rate Annual Rate of Indexed Credits for each Index Account does not exceed the lesser of the maximum credited rate Annual Rate of Indexed Credits for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the credited rate Annual Rate of Indexed Credits for each Index Account shall not exceed the average of the maximum credited rate Annual Rate of Indexed Credits for the illustrated scale and the guaranteed credited rate Annual Rate of Indexed Credits for that account. However, the credited rate Annual Rate of Indexed Credits for each Index Account shall never be less than the guaranteed credited rate Annual Rate of Indexed Credits for that account.

ii. If the illustration includes a loan, the illustrated rate credited to the loan balance does not exceed the illustrated loan charge. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding hedge assets for Indexed Credits), less provisions for investment expenses and default cost, allocated to support the policy. Charges of any kind cannot be used to increase the Annual Net Investment Earnings Rate.

B.C. Annual Rate of Indexed Credits: The total annualized Indexed Credits expressed as a percentage of the account value used to determine the Indexed Credits.

C.D. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.
vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.

vi. The Hedge Budget used to determine the cap in 3 (D) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind cannot be used to increase the annual cap.

viii. There are no enhancements or similar features that provide additional Indexed Credits in excess of the interest provided by 3 (D) (i) through 3 (D) (v), including but not limited to experience refunds, multipliers, or bonuses.

ix. There are no limitations on the portion of account value allocated to the account.

x. A single Benchmark Index Account will be determined for each policy. This can be either an Index Account offered with the illustrated policy or determined according to Section 4 (A) (ii) for purposes of complying with this guideline. A policy shall have no more than one Benchmark Index Account.

D. Fixed Account: An account where the credited rate is not tied to an external index or index; there are no Indexed Credits.

E. Hedge Budget: For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This total annualized amount should be consistent with the hedging program of the company.

F. Index Account: An account where some or all of the amounts credited are Indexed Credits.

G. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Amounts credited to the policy resulting from a floor greater than zero on an Index Account are included.

H. Loan Balance: Any outstanding policy loan and loan interest, as defined in the policy.

I. Policy Loan Interest Rate: The current annual interest rate as defined in the policy that is charged on any Loan Balance. This does not include any other policy charges.

J. Policy Loan Interest Credited Rate: The annualized interest rate is tied to an external index or indices credited that applies to the portion of the account value backing the Loan Balance:

i. For the portion of the account value in the Fixed Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate.

ii. For the portion of the account value in an Index Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the Annual Rate of Indexed Credits, net of any applicable Supplemental Hedge Budget, for that account.

L. Supplemental Hedge Budget: For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

4. Illustrated Scale

The credited rate of Annual Rate of Indexed Credits for the illustrated scale for each Index Account shall be limited as follows:
A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).

ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of the Benchmark Index Account, and shall use that cap in 4 (A).

B. For each applicable Benchmark Index Account, the Annual Rate of Indexed Credits shall not exceed the minimum of (i) and (ii):

i. The arithmetic mean of the geometric average annual credited rates calculated in 4 (A) shall be the maximum credited rate(s) for the illustrated scale.

ii. 145% of the Annual Net Investment Earnings Rate.

C. For any other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. The determination shall reflect that the Index Account that is not the Benchmark Index Account in 3 (C), the Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii):

i. The Annual Rate of Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the Index Account.

ii. The Annual Rate of Indexed Credits reflecting the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. In no event shall the credited rate for the illustrated scale exceed the applicable rate calculated using actuarial judgment to determine this value using lookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.

D. For the Purposes of compliance with Section 5 (C) of Model #582, the Supplemental Hedge Budget is subtracted from the illustrated rate before comparing to the earned interest rate underlying the Disciplined Current Scale.

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for index-based interest Indexed Credits in an account, the assumed earned interest rate underlying the disciplined current scale shall not exceed 145% of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the account, inclusive of all general account assets (excluding hedges for index-based credits) allocated to both hedge and non-hedge assets, that support the policy's net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed:

i. the Annual Net Investment Earnings Rate, plus

ii. 45% of the lesser of (1) and (2);
1. Hedge Budget minus any annual floor, to the extent that the floor is supported by the Hedge Budget.

2. The minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account.

These rates should be adjusted for timing differences in the hedge cash flows to ensure that fixed interest is not earned on the Hedge Budget minus any annual floor, to the extent that the floor is supported by the Hedge Budget.

The assumed earned rate used in testing the Disciplined Current Scale may not exceed the Annual Rate of Indexed Credits plus the excess of the Annual Net Investment Earnings Rate over the Hedge Budget.

Guidance Note: The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate underlying the disciplined current scale.

For a policy with multiple Index Accounts, a maximum rate in 5.A. should be calculated for each account. All accounts, fixed and indexed, within a policy can be tested in aggregate.

B. If an insurer does not engage in a hedging program for index-based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy Annual Net Investment Earnings Rate.

C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy’s account value.

D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

6. Policy Loans

If the illustration includes a loan, the illustrated rate credited to the loan balance Policy Loan Interest Credited Rate shall not exceed the illustrated loan charge Policy Loan Interest Rate by more than 100 basis points. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4.50%.

7. Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical indexed interest rates Indexed Credits using current index parameters for the most recent 20-year period.
Removing the 4% floor on minimum non-forfeiture rates has the potential to increase cash values on traditional whole life coverage, thus limiting the affordability and/or the amount of insurance protection for many Americans at a time when getting life insurance is more important than ever!

Overview of Whole Life Coverage – Two Approaches Used to Determine Policy Premiums

1. For traditional whole life coverage, many companies determine policy premiums based on anticipated costs which include:
   - The cost of providing Death Benefits
   - The cost of providing Cash Values or Surrender Benefits including In-Kind Benefits
   - The cost of underwriting and other acquisition expenses
   - The cost of administration
   - The cost of holding statutory reserves in excess of economic reserves
   - The cost of capital given the risks taken.

2. For mutual companies, it is common to determine premiums based on the Statutory Reserve Valuation Net Premium which is generally conservative and may provide the opportunity to pay policyholder dividends after reflecting the company’s costs in #1 above. So the policy premium may be independent of the cash values provided.

Companies have the option to provide cash values that are greater than the minimum required. So a 4% floor on discount rates used to determine minimum cash values does not preclude companies from this option and offering higher cash values.

The Nonforfeiture Interest Rate is a Discount Rate which is used to determine cash values – this discount rate determines how cash values emerge through maturity at which time they converge to equal the face amount for traditional whole life policies regardless of the discount rate.

At a 2% discount rate cash values are 30% higher than at a 4% discount rate in the 20th policy year. Minimum Cash Values increase with lower discount rates resulting in higher surrender benefits. The cost of providing these higher benefits is reflected in the costs used to determine premiums; higher benefits lead to higher premiums.

Cash Values as determined at 2%, 2.5%, 3%, and 3.5% as a % of Minimum Cash Values determined using 4%
Upon Surrender, life insurance policies provide one or more in-kind benefits (Paid Up coverage or Extended Term Insurance) in lieu of cash surrender. The Cash Surrender value is used to determine the amount of these in-kind benefits; ideally, they should be economically equivalent. A lower interest rate used to determine Paid Up (or other in-kind) benefit amounts that is more aligned with the current market rate environment has the potential to reduce overall policy costs and supports lower policy premiums.

We urge LATF to consider an amendment to APF 2020-07, which would keep costs low for basic protection life insurance thus helping the affordability and accessibility of life insurance protection for many Americans at a time when getting life insurance protection is more important than ever.

Proposed Amendment:
The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on or after the operative date of this amendment shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%. Provided, however, that the nonforfeiture interest rate shall not be less than the applicable interest rate used to meet the definition of life insurance in the Cash Value Accumulation Test under section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

Amendment Benefits:
- Maintains the current 4% floor established in the valuation manual for the discount rate used to determine minimum cash values.
- Mitigates the impact of lower interest rates on the cost of providing minimum cash values and therefore on premiums or dividends.
- Allows for a lower interest rate to determine the amount of paid-up and in-kind benefits aligned with the rates permissible under 7702 and proposed amendments aligning better with current interest rates.
Brian Bayerle  
Senior Actuary  

June 17, 2020  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)  

Re: ACLI Comments on APF 2020-07 (Nonforfeiture Floor)  

Dear Mr. Boerner:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments regarding the APF 2020-07, which changes the cash value floor for the nonforfeiture rate in VM-02. ACLI continues to support this change, and we provide the following comments to address concerns raised by regulators.  

**Standard Nonforfeiture Law Addresses Timing Concerns**  

Several regulators expressed concern about the timing required for companies to reprice and refile depending on when adoption of federal legislation revising the Internal Revenue Code (IRC) §7702 would occur. The Standard Nonforfeiture Law provides companies 18 months to comply with a new lower rate; NAIC Model #808 Section 5c (H) (1) states the following:  

(1) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year.  

If this APF is passed, there is no additional pressure for companies to reprice this year versus a deferral on adoption. If the APF is adopted this year it provides companies more flexibility on timing for the newly priced products, assuming Federal action. Delaying action may actually create a worse situation for companies: companies cannot file until the NAIC adopts the Valuation Manual, and the Interstate Insurance Product Regulation Commission would need to update their standards quickly.  

**Greater Benefit to Consumers**  

A lower maximum nonforfeiture interest rate provides higher minimum benefits to consumers upon surrender. Higher nonforfeiture benefits encourages policyholders to continue paying premiums to build up greater value. Proponents of the floor would argue maintaining the floor may result in lower premiums, but this would be contingent on companies passing the savings of lower nonforfeiture
benefits to consumers. If the 4% floor is removed, then such benefits are required to be passed to policyholders upon surrender.

**The Floor Will Alter Relationship between Valuation and Nonforfeiture Values**

Assuming the valuation rate updates to 3.0%, the calculated nonforfeiture rate will decrease to 3.75%. If the floor is kept at 4.0%, this is a 25bp higher discount rate companies can use, and breaks the 125% relationship between the nonforfeiture rate over the valuation interest rate. This difference would become more magnified if the valuation interest rate decreased even further; if the valuation interest rate decreased to 2.5% while retaining the 4.0% floor the margin increases to 60%. Increasing the margin on nonforfeiture would likely lead to more lapse-supported permanent policies. For such products, companies begin to profit from policyholders who lapse their policy, because it costs the company less to pay the surrender benefit than it does to keep the policy in-force.

**No Issues if Tax Code Is Not Changed**

Adopting this APF does not create any potential issues in the event the Federal Government does not act on legislation. The APF just links the nonforfeiture interest rate floor to the tax code, which is why the interest rate floor in VM-02 exists in the first place. If the APF is adopted and the tax code is not updated, then the nonforfeiture floor stays at 4%, consistent with current requirements.

We look forward to a discussion on this important issue.

Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
BY E-MAIL

June 17, 2020

Mike Boerner
Chair, NAIC Life Actuarial (A) Task Force

Attention: Reggie Mazyck (rmazyck@naic.org)

Re: APF 2020-07 on Life Nonforfeiture

Dear Chair Boerner,

Our companies appreciate the opportunity to comment on APF 2020-07. We strongly support the proposal to replace the 4.0% interest rate floor in life nonforfeiture requirements with a reference to the tax code as it best protects policyholders in a low interest rate environment. Moreover, this proposal is consistent with the fundamental purpose and intent of the nonforfeiture requirements – to provide fair value to policyholders who surrender their policies after years of paying premiums. In a low interest rate environment, a minimum nonforfeiture standard that includes an artificial 4% interest rate floor permits the development and sale of products that deprive policyholders from receiving equitable value upon surrender after years of policy contributions, at a time when they no longer need or are able to afford coverage.

**Nonforfeiture Objective is to Provide Equitable Value to Consumers**

The intent of the nonforfeiture law is to provide equitable policyholder value between those who surrender versus those who persist. This is done by passing a value linked to the reserve to consumers through cash surrender value and other nonforfeiture options. If the 4.0% interest rate floor remains, products can be designed where consumers will not receive equitable value upon surrender in the current low interest rate environment. If the nonforfeiture interest rate is floored at an artificially high level, minimum guaranteed cash values will be smaller relative to the size of the reserve, making whole life a lapse-supported product.

When a policyholder surrenders a whole life contract, the company releases reserves that are larger than surrender benefits, receiving a surrender gain. The nonforfeiture interest rate is 125% of the valuation interest rate, allowing 25% of the investment income to be retained by the company.

In the likely scenario that the valuation rate drops to 3.0% for policies issued in 2021, but the 4.0% floor remains, the discount rate cushion would increase from 25% to 33% (4.0%/3.0%-1), allowing increased surrender gains to be retained by the company. If the current low rate environment persists and the valuation rate drops to 2.5%, and if the 4.0% floor remains, the discount rate cushion would increase to 60% (4.0%/2.5%-1), allowing for even more surrender gains to be retained by the company. In such a scenario, consumers who pay into policies for years and surrender the policy in a time of need would not receive value commensurate with their policy. In contrast, the company would realize a gain that may or may not be passed back to
the consumer via reduced premiums. If the 4.0% floor is kept, then the lower the interest rate environment, the greater the amount that can be withheld from the policyholder upon surrender.

The following chart shows examples of an insurance company’s “surrender gains”, which are the excess of the minimum reserves over the minimum nonforfeiture values (cash values). This is shown for a sample policy under two different reserve valuation rate scenarios (3.0% and 2.5%), with and without the current 4.0% nonforfeiture interest rate floor.

<table>
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<th>“Surrender Gains” – Difference between Reserves and Minimum Cash Values</th>
<th>Valuation Rate = 3.0%</th>
<th>Valuation Rate = 2.5%</th>
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<tr>
<td><strong>Nonforfeiture Rate</strong></td>
<td><strong>Additional Value Withheld</strong></td>
<td><strong>Additional Value Withheld</strong></td>
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<td>3.75% (No NF Floor)</td>
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As shown in the chart above, maintaining the current 4.0% interest rate floor in a low interest rate allows the insurer to realize a higher surrender gain in all durations. As illustrated, the more years the policyholder pays into the policy, the more the company is able to withhold additional value from the consumer upon surrender if the 4.0% floor remains.

**Leaving in the 4.0% Floor Harms Consumers**

Claims that removing the 4.0% floor would harm consumers by increasing premiums is a misdirected argument. In fact, if the floor remains, companies would be permitted to withhold value from consumers, resulting in greater gains for the company. These gains could either be passed through as lower premiums (creating a lapse-supported product) or pocketed by the company in a low interest rate environment. There is no requirement to lower premiums. To frame lower minimum benefits to the consumer as helping the consumer is fundamentally misguided.

The nonforfeiture requirements are designed to protect policyholders who do not stay inforce, either because they no longer want or need coverage or are unable to afford coverage. Requiring a higher exit value maintains parity with persisting policyholders and protects all customers, not just those who persist.

1 If the company passes the surrender gain back to policyholders in the form of lower premiums it is potentially (1) creating inequities between persisting and surrendering policyholders and (2) creating a lapse-supported policy, where the company is financially incented to have a greater percentage of policyholders surrender.
**Holding Archaic Remnants of the Tax Code Hostage**

The change to the nonforfeiture law in 2014 to include the 4.0% interest rate floor was not made to lower nonforfeiture benefits, but instead solely to avoid conflict between the minimum nonforfeiture values and the maximum funding values permitted under Section 7702 of the Internal Revenue Code (“Section 7702”). However, if Section 7702 is amended so that it no longer includes a hard-coded 4% minimum rate, the 4% floor in the nonforfeiture interest rate would no longer be appropriate. APF 2020-07 proposes to eliminate this floor in the interest of providing greater equity to policyholders who surrender. We support returning to the level of fairness that was always intended by the Standard Nonforfeiture Law.

**Conclusion**

We strongly urge LATF to adopt APF 2020-07 to maintain equity between persisting and surrendering policyholders consistent with the purpose of the Standard Nonforfeiture Law. Leaving the current 4.0% floor in VM-02 is not only arbitrary, but deprives surrendering policyholders of value in a low interest rate environment. Consumers are not helped by lower premiums that may or may not come to fruition. In contrast, they are helped by ensuring that minimum nonforfeiture values are fair and equitable relative to the value they have already paid into their policy.

Sincerely,

Elizabeth K. Brill  
Senior Vice President & Chief Actuary  
New York Life Insurance Company

Jason T. Klawonn  
Senior Vice President & Chief Actuary  
The Northwestern Mutual Life Insurance Company

Arthur W. Wallace  
Chief Actuary  
Massachusetts Mutual Life Insurance Company

Michael Slipowitz  
Senior Vice President, Corporate Chief Actuary & Chief Risk Officer  
The Guardian Life Insurance Company of America
RE-EXPOSURE OF APF 2020-07

Comments should be submitted to Reggie Mazyck (RMazyck@NAIC.ORG) by COB June 17, 2020

Please comment on the change of wording from “used” to “prescribed”

Additionally, provide an opinion of the pro and cons of adopting or not adopting the wording of the proposal. Particularly, concerns about the potential impacts of the proposed change on companies are welcomed.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Brian Bayerle, ACLI

Title of the Issue:
Remove 4% Floor from Life Standard Nonforfeiture Rate.

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

January 1, 2020 NAIC Valuation Manual – VM-02 Section 3.A

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

See attached.

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

Upon any possible tax code (IRC, S. 7702) modifications to remove the hardcoded interest rate floor starting in 1/1/2021, the life standard nonforfeiture rate is being updated to ensure the minimum funding under state requirements does not exceed the maximum funding under federal requirements for life insurance contracts issued starting in 1/1/2021.

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

NAIC Staff Comments:

<table>
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<th>Dates: Received</th>
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Notes: VM APF 2020-07
VM-02

Version 1: Remove floor

Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the *Valuation Manual* shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the *Valuation Manual* for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the applicable interest rate prescribed to meet the definition of life insurance in the Cash Value Accumulation Test under Section 7702 (*Life Insurance Contract Defined*) of the U.S. Internal Revenue Code.

**Guidance Note:** For flexible premium universal life insurance policies as defined in Section 3.D of the *Universal Life Insurance Model Regulation* (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.
Re-Exposure of APF 2020-06
Updated 6/11/20 v.2

This version of APF is the same as the initial version exposed after the June 11 LATF call with the exception that the following sentences

“When LIBOR is terminated or its use becomes de minimis, the LIBOR rates will be replaced with the most appropriate replacement rates for the specified purpose. The NAIC will monitor these market observable values and, in the event the then current values are discontinued or replaced, will recommend an appropriate replacement to the Life Actuarial (A) Task Force.”

have been replaced by the sentence below

“When the NAIC determines LIBOR is no longer effective, the NAIC shall recommend a replacement to LATF which shall be effective upon adoption by Life Actuarial (A) Task Force.”

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

1. Identify yourself, your affiliation and a very brief description (title) of the issue.  
   Brian Bayerle, ACLI – Interest Rate Swap Spread Determination  

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

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)  
   Interest Rate Swap Spreads are currently being calculated by the NAIC under methodology outlined in the Valuation Manual. This APF changes the methodology for calculation of the 3-month and 6-month swap spreads to use market observable values for Treasury rates and LIBOR, rather than the average of these values from JP Morgan and Bank of America.  
   With the forthcoming termination of LIBOR, the requirements of the Valuation Manual will need to change. This APF provides broad guidance allowing for one or more currently unnamed rate to replace LIBOR in these calculations.  
   Additionally, this APF allows the company to calculate its own current swap spreads based on market observable values. The spread requirements are currently included in VM-20, with VM-21 referencing the applicable sections. With the potential of VM-22 likely having similar references, LATF may want to consider moving these and other asset requirements to their own section.  

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

NAIC Staff Comments:  

<table>
<thead>
<tr>
<th>Dates</th>
<th>Received</th>
<th>Reviewed by Staff</th>
<th>Distributed</th>
<th>Considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/4/20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: VM APF 2020-06
Options for LATF consideration: Per the 6/11 LATF discussion, in addition to adopting the full text of the APF, regulators wanted to consider not allowing for companies to produce their own current swap spreads. This option would be to retain “prescribed” instead of “calculated”, would strike the paragraph beginning “The company may elect to produce their own current swap curves...”, and would remove the VM-31 Section 3.D.6.v and VM-31 Section 3.F.4.h language.

VM-20 Section 9.F.8.d
Interest rate swap spreads over Treasuries shall be prescribed/calculated by the NAIC for use throughout the cash-flow model wherever appropriate for transactions and operations including, but not limited to, purchase, sale, settlement, cash flows of derivative positions and reset of floating rate investments. A current and long-term swap spread curve shall be prescribed/calculated for year one and years four and after, respectively, with yearly grading in between. The three-month and six-month points on the swap spread curves represent the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries shall be the market-observable values for these tenors. Currently, this shall be the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries. When LIBOR is terminated or its use becomes de minimis, the LIBOR rates will be replaced with the most appropriate replacement rates for the specified purpose. The NAIC will monitor these market-observable values and, in the event that the current values are discontinued or replaced, will recommend an appropriate replacement to the Life Actuarial (A) Task Force. When the NAIC determines LIBOR is no longer effective, the NAIC shall recommend a replacement to LATF which shall be effective upon adoption by LATF.

The company may elect to produce their own current swap spread curves based on current observable rates. The company will document the data source(s) of the observable rates and the methodology of interpolation of non-published rates in the VM-31 report.

VM-20 Appendix 2.F.1
F. Current Benchmark Swap Spreads

1. For tenors of one-year to thirty-years, extract swap spread data determined as of the last business day of the month by maturity. For Bank of America data, convert the swap rate for each maturity to a swap spread by subtracting the corresponding maturity Treasury yield from the swap rate. For JP Morgan, the swap spread is provided for each maturity.

VM-31 Section 3.D.6.v (additional bullet):

v. Current Swap Spreads Data Source: If the company used something other than the NAIC produced current swap spreads as permitted by VM-20 Section 9.F.8.d, documentation of the data source(s) used in the determination of the swap spreads, and the methodology used to determine the non-published tenors.

VM-31 Section 3.F.4.h (additional bullet):

v. Current Swap Spreads Data Source: If the company used something other than the NAIC produced current swap spreads as permitted by VM-20 Section 9.F.8.d, documentation of the data source(s) used in the determination of the swap spreads, and the methodology used to determine the non-published tenors.

Commented [MR1]: The word “calculated” was proposed as a replacement for the word “prescribed” if the paragraph starting “The company may select…” was adopted. The paragraph was rejected so this language goes back to “prescribed.”

Commented [MR2]: The word “calculated” was proposed as a replacement for the word “prescribed” if the paragraph starting “The company may select…” was adopted. The paragraph was rejected so this language goes back to “prescribed.”

Commented [MR3]: This paragraph was not accepted, which results in the proposal reverting to the word “prescribed” and the deletion of the two proposed revisions to VM-31 below.

Commented [MR4]: See the note above.
The Life Actuarial (A) Task Force met via conference call June 18, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Exposed the ACLI Revisions to AG 49-A

Mr. Andersen discussed the proposed loan leverage options. He said option 1 limits some of the good features available in policies and limits the ability to illustrate the loan leveraging aspects of those features. He said the illustrations allowed by option 1 permit relatively high values related to those features, which is contrary to the preferences of some state insurance regulators. He said option 2 eliminates some of the undesirable features that would inflate illustration values, but option 2 also limits some desirable features. Mr. Andersen said option 3 is like option 1, but the value of the option features would be mitigated by limiting the loan leverage.

Alex Silva (John Hancock) discussed the IUL Coalition examples (Attachment Two-A) of the workings of each of the three loan leveraging options. He noted the IUL Coalition’s concern about an example (Attachment Two-B) submitted by Securian Financial. He characterized the example as misleading.

Graham Summerlee (Lincoln Financial), also a member of the IUL Coalition, provided examples (Attachment Two-C) refuting the assertions of the Securian Financial examples. He said the Securian example shows fixed bonuses but fails to show the related costs. He reiterated the IUL Coalition’s support for option 1.

Seth Detert (Securian Financial) said he is concerned that there is no requirement for charges related to the bonuses. He said it is a mistake to assume that every company would choose to cover bonuses with specific costs tied to the value of the fixed bonuses. He said the examples Securian provided are representative of common industry scenarios. He said the fixed bonuses on loans creates a loophole. He said the Securian Financial comment letter (Attachment Two-D) supports option 2 to close the loophole.

Mr. Yanacheak said it seems that option 2 goes too far and complicates consumer understanding of the illustration. He said the option 2 limit on wellness bonus credits is excessive. He said he supports option 1.

When polled by Mr. Boerner, 14 Task Force members said they preferred an option more conservative than option 1.

Mr. Andersen said he supports option 2.

Mr. Yanacheak said he does not fully agree with option 2 and thinks that option 3 relitigates the loan leverage discussion. He said he has previously stated his dislike for loan leveraging but does not consider wellness bonuses as loan leverage and would support option 3.

Mr. Andersen was asked to consider allowing companies to use either option 2 or option 3 depending on the policy circumstances.

Mr. Yanacheak said writing the language for allowing company choice would be difficult.
Mr. Boerner asked whether Task Force members preferred option 2 or option 3. Eleven members preferred option 3. Five members voted for option 2. Three members abstained.

Brian Bayerle (American Council of Life Insurers—ACLI) discussed the technical edits (Attachment Two-E) made to AG 49-A, the proposed revision of Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49). Mr. Chupp suggested several nonsubstantive edits.

Mr. Andersen made a motion, seconded by Mr. Schallhorn, to expose the ACLI revisions to AG 49-A, including the language for option 3 and the edits suggested by Mr. Chupp, for a seven-day public comment period ending June 24. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

W:\National Meetings\2020\Summer\TF\LA\LATF Calls\06-18\June 18 Minutes.docx
June 12, 2020

Fred Andersen  
Deputy Commissioner of Insurance  
Minnesota Department of Commerce  
Chair, NAIC IUL Illustration (A) Subgroup

Re: Proposed Changes to Actuarial Guideline 49 Loan Illustration Provisions

Fred:

On behalf of the companies listed below (the “IUL Coalition”), we are submitting this letter in support of Option 1 in the draft of Actuarial Guideline 49 (“AG 49-A”) that was submitted by the ACLI to the Life Actuarial Task Force (“LATF”).

Lincoln Financial Group  
Pacific Life Insurance Company  
National Life Group  
John Hancock  
Sammons Financial Group

Background

Indexed loans allow policyholders to take loans from their policies and continue to earn indexed interest on the loaned policy cash values designated by the insurer as loan collateral. The mechanics that support indexed interest on loaned values are very similar to the mechanics that support indexed interest on unloaned values:

- **Account value (AV)**  
- **Company earns yield (e.g., 4%)**  
- **Yield used to buy hedges**  
- **Hedge payoffs support index credits (e.g., 7.00%)**

- **Unloaned AV**
- **Company earns yield (e.g., 4%)**  
- **Yield and loan charges used to buy hedges**
- **Hedge payoffs support index credits (e.g., 7.00%)**

- **Loaned AV**
- **Company collects loan charges (e.g., 4%)**
The same risk premium that supports index credits in excess of the company’s portfolio yield also supports index credits in excess of the collected loan charge.

Although the mechanics that support indexed interest on loaned and unloaned values are very similar, the presence of a loan balance can make IUL policies more sensitive to indexed returns. Thus, when LATF first adopted AG 49, regulators chose to limit the illustrated “loan leverage” (the difference between the illustrated credits on cash values held as loan collateral or “indexed loan credit” and the loan charge) to 100 basis points.

Today, LATF has exposed three options for consideration. Each of those options would limit indexed loan leverage inclusive of all index multipliers, index bonuses, and other index credits. The options differ in the following ways:

- Option 1 would limit indexed loan leverage to 100 basis points;
- Option 2 would limit all indexed and non-indexed loan credits in excess of the loan charge to 100 basis points; and
- Option 3 would limit indexed loan leverage to 50 basis points.

The IUL Coalition Supports Option 1

Option 1 achieves the stated goal of imposing an appropriate level of new, additional conservatism on illustrations of indexed loan leverage. Option 1 is consistent with the underlying principles underlying the original loan leverage rule in AG 49. Options 2 and 3, on the other hand, go beyond regulators’ stated concerns about IUL illustrations and would create new limits on illustrations applicable to all IUL products.

The purpose of the original loan leverage rule in AG 49 was to limit the difference between the indexed loan credit and the loan charge. That limit was considered desirable because “leverage” causes increased policy sensitivity. That rationale does not, however, apply to non-indexed credits. Non-indexed credits (e.g. a fixed, guaranteed persistency bonus or wellness credits) are not supported by hedge returns that can vary and do not contribute to increased policy sensitivity. Instead, non-indexed credits are supported by mechanisms that are not dependent on indexed returns, such as policy charges and/or margins on COIs. Furthermore, there are already limits to the amount of non-indexed credits that can be illustrated, as the illustrated level of non-indexed credits are subject to self-support/lapse-support tests. We therefore urge LATF to adopt Option 1 in AG 49-A because it addresses regulator concerns and accomplishes the purpose of the loan leverage rule in AG 49 without unnecessarily limiting non-indexed credits.

In addition to concerns that have been expressed about the use of the term “charge reductions” in Option 2, we do not support Option 2 for additional reasons. Specifically, Option 2 goes beyond indexed loan leverage by limiting all credits, regardless of whether they are tied to an index. Option 2 would apply to illustrations for all products - including products without multipliers or other enhancements. Option 2 would also discourage innovation. For example, a company desiring to offer non-indexed bonuses would need to illustrate the charges related to the bonus, yet would also be prohibited from illustrating the benefit on loaned account values with indexed loans. Option 2 would also introduce inconsistencies that would cause customer confusion (e.g. inconsistent treatment of features between unloaned AV vs loaned AV, standard loans vs indexed loans, max illustrated rate vs lower illustrated rates, and UL vs IUL).
Likewise, we do not support Option 3 because it would also add conservatism for illustrations of all IUL products (including products without multipliers or other enhancements). The 100 basis point loan leverage limit already includes conservatism for index loans.

The following example demonstrates the impact of the different options:

<table>
<thead>
<tr>
<th>A. Assumed illustrated rate</th>
<th>Pre AG49</th>
<th>AG49</th>
<th>AG49-A Option 1</th>
<th>AG49-A Option 2</th>
<th>AG49-A Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Asset based charge</td>
<td>7.00%</td>
<td>7.00%</td>
<td>7.00%</td>
<td>7.00%</td>
<td>7.00%</td>
</tr>
<tr>
<td>C. Index multiplier</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
</tr>
<tr>
<td>D. Index loan charge rate</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>E. Section 6 Limit1</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
</tr>
<tr>
<td>F. Index loan credit rate2</td>
<td>8.50%</td>
<td>5.50%</td>
<td>5.00%</td>
<td>5.00%</td>
<td>4.50%</td>
</tr>
<tr>
<td>Loan Leverage (Total Index Credits - Charge Rate = F - D)</td>
<td>4.50%</td>
<td>1.50%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>0.50%</td>
</tr>
<tr>
<td>G. Non-indexed bonus (e.g. persistency bonus) applicable to indexed loaned amount</td>
<td>0.25%</td>
<td>0.25%</td>
<td>0.25%</td>
<td>0.00%</td>
<td>0.25%</td>
</tr>
</tbody>
</table>

**Allowed to illustrate on indexed loaned amount?**

| Wellness credits | Yes | Yes | Yes | No | Yes |
| Fixed, guaranteed persistency bonus | Yes | Yes | Yes | No | Yes |
| Other non-indexed credits & bonuses | Yes | Yes | Yes | No | Yes |

100 bps for AG 49 (excluding index multiplier and charge), 100 bps for Option 1 (including index multiplier and charge), 100 bps for Option 2 (including ALL bonuses and credits), 50 bps for Option 3

<table>
<thead>
<tr>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1 substantially limits the indexed credit to the loan amount, and adds conservatism for illustrations of products with multipliers or other enhancements beyond the current rule in AG 49 to address the stated concerns</td>
</tr>
<tr>
<td>Option 2 would add even more conservatism for illustrations of all products because it would not allow the illustration of non-indexed credits &amp; bonuses such as wellness credits or fixed, guaranteed persistency bonuses</td>
</tr>
<tr>
<td>Option 3 would also add more conservatism for illustrations of all IUL products</td>
</tr>
</tbody>
</table>
March 25 IUL Coalition Comment Letter

In our comment letter dated March 25, 2020, we provided additional support for Option 1. For ease of reference we are providing a summary of key points from that letter:

1. Non-indexed credits do not contribute to loan “leverage.” As described in the ACLI comment letter, loan “leverage” is when the index credit is higher than the loan charge. Non-indexed credits do not impact the index return or the loan charged rate, so **Option 1 and Option 2 provide the same limit to loan leverage.**

2. Option 2 creates inconsistencies.
   a. **Loaned vs. Unloaned Values within IUL product.** Option 2 would allow the illustration of non-indexed credits on unloaned values but not on loaned values. This leads to difficulties for a consumer to compare and understand the costs associated with a loan and the impact on benefits under the policy.
   b. **Standard Loans vs. Indexed Loans within IUL product.** Option 2 would allow the illustration of non-indexed credits on Standard Loans but not on Indexed Loans. This creates confusion to the consumer when determining which type of loan would be best suited for them.
   c. **Maximum illustrated rate vs. lower illustrated rates.** Option 2 would allow the illustration of non-indexed credits at lower illustrated rates. This is misleading because it gives the consumer the impression that the bonus amount truly varies by index performance.
   d. **UL vs. IUL.** Option 2 would create a discrepancy between UL and IUL illustrations because UL policies can illustrate non-indexed credits on loaned values. This difference will make it more difficult for the applicant to understand which product better suits his or her needs and will also make it more difficult to compare the mechanics of each product.

3. **Innovative products will be disadvantaged.** Many innovative products are designed to add non-indexed credits that could increase a customer’s policy value. The best way for a customer to understand the benefits derived from these features is in the illustration. Option 2 would create a disadvantage for innovative product designs, such as policies that offer wellness credits to customers who engage in activities that help them live longer and healthier lives.

4. **Option 1 does not provide any undue “optimism” compared to Option 2.** The illustration of non-indexed credits does not add any additional optimism because the credits will be paid regardless of future index performance. Therefore the level of “optimism” in projecting uncertain events like indexed returns is identical between the two options.

In conclusion, AG 49 was created to limit the illustration of indexed performance. Option 2 goes beyond the scope of AG 49 by restricting the illustration of non-indexed credits and would add conservatism for all IUL products (including products without multipliers or other enhancements). Option 3 would also add conservatism for all IUL products (including products without multipliers or other enhancements). Thus, the IUL Coalition urges LATF to adopt Option 1 in AG 49-A because Option 1 limits the illustration of indexed loan credits while allowing for the illustration of innovative non-indexed product features.
We appreciate the opportunity to provide input to the IUL Subgroup and look forward to further discussions.

Respectfully Submitted,

Scott R. Harrison
High Point Strategies, LLC
scott@highpointstrategies.llc

cc: Reggie Mazyck, NAIC
**Illustration of Loan Options**

Issue age 55

$35,000 annual premium for 15 years

20 years of annual loans starting in policy year 16

6% Index Interest Credit - Option 1 & 2 (Option 3 only 5.5%) ; 5% Loan Charge

---

**Example shows impact of non-indexed bonuses under different AG49 loan options – differences from Option 2 (Recommendation) in red.**

<table>
<thead>
<tr>
<th>Bonus not linked to index performance - illustrative examples, future designs may be higher</th>
<th>Option 1 (Bonus applied to non-loaned AV and loaned AV in excess of 100 bp loan leverage)</th>
<th>Option 2 (Bonus applied to non-loaned AV only; limited to 100 bp loan leverage)</th>
<th>Option 3 (Bonus applied to non-loaned AV and loaned AV in excess of 50 bp loan leverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>57,564</td>
<td>57,564</td>
<td>54,498</td>
</tr>
<tr>
<td>0.50%</td>
<td>66,110</td>
<td>62,482</td>
<td>62,482*</td>
</tr>
<tr>
<td>1.00%</td>
<td>75,861</td>
<td>67,738</td>
<td>71,570</td>
</tr>
<tr>
<td>1.50%</td>
<td>86,982</td>
<td>73,354</td>
<td>81,910</td>
</tr>
<tr>
<td>2.00%</td>
<td>99,664</td>
<td>79,352</td>
<td>93,669</td>
</tr>
</tbody>
</table>

*Same results as “Option 2” because here “Option 3” effectively shows 1% loan leverage.
June 17, 2020

Fred Andersen
Deputy Commissioner of Insurance
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: Proposed Changes to Actuarial Guideline 49 Loan Illustration Provisions – Added Example

Fred:

On behalf of the companies listed below (the “IUL Coalition”), we are submitting examples in addition to our June 12 letter in support of Option 1 in the draft of Actuarial Guideline 49 (“AG 49-A”) that was submitted by the ACLI to the Life Actuarial Task Force (“LATF”). Our objective through these examples is to increase understanding about each of the three loan options that LATF is considering, and their potential impact.

Lincoln Financial Group
Pacific Life Insurance Company
National Life Group
John Hancock
Sammons Financial Group

These examples demonstrate each of the following key takeaways:

- The impact of fixed persistency bonuses is vastly overstated if the corresponding charge is not included.
- Our examples show Option 2 results in policies with fixed persistency bonuses illustrating worse than policies without fixed persistency bonuses when indexed loans are also illustrated.
- Option 1 does not create the risk of runaway illustration values.
- Option 2 creates inconsistent treatment of non-index credits between indexed loans and standard loans.

Discussion

Concerns about Option 1 claim that it creates the risk of “runaway illustrations,” (i.e., that non-indexed features could significantly enhance illustrated values). These concerns fail to acknowledge the critical fact that the illustrated values would also need to reflect the corresponding cost of the benefit. Our examples show that while the benefits of non-indexed features can be material, once the associated cost is also included the resulting net impact on illustrated values is less material.

The hypothetical examples below assume the illustration of an IUL policy where the insured’s issue age is 55 years old, premiums are paid on the policy for 15 years and an indexed loan is taken for 20 years. The
illustrated loan interest crediting rate is 6% and the loan interest charged rate is 5%, so the illustration values are at the maximum 1% difference between the index loan credited rate and charged rate.

Based on the above assumptions, the following hypothetical examples compare how Options 1, 2 and 3 impact illustrated values under three different scenarios:

(A) No fixed bonus  
(B) 0.50% fixed bonus paid each year on both loaned and non-loaned values  
(C) 1.00% fixed bonus – paid each year on both loaned and non-loaned values

Options 1 and 3 allow the full amount of the bonus to be included in illustrated values for both loaned and non-loaned values. Option 2 limits the illustration of the bonus to non-loaned values only. Option 3 has lower illustrated values than Option 1 because the 1% loan leverage limit is reduced to 0.50%. Standard loans are also included as a comparison point.

<table>
<thead>
<tr>
<th>Bonus not linked to index performance</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Std Loan Option 1, 2, &amp; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>58,202</td>
<td>58,202</td>
<td>55,160</td>
<td>52,421</td>
</tr>
<tr>
<td>0.50%</td>
<td>66,995</td>
<td>63,406</td>
<td>63,406</td>
<td>60,176</td>
</tr>
<tr>
<td>1.00%</td>
<td>76,906</td>
<td>68,869</td>
<td>72,666</td>
<td>68,869</td>
</tr>
</tbody>
</table>

As expected, if only the bonus amount is included without reflecting the associated cost, the illustrated values could be significantly higher when adding a fixed bonus. This is not how the illustrated values are determined, however. In actual practice, the carrier needs to offset the cost of the bonus to maintain profitability levels, and to pass illustration testing. This offset results in a material change in the illustrated values and mitigates the risk of runaway illustrations.

The examples were then updated to include the following costs:

- No fixed bonus, no additional cost
- 0.50% fixed bonus, with an associated cost of 5.59% of premium
- 1.00% fixed bonus, with an associated cost of 10.92% of premium
<table>
<thead>
<tr>
<th>Bonus not linked to index performance</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Std Loan Option 1, 2, &amp; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>58,202</td>
<td>58,202</td>
<td>55,160</td>
<td>52,421</td>
</tr>
<tr>
<td>0.50%</td>
<td>61,503</td>
<td>58,190</td>
<td>58,190</td>
<td>55,217</td>
</tr>
<tr>
<td>1.00%</td>
<td>64,816</td>
<td>57,997</td>
<td>61,217</td>
<td>57,997</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Change from no bonus</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Std Loan Option 1, 2, &amp; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.50%</td>
<td>3,301</td>
<td>(11)</td>
<td>3,030</td>
<td>2,796</td>
</tr>
<tr>
<td>1.00%</td>
<td>6,614</td>
<td>(204)</td>
<td>6,057</td>
<td>5,577</td>
</tr>
</tbody>
</table>

When reflecting the cost of the bonus in Options 1 and 3, the illustrated values are increased by adding a fixed bonus. Option 2 shows reduced illustrated values. This reduction results because, while the full amount of the bonus needs to be accounted for in setting the cost of providing the bonus, Option 2 does not allow the bonus to be illustrated on loaned values. This example demonstrates, however, that the additional illustrated value from an indexed loan is relatively modest when compared to the impact on standard loan illustrated values. The treatment of the fixed persistency bonus is consistent between Indexed Loans and Standard Loans for Option 1 (similar size increase in maximum annual loan) while the treatment is inconsistent between Indexed Loans and Standard Loans for Option 2 (maximum annual loan decreases for Indexed Loans but increases for Standard Loans).

Furthermore, the policyholder would also see a reduction in early cash value on the illustration due to the added charge to cover the associated cost of the bonus. This would be an important consideration for a policyholder evaluating the costs and benefits of the bonus.

In conclusion, these examples demonstrate that the impact on illustrated values from adding a fixed bonus on indexed loan illustration values is not significantly greater than illustrated values for a standard loan. They also address stated concerns about a significant risk that illustrated values will substantially increase under Option 1. For the reasons outlined in our June 12 letter, we urge LATF to adopt Option 1.

We appreciate the opportunity to provide input to the IUL Subgroup and look forward to further discussions.

Respectfully Submitted,

Scott R. Harrison
High Point Strategies, LLC
scott@highpointstrategies.llc

cc: Reggie Mazyck, NAIC
June 12, 2020

Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101

Dear Fred,

The undersigned companies present these comments in response to the NAIC IUL Illustrations (A) Subcommittee request for comments on the exposed draft of the ACLI recommended changes to AG49.

Respectfully,

Seth Detert, Securian Financial
Pete Rothermel, Nationwide
Jacqueline Fallon, Penn Mutual Life Insurance Co
Seth Harlow, Mutual of Omaha

We want to take this opportunity to reiterate that it is our belief that the exposed ACLI revisions to AG49 meet the stated requirements of LATF:

- That products with charged-for multipliers and/or buy-up accounts illustrate substantially similar to those products without the additional charges.

- That, within an illustration, there is consistent treatment of policy features such as multipliers, index bonuses, participating loan crediting, and non-benchmark indices across the industry.

We appreciate the time and energy spent by the Subcommittee, the ACLI, and the ACLI member companies driving us towards a vote on the revisions to AG49. On the most recent call there was a lively discussion around the two options for loan leverage presented in the ACLI recommendation. This spawned a third option to be introduced and added to the subsequent ACLI recommendation.

We continue to recommend the Subcommittee adopt Option #2 of the ACLI comment letter in regard to the applicability of loan leverage. The impact of participating loans is unique to the IUL product and that in and of itself gives IUL products certain advantages over other product types in the industry. Thus, it is important that illustrations be inclusive of all types of credits in the loan leverage limit to not overemphasize the impact participating loans can have on the illustrated values of IUL products and avoid giving consumers unrealistic expectations.

During the call a comment was made that having examples showing the impact of the three different loan arbitrage options would help regulators understand the impacts of each option. Below we have provided a summary table of the work we have done quantifying the impact of each loan option on a hypothetical illustrated scenario for supplemental retirement income.
**Illustration of Loan Options**

Issue age 55

$35,000 annual premium for 15 years

20 years of annual loans starting in policy year 16

6% Index Interest Credit - Option 1 & 2 (Option 3 only 5.5%); 5% Loan Charge

---

**Example shows impact of non-indexed bonuses under different AG49 loan options – differences from Option 2 (Recommendation) in red - on annual illustrated distribution amounts**

<table>
<thead>
<tr>
<th>Bonus not linked to index performance - illustrative examples, future designs may be higher</th>
<th>Option 1 (Bonus applied to non-loaned AV and loaned AV in excess of 100 bp loan leverage)</th>
<th>Recommendation: Option 2 (Bonus applied to non-loaned AV only; limited to 100 bp loan leverage)</th>
<th>Option 3 (Bonus applied to non-loaned AV and loaned AV in excess of 50 bp loan leverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>57,564</td>
<td>57,564</td>
<td>54,498</td>
</tr>
<tr>
<td>0.50%</td>
<td>66,110</td>
<td>62,482</td>
<td>62,482*</td>
</tr>
<tr>
<td>1.00%</td>
<td>75,861</td>
<td>67,738</td>
<td>71,570</td>
</tr>
<tr>
<td>1.50%</td>
<td>86,982</td>
<td>73,354</td>
<td>81,910</td>
</tr>
<tr>
<td>2.00%</td>
<td>99,664</td>
<td>79,352</td>
<td>93,669</td>
</tr>
</tbody>
</table>

*Same results as "Option 2" because here "Option 3" effectively shows 1% loan leverage.
Background
The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for inforce illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text
1. Effective Date

This Actuarial Guideline shall be effective for all new business and in force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption].

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

i. The policy is subject to Model #582.

ii. The policy offers Indexed Credits.

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The total annual percentage rate (Annual Rate) of Indexed Credits for each Index Account does not exceed the lesser of the maximum total annual percentage rate (Annual Rate) of Indexed Credits for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the total annual percentage rate (Annual Rate) of Indexed Credits for each Index Account shall not exceed the average of the maximum total annual percentage rate (Annual Rate) of Indexed Credits for the illustrated scale and the guaranteed total annual percentage rate (Annual Rate) of Indexed Credits.
Credits for that account. However, the **total annual percentage rate** (Annual Rate) of Indexed Credits for each Index Account shall never be less than the guaranteed **total percentage rate** (Annual Rate) of Indexed Credits for that account.

ii. If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. **Annual Net Investment Earnings Rate:** Gross portfolio annual earnings rate of the general account assets (excluding hedge assets for Indexed Credits), less provisions for investment expenses and default cost, allocated to support the policy. Charges of any kind are not included. Charges of any kind are not used to increase the Annual Net Investment Earnings Rate.

C. **Annual Rate of Indexed Credits:** The total annualized Indexed Credits expressed as a percentage of the account value used to determine the Indexed Credits.

D. **Benchmark Index Account:** An Index Account with the following features:
   i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)
   ii. An annual cap is used in the interest calculation.
   iii. The annual floor used in the interest calculation shall be 0%.
   iv. The participation rate used in the interest calculation shall be 100%.
   v. Interest is credited once per year.
   vi. The **hedge budget** (Hedge Budget) used to determine the cap in 3 (D) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind are not included when determining the applicable annual cap rate.
   vii. There are no enhancements or similar features that provide additional amounts credited that are linked to an index or indices. Indexed Credits in excess of the interest calculation, provided by 3 (D) (i) through 3 (D) (v), including but not limited to experience refunds, multipliers, and bonuses.
   viii. There are no limitations on the portion of account value allocated to the account.
   ix. A single Benchmark Index Account will be determined for each policy. This can be either an Index Account offered with the illustrated policy or determined according to Section 4 (A) (ii) for purposes of complying with this guideline. A policy shall have no more than one Benchmark Index Account.

E. **Fixed Account:** An account where the amounts credited are not tied to an index or indices. Indexed Credits.

F. **Index Account:** An account where some or all of the amounts credited are Indexed Credits.

G. **Indexed Credits:** Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that are linked to an index or indices. Indexed Credits to the policy resulting from a floor are included.

H. **Hedge Budget:** For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This total annualized amount should be consistent with the hedging program of the company.

G. **Index Account:** An account where some or all of the amounts credited are Indexed Credits.
H. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Amounts credited to the policy resulting from a floor greater than zero on an Index Account are included.

I. Loan Balance: Any outstanding policy loan and loan interest, as defined in the policy.

J. Policy Loan Interest Rate: The current annual interest rate as defined in the policy that is charged on any Loan Balance. This does not include any other policy charges.

K. Policy Loan Interest Credited Rate: The annualized interest rate credited that applies to the portion of the account value backing the Loan Balance, as defined in the policy.
   i. For the portion of the account value in the Fixed Account that is backing the Loan Balance that is in a Fixed Account, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate, as defined in the policy.

   [OPTION FOR CONSIDERATION: Please see commentary on these approaches in the ACLI April 14, 2020 Comment Letter. There is an Option 3 that would use the language from Option 1 and Option 2 may need to reduce the limit in Section 6 from 100bp to be tightened up to 50bp.]

   Option 1: ii. For any portion of the account value in an Index Account that is backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage Annual Rate of Indexed Credits, net of any applicable Supplemental Hedge Budget, for that account, as defined in the policy.

   Option 2: ii. For any portion of the account value in an Index Account that is backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage Annual Rate of Indexed Credits and all illustrated bonuses, charge reductions or other enhancements intended to impact the portion of the account value backing the Loan Balance, net of any applicable Supplemental Hedge Budget for that account, as defined in the policy.

L. Supplemental Hedge Budget: For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that determines used in the determination of the Benchmark Index Account. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

4. Illustrated Scale

The total Annual Rate of Indexed Credits for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for the Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.
   i. If the insurer offers a Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the Benchmark Index Account in 4 (A).
   ii. If the insurer does not offer a Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of the Benchmark Index Account, and shall use that cap in 4 (A).

B. For the Benchmark Index Account the Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account shall not exceed the minimum of (i) and (ii):
i. the arithmetic mean of the geometric average annual credited rates calculated in 4 (A).

ii. 145% of the Annual Net Investment Earnings Rate.

C. For any other Index Account that is not the Benchmark Index Account in 3 (C), the total Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii):

i. The maximum Annual Rate of Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the Index Account.

ii. The total Annual Rate of Indexed Credits that reflects the fundamental characteristics of the Index Account and the appropriate relationship to the expected risk and return of the Benchmark Index Account. The illustration actuary shall use actuarial judgment to determine this value using lookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.

D. For purposes of compliance with Section 6 (C) of Model #582, the Supplemental Hedge Budget may cause the illustrated rate before comparing to exceed the earned interest rate underlying the Disciplined Current Scale.

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for Indexed Credits in an account, the assumed earned interest rate underlying the disciplined current scale for the account, inclusive of all general account assets both hedge and non-hedge assets, that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed:

i. the Annual Net Investment Earnings Rate, plus

ii. 45% of the lesser of (1) and (2):

1. Hedge Budget minus any floor, annual floor, to the extent that the floor is supported by the Hedge Budget.

2. The minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account.

These rates should be adjusted for timing differences in the hedge cash flows to ensure that fixed interest is not earned on the Hedge Budget minus any annual floor, to the extent that the floor is supported by the Hedge Budget.

Guidance Note: The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate underlying the disciplined current scale.

B. If an insurer does not engage in a hedging program for Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the Annual Net Investment Earnings Rate.

Commented [A8]: One of several edits addressing Academy S.A. Comment #3

Commented [A9]: Suggested language to address the floor

Commented [A10]: This language shouldn’t inherently disadvantage multiplier designs. The timing adjustment will impact both multiplier and non-multiplier designs. For multiplier designs, the Supplemental Hedge Budget definition allows for an amount “consistent with the hedging program of the company”, which may allow the timing difference to be reflected in that value and not disadvantage a multiplier.

Commented [A11]: If a product does not have an interest spread (i.e., the full NIER is spent on hedging), it should not generate excess hedge earnings in the testing which would not be the case in reality.

Commented [A12]: Changes address VA Comment #6

Commented [A13]: Reflects Academy S.A. Comment #1
C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy’s account value.

6. Policy Loans

**OPTION FOR CONSIDERATION:** In addition to the 2 options outlined in 3.K, a third option was suggested to use the Option 1 language but reduce below from 100 to 50 bps.

If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate by more than [Options 1 and 2: 100; Option 3: 50] basis points. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 5%.

7. Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical Indexed Credits using current index parameters for the most recent 20-year period.
The Life Actuarial (A) Task Force met via conference call June 11, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Manny Hidalgo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted Revisions to Model #805**

   Jason Berkowitz (Insured Retirement Institute—IRI) said the IRI comment letter (Attachment Three-A) supports the revision of the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805) that lowers the nonforfeiture interest rate floor 1% to 0%.

   Brian Bayerle (American Council of Life Insurers—ACLI) said there is an urgent need for adoption of the revisions. He said the ACLI is open to revisiting the issue later if other considerations arise.

   Mr. Chou made a motion, seconded by Mr. Carmello, to adopt the revisions to Model #805 (Attachment Three-B). The motion passed unanimously.

2. **Re-exposed APF 2020-06**

   Pat Allison (NAIC) said the NAIC calculates swap spreads using methodology outlined in the *Valuation Manual*. She said the first section of the proposal addresses how the NAIC use of J.P. Morgan and Bank of America values has become an issue, particularly for variable annuity (VA) writers. Amendment proposal form (APF) 2020-06 changes the methodology for calculation of the three-month and six-month swap spreads to use market observable values for U.S. Treasury rates and the London Interbank Offered Rate (LIBOR), rather than the average of the values from JPMorgan and Bank of America. She said another section of the proposal provides language that facilitates the replacement of LIBOR, when NAIC staff determine that using LIBOR values is no longer feasible. The third section of the proposal allows companies to calculate their own swap spreads using market observable values. Ms. Allison noted that market observable values are available only at certain tenors of the swap rate curve. She said companies will have to decide how to determine the rates at points between tenors and will be required to disclose their methodologies.

   Mr. Bayerle said that, in addition to disclosing their methodologies, the proposal requires companies to disclose their data sources. He said the ACLI is comfortable with the NAIC determining when to discontinue use of LIBOR.

   Mr. Ostlund suggested the word “calculated” be replaced with the word “prescribed.”

   Mr. Boerner said the option of making that change could be included as part of the exposure.

   Mr. Ostlund also suggested that the language describing the replacement of LIBOR be revised.

   Ms. Allison will work Mr. Bayerle, Mr. Ostlund and Mr. Carmello to revise the wording for the exposure.

   Mr. Ostlund made a motion, seconded by Mr. Carmello, to re-expose APF 2020-06 (Attachment Three-C), with the edits suggested by Mr. Ostlund and provided by Ms. Allison, for a seven-day public comment period ending June 17. The motion passed unanimously.
3. **Re-exposed APF 2020-07**

Jim Hodges (National Alliance of Life Companies—NALC) said the NALC comment letter (Attachment Three-D) opposes adoption of APF 2020-07. He suggested the Task Force pursue a comprehensive solution that modernizes the *Standard Nonforfeiture Law for Life Insurance* (#808). He said the Task Force should wait until after the U.S. Congress takes official action on changes to Section 7702 of the Internal Revenue Code (IRC) before considering the amendment proposal. He said any change should consider the effect on low- to middle-income consumers.

Tom Kalmbach (Globe Life) said the Globe Life comment letter (Attachment Three-E) also opposes the amendment proposal and asks for consideration of the impact on consumers of lowering the nonforfeiture rate floor. He suggested lowering the interest rate on in kind benefits as an alternative. He said that in an era of higher interest rates, setting the nonforfeiture rate at 125% of the valuation interest rate provided a sufficient margin between the rates. He said as interest rates declined the margin also declined. He suggested that a revision to the law may be warranted.

Mr. Bayerle said the low interest environment presents several challenges. He said the ACLI comment letter (Attachment Three-F) explains that the proposed change is in response to congressional legislative action and maintains the important relationship between the valuation rate and the nonforfeiture rate. He said that as the valuation rate drops, there is an element of fairness in commensurately increasing the cash value. He said there have been discussions of revising #808, but that is a longer process that would not allow for a timely resolution of the issue.

Mr. Kalmbach said companies can provide higher cash values even if the nonforfeiture floor remains at the current level.

Ms. Ahrens said if companies are required to use a rate lower than the nonforfeiture rate floor to comply with the requirements of Section 7702 they would do so regardless of whether the amendment proposal is adopted.

Mr. Robinson suggested that the word “used” be replaced with “prescribed.” Mr. Bayerle agreed to the change.

Mr. Leung made a motion, seconded by Mr. Sartain, to re-expose APF 2020-07 (Attachment Three-G) with the edits suggested by Mr. Robinson, for a seven-day public comment period ending June 17. The motion passed unanimously.

4. **Adopted APF 2020-05**

APF 2020-05 clarifies that the net premium reserve (NPR) is intended to reflect continuous payment of premiums and immediate payment of death claims.

Mr. Hidalgo said his comment letter (Attachment Three-H) suggested adding wording to clarify that death claims on riders and supplemental benefits are intended to be reflected in the NPR.

Jason Kehrberg (PolySystems, Inc.) agreed that the wording of the amendment proposal was intended to cover death claims on riders and supplemental benefits. The amendment proposal was edited to provide the clarification suggested by Mr. Hidalgo.

Mr. Ostlund made a motion, seconded by Mr. Robinson, to adopt APF 2020-05 (Attachment Three-I) with the recommended edits. The motion passed unanimously.

5. **Discussed APF 2020-02**

Bill Wilton (unaffiliated) said his comment letter (Attachment Three-J) makes the case that the amendment proposal is unnecessary because the requirements it attempts to clarify need no further clarification. He said he also has concerns about the use of the pre-tax interest maintenance reserve (IMR).

Ms. Allison said the amendment proposal seeks to clarify that there are steps outlined in VM-20, Requirements for Principle-Based Reserves for Life Products, that cannot be skipped. She said reviews of principle-based reserving (PBR) actuarial reports have revealed that some companies are skipping steps.
Mr. Bock gave an example of companies holding zero reserves on small blocks of business, because they consider the block immaterial. He said that violates Section 2.G of VM-20, which says an approximation should not be biased in a downward direction.

Mr. Carmello suggested the language in the proposed guidance note should be moved to the text.

Philip Wunderlich (Nationwide) said the Nationwide comment letter (Attachment Three-K) suggests that the requirements should be balanced with practicality. He also said that requirements demonstrated in one year should not require demonstration in future years if there has not been a material change.

Mr. Bayerle said the ACLI comment letter (Attachment Three-L) suggests that adding a new requirement when some companies are doing PBR for the first time creates an additional burden. He said rather than adding prescription, state insurance regulators should approach specific companies with their issues.

Mr. Robinson suggested that the companies should be able to consider the materiality of the pre-tax IMR.

Ms. Ahrens advocated tabling the amendment proposal and expanding the use of VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, instead of adding prescription.

Mr. Boerner said the Task Force will resume the discussion on a future call.

Having no further business, the Life Actuarial (A) Task Force adjourned.
May 29, 2020

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force (LATF)

Mr. Reggie Mazyck
Life Actuary, NAIC

Re: Model 805 Exposure, Standard Nonforfeiture Law for Individual Deferred Annuities

Dear Mr. Boerner and Mr. Mazyck:

On behalf of our members, the Insured Retirement Institute (“IRI”)\(^1\) appreciates the opportunity to comment on the proposed change to Model 805 Exposure. For the reasons set forth below, we support the proposal and respectfully urge the NAIC to move expeditiously to adopt the proposal.

The current financial environment is challenging institutional and individual investors and product offerings. The proposed change from 1% to 0% will give companies more flexibility to provide the value and benefits wanted and needed by consumers. If companies are required to offer 1% crediting rates, and interest rates remain low or decrease further, certain products will no longer be feasible to offer. The products most at risk are often those in greatest demand by consumers. For example, products with short surrender charge periods may not be able to find investments that have a high enough yield to support a 1% rate. At the same time, many consumers will be understandably hesitant to purchase long term products in a low yield environment. Additional guarantees in contracts such as a return of premium benefit may become unaffordable if the asset yield available is exhausted by the 1% guarantee.

IRI is committed to responding to the country’s economic condition with policy recommendations that support individual investment. Companies must have a diverse product portfolio to respond to the

\(^1\) IRI is the leading association for the entire supply chain of insured retirement strategies, including life insurers, asset managers, and distributors such as broker-dealers, banks and marketing organizations. IRI members account for more than 95 percent of annuity assets in the U.S., include the top 10 distributors of annuities ranked by assets under management, and are represented by financial professionals serving millions of Americans. IRI champions retirement security for all through leadership in advocacy, awareness, research, and the advancement of digital solutions within a collaborative industry community.
changing economic and individual situation. IRI supports the responsive approach of Model 805 and encourages the Life Actuarial Task Force to adopt as proposed.

Thank you again for the opportunity to share our views on this important subject. Please contact the undersigned if you have questions about anything in this letter, or if we can be of any further assistance in connection with this important regulatory effort.

Sincerely,

Jason Berkowitz
Chief Legal & Regulatory Affairs Officer
Insured Retirement Institute

Liz Pujolas
Director, State Affairs
Insured Retirement Institute
STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES
ACLI DRAFT EDIT APRIL 30, 2020

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Section 1. Title

This Act shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

Section 2. Applicability

A. This Act shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

B. Sections 3 through 8 shall not apply to contingent deferred annuities.

C. Notwithstanding Subsection B, the commissioner shall have the authority to prescribe, by regulation, nonforfeiture benefits for contingent deferred annuities that are, in the opinion of the commissioner, equitable to the policyholder, appropriate given the risks insured, and to the extent possible, consistent with general intent of this law.

Drafting Note: It is expected that any regulation prescribing specific nonforfeiture requirements for the CDAs and promulgated by the commissioner under Subsection C above would apply only to the CDA contracts issued subsequent to the effective date of such regulation.

Section 3. Nonforfeiture Requirements

A. In the case of contracts issued on or after the operative date of this Act as defined in Section 13, no contract of annuity, except as stated in Section 2, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Sections 5, 6, 7, 8 and 10;

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is
specified in Sections 5, 6, 8 and 10. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

B. Notwithstanding the requirements of this section, a deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than $20 monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

Section 4. Minimum Values

The minimum values as specified in Sections 5, 6, 7, 8 and 10 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

A. (1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in Subsection B of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of Paragraphs (a) through (d) below:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection B;

(b) An annual contract charge of $50, accumulated at rates of interest as indicated in Subsection B;

(c) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection B; and

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(2) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

B. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:
The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20th of one percent, specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under Section 4B(4);

Reduced by 125 basis points;

Where the resulting interest rate is not less than one zero percent (10%); and

The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

C. During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Subsection B(2) above by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

D. The commissioner may adopt rules to implement the provisions of Section 4C and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

Section 5. Computation of Present Value

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Section 6. Calculation of Cash Surrender Value

For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Section 7. Calculation of Paid-up Annuity Benefits

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.
Section 8. Maturity Date

For the purpose of determining the benefits calculated under Sections 6 and 7, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant’s seventieth birthday or the tenth anniversary of the contract, whichever is later.

Section 9. Disclosure of Limited Death Benefits

A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

Section 10. Inclusion of Lapse of Time Considerations

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

Section 11. Proration of Values; Additional Benefits

For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Sections 5, 6, 7, 8 and 10, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Act. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Section 12. Rules

The commissioner may adopt rules to implement the provisions of this Act.

Section 13. Effective Date

After the effective date of this Act, a company may elect to apply its provisions to annuity contracts on a contract form-by-contract form basis before the second anniversary of the effective date of this Act. In all other instances, this Act shall become operative with respect to annuity contracts issued by the company after the second anniversary of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2017 3rd Quarter (amended).
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Brian Bayerle, ACLI – Interest Rate Swap Spread Determination

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


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

See attached.

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

Interest Rate Swap Spreads are currently being calculated by the NAIC under methodology outlined in the Valuation
Manual. This APF changes the methodology for calculation of the 3-month and 6-month swap spreads to use market
observable values for Treasury rates and LIBOR, rather than the average of these values from JP Morgan and Bank
of America.

With the forthcoming termination of LIBOR, the requirements of the Valuation Manual will need to change. This
APF provides broad guidance allowing for one or more currently unnamed rate to replace LIBOR in these
calculations.

Additionally, this APF allows the company to calculate its own current swap spreads based on market observable
values. The spread requirements are currently included in VM-20, with VM-21 referencing the applicable sections.
With the potential of VM-22 likely having similar references, LATF may want to consider moving these and other
asset requirements to their own section.

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

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Notes: VM APF 2020-06
VM-20 Section 9.F.8.d
Interest rate swap spreads over Treasuries shall be prescribed calculated by the NAIC for use throughout the cash-flow model wherever appropriate for transactions and operations including, but not limited to, purchase, sale, settlement, cash flows of derivative positions and reset of floating rate investments. A current and long-term swap spread curve shall be prescribed calculated for year one and years four and after, respectively, with yearly grading in between. The three-month and six-month points on the swap spread curves represent the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries, shall be the market-observable values for these tenors. Currently, this shall be the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries. There is an expectation that LIBOR will be discontinued, and prior to that time, the use of LIBOR will decline substantially. At such point, the LIBOR rates should be replaced with the most appropriate rates that replace LIBOR for the specified purpose. The NAIC will monitor these market-observable values and, in the event the then-current values are discontinued or replaced, will recommend an appropriate replacement to the Life Actuarial (A) Task Force.

The company may elect to produce their own current swap spread curves based on current observable rates. The company will document the data source(s) of the observable rates and the methodology of interpolation of non-published rates in the VM-31 report.

VM-20 Appendix 2.F.1
F. Current Benchmark Swap Spreads

1. For tenors of one-year to thirty-years, extract swap spread data determined as of the last business day of the month by maturity. For Bank of America data, convert the swap rate for each maturity to a swap spread by subtracting the corresponding maturity Treasury yield from the swap rate. For JP Morgan, the swap spread is provided for each maturity.

VM-31 Section 3.D.6.v (additional bullet):

v. Current Swap Spreads Data Source: If the company used something other than the NAIC produced current swap spreads as permitted by VM-20 Section 9.F.8.d, documentation of the data source(s) used in the determination of the swap spreads and the methodology used to determine the non-published tenors.

VM-31 Section 3.F.4.h (additional bullet):

v. Current Swap Spreads Data Source: If the company used something other than the NAIC produced current swap spreads as permitted by VM-20 Section 9.F.8.d, documentation of the data source(s) used in the determination of the swap spreads and the methodology used to determine the non-published tenors.
June 8, 2020

Mr. Mike Boerner  
Chair, Life Actuarial Task Force  
NAIC

Re: ACLI Proposal Regarding Non-Forfeiture Rates

Dear Mike:

I am writing on behalf of the members of the National Alliance of Life Companies (the NALC), a trade group composed of small and mid-sized life and health insurers across the United States. Our members focus on addressing the life insurance needs of middle income and working class Americans, and are pleased to offer comments on behalf of the policyholders we serve to the proposal by the American Council of Life Insurance (the ACLI) to eliminate the 4% floor for non-forfeiture interest rates set out in the Valuation Manual.

After carefully considering the proposal, we must share our opposition to its adoption until more thorough study is completed. Many of the customers of our member companies are working class Americans who buy basic whole life policies. We have concerns that pricing may increase for these customers as a result of these changes, and would encourage the Committee to thoroughly and carefully evaluate the potential impact of this proposal on this group of customers.

Basic whole life customers are price sensitive and budget conscious, and these changes may possibly mean less coverage or higher premiums. The problems associated with millions of underinsured Americans in this demographic are well documented and have been a concern of state insurance regulators for years.

There is a more comprehensive solution to this dilemma- modernizing the Model Non-Forfeiture Law to better address changes in the economy as well as the way life insurers now do business.
Everyone would benefit from this approach. In the interim, we could support a temporary step that carves out basic whole life from this proposal.

On a final note, we understand the hurried nature of this proposal is because of efforts by proponents to align discussions with current efforts to enact tax law changes in the U.S. Congress. To use a well-worn phrase, we seem to be “putting the cart before the horse.” The NAIC should be waiting for Congress to act, rather than making changes in the Valuation Manual that are dependent on congressional activity that may never take place.

Thank you for allowing the NALC to comment.

Sincerely,

Jim Hodges  
Executive Director  
NALC
June 8, 2020

Mike Boerner  
Chair, Life Actuarial (A) Task Force (LATF)  
National Association of Insurance Commissioners (NAIC)  
via RMazyck@NAIC.org

Re: APF 2020-07

Dear Mike:

We appreciate the opportunity to provide comments on APF 2020-07. At Globe Life, our purpose is to help working class families, with a focus on basic protection life and supplemental health products for low to middle income families. In the past few years, we issued more than a million life insurance policies through our operating companies; this may be more than any other insurance group in the US. Keeping costs low is an important element in making life insurance accessible to low and middle income families.

We do not support changes to the Valuation Manual as proposed in APF 2020-07 regarding non-forfeiture rates that simply remove the 4% interest rate floor. Although simple, this proposal is a source of concern particularly as it has the potential to increase the cash value on whole life insurance, which we believe will lead to higher costs for these products, thus limiting the affordability and amount of life insurance protection for many Americans at a time when getting life insurance is more important than ever. The 4% rate limit in the Valuation Manual sets a floor for the minimum cash values. A company would have the option to offer higher cash values than this floor if rates needed to meet the Internal Revenue Code definition of life insurance (Section 7702 rates) fall below 4%; thus there is no need to eliminate the current 4% limit.

Instead, we support an option that causes the non-forfeiture interest rates used to determine in-kind benefits like paid-up additions and extended term insurance to be more aligned with the current interest rate environment and rates needed to meet the definition of life insurance. This change could lead to reductions in insurance company costs and thus support lower premiums or higher dividends. We support this option as a stop gap measure until a comprehensive solution can be considered:

**VM-02**

**Section 3: Interest**

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the Valuation Manual shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes,
rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than 4%, but the nonforfeiture interest rate to determine paid-up benefits and other in-kind nonforfeiture benefits shall not be less than the applicable interest rate used to meet the definition of life insurance in the Cash Value Accumulation Test under Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

Finally, we favor a more deliberative process that would consider the comprehensive modernization of non-forfeiture laws that are reflective of the current economic environment and costs associated with selling and maintaining permanent life insurance contracts today. In the past, there has been reluctance in doing so given the Internal Revenue Code definition of life insurance and tax reserve requirements. With the current proposal to change the definition of life insurance interest rates and recent tax reserve changes, there are fewer constraints to moving forward with modernization of non-forfeiture requirements. Today’s non-forfeiture requirement dates back to the 1940’s – it is hardly modern -- and has not kept pace with changes to product designs (no-lapse guarantee products), industry mortality tables, interest rates, inflation and associated costs of acquiring business. A comprehensive rewrite is needed to effectively consider all these items rather than addressing them piecemeal, with the goal of making insurance more accessible to many more Americans.

Thank you, we look forward to working with LATF on this proposal.

Tom Kalmbach

Thomas P. Kalmbach
Executive Vice President and Chief Actuary
Brian Bayerle
Senior Actuary

June 10, 2020

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force

Re: ACLI Comments on APF 2020-07

Dear Mr. Boerner:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to provide comments regarding the APF 2020-07, which eliminates the cash value floor for the nonforfeiture rate in VM-02. ACLI is supportive of this change.

Likely Change to Federal Code Makes Floor Unnecessary

The floor of 4% was added to the NAIC Valuation Manual in 2014 to provide consistency with the codified limitations in the Internal Revenue Code (IRC) §7702. Given low interest rates, US Congress has proposed changing the fixed limits in IRC §7702 to a variable indexed rate. This change has passed in the US House of Representatives, and will hopefully become signed legislation this year. APF 2020-07 was structured to address this potential uncertainty by referencing the Cash Value Accumulation Test (CVAT) rate within IRC §7702, which is currently 4% (consistent with the floor). Were the legislation to become law, the reference would automatically be updated, thus lowering the floor. If nothing passes, the reference will remain consistent with the current requirements. We note the reference to CVAT rate is only needed to Congressional uncertainty. If Congress changes the law, we can simply remove the floor for the following year’s NAIC Valuation Manual.

Consumer Costs Will Likely Increase Regardless of the Change

The low interest rate environment will continue to challenge the investment return on insurance products, which will likely lead to higher insurance premiums. Notably, there is likely to be a reduction in the valuation interest rate in 2021, which will lead to higher reserves that will be financed by higher premiums. Eliminating the interest rate floor in the nonforfeiture calculation will maintain the existing relationship between the rates (since nonforfeiture interest rate is 125% of the valuation rate), and will lead to more equitable nonforfeiture benefits for consumers.

We look forward to discussing our comments on a future call.

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\(^1\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.
Sincerely,

[Signature]

cc   Reggie Mazyck, NAIC
RE-EXPOSURE OF APF 2020-07

Comments should be submitted to Reggie Mazyck (RMazyck@NAIC.ORG) by COB June 17, 2020

Please comment on the change of wording from “used” to “prescribed”

Additionally, provide an opinion of the pro and cons of adopting or not adopting the wording of the proposal. Particularly, concerns about the potential impacts of the proposed change on companies are welcomed.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

**Identification:**
Brian Bayerle, ACLI

**Title of the Issue:**
Remove 4% Floor from Life Standard Nonforfeiture Rate.

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

   January 1, 2020 NAIC Valuation Manual – VM-02 Section 3.A

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

   See attached.

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

   Upon any possible tax code (IRC, S. 7702) modifications to remove the hardcoded interest rate floor starting in 1/1/2021, the life standard nonforfeiture rate is being updated to ensure the minimum funding under state requirements does not exceed the maximum funding under federal requirements for life insurance contracts issued starting in 1/1/2021.

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

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**Notes:** VM APF 2020-07
VM-02

Version 1: Remove floor

Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the *Valuation Manual* shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the *Valuation Manual* for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the applicable interest rate prescribed to meet the definition of life insurance in the Cash Value Accumulation Test under Section 7702 (*Life Insurance Contract Defined*) of the U.S. Internal Revenue Code 4%.

**Guidance Note:** For flexible premium universal life insurance policies as defined in Section 3.D of the *Universal Life Insurance Model Regulation* (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.
Manny Hidalgo Comment on APF 2020-05

Jason,

With regard to APF 2020-05, you may want to address how riders and supplemental benefits are treated with regard to immediate payment of benefits. Per page 10 of the Valuation Manual, Section II, Subsection 6. B:

"For supplemental benefits, including Guaranteed Insurability, Accidental Death or Disability Benefits, Convertibility, or Disability Waiver of Premium Benefits, the supplemental benefit may be included with the base policy and follow the reserve requirements for the base policy under VM20, VM-A and/or VM-C, as applicable."

So, it is possible for a company to include supplemental benefits in the NPR calculation. I assume it’s the same with riders.

Thank you,

Manny

Manuel V. Hidalgo, FSA, MAAA, CFA
Insurance Actuary | State of Connecticut Insurance Department
P.O. Box 816 | Hartford, CT 06142-0816 |
( 860.297.3828 | Fax: 860.297.3978 | manuel.hidalgo@ct.gov
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

   Jason Kehrberg, Vice President, PolySystems, Inc.

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


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


   4. The NPR shall reflect the immediate payment of claims.

   Proposed VM-20 3.C.4 (revised):

   4. The NPR shall reflect continuous deaths and the immediate payment of death claims, including death claims on any riders or supplemental benefits for which the NPR is being calculated.

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

   I believe the intent was that 3.C.4 apply to death claims, e.g. not to payment of positive cash surrender values upon lapse, and that on a present value basis the calculated periodic death claim payments equate to immediate claim payment on deaths assumed to occur continuously.

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March 4, 2020

Reggie Mazyck  
National Association of Insurance Commissioners  
1100 Walnut Street – Suite 1500  
Kansas City, MO  64106-2197

Re: VM-20, Exposure 2020-02

I appreciate the opportunity to provide comments on the Amendment Proposal Form 2020-02 submitted jointly by NAIC staff and Staff of Office of Principle-Based Reserving, California Department of Insurance.

My comments relate to the proposed addition of Section 2.I.

I personally believe the requirements are clear and that the issue being addressed is better handled in VM-31 (which is designed to establish minimum reporting requirements) as opposed to VM-20.

I believe the purpose of the valuation manual, as stated in the Introduction of the Valuation Manual, is to “set forth the minimum reserve requirements…” One of the reasons the movement to principle-based approaches has occurred is it is nearly impossible to define every formula, every assumption, or every process / step required to establish an appropriate reserve.

A couple items of specific note:

1. We file reserves with quarterly statements. How many times a year do we need to show / model, as opposed to analyzing, prescribed spreads and prescribed defaults to prove that the limitation of Section 7.E.1.g. (50% Aa2 and 50% A2 non-callable bonds) produces a higher reserve than the company’s investment strategy? This is already an annual requirement of VM-31, Section D.6.s.

2. In my opinion, PIMR is an ill-conceived concept, appears to be mis-understood by many in the industry, and should be completely eliminated from actuarial literature and reserve requirements. Conceptually, reserves are being set at the level for asset cash flows and future premiums to result in the liquidation of projected benefits. (Section 4.B.) PIMR is an artificial actuarial / accounting construct that does not impact cash flows. Therefore, if PIMR is zero or a non-zero number, conceptually the same reserve should be quantified.
The Deterministic Reserve, as outlined in Section 4.B. is equal to a-b, where b is PIMR. In essence if the PIMR liability is included in starting assets, the value of assets supporting it must be subtracted to determine the Deterministic Reserve. The same goes for the Stochastic Reserve and is further explained in Section 7.D. The embedded file below contains analysis submitted to the Life Actuarial Task Force in 2014. Although not directly related to the required adjustment, it does demonstrate equivalency and irrelevance of PIMR in establishing reserves.

I believe the items in Section 2.I are best confirmed by auditors and disclosed in VM-31. If additional information is desired by the task force to better understand the impact of prescribed assumptions, then VM-31 would appear to be the more appropriate place for periodic disclosures of calculated amounts and methods utilized to comply with the requirements of VM-20, much of what is already included in VM-31. Mandating steps that add no value only increases the cost of establishing reserves resulting in less value provided and more cost to the policyholders.

Therefore, the Life Actuarial Task Force should not approve the addition of proposed Section 2.I. to VM-20 and specifically exclude from the guidance note the comment relating to PIMR.”

I would like to thank LATF for the opportunity to comment on this exposure draft.

Sincerely,

William H. Wilton, CFA, FSA, MAAA
March 4, 2020

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force

Re: APF 2020-02

Dear Mike:

Nationwide appreciates the opportunity to comment on APF 2020-02 regarding the topic of materiality in VM-20. Materiality is an important consideration within a PBR framework. While we believe VM-20 should ensure that all material risks are reserved for appropriately, any explicit materiality requirements within VM-20 should be balanced against practicality issues facing companies and the resulting operational burden which would be created by potential requirements.

We believe the suggested language in APF 2020-02 is too restrictive and does not consider the practical issues which companies encounter frequently. For example, most companies will at some point encounter immaterial blocks of business subject to PBR, which under any reasonable lens of materiality could be adequately reserved for with a proxy. In these situations, companies should be ready to defend their approach to regulators, but to remove this option entirely is impractical and would result in the unnecessary burden of creating and maintaining additional complex PBR models.

In addition, the proposed language requires certain items, like the alternate investment strategy, to be proven every year. Over time companies will have verified repeatedly that the alternate investment strategy produces a higher reserve. If the additional reserve using the alternate investment strategy is large, and the company’s investment strategy has not changed, does this comparison need to be retested every year? It seems unnecessarily burdensome on companies to repeatedly demonstrate an obvious result. As we move forward under the new PBR framework, it will be important to find appropriate ways to reduce the operational burden associated with the PBR framework.

We appreciate your consideration of our comments.

Sincerely,

Philip Wunderlich, FSA, MAAA
Associate Vice President, Appointed Actuary
Nationwide Financial

Brian J. Wagner, FSA, MAAA
Associate Vice President, Actuary
Nationwide Financial

cc Reggie Mazyck, NAIC
    Pete Weber, Ohio Department of Insurance
March 16, 2020

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force

Re: APF 2020-02

Dear Mr. Boerner:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to submit the following comments on APF 2020-02.

ACLI is concerned with this APF as drafted. The standard imposed by the language suggests companies perform significant work when actuarial experience or materiality would suggest it is not necessary. We note the following areas of concerns:

1. **Immateriality:** Most companies are going to have small pockets of business where the cost of doing a precise VM-20 calculation will far exceed the reserve, and possibly even the sum at risk. In such situations, the cost of needing to perform a mortality experience study (just to prove that mortality wasn't higher than the fully loaded prescribed table), building out a full asset model, etc. would be cost and time prohibitive. ACLI believes skipping such steps is reasonable if the impact is truly immaterial, and meets both the spirit and letter of Section 2.G:

   A company may use simplifications, approximations and modeling efficiency techniques to calculate the NPR, the deterministic reserve and/or the stochastic reserve required by this section if the company can demonstrate that the use of such techniques does not understate the reserve by a material amount, and the expected value of the reserve calculated using simplifications, approximations and modeling efficiency techniques is not less than the expected value of the reserve calculated that does not use them.

2. **Annual demonstration:** Actuarial judgment is a necessary and appropriate component to PBR. While demonstrations of the impact of modeling simplifications are appropriate, we are concerned that annual demonstrations are excessive, particularly when the actuary reasonably expects no change in the result. For example, for many companies, the alternative reinvestment strategy will consistently produce a higher reserve; it seems excessive to have to demonstrate this annually when the qualified actuary reasonably expects this to be the case. We support

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\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
addressing this with a simple statement within the VM-31 documentation that notes why the qualified actuary believes a formal demonstration provides no value.

3. **Short-term latitude:** While a few companies have been doing PBR for a few years, 2020 will be the first time it is mandatory for many companies. While companies have done a best effort of getting their products ready, adding this as a mandate creates practical implementation concerns.

ACLI would appreciate the opportunity to further discuss this APF with regulators; we believe we can find a solution that addresses the concerns raised with this APF without codifying excessive requirements that go against the spirit of reasonable model simplifications.

We look forward to a discussion of our proposed language. Thank you.

Sincerely,

[Signature]

cc  Reggie Mazyck, NAIC
The Life Actuarial (A) Task Force met via conference call June 4, 2020. The following Task Force members participated:

Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Manny Hidalgo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Exposed Revisions to AG 49**

Brian Bayerle (American Council of Life Insurers—ACLI) said the language in Section 3.k of the proposed revisions to *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49)* requires tweaking to clarify how loan leverage option 2 applies to charge reductions. He said as it stands, the language may have unintended consequences.

Seth Detert (Securian Financial) suggested removing references to charge reductions from the option 2 language. He said the opportunities for exploiting any loophole created by removing the language are small.

Mr. Bayerle said the ACLI will review the language and propose revisions.

Mr. Ostlund asked if there is also an issue with the “other enhancements” referenced in the option 2 language.

Mr. Andersen said that concern could be addressed later.

Mr. Andersen said constraints were placed on loan arbitrage in 2015 when AG 49 was developed. He said prior to AG 49, loan arbitrage allowed interest credited on the loan values to be substantially higher than the loan interest charges. He said that resulted in illustrations that were inflated. AG 49 placed a limit on the differential between the credited rate and the loan interest rate to 1%. He said a current concern is that the relationship of the overall returns of the illustration and the loan interest rate is higher than when AG 49 was developed, leading to a higher probability of illustrated values being unrealized. He said the loan options being considered address these issues.

Birny Birnbaum (Center for Economic Justice—CEJ) recommended that if option 1 is chosen, the differential between the loan rate and the crediting rate should be zero.

Mr. Andersen recommended a third option, which would use a 50-basis point differential between the crediting rate and the policy loan interest rate.

Mr. Bayerle said the third option could be included in the next exposure of edits.

Mr. Andersen suggested the Task Force decide whether the proposed revisions should apply only to new issues after a certain date or to all illustrations, including in-force illustrations.

Mr. Birnbaum said the CEJ is advocating for application of the revisions to all illustrations, so as not to deprive illustrations of the benefits of the revisions.
Mr. Serbinowski said the issue is not actuarial. He suggested the issue should be decided by the Life Insurance and Annuities (A) Committee.

Mr. Bayerle said the ACLI favors applying the revisions to the illustration of new policies only.

Mr. Boerner asked for a straw vote on whether the revisions will apply to illustrations of new policies only or to all illustrations. The Task Force voted to apply the revisions to illustrations of new policies only.

The Task Force agreed to expose the current set of proposed edits (Attachment Four-A) for a seven-day public comment period ending June 12.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Actuarial Guideline XLIX-A – Draft [ACLI DRAFT JUNE 4, 2020]
THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST SOLD AFTER [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption*]

Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for in-force illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective as follows for all new business and in-force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption*].

i. Sections 4 and 5 shall be effective for all new business and in-force life insurance illustrations on policies sold on or after September 1, 2015.

ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

iii. Sections 6 and 7 shall be effective for all new business and in-force life insurance illustrations on policies sold on or after March 1, 2016.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:
i. The policy is subject to Model #582.

ii. Interest credits are linked to an external index or indices.

ii. The policy offers Indexed Credits.

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The credited rate Annual Rate of Indexed Credits for each Index Account does not exceed the lesser of the maximum credited rate Annual Rate of Indexed Credits for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the credited rate Annual Rate of Indexed Credits for each Index Account shall not exceed the average of the maximum credited rate Annual Rate of Indexed Credits for the illustrated scale and the guaranteed credited rate Annual Rate of Indexed Credits for that account. However, the credited rate Annual Rate of Indexed Credits for each Index Account shall never be less than the guaranteed credited rate Annual Rate of Indexed Credits for that account.

ii. If the illustration includes a loan, the illustrated rate credited to the loan balance does Policy Loan Interest Credited Rate shall not exceed the illustrated loan charge Policy Loan Interest Rate. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding hedges for Indexed Credits), less provisions for investment expenses and default cost, allocated to support the policy. Charges of any kind cannot be used to increase the Annual Net Investment Earnings Rate.

C. Annual Rate of Indexed Credits: The total annualized Indexed Credits expressed as a percentage of the account value used to determine the Indexed Credits.

B.D. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.
vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.

vi. The Hedge Budget used to determine the cap in 3 (C) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind cannot be used to increase the annual cap.

vii. There are no enhancements or similar features that provide additional Indexed Credits, including but not limited to experience refunds, multipliers, or bonuses.

viii. There are no limitations on the portion of account value allocated to the account.

ix. A single Benchmark Index Account will be determined for each policy. This can be either an Index Account offered with the illustrated policy or determined according to Section 4(A)(ii) for purposes of complying with this regulation. A policy shall have no more than one Benchmark Index Account.

C.E. Fixed Account: An account where the credited rate is not tied to an external index or indices; there are no Indexed Credits.

F. Index Account: An account where some or all of the amounts credited are Indexed Credits.

G. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Amounts credited to the policy resulting from a floor greater than zero on an Index Account are included.

H. Hedge Budget: For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This total annualized amount should be consistent with the hedging program of the company.

I. Loan Balance: Any outstanding policy loan and loan interest, as defined in the policy.

J. Policy Loan Interest Rate: The current annual interest rate as defined in the policy that is charged on any Loan Balance. This does not include any other policy charges.

D.K. Policy Loan Interest Credited Rate: The annualized interest rate is tied to an external index or indices. That applies to the portion of the account value backing the Loan Balance:

i. For the portion of the account value in the Fixed Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate

[OPTION FOR CONSIDERATION: Please see commentary on these approaches in the ACLI Comment Letter; language for Option 1 and Option 2 may need to be tightened up:

Option 1: ii. For the portion of the account value in an Index Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the Annual Rate of Indexed Credits, net of any applicable Supplemental Hedge Budget, for that account.

Option 2: ii. For any portion of the account value in an Index Account that is backing the Loan Balance, the Policy Loan Interest Credited Rate is the total of the Annual Rate of Indexed Credits and all illustrated bonuses, charge reductions or other enhancements that impact such values, net of any applicable Supplemental Hedge Budget for that account.

L. Supplemental Hedge Budget: For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account.
The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

Illustrated Scale

The total Annual Rate of Indexed Credits for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).

ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of the Benchmark Index Account, and shall use that cap in 4 (A).

B. For each applicable Benchmark Index Account, the Annual Rate of Indexed Credits shall not exceed the minimum of (i) and (ii):

iii. the arithmetic mean of the geometric average annual credited rates calculated in 4 (A) shall be the maximum credited rate(s) for the illustrated scale.

ii. 145% of the Annual Net Investment Earnings Rate.

C. For any other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. The determination shall Account that is not the Benchmark Index Account in 3 (C), the Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii):

i. The Annual Rate of Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the Index Account.

ii. The Annual Rate of Indexed Credits should reflect the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. In no event The illustration actuary shall use actuarial judgment to determine this value using lookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.

B.D. For the credited Purposes of compliance with Section 6 (C) of Model #582, the Supplemental Hedge Budget is subtracted from the illustrated rate before comparing to the earned interest rate underlying the Disciplined Current Scale as it is supported by policy charges and not the earned interest rate for the illustrated scale exceed the applicable rate calculated in 4 (B).

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:
A. If an insurer engages in a hedging program for index-based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale for the policy, inclusive of all general account assets, both hedge and non-hedge assets, that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed 145:

i. the Annual Net Investment Earnings Rate, plus

ii. 45% of the lesser of (1) and (2):

1. Hedge Budget minus any annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding floor).

2. The minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that is used in the determination of the Benchmark Index Account.

These amounts should be adjusted for timing differences to ensure that fixed interest is not earned on the hedge cost. The assumed return on hedges for index-based credits allocated to support shall only be used in the disciplined current scale testing to support the illustrated Index Credits in the policy.

Guidance Note: The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate underlying the disciplined current scale.

For a product with multiple Index Accounts with different Hedge Budgets, a maximum rate in 5.A. should be calculated for each set of accounts with different Hedge Budgets.

A.B. If an insurer does not engage in a hedging program for index-based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy Annual Net Investment Earnings Rate.

B.C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy’s account value.

C. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

6. Policy Loans

If the illustration includes a loan, the illustrated rate credited to the loan balance Policy Loan Interest Credited Rate shall not exceed the illustrated loan charge Policy Loan Interest Rate by more than 100 basis points. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 5%.

7. Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical interest rates Indexed Credits using current index parameters for the most recent 20-year period.
The Life Actuarial (A) Task Force met via conference call May 28, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlern (AL); Ricardo Lara represented by Perry Kupferman and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Choup and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Cllora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Discussed Comments on the ACLI AG 49 Proposal

Mr. Andersen said a large number of comments were submitted in support of either the American Council of Life Insurers (ACLI) proposal (see NAIC Proceedings – Summer 2020, Life Actuarial (A) Task Force, Attachment Seven-A) or the Independent Proposal (see NAIC Proceedings – Summer 2020, Life Actuarial (A) Task Force, Attachment Seven-D). He said comment letters, for and against the Independent Proposal, were summarized on a detailed list (Attachment Five-A).

Bobby Samuelson (The Life Product Review) said Mr. Andersen’s list captured the important points from his comment letter (Attachment Five-A). Mr. Samuelson said the use of indexed universal life (IUL) multipliers and buy up caps is consistent with the requirements of Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49). He said the incentives for using buy ups and caps are created by the hypothetical historical lookback methodology used in AG 49. He said the scope of the Independent Proposal broadly affects all IUL products because it is not possible to separate the guideline’s application to multiplier, buy up caps and other similar product features from its application to the base IUL product.

Mr. Samuelson said the hypothetical historical lookback methodology applies to hypothetical assumptions about caps to historical data to create the maximum AG 49 rate. He indicated that industry often refers to the use of the hypothetical caps as a proxy for the risk premium. He noted that while a risk premium is created and illustrated in perpetuity, there is no parallel disclosure of the corresponding risk. He said IUL products illustrate better than universal life (UL) products because the reward is not risk-adjusted in the IUL illustration. He said the Independent Proposal’s use of the Black-Scholes model in the illustration addresses that concern by being risk-neutral. It also allows for the disclosure of the reward provided by the policy return. He reiterated that the rewards of the policy should not be illustrated without illustrating the corresponding risks.

Larry Rybka (Valmark) said consumers do not understand the risks inherent in the IUL illustration. He advocated using a best interest standard for IUL illustrations.

Steven Roth (Wealth Management International Inc.) said he is concerned that insurers are not required to disclose the basis for the assumptions on which the caps and participation rates are based nor are they required to justify decreases in caps and participation rates. He said the Independent Proposal remedies those shortcomings.

Mr. Andersen said an equally large number of comments against the Independent Proposal were received.

Brian Bayerle (ACLI) said the IUL illustration discussions have been ongoing for a year and a half. He said at no time during that period was the Task Force directed to change the scope of the charge given by the Life Insurance and Annuities (A) Committee. He provided a 2014 ACLI letter (Attachment Five-B) that indicates that several of the issues raised by the Independent Proposal were previously addressed by the Task Force.
Scott Harrison (High Point Strategies LLC) said when the IUL illustration efforts were initiated more than a year ago, the revisions to AG 49 was one of two tracks for addressing the IUL illustration issues. The other track was enhancing the required disclosures for IUL illustrations. He said the members of the IUL Coalition are looking forward to moving on to the disclosure efforts.

Gayle Donato (Nationwide) said Nationwide supports the ACLI proposal. She said the proposal satisfies the directives issued by the Task Force and should be adopted.

Seth Detert (Securian Financial) agreed with Ms. Donato and Mr. Harrison, and encouraged adopting the ACLI proposal and moving on to addressing disclosures.

Birny Birnbaum (Center for Economic Justice—CEJ) said the Independent Proposal satisfies the Task Force directives and additionally resolves some systemic problems of AG 49. He said the ACLI proposal is a massive rewrite of AG 49 and does not adhere to the Task Force directives. He said he doubts that disclosures will help consumers understand the IUL policy risks and rewards.

Mr. Andersen provided an explanation of the hypothetical historical lookback methodology. He said the 145% net investment interest rate test reflects the historic equity risk premium present in other NAIC standards. He said the returns on stocks can be replicated using a combination of a bond returns portfolio and a Standard & Poor’s (S&P) 500 call option. He said the risk for a call option is much higher than the risk of S&P 500 investments and the call option should have a higher return to reflect the higher risk. He said the return on the S&P call option has historically been roughly 45% but the investor must understand that 25% of the time the option will result in a complete loss.

Mr. Andersen said the Independent Proposal assumes the call option earns no more than the net investment earned rate due to the risk-neutral assumption applied by the proposal. He said the Independent Proposal goes beyond the current Task Force charge by not only aligning IUL multiplier and cap buy ups illustrations with regular IUL illustrations, but also by aligning IUL multiplier and cap buy up illustrations with regular UL illustrations, even though returns for IUL products have historically outperformed returns for regular UL products. He noted that the Independent Proposal is more conservative than the Task Force desires but could be considered in the future if AG 49 abuses continue.

Brian Lessing (AXA-Equitable) said the Equitable proposal (Attachment Five-C) blends elements of the ACLI Proposal and the Independent Proposal. He said the proposal uses the Black-Scholes methodology and proposes a 5% safe harbor for equity returns.

The Task Force conducted a straw vote to determine whether the Task Force favored the ACLI proposal or the Independent Proposal. The Task Force voted 15-2 to proceed with the ACLI proposal, with Mr. Carmello and Mr. Kupferman voting for the Independent Proposal. The representative from New Mexico did not respond when called to vote.

Having no further business, the Life Actuarial (A) Task Force adjourned.
### Summary of Comments on AG 49A Proposals

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<tr>
<th>Comments for the Bobby Samuelson proposal</th>
<th>Comments against the Bobby Samuelson proposal</th>
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<td>Levels playing field b/w IUL and UL</td>
<td>Changes scope for current charge from products with charged-for multipliers &amp; other enhancements to all IUL designs</td>
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<tr>
<td>Historical look is not appropriate</td>
<td>Historical performance for IUL exceeds that for UL, reflects risk premium</td>
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<tr>
<td>Risks are understated and illustrations can be unrealistic, particularly with loans, multipliers, bonus designs</td>
<td>ACLI proposal addresses multiplier &amp; other enhancement issues; Option 2 addresses loan issue</td>
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<tr>
<td>ACLI: too high a risk of failure</td>
<td>Already decided by LATF that IUL should be allowed to illustrate higher than UL</td>
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<td>IUL warrants more discipline than UL</td>
<td>Application will be inconsistent</td>
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<td>Better manage consumer performance expectations</td>
<td>Doesn't address stated concerns</td>
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<td>Makes illustrations more understandable</td>
<td>Introduces additional complexity &amp; lack of transparency and does not differentiate IUL from UL</td>
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<td>Risk/reward concerns / options don't lead to profits / cap sustainability</td>
<td>Cap is declared parameter that needs to be translated into an illustrated rate</td>
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<tr>
<td>More conservative IUL illustrations are warranted</td>
<td>Limits IUL illustrations to fixed rate, no equity risk premium; Alternate scale already exists</td>
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<tr>
<td>Reduces marketplace concerns</td>
<td>ACLI proposal has consensus among wide range of views of companies</td>
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<td>ACLI proposal will lead to more game playing</td>
<td>Risk-neutral valuation may not be appropriate for this purpose</td>
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<tr>
<td>Avoids massive re-write of AG 49</td>
<td>Preserves concepts of AG 49 for products without enhancements</td>
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**Equitable Proposal**

Integrates ACLI w/ Bobby proposal, 20% option return
May 27, 2020

Mr. Mike Boerner, Chairperson, Life Actuarial (A) Task Force (LATF)
Mr. Fred Andersen, Chairperson, IUL Illustration (A) Subgroup
National Association of Insurance Commissioners

Re: Bobby Samuelson’s Proposal

Mr. Boerner and Mr. Andersen,

Thank you for the opportunity to provide comments in response to Mr. Samuelson’s proposal for Actuarial Guideline 49 (AG 49).

During the LATF call on May 14, 2020, interested parties made a number of unfounded claims. Many of these claims were also made when AG 49 was originally developed, so the ACLI created a whitepaper in 2014 to correct the misinformation. We encourage you to review the whitepaper for discussion of the following topics:
- Why analysis of the BXM index is not indicative of the value of an IUL policy (page 8);
- Why a 45% return assumption on highly leveraged investments is reasonable (page 9); and
- Why the use of options should be evaluated as a part of an entire investment portfolio and not in isolation (page 9).

When AG 49 was originally developed, LATF considered a proposal from Mr. Samuelson that would limit IUL illustrated rates at the fixed account rate. After careful review, LATF rejected that proposal and voted in 2015 for an approach that allowed the illustration of risk premium. LATF also included an alternate scale illustration at the fixed account rate to educate policyholders on the potential for different levels of interest.

Here again, Mr. Samuelson’s proposal would effectively limit IUL illustrated rates at the fixed account rate. We urge LATF to reject this proposal because it removes risk premium from IUL illustrations, which adds conservatism for illustrations of all products (including products without multipliers or other enhancements). In addition, the proposal contains fundamental flaws that would take significant time and effort to correct.

**The Importance of Illustrating Risk Premium in IUL Policies**

As shown in the spreadsheet provided by Mr. Samuelson, the proposal would lead to illustrated rates that do not exceed the NIER. As a result, IUL illustrated rates would be roughly equal to fixed account rates and IUL policies would illustrate the same as traditional fixed UL policies. This would not only limit the illustration of multipliers and buy-up caps, but would also limit the illustration of products without such features, leading to overly conservative illustrations of IUL policies.

The proposal neglects to recognize the risk premium that is inherent in indexed products such as IUL. The existence of risk premium is supported by both theory (as shown in the ACLI white paper) and experience. At Allianz, we are proud of the value our IUL products have delivered to our customers and this value clearly shows the existence of risk premium.
The table below contains a breakdown of our actual customer experience. The table shows the average index credits and fixed account credits by issue year. Note that our fixed account rates have been approximately equal to our option budgets.

<table>
<thead>
<tr>
<th>Issue Year</th>
<th>Index Credit</th>
<th>Fixed Credit</th>
<th>Risk Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>6.77%</td>
<td>3.86%</td>
<td>75%</td>
</tr>
<tr>
<td>2007</td>
<td>6.65%</td>
<td>3.98%</td>
<td>67%</td>
</tr>
<tr>
<td>2008</td>
<td>6.78%</td>
<td>4.09%</td>
<td>66%</td>
</tr>
<tr>
<td>2009</td>
<td>8.70%</td>
<td>3.97%</td>
<td>119%</td>
</tr>
<tr>
<td>2010</td>
<td>7.12%</td>
<td>4.04%</td>
<td>76%</td>
</tr>
<tr>
<td>2011</td>
<td>7.50%</td>
<td>3.93%</td>
<td>91%</td>
</tr>
<tr>
<td>2012</td>
<td>7.52%</td>
<td>4.13%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Table includes all policy credits through 12/31/2019
Risk premium = [Index Credit]/[Fixed Credit] – 1
Table shows average policy credits; individual policy credits vary and have been as low as 0%

In aggregate, we have credited our IUL policies an average index credit of 7.18% and an average fixed credit of 3.97%. This demonstrates an average realized risk premium of 80%, which is more than the 45% return limit in AG 49. If the illustrated rate had been limited to the fixed account rate as proposed, the illustrations for these policies would have omitted the illustration of risk premium. This would have denied our customers relevant product education and understanding of the features of IUL.

Although past performance is not a prediction of future results, the underlying theory of risk premium that was present when these policies were sold continues to be present for the policies sold today.

The Misuse of Black-Scholes in the Proposal is Fundamentally Flawed

The Black-Scholes formula was designed to calculate the price of calls and puts. The user inputs the current stock price, a strike price, the risk-free interest rate, volatility, and the dividend yield, and the formula outputs a cost for the call or put. This output is not a growth rate and should not be used to project illustrated values. In addition, Black-Scholes cannot be used for the many index accounts that are supported by hedge instruments other than calls and puts.

Furthermore, although the Black-Scholes formula uses a risk-free interest rate to calculate the cost of a put or call, it should not be misunderstood that puts and calls are risk neutral. In reality, option returns will be driven by real-world interest rates and volatility, not the risk-free interest rates and implied volatility used in a Black-Scholes valuation.

Creating an option valuation framework for AG 49 that can be used for all index accounts, has agreed upon inputs, and reflects the expected option returns would be a complex task and may significantly delay the implementation of an updated AG 49.

***

In conclusion, we do not support Mr. Samuelson’s proposal because it goes against previous LATF decisions to allow the illustration of risk premium and it misuses Black-Scholes. Instead, we strongly support the ACLI proposal because the ACLI proposal accomplishes the goals set forth by regulators, has broad industry support, and is close to completion.
Thank you for the opportunity to provide these comments.

Regards,

[Signature]

Austin Bichler, FSA, MAAA
Senior Director Actuary & Illustration Actuary
Allianz Life Insurance Company of North America
May 27, 2020

Mr. Mike Boerner  
Chair, Life Actuarial (A) Task Force (LATF)  
National Association of Insurance Commissioners (NAIC)

Dear Mr. Boerner,

On behalf of the American Academy of Actuaries\(^1\) Life Illustrations Work Group (the “Work Group”), I appreciate the opportunity to provide comments to LATF on the “Independent Proposal.”

The methodology is very different from the methodology that has been in place for most indexed universal life (IUL) product illustrations even before Actuarial Guideline XLIX (AG 49) went into effect, and although there are few modifications to the text of AG 49 in the Independent Proposal, applying the proposal would not be a simple modification.

On the surface, the proposal appears to limit the illustrated rate to an amount approximately equal to the option budget or fixed account rate due to no risk premium being assumed on the option. This would cause the illustrated scale to be nearly identical to the alternate scale, because the alternate scale generally uses the fixed account rate. Illustrating at the fixed rate was discussed when AG 49 was originally drafted, and this concept was rejected in 2015.

We note that using an option cost-pricing formula to calculate an illustrated credited interest rate seems disconnected. The Work Group would need more time to consider whether it is reasonable to use a pricing formula such as Black-Sholes to calculate a longer-term illustrated credited rate. The Work Group would also need to consider how the short-term nature of the Black-Sholes formula (12 months) can be reconciled with ASOP No. 24, *Compliance with the NAIC Life Insurance Illustrations Model Regulation*, section 3.4.1, which states that actuaries “should consider an appropriate time frame commensurate with [business or economic] cycles” when setting investment return assumptions.

In addition, the Work Group would like to make some general comments in response to some of the verbal comments made during the presentation of the proposal. First, while options are commonly priced using a risk-neutral methodology, the pricing methodology should not be misunderstood to imply that the options themselves are risk-neutral. Second, options should be

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
evaluated as a part of an entire investment portfolio (i.e., not in isolation), because options are often mixed with other types of investments to achieve a desired risk profile. Even though some option positions may not seem particularly valuable when considered in isolation, it does not discredit them; indeed, some investors are willing to incur costs to ensure that they are protected from rare events (i.e., investment insurance).

Finally, we also note the Independent Proposal does not address the question of what should be included in the 100-basis-point limit between loan charges and loan credits.

We hope these comments are helpful. Given the relatively short exposure period, The Work Group has not had sufficient time to evaluate all aspects of the proposal. If LATF would like us to provide more specific comments about the proposal, we would require additional time to review the proposal and the spreadsheet examples.

The Work Group appreciates the efforts of the LATF and IUL Illustration Subgroup to review AG 49. If you have any questions or would like to dialogue on the above topics, please contact Ian Trepanier, life policy analyst, at trepanier@actuary.org.

Sincerely,

Donna Megregian, MAAA, FSA
Chairperson, Life Illustrations Work Group
American Academy of Actuaries
May 27, 2020

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)

Mr. Fred Andersen  
Chair, NAIC IUL Illustration (A) Subgroup

Re: ACLI Comments on AG 49-A and Independent Proposal

Dear Messrs. Boerner and Andersen:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to provide further commentary on the ACLI proposal and the Independent Proposal. We appreciate the hard work of the Life Actuarial (A) Task Force (LATF) and the IUL Illustration (A) Subgroup (Subgroup), and the contributions from the American Academy of Actuaries, individual companies, consumer advocates, and others.

The ACLI proposal best achieves the stated regulatory objectives and represents industry consensus. The ACLI proposal is a product of a year of dialogue with regulators, consumer advocates, and others. Our proposal does not represent the interests of a handful of IUL writers, but rather the input of a broad collection of companies, including those who write IUL (with and without multipliers), and non-IUL writers. We have crafted a proposal consistent with regulators’ decisions. Further, in our accompanying spreadsheet, we have provided illustrative examples of how our proposal meets the goal of regulators to restrict the illustration of multipliers and other enhancements (see below). Furthermore, for ease, we have added the Independent Proposal calculation to our spreadsheet, along with a summary of the current AG49 approach against the two proposals (‘Summary of Results’).

\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
### 1.) Independent Proposal Disregards Prior Regulator Decisions

The Independent Proposal seemingly disregards the past year of dialogue by attempting to re-litigate issues that were resolved back in 2014. At that time, regulators considered a proposal to limit the illustrated rate to the fixed rate but rejected that proposal in favor of an approach that allows the illustration of some risk premium. Regulators also wanted to include an illustration of more conservative returns, so they created an alternate scale that illustrates at the fixed rate. The alternate scale is shown side-by-side with the illustrated scale to ensure that policyholders see both scales.

ACLI has attached our October 28, 2014 letter that addresses many of the concerns raised, notably on the rationale of the 145% factor.

### 2.) The Independent Proposal is Overly-Conservative

The direction from LATF was to reduce the illustrated value of charged-for index features. The Independent Proposal takes conservatism to the next level, by fundamentally changing how all IUL products are illustrated.

The Independent Proposal limits the illustrated rate to the hedge cost, dramatically restricting illustrations of all IUL products. Even in the case of the Benchmark Index Account, the illustration is limited to the hedge cost. This proposal may lead to identical illustrations across virtually every IUL product, causing confusion among policyholders who will have no way to differentiate features among carriers. This is not consistent with the regulator request.

### 3.) Concerns with the Independent Proposal Would Take Significant Time to Resolve

The Independent Proposal contains a number of flaws that would take substantial time to resolve and further delay implementation of a solution. In the short exposure period, we have identified the following flaws (elaborated on below): inappropriate use of Black-Scholes to model illustrated credits,
elimination of any level of risk premium, undue volatility in illustrations, and missing assumptions and inputs for the proposed approach.

The Independent Proposal approach, while reasonable for determining hedge costs, is not a reasonable basis to illustrate credits. The Black-Scholes formula is risk neutral and while appropriate to price a call or a put, it is not intended to determine the expected return on the option. Our October 28, 2014 letter (p.9) explained the justification of what ultimately led to the 145% limit in AG 49.

We have identified several technical flaws in the Independent Proposal that would further delay this process to thoroughly address. Given the Independent Proposal relies solely on hedge cost, illustrated rates could vary quite significantly from year to year. To illustrate this, we are providing the following examples. The Black-Scholes method will return a value equal to the option cost. As a result, we only need to look at historical option costs to see the variability.

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg Cost 12% Cap</th>
<th>NI ER</th>
<th>Illustrated Rate</th>
<th>Chg. in IR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>4.82%</td>
<td>5.00%</td>
<td>5.06%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>4.89%</td>
<td>5.00%</td>
<td>5.06%</td>
<td>0.07%</td>
</tr>
<tr>
<td>2017</td>
<td>4.57%</td>
<td>5.00%</td>
<td>5.13%</td>
<td>0.07%</td>
</tr>
<tr>
<td>2018</td>
<td>5.20%</td>
<td>5.00%</td>
<td>4.80%</td>
<td>-0.34%</td>
</tr>
<tr>
<td>2019</td>
<td>5.18%</td>
<td>5.00%</td>
<td>5.46%</td>
<td>0.66%</td>
</tr>
</tbody>
</table>

The Independent Proposal utilizes costs from the prior year to generate the illustrated rate for the then current year. For example, the 2016 rate of 5.06% is derived as 4.82% x (1 + 5.00%). The above table shows that, with anunchanging cap, the illustrated rate varies by 66bps over the past 3 years. In contrast, applying the AG49’s lookback calculation with a 12% cap to that index history produces a maximum illustrated rate for a 12% cap has varied by 10bps, resulting in a more consistent outcome for consumers.

While the example above assumes that a company’s cap remains the same during this sample period (2015-2019), it is also worth considering an example where the cap rate does change. Under the Independent Proposal, if the hedge cost changes each year, a change to the cap would result in no change to the illustrated rate. For example, if a 12% cap costs 5% one year, but then the costs decrease and a 13% cap now costs 5%, both would be illustrated at 5%. This would convey no important information to consumers regarding changes to their policy which would stand in contrast with AG49’s stated objective of aiding consumer understanding.

Finally, the Independent Proposal may require an administrative procedure to collect and publish historical data to be used as inputs for the Black-Scholes model, which will take time to determine.

We urge LATF to recognize that the Independent Proposal does not implement the direction from regulators and turn their attention to resolving the remaining issues with the ACLI proposal.

We look forward to a discussion on this important issue.

Sincerely,

cc Reggie Mazyck, NAIC
May 26, 2020

Sent via email to RMazyck@NAIC.org

Mr. Fred Andersen
Chair, NAIC IUL Illustration (A) Subgroup
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: AG49 Independent Proposal

Mr. Andersen and Members of the Committee:

I added my name to the proposal Bobby Samuelson previously forwarded to the subgroup laying out the merits of the Independent Proposal. This letter amplifies my hope that the committee will adopt the Independent Proposal as submitted.

Having spent the better part of the last 14 years working with Trustees and Fiduciaries nationwide in the Trust Owned Life Insurance (TOLI) space, I have seen firsthand how Index UL illustrations can cloud the decision making process of professionals who have a duty to “do right” by the client.

Consumers also struggle to comprehend illusive illustrations that generate unrealistic expectations. This often leads to client dissatisfaction that harms the life insurance industry.

I believe that the stated goal to “to ensure that illustrations do not mislead purchasers of insurance and to make illustrations more understandable” is noble – and needed.

I believe that the best way to get there is to adopt the Independent Proposal and urge the committee to do so.

Thank you for your time and consideration,

Michael Brohawn, CFP®, CLU®, CAP®
Comments for the Center for Economic Justice
To the NAIC Life Actuarial Task Force
Support for the AG49 Independent Proposal / Opposition to the ACLI Proposal
May 27, 2020

CEJ writes in support of the Independent Proposal (“IP”) and in strong opposition to the ACLI proposal for revisions to AG49 to stop the problems with current indexed universal life (“IUL”) insurance products.

Gut-Check Time for Insurance Regulators

As insurance regulators, there are a few times in your career when you can make an era-defining difference. What would you do differently if you had the chance to go back to 1990 and review LTCI rate and form filings? What would you do differently if you had the chance to go back and stop the vanishing premium illustrations? For many of these epochal consumer protection failures, regulators did not have the information or knowledge to do things differently. Who expected a decade or more of interest rates lower than any time in the prior 50 years?

Indexed UL is undoubtedly a new era in life insurance and now accounts for more than a third of new permanent life insurance sales. But when it comes to AG49, you are not only at another epochal point in regulatory history, but you have the knowledge and foresight to prevent future consumer harm. How do you want to be judged in 10 or 20 years? As the regulators who ensured consumer retirement security or the regulators who destroyed that security for millions of consumers?

Both Proposals Start from the Same Two Values

Both the IP and ACLI proposal start from the same two values – Net Investment Earnings Rate and Market Cost of Hedges, as universally determined by application of the Black-Scholes option pricing model, to support the indexed product features. The IP relies on the NIER, which is not disclosed on the illustration, for illustration actuary testing and uses the Black-Scholes option valuation model for the purposes of illustrated performance.
In contrast, the ACLI proposal starts with these values and then transmogrifies these values into a variety of other values which are then used to develop the maximum crediting rate. The ACLI proposal starts with the market cost of hedges to create the Hedge Budget and the Supplemental Hedge Budget. The ACLI proposal creates a BIA crediting rate cap based on the lesser of the Section 4A hypothetical historical credited rate (HHCR) or NIER x 145%. Both of these values bear no – none, zero, zilch, nada, null – relationship to historical returns or future expected returns. As a result, the maximum credit rate is based on numbers picked out of thin, very thin air. We are not aware of the ACLI presenting long-term historical data or testimony of an independent third party on the validity and appropriateness of either the HHCR or the 145% factor applied to the NIER.

The HHCR is a flawed measure of historical outcomes and unlike anything we’ve seen used to evaluate historical performance of financial instruments. The calculation is based on 42 years of daily calculations of 25 year geometric returns requiring a 66-year experience period. Then the arithmetic mean of these nearly 11,000 results is calculated. This procedure gives massively unequal weight – 25 to 1 – to different years’ outcomes. Years 1 and 66 get one year’s worth of weight, while years 25 to 42 get 25 years’ worth of weight. Early and late years in the 66-year period get far less weight than middle years. As a result, the calculation bears no relationship to actual historical returns and, consequently, the ACLI part 4Bi is a nonsensical value.

ACLI part 4Bii is NIER times the unsupported and fabulous 145%. Again, no relationship to actual historical returns and certainly not remotely reasonable of future long-term expected returns. Nevertheless, the 145% now takes center stage in the ACLI proposal as a guardrail. If 145% were a reasonable expectation, then why wouldn’t other investment managers be using this methodology to enhance their long-term returns? Why would investment managers instead advocate selling options rather than buying them? And, finally, why would regulators believe that 45% annual profits forever should serve as the baseline expectation for consumers purchasing a fixed life insurance product?

It is beyond baffling why regulators would prefer the ACLI approach -- overly complex, untethered to reality and virtually impossible for regulatory or consumer accountability -- to develop a maximum crediting rate to the IP approach – direct, tightly-linked-to-market-values, and much simpler with greater accountability to regulators and consumers.
ACLI Proposal Fails to Address the Reward without Risk Problem While the IP Solves It

As has been discussed in prior comments, the current AG49 and ACLI proposal continue to permit illustrations to show riskless arbitrage benefits. This shows up in the loan arbitrage provisions. In addition, even if the ACLI proposal stops the riskless arbitrage for cap buy-ups, multipliers and bonuses, it doesn’t stop the problem from occurring with other product designs. The IP proposal solves the riskless arbitrage benefit problem.

The ACLI Proposal is a Massive Re-Write of AG49. Any Argument That the IP Exceeds the Narrow Parameters of the LATF Guidance Doesn’t Hold Water.

In prior meetings, the IP was criticized or dismissed because it allegedly went beyond the decisions/guidance by LATF. Given the massive re-write of AG49 in the ACLI proposal with a host of new sections and new terms, it is not reasonable or fair to lodge these criticisms of the IP.

ACLI’s introduction of Annual Percentage Rate Will Likely Confuse Consumers

In section 3.A. Alternate Scale – ACLI introduces a number of new terms, including “annual percentage rate.” Annual Percentage Rate or APR has a well-known meaning in consumer finance much different than used in the ACLI proposal.

We Continue to Have Concerns about Anti-trust Violations with ACLI’s Coordination of Industry Comments and Possible Suppression of Dissenting Insurer Views

We understand that ACLI has sent a message to its members to support the ACLI proposal and to oppose the IP. At best, such action by ACLI can prevent LATF members and other interested parties from learning the views and recommendations of insurers. At worst, such an action is coordination among insurers on an issue directly related to product design and an antitrust violation. While it is one thing for regulators to ask the ACLI for advice and feedback, it is completely different for ACLI to promote collusion or stifle dissenting voices. We ask LATF to determine if ACLI has sent such a letter and, if so, to actively encourage individual insurers to offer their perspectives. Given prior comments like those of Equitable, we expect there are insurers who disagree with the ACLI proposal, but now fear speaking out for the IP.

Application to All New Illustrations

We’ve discussed this issue several times so will be brief here. The ACLI proposal applies the new AG49 guidelines only to illustrations for new and in-force policies issued on or after the effective date. This means that for policies issued prior to the effective date, all new illustrations for those policies will continue to use an older methodology/guideline.
The purpose of the AG49 exercise is to stop unrealistic illustrations and provide consumers with better information and expectations about how the product will operate and perform. The revisions to AG49 are intended to provide consumers with better information, presumably to make more informed decisions and have more realistic expectations about the future performance of the IUL product.

ACLI argues against applying AG49 to all new illustrations based on false claims about consumer confusion and retroactive application of a guideline. Applying a revised AG49 to all new illustrations is clearly not retroactive application as AG49 was not written into any IUL contract. The argument about consumer confusion is simply jaw-dropping – We lied to you before with the earlier illustrations, but we want to keep lying to you because the truth will confuse you.

The sad fact about this argument – beyond the absurd claims of consumer confusion and “retroactivity” – is the tacit acknowledgement that illustrations don’t serve the purpose they are intended for – to educate consumers about the operation of the product – but function to mislead consumers. Why else would insurers resist providing better information to consumers?
AG49 Comment Letter

Mr. Fred Andersen  
Chair, NAIC IUL Illustration (A) Subgroup

Re: ACLI proposed draft of Actuarial Guideline 49-A

Dear Mr. Andersen:

Equitable appreciates the opportunity to submit this follow-up to our proposal regarding AG49-A on prospective requirements for IUL illustrations.

This follow-up proposal integrates select elements of the Independent and Equitable proposals into the ACLI proposal structure. The resultant “Integrated Proposal” leverages the effort to develop the ACLI proposal but adjusts features required to satisfy our understanding of regulator objectives – including several valid concerns raised by non-ACLI commentators about the ACLI proposal that, if not addressed, jeopardize the durability of the AG49 revisions. Critical features of the Integrated Proposal are its greater clarity and simplicity.

A draft of the Integrated Proposal, redlined from the ACLI proposal, is attached for reference.

The remainder of this letter is organized to accomplish the following objectives:

1. Articulate our (refined) understanding of the regulator governance objectives

2. Propose an “integrated proposal” that accomplish regulator objectives

3. Suggest next steps for regulators to finalize AG49 revisions

I. Our (refined) understanding of the IUL illustration governance objectives

The stated goals of AG 49 are to (i) guide the determination of maximum illustrated crediting rates and earned interest rates for the disciplined current scale and (ii) require additional side-by-side illustrations and disclosures to aid consumer understanding. As noted in our prior letter, we believe this reflects the overarching regulator desire to ensure policy illustrations depict a realistic projection of long-term policyholder returns upon which a current or prospective policyholder can establish realistic expectations for account performance and funding requirements.

From a technical perspective, we bifurcate the elements of the illustration that require governance into the:

a) Size of the "option budget": the amount of total contract value "put at risk" by investing in equity options or other risky investments.
b) **Rate-of-return on the “option budget”:** the illustrated long-term return of the instruments in which the option budget is invested.

Figure 1: Elements of the IUL illustrated return and associated regulator concerns

With respect to the **size** of the option budget, we understand the foremost regulator concern to be option budgets that are substantially larger than what can be supported by investing the contract value at yields on prevailing high-quality investments — especially given the expected decline of current portfolio NIERs given far lower prevailing investment yields. This concern has not been addressed by the ACLI proposal, which was developed before interest rates declined to their present level and the examples for which continue to reflect assumed NIERs of 4.5%.

With respect to the **rate-of-return** on the option budget, we understand the foremost regulator concern to be illustrated returns well in excess of high grade investment yields — i.e. overly optimistic assumptions about the realization of market risk premia.

These concerns manifest in the ultimate regulator concern that consumers predicate decisions on unrealistic expectations of contract performance, irrespective of whether the option budgets themselves are overstated or the rate-of-return on the option budget are overstated.

## II. Proposed “Integrated Solution”

In order to address these concerns in a manner that builds upon the time and thought invested into the ACLI proposal, Equitable proposes to integrate elements of the Independent Proposal and prior Equitable proposal into the ACLI proposal structure. The table below summarizes the principal adjustments to the ACLI proposal that we believe are necessary to accomplish the regulator objectives. The table includes a description and rationale for each adjustment.
The key beliefs behind the Integrated Proposal adjustments to the ACLI proposal are below:

- **Past performance is no guarantee of future returns:** The Integrated Proposal reduces the reliance on backtesting to forecast long-term future returns. Equitable believes backtesting of a given strategy can be part of the product sale process – as reflected in the section 7 table of historical index returns – but has a limited role in the illustration of long-term returns given their unproven predictive power for future returns over multiple decades.

- **A 45% annual excess return is an imprudent basis for long-term return expectations:** The Integrated Proposal reduces the maximum long-term realization of risk premia to 20% per year. Equitable believes this level could still be viewed as overly optimistic – but strikes a compromise relative to the existing 45%. To be sure, a 45% annual return over a multi-decade illustration timeframe leads to significant levels of
projected contract outperformance (three-fold account levels over 50 years), as
summarized in the table below.

**Table I: Long-term accumulated returns of $1 by proposed annual return cap**

<table>
<thead>
<tr>
<th>Return cap (5% hedge budget)</th>
<th>Contract return</th>
<th>Projection length (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>100%</td>
<td>5.00%</td>
<td>4</td>
</tr>
<tr>
<td>120%</td>
<td>6.00%</td>
<td>6</td>
</tr>
<tr>
<td>145%</td>
<td>7.25%</td>
<td>8</td>
</tr>
</tbody>
</table>

Of paramount importance to the success of AG49 is that the policyholder expectation for contract performance does not rely on excessive long-run outperformance of the instruments in which the option budget (of whatever size) is invested. The table above demonstrates the considerable outperformance that is assumed in current proposals.

- **The size of the option budget should be governed distinctly from the rate-of-return of the option budget**: The prior belief notes the significant impact of high annual illustrated risk premia. Better governance of the rate-of-return enables more latitude in the illustration of option budgets that rely, in part, on supplemental charges (not investment returns). This view reflects a belief that (a) a policyholder may reasonably seek a contract with greater market exposure than what can be created by an option budget supported only by prevailing yields on high quality investments – and hence who desire a larger option budget and (b) an outsized (e.g. 145%) rate-of-return on the supplemental charges is not illustrated given more strict governance of the rate-of-return.

To reinforce this point, we consider Indexed UL as offering a spectrum between fixed UL and Variable UL – and a VUL policy has a 100% market exposure since all contract value can be invested in equities, far above the proposed 5% cap for IUL illustrations.

- **Standardization of option budget sizes is critical to consistency of illustrations**: The Integrated Proposal embraces the Independent Proposal use of Black-Scholes to determine option budget size. Use of a Black-Scholes methodology will ensure consistent inputs are used to size the illustrated option budgets. The prospect of two companies with substantially similar index crediting features and NIERs that illustrate different returns is an objectionable feature of the ACLI proposal.

- **Black-Scholes is the best available method to ensure consistent option budgets**: Black-Scholes is simply another term for market pricing – and is a practical and robust method to size long-run option budgets. First, Black-Scholes inputs are readily accessible (the ACLI analysis demonstrates this). Second, any market risk premia in Black-Scholes has been demonstrated to be modest over time and, to be sure, any conservatism is far more than offset by the allowance of up to 20% annual excess returns on the option budget investments. Third, any concerns about rate stability year-over-year are irrelevant given (i) rates are, by nature, not stable given fluctuations in market risk from year-to-year and (ii) rate stability has not been identified as a regulator objective.
- **Realistic ‘downside scale’ performance add valuable transparency to consumers:**
  The requirement to include an equally prominent, side-by-side illustration of the downside (aka “alternate”) scale that differs only in the rate-of-return of the option budget offers consumers valuable insight into contract performance and potential funding requirements should risk premia not be realized. Holding constant all other elements of the illustration helps to ensure such alternate illustrations are not disregarded as overly conservative by consumers.

### III. Suggested next steps for regulators to close out AG49 revisions

Equitable believes the Integrated Proposal represents a pragmatic solution that leverages the investment of time in the ACLI proposal with critical adjustments to ensure its durability.

To bring the AG49 revisions to a close we suggest the regulators confirm or reject the concerns outlined in Section I and the associated key beliefs behind the “integrated proposal” in Section II. This will enable a more rapid convergence on the final features of the AG49 revision and use of the Integrated Proposal (practical given it starts with the structure of the ACLI proposal).

Thank you once again for the opportunity to share our thoughts with you on this important issue. Please do not hesitate to contact me should you have any questions or concerns regarding our proposal.

---

**Signature:**

*Brian R. Lessing, FSA, MAAA*

*Senior Director-Actuarial*

---

**Signature:**

*Aaron Sarfatti, ASA*

*Chief Risk Officer*
May 27, 2020

Mr. Fred Andersen  
Chair, NAIC IUL Illustration (A) Subgroup  
Mr. Reggie Mazyck  
Life Actuary, NAIC

Re: Exposure of Independent Proposal and Draft AG49

Dear Mr. Andersen and Mr. Mazyck,

At the fall NAIC meeting, LATF members indicated that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. The American Council of Life Insurers Proposal (ACLI Proposal) achieves this objective by clarifying AG49 requirements for these new IUL product designs. As detailed below, the Independent Proposal:

1. Changes the AG49 requirements for all IUL illustrations, not just the new designs. This was beyond the scope sought by LATF and is not in the spirit of AG49.
2. Increases variability in illustrated rates that will deter consumer understanding. The stability of illustrated rates for a given cap fosters consumer education and the Independent Proposal replaces stability with variability.
3. Contradicts itself in its advocacy, creating further confusion for the consumer. This utilization of different credited rate methodologies fails to meet AG49’s goals.

Global Atlantic recommends rejection of the Independent Proposal and adoption of the ACLI Proposal.

Changes to All IUL Product Illustrations

The Independent Proposal purportedly replaces the lookback approach in AG49 Section 4 with a Black-Scholes calculation. As shown in the examples provided by the Independent Proposal team, however, the detailed Black-Scholes description covers up the calculation’s simple use of the hedge budget. This change is applicable to all IUL designs. Illustrations for all IUL products, not just those with multipliers or cap buy-ups, would change under this proposal. The original draft of AG49 considered the same suggestion as the current Independent Proposal, choosing the lookback approach within AG49 over this proposed approach. The Independent Proposal thus changes the spirit of AG49 beyond that previously established and currently requested by LATF.

The Independent Proposal indicates that the lookback approach is only used with index products. IUL products are the only products subject to the Illustration Regulation that utilize a lookback approach. AG49 was developed because of IUL’s crediting feature and the lack of illustrated rate consistency prior to AG49. All products subject to the Illustration Regulation, including IUL, declare a non-guaranteed credited parameter. For UL, it is the fixed credited rate. For WL, it is within the dividend scale. For both UL and WL, the declared rate is the rate illustrated. For IUL, the declared parameter, for a
Benchmark Account, is the cap. The cap is not the credited rate within the illustration. IUL is therefore
the only product that needs to translate the declared parameter into an illustrated rate. It is therefore
not noteworthy that illustration requirements stipulate a lookback approach only with IUL products as
suggested by the Independent Proposal. It is simply out of necessity. The drafting of AG49 recognized
this necessity and developed the lookback approach as a straightforward, understandable approach to
foster consistency of illustrations and consumer understanding of product design. This approach
should be retained, not replaced.

Increased Variability in Illustrated Rates
The Independent Proposal replaces the lookback calculation within AG49 Section 4 with an alternate
calculation. The lookback approach was designed to bring consistency and stability in maximum
illustrated rates. It also fosters consumer education as the lookback approach is understandable.

The Independent Proposal’s approach will produce notably more variability in maximum illustrated
rates year-over-year for a given cap. Variations in option costs will generate these notable changes.
This lack of stability will cause consumer confusion, further hindering the consumer’s understanding.
AG49’s lookback approach, retained within the ACLI Proposal, maintains maximum illustrated rate
stability, benefitting the consumer.

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg Cost 12% Cap</th>
<th>Independent Proposal</th>
<th>AG49 &amp; ACLI Proposal</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Illustrated Rate</td>
<td>Change</td>
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<td>5.06%</td>
<td>6.90%</td>
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<tr>
<td>2017</td>
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<td>2019</td>
<td>5.18%</td>
<td>5.46%</td>
<td>0.66%</td>
</tr>
</tbody>
</table>

Contradictory Methods to Illustrated IUL’s Crediting Feature
The Independent Proposal adds an additional requirement in Section 7B. This would add additional
crediting rates to the illustration. These rates are calculated using a lookback approach. The
approaches in Sections 4 and Sections 7 of the Independent Proposal therefore contradict each other,
producing a myriad of unstable rates determined using different methodologies within a single
illustration. Additional rates using different methodologies fails to foster consumer education. It
instead will decrease consumer understanding and add to consumer confusion. If the display of
lookback interest rates in line with that required by the index annuity illustration is desired, they could
be added to the ACLI Proposal which maintains the lookback approach that the Independent Proposal
abandoned.

Summary
Global Atlantic remains supportive of updating AG49 to ensure that new IUL product designs are
illustrated within the spirit of AG49. The ACLI Proposal succeeds in doing so, meeting LATF’s
objectives. The Independent Proposal fails to do so and should be set aside. The Independent
Proposal team’s recommendation for additional disclosures within the ACLI Proposal should also be set
aside. Requiring disclosure of the NIER within IUL illustrations would lead to an uneven playing field as
universal life and whole life products are not required to display their NIER. Listing the NIER will likely lead to companies seeking to have the highest rate displayed. The original illustration regulation was developed to eliminate this exact situation. The Independent Proposal’s recommendation for just IUL products therefore further contradicts the premise of the entire illustration regulation. Requiring such disclosure would also reveal proprietary information, thereby leading to anti-trust issues.

We appreciate your continued work ensuring the spirit of AG49 and welcome further engagement on the subject.

Thomas A. Doruska  
Head of Life Product Development

David P. Wilken  
President - Life
May 27, 2020

Mr. Fred Andersen
Acting Deputy Commissioner of Insurance
Chair, NAIC IUL Illustration (A) Subgroup
Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101

Via E-Mail only to: rmazyck@naic.org

Dear Mr. Andersen:

This letter is to convey the reasons for our support for the Independent Proposal. In no way should our support for the Independent Proposal be interpreted to denigrate or minimize the incredible efforts and countless hours your subgroup and the industry and actuarial organizations have expended in the effort to improve the illustration of Indexed Universal Life.

The chief reasons for our support for the Independent Proposal are listed below. The opinion below are our own personal opinions and observations.

The Independent Proposal is a more complete solution.

The alternative is the ACLI proposal, and while it does a reasonable job addressing the target issues, it does so in a complicated and incomplete manner. The Independent Proposal does a better job of minimizing the potential for future modifications to AG 49 to address product designs that are unknowable at this time.

The Independent Proposal reflects the current environment.

As with fixed Universal Life, it is important to reflect the current economic environment in the illustrated crediting rate. Basing the illustrated crediting rate for a fixed UL policy on historical average interest rates is not appropriate because it does not reflect current economic and market conditions. We believe the same principle should apply to indexed products as well. While history does provide some frame of reference for future performance (and we support the additional return disclosure in section 7 of the Independent Proposal), predicting future performance is not a valid use of illustrations.
The Independent Proposal promotes proper usage of illustrations.

This crucial issue is one identified many years ago in the Final Report of the SOA Task Force for Research on Life Insurance Illustrations. In the report, Type A illustration usage – which is defined as illustrating how the policy works – makes an illustration a useful tool. It is important to show how the policy being illustrated functions under different scenarios of future non-guaranteed experience. A weakness in the industry's current approach is that it focuses on a single maximum-rate illustration, and it is shown along with the required and frequently ignored guaranteed and midpoint scenarios.

Type B usage is defined as projecting likely or best estimate future performance, and evaluating comparative cost or performance of several policies – and therefore helps the consumer understand which policy is the “best buy.” This type of usage is savaged by the SOA's task force report as being a wholly inappropriate usage of illustrations.

Further from the report, “It can be seen that Type B usage is inappropriate unless the illustrations include a measure of relative risk. For example, if one illustration shows 15 percent lower premiums, but has a 60 percent greater risk of not achieving projected values, then lack of risk disclosure renders the comparison meaningless. Type B questions assume similar degrees of relative risk...However, since there are really no practical means of assuring similar relative risks, Type B usage for illustrations is fundamentally inappropriate.” [emphasis added]

Many of today's IUL product illustrations include one or more of these features:
- borrowing to pay premiums
- borrowing to provide retirement income
- cap buy-ups
- multipliers
- non-guaranteed bonus features
- increased policy charges that are leveraged for investment gain

These features can be easily demonstrated to affect the relative risk of failing to achieve illustrated policy performance. In spite of the SOA task force report's sage advice, policies which contain these features have the appearance of identical relative risk as those that do not – and that has a potential to misrepresent the risks of policy underperformance to the consumer, which is contrary to one of the primary purposes of insurance regulation, i.e. to protect the public.

The opaque nature of Indexed Universal Life demands more illustration discipline and disclosure than fixed Universal Life.
With fixed UL, it was understood by most that interest rates in the 1980’s would not stay at historically high levels indefinitely into the future. Agents and policyholders had a reasonable expectation that fixed UL credited rates would generally follow prevailing rates on investments. In spite of this, many did not fully focus on the severity and required remediation of the effects of declining interest rates on policy performance.

With Indexed UL, policyholders (and possibly agents) DO NOT understand all – or perhaps any – of the factors that will affect policy performance due to changes in the crediting rate and how those are likely to fluctuate in the future. For instance, what future economic conditions would make a “cap” go up or down? What would make a “participation rate” go up or down?

We must admit that the use of illustrations as a competitive tool (Type B usage) is a prevalent use of illustrations. The more we can make use of illustrations to demonstrate how the policy works (Type A usage) and thus allowing the agent and consumer to make an informed decision regarding their financial future, the better we will serve our customers.

Having primary responsibility over the parameters at which IUL credited rates are illustrated, the subgroup should take this opportunity to adopt a guideline that will:

- Base maximum illustrated rates on the current environment and in a prudent manner.
- Minimize manipulation of policy features that increase the risks of policy underperformance, presented in an illustration that is ill-suited for disclosure of the nature and magnitude of such risks.

We believe the Independent Proposal serves these goals better than the ACLI proposal, and we encourage the subgroup to adopt the framework advocated therein.

Respectfully,

Christopher H. Hause  
Randall A. Stevenson

Hause Actuarial Solutions: 7201 W. 129th St., Suite 310, Overland Park, KS 66213  
913.685.2200 • solutions@hausenactuarial.com • www.hauseactuarial.com
May 27, 2020

Fred Andersen
Deputy Commissioner of Insurance
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: IUL Coalition Comments on the ACLI’s Proposed AG 49-A and Other Proposals

Fred:

Thank you for the opportunity to comment on the ACLI’s Proposed AG 49-A, and another proposal recently submitted by Mr. Samuelson and others. This letter is submitted on behalf of the following companies listed below (the “IUL Coalition”).

- Lincoln Financial Group
- Pacific Life Insurance Company
- National Life Group
- John Hancock
- Sammons Financial Group

The IUL Coalition strongly endorses the ACLI’s proposal and urges its timely adoption by the NAIC Life Actuarial Task Force (“LATF”). Along with the ACLI and others, we also have very serious concerns with the alternative proposal.

The starting point for consideration of the merits of either proposal is whether it achieves the objectives laid out by LATF in votes taken in October and December of last year. Those votes directed that changes to AG 49 be made that ensure that IUL products with charged-for indexed features not illustrate more favorably than IUL products without those features.

As the table on the first page of the ACLI comment letter demonstrates, the ACLI proposal satisfies that test: IUL products with charged-for indexed features will not illustrate more favorably than IUL products without those features. Achieving this goal was a highly complex and time-consuming undertaking that included active involvement and input from a broad spectrum of the life insurance industry; including many companies that are not active writers of IUL products. The ACLI comment letter accurately describes its proposal as representing the consensus of a “broad collection of companies.”

In contrast, the proposal put forth by Mr. Samuelson is inconsistent with LATF’s stated objectives. Mr. Samuelson’s proposal overreaches, extending far beyond regulator direction. The Samuelson
proposal would fundamentally alter illustration practices for every IUL product in the market. The IUL Coalition does not believe that broad and sweeping changes to IUL illustrations – including IUL products without enhancements - are what LATF and other regulators intended when the current review of AG 49 began last year. Neither vote taken by LATF directed or even contemplated such far-reaching impact on every IUL product in the market.

It is also worth mentioning that the key elements of the Samuelson proposal are not new. In fact, these same ideas and arguments were presented to and rejected by LATF in 2015, when AG 49 was originally adopted by the NAIC after extensive debate and discussion.

The IUL Coalition also concurs with the ACLI’s concerns that Mr. Samuelson’s proposal is fundamentally flawed. We note that many of these same flaws were addressed and refuted in an October 28, 2014, ACLI white paper. The ACLI has attached that paper to its comment letter for your review. Any attempt to fix those flaws – even if that could be achieved - would take significant time, potentially months, without any associated consumer benefit. The ACLI proposal by contrast could be finalized in the coming weeks. Taking the time to attempt to fix a fundamentally flawed proposal would needlessly delay the regulators’ stated intent to move quickly on changes to AG 49 before moving on to a “Phase Two” discussion of enhanced consumer disclosures in IUL illustrations.

We appreciate the opportunity to provide our comments and look forward to further discussions.

Respectfully Submitted,

Scott R. Harrison
High Point Strategies, LLC
scott@highpointstrategies.llc

cc: Reggie Mazyck, NAIC
May 27, 2020
Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101

Dear Fred,

The undersigned companies present these comments in response to the NAIC IUL Illustrations (A) Subcommittee request for comments on the exposed draft of the Samuelson Proposal for recommended changes to AG49.

Respectfully,

Seth Detert, Securian Financial
Pete Rothermel, Nationwide
Jacqueline Fallon, Penn Mutual Life Insurance Co
Seth Harlow, Mutual of Omaha

We believe that without substantial revisions, the Samuelson Proposal’s exposed revisions to AG49 do not meet the stated requirements of LATF:

- That products with charged-for multipliers and/or buy-up accounts illustrate substantially similar to those products without the additional charges.

- That, within an illustration, there is consistent treatment of policy features such as multipliers, index bonuses, participating loan crediting, and non-benchmark indices across the industry.

Furthermore, we believe that the exposed version is an attempt to relitigate decisions pertaining to the original AG49. If adopted, the Samuelson Proposal would result in Indexed Universal Life contracts being at a disadvantage versus other fixed products from an illustration perspective.

Below are some concerns we have with the Samuelson Proposal. It is not to be viewed as an exhaustive list of our concerns.

- The proposal as written doesn’t establish guidelines for consistent application of the proposed rules to the variety of different ways products credit interest (such as multipliers, bonuses linked to index credits, or persistency bonuses).
  - The examples provided by Samuelson show their approach to achieve the desired LATF results on a variety of product designs. However, the wording in their proposal leaves the application of the regulation to the discretion of each carrier.

- Several clarifications and definitions would need to be added to AG49 to provide clarity and allow for consistent application throughout the industry.
Without the NAIC or another industry group publishing the required inputs, there is a lot of ambiguity around the inputs for the Black-Scholes valuation that will lead to inconsistencies throughout the industry.

Using 12 months average lookback on implied volatility will cause volatility in maximum illustrated rates from year to year versus the current AG49 66-year lookback methodology.

With LIBOR being phased out, it is not a good long-term choice. This section needs to be revisited because “another appropriate interest rate measure” is too generic and will result in inconsistent application throughout the industry.

Section 7 is acknowledging and showing the risk premium associated with different index crediting strategies. We find this inconsistent because the concept of long-term risk premium is the main premise underlying the Samuelson Proposal’s concerns with the ACLI’s recommendation.

The Samuelson Proposal lists concerns that they have with the ACLI proposal, but we do not see how their proposal addresses those concerns:

- The Samuelson Proposal puts emphasis on how each carrier defines their inputs for the Black-Scholes Valuation. Therefore, we believe there is incentive for carriers to use proprietary or less used indices to increase the illustrated rate. Proprietary and lesser used indices will have less consistent data around the Black-Scholes inputs and this could be manipulated by carriers.

- While there is always the potential for new, innovative product designs, the Samuelson Proposal is also susceptible to its application not being applied effectively to new product designs. As currently written, the Samuelson Proposal does not effectively cover the variety of already existing product designs.

- We don’t believe the Samuelson Proposal addresses the “timing differences” noted because the basis for which you credit interest or take asset charges on is not defined.

In closing, we believe that the Samuelson Proposal is farther reaching than the stated goals of LATF when they opened up AG49 for revision. Due to the issues we raised above, the Samuelson Proposal in its current form is incomplete and needs meaningful revisions before it is even to be considered as a solution to LATF’s stated goals. That process will take time, and meanwhile the stated goals of LATF would continue to be unmet and IUL contracts with multipliers and buy-ups could continue to show aggressive illustrations to new clients. For those reasons, we strongly urge the Subcommittee to bring forward the ACLI proposal for vote and ultimate adoption. The ACLI recommendation is a meaningful step forward in the consistent illustration of IUL products and by Samuelson Proposal’s admission addresses the goals of LATF.
May 27, 2020

Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101

Dear Fred,

Securian Financial presents these comments in response to the NAIC IUL Illustrations (A) Subcommittee request for comments on the exposed draft of the ACLI recommended changes to AG49.

Securian believes the ACLI’s exposed revisions to AG49 accomplishes the main tasks set forth by the Subcommittee:

- That products with charged for multipliers and/or buy-up accounts illustrate substantially similar to those products without the additional charges.

- That within an illustration there is consistent treatment of policy features such as multipliers, index bonuses, participating loan crediting, and non-benchmark indices across the industry.

We would like to commend the ACLI for the job they have done in facilitating the drafting sessions and allowing interested parties to comment on the proposed language. We believe the ACLI has appropriately brought together the previous exposed recommendations to AG49, including new language to address the majority of the concerns raised during the drafting sessions.

We recommend the Subcommittee adopt Option #2 of the ACLI comment letter in regard to the applicability of loan leverage. We believe that the impact of participating loans is unique to the IUL product and that in and of itself gives IUL products certain advantages over other product types in the industry. Thus, it is important that illustrations be inclusive of all types of credits in the loan leverage calculation and not over emphasize the impact participating loans can have on the illustrated values of IUL products.

Securian urges the Subcommittee to bring forward the ACLI proposal for vote and ultimate adoption. The ACLI recommendation is a meaningful step forward in the consistent illustration of IUL products. Additionally, Securian looks forward to working with LATF and the industry on new illustrated practices and disclosures as part of the continued evolution towards transparency and furthering consumer understanding of IUL products.

Respectfully,

Seth Detert, Securian Financial

Securian Financial is the marketing name for Securian Financial Group, Inc. and its affiliates. Insurance products are issued by its affiliated insurance companies. Securities and investment advisory services offered through Securian Financial Services, Inc., registered investment advisor, member FINRA/SIPC.
Mr. Fred Andersen  
Acting Deputy Commissioner of Insurance  
Chair, NAIC IUL Illustration (A) Subgroup  
Minnesota Department of Commerce  
85 7th Place East, Suite 280  
St. Paul, MN 55101  

Via E-Mail only to: rmazyck@naic.org  

May 22, 2020  

RE: AG49 Independent Proposal Request for Adoption  

Dear Mr. Anderson,  

I implore the committee to adopt the Independent Proposal as it best aligns with the stated goals of NAIC’s Model Illustrations Regulation and helps better protect consumers from misleading sales illustrations. The complexity of IUL products is staggering especially with products using multipliers, bonuses, and proprietary indexes. The illustration is a woefully incomplete picture of such products, yet that is precisely what consumers are shown to induce a purchase. It is simply unreasonable to expect consumers to identify omissions of material facts, infer under-disclosed risks, or catch inherent nuances in language that imply significant performance reliability (that doesn’t exist) when reviewing IUL illustrations. Consumers need stronger protections from current IUL illustration practices, and the adoption of the Independent Proposal is a good step for the committee to help protect vulnerable consumers.

I have been in the life insurance industry for 28 years, working for life insurance companies, as a producer, and now in the role of VP, Insurance Analytics at Valmark Financial Group. I have written extensively on life insurance topics and given countless speeches to agents, financial planners, CPAs, attorneys, and trustees helping them to better understand products. Frustration with the common public misperception that the illustration is an accurate representation of a life insurance policy contract was the inspiration behind an article I co-authored, “Beyond Illustrations – The Importance of Contract Language”, which was published in the Journal of Financial Service Professionals in July 2017. I work every day with agents, life wholesalers, and other professional advisors reviewing and trying to understand products and illustrations. I have found that few people really understand or appreciate the complexity of IUL products and the significant on-going administrative expertise required over many decades to avoid consumer headaches down the road.

A quirk in the life insurance business is that policy contracts with client specific pricing and features are not available until a policy is issued for delivery. Reversal of the course of action is often impractical at that point especially in cases involving Section 1035 exchanges. As a result, consumer expectations of the product are, unfortunately, shaped almost exclusively by the sales illustration. Consumers are not harmed when an IUL product performs better than expected.
However, product underperformance can be devastating for consumers. The reliance upon IUL illustrations puts consumers at risk of:

- Unrealistic expectations of product performance
- Failure to understand the sequence of return risk
- Misinterpretation of carrier control over key drivers of policy performance
- Misunderstanding of the broad spectrum of product risks
- Increased out of pocket premiums
- Loss of insurance protection for family members
- Elimination of an anticipated source of retirement income
- Potentially large income tax bills if coverage terminates (in policies using loans for retirement income)

Like many of the supporters of the Independent Proposal, I have seen numerous dubious IUL illustration designs that are, in my opinion, destined for disaster. The net effect of the Independent Proposal is to produce a more conservative illustration than the current AG49 standards or the modifications proposed by the ACLI. It is important to take a step back from the calculation minutia and look at the big picture effect of what a more conservative illustration means to the consumers. It is likely that a more conservative illustration would:

- Effectively require a higher illustrated premium. However, if the consumer experiences better actual performance over time, future premiums may be reduced at the discretion of the consumer. Alternatively, the consumer may utilize the higher cash values that result from better than expected performance.
- Lead to a better statistical probability of adequate funding to achieve policy goals and reduce the risk of harmful policy termination.
- Create a policy better positioned to absorb two key elements that aren’t adequately reflected in illustrations, but which are key drivers of actual policy performance: sequence of returns and carrier changes to non-guaranteed elements like caps, participation rates, or thresholds. (It should be noted that products using multipliers, bonuses and some proprietary indexes are often much more sensitive to changes in these elements.)
- Inherently protect the consumer from some of the poorly understood mechanics and risks unwittingly assumed when purchasing complex IUL products.
- Better manage consumer performance expectations in the IUL products they purchase.
- Reduce some of the marketplace conduct concerns in IUL sales.

A more conservative illustration would NOT:

- Restrict the consumer’s choice of carrier, product, or features.
- Prevent a carrier from utilizing creative product designs or having innovative features.
- Eliminate leverage or arbitrage opportunities in the product if the consumer wanted to utilize it.
There’s little downside to the Independent Proposal. It would help protect vulnerable consumers from the bad actors without restricting choices in the marketplace. I encourage the committee to make the bold choice to embrace the Independent Proposal and better protect the consumers that rely upon the leadership of the committee and other NAIC members.

Respectfully,

Thomas R. Love, CLU, FLMI
VP, Insurance Analytics
Mr. Fred Andersen  
Acting Deputy Commissioner of Insurance  
Minnesota Department of Commerce  
Chair, NAIC IUL Illustration (A) Subgroup  
85 7th Place East, Suite 280  
St. Paul, MN 55101  

Re: Life Actuarial Task Force (LATF) request for comments on the Samuelson’s Proposal  

Dear Mr. Andersen:  

Broadly-speaking, we feel the objective of life insurance product illustrations should be to help consumers make informed financial decisions by demonstrating how the product works and the potential risk and return opportunities. While we believe sales professionals are accountable for reviewing the risk and return associated with indexed universal life insurance policies with consumers, we also see an opportunity for improvement in the way these products are illustrated. We look forward to continuing to work with the NAIC on longer-term, more holistic changes to provide better consumer clarity.  

The direction that LATF gave in late 2019 was that index accounts with multipliers, cap buy-ups, and other index-linked enhancements should illustrate the same as an index account without such features. We believe that the ACLI’s AG 49A proposal represents a collaborative effort by the industry and accomplishes LATF’s directives.  

We are concerned that many of the issues discussed over the past year and carefully considered when drafting the ACLI’s AG 49A proposal, will not be resolved by the Samuelson Proposal. The Samuelson Proposal makes minimal changes to the wording in AG 49 and does not account for all product designs. As such, the Samuelson Proposal changes the foundation set by LATF for AG 49 and introduces substantial complexity that would require further review. Furthermore, the calculations in the Samuelson Proposal lack transparency for the consumer through the use of the Black-Scholes option valuation in determining illustrated rates.  

We continue to support the ACLI AG 49A proposal as submitted on April 30, 2020. We welcome the opportunity to discuss and I can be reached at (614) 249-5947.  

Regards,  

Pete Rothermel  
VP, CFO – Individual Life
RE: AG49 Independent Proposal Request for Adoption

Dear Mr. Andersen,

I am writing to express my support for the Independent Proposal on the IUL AG49 refinements. I have been in the life insurance industry for 40 years.

I am a lawyer by education and admitted to the bar in Ohio, my home state, and Florida, and I am frequently asked by attorneys, accountants, and trustees to review IUL proposals that are being promoted to their clients. I can personally attest to the lack of consumer understanding of IUL products and misleading nature of the sales pitch using the IUL illustration. The consumer isn’t educated in the subtleties of illustration disclosure language or the mathematics used in the illustration. As a result, consumers are frequently left with the impression that their IUL will outperform equity markets with zero risk to them.

The risks are particularly understated in products using policy loans and multiplier or bonus designs which, in my experience, is the prevalent product structure being promoted today. This lack of understanding has been exacerbated by the influx of products using multipliers, buy-up caps, and other mechanisms to use an effective earnings rate that is several percentage points higher than the stated return on the illustration.

AG49 has been abused by life insurers and agents to sell life insurance policies with illustrated results that have no possibility of coming true. Consumers are sheep being lead to financial slaughter with no disclosure of the risks involved with financed and non-financed IUL proposals.

The ACLI proposal will only result in greater product complexity and consumer confusion beyond the high levels of confusion today. The Independent Proposal is a better alternative to protect consumers. I urge the committee to adopt the Independent Proposal.

Richard Connolly, J.d.

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614-486-9260 Phone
614-486-5103 Fax
rich@wardcon.com
www.wardcon.com
Fred,

Thank you for exposing the Independent Proposal and providing the opportunity to comment on it.

A Fundamental Misconception about Multipliers and Buy-Up Caps

The Independent Proposal was created and submitted for a very specific reason, but perhaps not the one that the members of the Subgroup or the supporters of the ACLI proposal imagine. For the past 18 months, the Subgroup has been evaluating newly created features of Indexed UL products that appear to circumvent the letter and spirit of the original AG 49. Late last year, the Subgroup took a directional vote that these features, particularly multipliers and buy-up caps, should not provide any illustrated benefits in excess of a base Indexed UL product. The implication from the Subgroup’s vote is that a product with these features should illustrate net performance no better than a product without them.

However, these new features are part and parcel to a base Indexed UL product. In fact, buy-up caps were contemplated by the original AG 49 and determined to be in accord with both the letter and spirit of the guideline. They were specifically accommodated by the allowance for multiple Benchmark Index Accounts. Similarly, multipliers are also consistent with the letter and spirit of the original AG 49 in that they do not augment illustrated performance beyond the applicable BIA rate. See below for a table of examples demonstrating the consistency of both buy-up caps and multipliers with AG 49.

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<tr>
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<th>BIA 1</th>
<th>Multiplier 1</th>
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<th>Multiplier 2</th>
</tr>
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<tbody>
<tr>
<td>Current Cap</td>
<td>10.00%</td>
<td>8.00%</td>
<td>14.00%</td>
<td>8.00%</td>
</tr>
<tr>
<td>Option Cost</td>
<td>5.05%</td>
<td>4.18%</td>
<td>6.64%</td>
<td>4.18%</td>
</tr>
<tr>
<td>AG 49 Illustrated Rate*</td>
<td>6.20%</td>
<td>5.13%</td>
<td>8.15%</td>
<td>5.13%</td>
</tr>
<tr>
<td>Implicit Charge</td>
<td>0.00%</td>
<td>0.87%</td>
<td>0.00%</td>
<td>0.87%</td>
</tr>
<tr>
<td>Explicit Charge</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.59%</td>
<td>1.59%</td>
</tr>
<tr>
<td>Multiplier</td>
<td>0.00%</td>
<td>20.81%</td>
<td>0.00%</td>
<td>58.85%</td>
</tr>
<tr>
<td>Net Illustrated Rate</td>
<td>6.20%</td>
<td>6.20%</td>
<td>6.56%</td>
<td>6.56%</td>
</tr>
</tbody>
</table>

*Adjusted so that ratio of Black-Scholes valuation to AG 49 Hypothetical Historical Lookback valuation is constant

Despite claims to the contrary, the companies using multipliers, buy-up caps and other types of product designs were not circumventing or aggressively interpreting AG 49. These companies were, in fact, operating in a manner consistent with the letter and spirit of the original guideline, using the tools specifically provided to them to augment their illustrated performance. The Subgroup is revisiting AG 49 because companies did exactly what the guideline allowed – and even encouraged – them to do. Accomplishing the goals set forth by the regulators regarding multipliers and buy-up caps is not a matter of replacing a faulty heart valve with a new one while keeping the heart itself intact. The guideline is clearly afflicted by a broader disease, of which multipliers and buy-up caps are only some of the symptoms. Limiting the reach of the disease, which is what the ACLI proposes, is only a temporary solution with problematic side effects. The Independent Proposal, by contrast, would permanently cure the disease – quickly, simply and with beneficial side effects for consumers and insurers alike.

The Hypothetical Lookback Methodology in AG 49 Shows Reward, but Not Risk

The source of the disease within AG 49 is readily apparent. The SOA Task Force on Illustrations described the incubator for such a virus in their 1992 report by writing that:
It can be seen that Type B usage [that is, usage of illustrations as performance projections] is inappropriate unless the illustration can include a measure of relative risk. For example, if one illustration shows 15% lower premiums but has 60% greater risk of not achieving projected values, then lack of risk disclosure renders the comparison meaningless.

It is well known and an uncontested fact that Type B usage of illustrations is pervasive in the market for all product types, not just Indexed UL. But Indexed UL has a particular advantage for Type B illustration usage that the Task Force clearly describes as “inappropriate” – AG 49 allows for the illustration of a “risk premium” without a commensurate measure of the risk. Although the ACLI and its constituent companies have repeatedly argued in favor of showing a risk premium in the illustrated scale, they have omitted a mathematical measure of the risk that creates the reward. Fortunately, calculating the risk within the strict confines of the maximum AG 49 illustrated rate is relatively easy.

The illustrated risk premium for Indexed UL is a function of the hypothetical historical lookback methodology (HHLM) detailed in Section 4 (A) of AG 49. This calculation is entirely arbitrary in that it defines a 66 year lookback period, prescribes 25-year rolling geometric averages and uses the arithmetic average of all of the observations as the maximum illustrated rate for the product. Currently, for example, a 10% Cap BIA would result in a 6.2% illustrated rate. Had the parameters been altered to different start dates and different segment lengths (50-10 years), the maximum illustrated rate could have ranged from a low of 5.83% to a high of 7.49%. Most importantly, the calculation uses the average of all of the 25-year segments. The lookback methodology prescribed in AG 49, in effect, dictates that the illustration should show the risk premium associated with a 50% failure rate based on the assumption of constant caps and future index performance mirroring past index performance.

To put this in stark terms, imagine the following example: A client purchases an Indexed UL product and plans to fund the product with a minimum premium to maintain coverage for life. Running the illustration at the maximum AG 49 illustrated rate produces an illustrated level premium of, say, $10,000 annually. What is the likelihood that the $10,000 will maintain coverage through maturity? Roughly 54%, using the actual historical data driving the HHLM in AG 49. Graphically, here is the outcome of returns for this scenario based on the hypothetical historical data feeding the maximum illustrated rate in the current AG 49 calculation for a 10% Cap BIA.
However, even this overstates the true likelihood of success because it rests on the assumptions that the index parameters will not change, that future equity performance will mirror past equity performance and does not show the impact of return volatility. Each of these assumptions are false or wildly aggressive. Future equity returns are broadly expected to be less than 7% and nowhere near the historical average of 11% for the S&P 500 Total Return. Indexed credits are vary in the real world and cause sequence of return risk. But most importantly, caps have fallen consistently since 2015 as a result of falling general account yields and adverse option pricing. For example, the ACLI spreadsheet assumes the price of a 10% cap to be 4.31% based on 2015-2019 data and the Black-Scholes formula. Today, an option budget of 4.31% would purchase an 8.5% cap. Below is the same graph as above but recalibrated with today’s fair-market cap of 8.5% as opposed to the 10% cap shown in the first graph.

Despite the fact that the baseline failure expectation of an illustration using the maximum AG 49 illustrated rate is nearly 50%, none of this risk is disclosed to clients. They see a risk premium, but no risk. It is little wonder, then, why Indexed UL has become the fastest growing part of the life insurance industry and now commands over a 3rd of new permanent life insurance premiums. It is also little wonder why multipliers and buy-up caps, which simply increase the risk and the potential reward of the strategy, have come to dominate the market. If the only thing clients are seeing is reward without any measure of risk, why would they choose anything different?

And, finally, it is little wonder why the ACLI and its constituents are clinging to this flawed methodology. Illustrations sell. Illustrations that show reward with no risk sell even better. What will happen to the Indexed UL sales if the product can no longer illustrate reward without risk? This is not an academic question, but a practical and essential one for life insurers selling Indexed UL. Of the top 20 Indexed UL writers, Indexed UL makes up the majority of sales for 16. More than half of Indexed UL premium is written at life insurers where Indexed UL makes up more than 80% of sales. Much is at stake. But as one regulator noted on a previous call, informed clients would not change their decision based on illustrated performance. In my experience working with countless retail clients, I completely agree with this sentiment. Informed clients see illustrations for their Type A usage, not for improper Type B projections. If life insurance companies have the same view, then why would they be so resistant to replacing a flawed methodology that has now resulted in two regulatory actions to rein in real or perceived abuses stemming from overly aggressive illustrations with something more reflective of fair-market values?
The Independent Proposal Provides the Only Permanent Solution

Remedying this disconnect between illustrated reward and non-illustrated risk is the only way to satisfy the goals stated by regulators. Both the ACLI proposal and Independent Proposal recommend eliminating the impact of the illustration of reward without risk. The ACLI proposal attempts to achieve the goals of the regulators by specifically eliminating the illustration of reward without risk for index-linked features, including multipliers and buy-up caps, that are funded with option budget in excess of the NIER. But in doing so, the ACLI proposal substantially modifies the original guideline in both its letter and spirit, introduces new and ambiguous definitions and formulas and allows non-disclosed elements to affect illustrated performance, rendering illustrations less understandable for consumers. We have detailed the problems with the ACLI proposal in previous letters. The long-run side effects of the strategy proposed by the ACLI proposal may prove to be worse than its benefits.

The Independent Proposal, by contrast, eliminates the illustration of reward without risk for all index-linked credits regardless of how they are funded. It is simple, effective and comprehensive. It meets all of the goals stated by the regulators regarding multipliers and buy-up caps. It does not “renegotiate” AG 49 – it requires just one simple change to Section 4, which is a modular section that can be swapped out without any impact to the rest of the guideline. It does not change the 145% factor in Section 5. Furthermore, the rates shown by the Independent Proposal would accurately reflect the level of the current index parameter, allowing for clear differentiation between the rates shown by different companies or in different accounts.

The only side effect of the Independent Proposal is that it produces more realistic and robust illustrations for consumers that will set expectations such that policies are funded to have a high likelihood of success over the long run. This is the basic concept behind all other fixed life insurance illustrations, where the likelihood of success is 100% assuming no changes to the non-guaranteed elements. The equivalent likelihood of success for an Indexed UL product assuming no changes to non-guaranteed elements and illustrating at the maximum AG 49 rate is 56%. It would be a bizarre argument for one to make the case that, somehow, clients are better served with illustrations that have lower illustrated premiums or higher illustrated distributions but a very high likelihood of failure. If regulators did not choose this illustration regime for other fixed products, then why Indexed UL?

However, the Independent Proposal recognizes that Indexed UL has the real possibility of outperformance as well as underperformance, particularly over short periods of time. Understanding the variability of returns and the potential for both upside and downside is absolutely essential for consumers to make an informed decision. As a result, the Independent Proposal provides for augmented supplemental crediting reports that show a range of variable returns, including those with a clear risk premium. This same methodology has been used in Fixed Index Annuity illustrations with broad support from life insurers. As in FIA, this methodology used in the supplemental crediting reports described in Section 7 of AG 49 would enhance the understanding of consumers, allow life insurers to differentiate their products and promote the potential benefits (and risks) of the index-linked crediting strategy. All of the marketing and promotion done by life insurers about the merits of their crediting strategies, including multipliers and buy-up caps, could be fully demonstrated in these reports. Life insurers would not be constrained in any way to both innovate their crediting strategies and position them with clients.

As a result, I urge the Subgroup to adopt the Independent Proposal. The ACLI and other life insurers who have spoken with their own voice, such as Equitable, can further enhance the proposal On behalf of my co-signers, I would welcome their input and input from regulators.

Bobby Samuelson  
Executive Editor  
The Life Product Review
May 26, 2020

Mr. Fred Andersen, Chair of the IUL Illustrations Subgroup
National Association of Insurance Commissioners
IUL Illustration (A) Subgroup
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Sent via E-mail to RMazyck@NAIC.org

Re: Proposed Actuarial Guideline XLIX (49) Revisions

Dear Mr. Andersen and Members of the Subgroup:

I support the adoption of the Independent Proposal. I am an actuary, fee-only insurance advisor, and expert witness in insurance litigation – and in my view, the current abuses surrounding the illustrations of Indexed Universal Life (IUL) polices are eerily reminiscent of past episodes that ended up being embarrassing and harmful for the entire life insurance industry.

Furthermore, I strongly believe that the ACLI proposal would ultimately be a step in the wrong direction if it were adopted, leading to more complexity, less transparency, more gamesmanship, and no doubt the reconvening of another NAIC subgroup to tackle the next round of abuses. (It’s worth noting that because I am compensated by my clients on only an hourly or project fee basis, I have no financial interest in favoring the Independent Proposal – in fact, maintaining the status quo or adopting the ACLI proposal would no doubt create more future business opportunities for me than adopting the Independent Proposal would.)

Our industry has basically been in a continuous cycle of product (or more accurately illustration) innovation pushing the bounds of plausibility and regulation attempting to reel in perceived abuses. High interest rates in the late 1970s and early 1980s (and the development of widespread computing power) led to arguably the first battleground for illustration wars, where the “best” illustrations had significant marketing advantages. Universal Life (UL) and whole life (WL) each had their moments in the sun, and many consumers purchased policies in the 1980s with false expectations that had been created by unreasonable illustrations used as the primary basis for the purchase decision.

The next battleground emerged within the next decade as booming stock market returns shifted the focus to variable products as the product du jour that could win the illustration wars.
My personal opinion is that the Illustrations Regulation that was promulgated in the 1990s was initially quite effective in curbing illustration abuses, but over time, the effectiveness of that regulation has eroded. With the advent of indexed products, it was apparent that there was a giant loophole in the Illustrations Regulation that did not address such products – and now IUL is the most prominent battleground in the current illustration wars. The original AG 49 attempted to close that loophole, but one need only look at today’s marketplace (and the existence of this subgroup) to see that we are further away than ever from the original intent of the Illustrations Regulation. And again, I do not believe that the ACLI proposal will do anything other than create opportunities for more gamesmanship whose sole purpose is to increase the allowable illustrated rate. Companies and agents have long recognized that the best way to sell insurance policies is to have the best illustration – and as long as regulation exists that rewards the companies that are most willing to push the envelope, there will always be a back and forth between abuses and regulations intended to curb those abuses.

The Independent Proposal properly reflects that the hedges used to mitigate the investment risks within an IUL policy are insurance rather than investments. I have yet to see any reasonable basis for believing that a hedging program is itself a source of profit; indeed, it seems that the primary justification for increasing the amount of hedging (through features like rate multipliers) within an IUL policy is to increase the effective illustrated rate of return (even though the stated illustrated rate of return is unchanged). This leads to disturbing observations in today’s IUL illustrations that are commonplace – and observations that in my view would ultimately NOT change under the ACLI proposal (because it keeps the door open for other potential abuses, some of which have already been identified in the Independent Proposal and others that we can’t anticipate). As I write this, I’m looking at a representative IUL multiplier illustration with an account value that increases by 7.8% from one year to the next, net of expenses and cost of insurance charges with no premiums paid in that year, in spite of the fact that the stated illustrated rate is 5.67%. This very same illustration shows a cash value and death benefit IRR at age 100 of 7.6%, which again is quite remarkable when the stated illustrated rate is only 5.67%. What consumer wouldn’t be attracted to an illustration that shows an effective rate of return in excess of 7% when it is being compared with other IUL and non-IUL products that are not taking advantage of the multiplier loophole (and therefore have effective illustrated returns likely under 5%)? Ultimately, I believe that these types of illustrations will continue to exist even if the ACLI proposal were adopted – they would just manifest themselves in ways other than the current multiplier technique.

This IUL illustration problem manifests itself in two other ways via leveraging. First, it is quite commonplace for IUL illustrations to show heavy internal borrowing for distributions during retirement. The most attractive illustrations utilize indexed loans, which combine a fixed policy loan rate with credited rates on borrowed funds that are unaffected by the
borrowing activity (think non-Direct Recognition on WL policies). When you combine a loan rate of say 4.67% with a 5.67% IUL illustration (100 bps is the widest spread allowed with AG 49 currently) that has an effective illustrated return of more than 7%, you arrive at the inescapable conclusion that you are better off by borrowing sooner, borrowing more, and borrowing longer – and that’s exactly what the most “competitive” illustrations do – without capturing any of the risk presented by the extra leveraging or the possibility of the dreaded “surrender squeeze” phenomenon on heavily loaned policies.

Second, it is increasingly common for premium financing proposals to utilize aggressively illustrated IUL as the product of choice. Again, when you are able to combine an initial premium financing loan rate of under 4% with an illustrated effective IUL return upwards of 7%, it’s easy to see how compound interest works its magic – at least on an illustrated basis. In my experience, these proposals often barely acknowledge the multi-layered risk that exists with the reliance on a continued positive arbitrage, and it all starts with the portrayal of the illustrated returns within the IUL policy being deemed reasonable and sustainable. Quite often, these premium financing proposals become dramatically less attractive or fall apart completely if they use a non-multiplier IUL or a non-IUL product instead of the IUL product with multipliers (or whatever the next version of a multiplier product would be under the ACLI proposal).

By utilizing the widely recognized Black-Scholes option valuation methodology, the Independent Proposal creates what I believe is a more transparent and more appropriately level playing field, not only with IUL vs. IUL comparisons but with IUL vs. non-IUL comparisons.

I believe that the NAIC has the opportunity to proactively address and prevent what may otherwise become another black eye for the industry. With all due respect to the tremendous amount of work encompassed therein, my view is that the ACLI proposal is a band-aid approach that virtually guarantees that we will once again be revisiting this topic and looking for regulatory revisions within the next few years.

Sincerely,

Scott J. Witt, FSA, MAAA
President, Witt Actuarial Services, LLC
October 28, 2014

Mr. Mike Boerner
Chairman – NAIC Life Actuarial Task Force

Re: Actuarial Guideline on Illustrations of Indexed Universal Life Policies

Dear Mr. Boerner;

The ACLI thanks the Life Actuarial Task Force (LATF) for the opportunity to provide comments on the two exposed Actuarial Guidelines for IUL Illustrations. In the comments that follow, we provide support for the ACLI’s proposal, questions about the alternative proposal, and highlight what we believe to be the strengths of ACLI’s proposal compared to the alternative proposal.

Illustrated rates vs. market conduct items

In our development of the proposed Actuarial Guideline, we focused on the value provided in an IUL and how it translates into an appropriate illustrated rate. We recognize that illustrated rates are not the only issue to be addressed; however, given the current lack of clear guidance, the ACLI chose to address illustrated rates first with an Actuarial Guideline. The advantage of an Actuarial Guideline is that it would:

- Apply to all carriers uniformly and immediately
- Clarify practices for actuarial functions
- Draw authority from existing regulations.

In February, the ACLI Life Insurance Committee charged the IUL Task Force to address, once the illustrated interest rate was settled, other important items such as loan illustrations, variability of returns, and other disclosures. Since these items potentially impact non-IUL life insurance products, and are not actuarial items, the ACLI believes it is appropriate to address them in an initiative separate from this Actuarial Guideline. While this work has currently taken a back-seat to the illustrated rate discussions, ACLI welcomes the opportunity to work with regulators on further improvements for broader illustration considerations. We do not believe that the existence of these

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1 The American Council of Life Insurers (ACLI) is a Washington, D.C.-based trade association with more than 300 legal reserve life insurer and fraternal benefit society member companies operating in the United States. ACLI advocates in federal, state and international forums. Its members represent more than 90 percent of the assets and premiums of the U.S. life insurance and annuity industry. In addition to life insurance, annuities and other workplace and individual retirement plans, ACLI members offer long-term care and disability income insurance, and reinsurance. Its public website can be accessed at www.acli.com.
other items should preclude resolution of guidance for illustrated rates as addressed in the exposed Actuarial Guideline proposed by ACLI.

**The ACLI’s proposal improves customer understanding**

IUL illustrations are subject to the life illustration regulation (NAIC Model 582) and Illustration Actuaries are subject to the Actuarial Standard of Practice on such illustrations (ASOP 24). While use of current interest parameters and current charges is clearly allowed in illustrations, existing guidance for the IUL illustrated rate is unclear, since the credited rate relies on the performance of an external index. As a result, various crediting rates are illustrated today.

The limited guidance for the Illustration Actuary and the lack of consumer understanding that results from inconsistent methods of determining illustrated rates was a focus of ACLI activity. The ACLI identified the following goals, and then drafted a proposed Actuarial Guideline that meets those goals:

1. Create consistency in determining illustrated rates for similar IUL products;
2. Ensure customer awareness of the likelihood for variability of returns;
3. Align with existing regulations and other general account products;
4. Allow for uniform and expedient applicability; and
5. Be adaptable for future new product development and future economic scenarios.

The ACLI’s recommendation meets these goals, and highlights the interest crediting features that are unique to IUL. Key features, which were influenced by all participating ACLI members including those who ultimately did not support the end product, include the following:

- Policy values are illustrated at two nonguaranteed interest rates in addition to the guaranteed rate in order to highlight the likelihood of variability of returns.
- A table of historical index rates is provided to highlight year-by-year variability of returns.
- A table of historical averages based on different index parameters is provided to highlight variability of nonguaranteed elements and the impact to credited rates.

The illustrations resulting from ACLI’s proposal will provide valuable disclosure to consumers and will educate consumers on the different types of index crediting options that are available within an IUL policy.

**The ACLI’s proposal is technically sound and supported by actual experience**

A key question that has been raised is whether a typical company’s investment strategy can support the rates that are determined by a look-back of past index performance. Often, the majority of a company’s assets supporting an IUL policy are typical general account assets (e.g. bonds and mortgages) and a smaller amount of assets are options that generate payoffs to support index-linked crediting rates.

A review of S&P 500 options since 1994 shows the cost of an annual 0%-12% call-spread has been relatively stable. Specifically, the mean cost was 5.09%, with a low cost of 3.74% and a high cost of 6.41%. At the time of the highest cost, a 10% cap would have brought the cost down close to the long-term average for the 12% cap. The average return over that period based on the cost of the

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2 Prices for 12 month S & P options obtained from reports provided by Credit Suisse
options was more than 50%, implying that a 5% budget would have produced a 7.5% average return with annual rates that varied from 0% to 12%.

In this light, the ACLI's proposed look-back methodology provides a result that is not unreasonable (7.6% for a one year S&P 500 index, using a 12% cap and a 0% floor). This is particularly true when viewed in the context of the various components of the proposal.

Strengths of the ACLI Proposal

The ACLI has reviewed the alternate proposal and all publicly available material in support of that proposal and wants to highlight the following strengths of the ACLI proposal:

An Illustration based on the ACLI proposal will:

- Educate consumers on IUL likelihood of variability of returns,
- Highlight the nonguaranteed nature of interest credits, that an illustration is not a projection,
- Show consistent illustrated rates for products with similar interest crediting options,
- Use illustrated rates that reflect the unique characteristics of the underlying index and crediting method,
- Align with NAIC Model 582 and ASOP 24:
  - Use non-guaranteed elements and actual experience in accordance with ASOP 24,
  - Be based on sound, accepted investment theory and actual experience,
- Be based on a disciplined current scale that results from clear, formulaic guidance for the Illustration Actuary, and
- Highlight risk tradeoffs in interest crediting options.

Conclusion

The ACLI continues to support our proposed Actuarial Guideline for IUL illustrated rates and looks forward to separate collaborations to address broader illustration considerations that impact all life insurance product illustrations. The ACLI welcomes the opportunity to work with LATF to discuss the proposed Actuarial Guideline and incorporate suggestions that will improve consumer understanding, protection, and disclosure within an IUL illustration that builds upon the foundation established within Model 582 and ASOP 24. Attached is a paper developed by a group of IUL carriers that provides additional detail and context to the various details of the proposals.

Cc Reggie Mazyck, NAIC
IUL Study: Theory, Practice, and Experience

Introduction
On August 14, 2014, the American Council of Life Insurers (ACLI) presented a proposed Actuarial Guideline for Indexed Universal Life (IUL) illustrations to the Life Actuarial Task Force (LATF). In this document we provide sound analytical support for this proposal. In response to the alternative proposal, actuaries from the ACLI majority coalition have put together the following detailed analysis, demonstrations, and case studies in support of IUL and the ACLI’s proposed guideline.

On September 5, 2014, a group of life insurance carriers distributed an alternative proposal for an IUL Actuarial Guideline and a letter describing the rationale behind the proposal. While we disagree with both the alternative proposal and the rationale, we share many of the goals and believe the ACLI’s most recent proposal contains robust solutions needed to address these issues.

In the analysis that follows, we will demonstrate:

- **IUL products provide strong value for consumers looking for more growth potential without risk of loss of principal by enabling them to exchange their fixed account return for an index-based return.**
- **The ACLI’s proposal**
  - Is consistent with existing regulation.
  - Is supported by actuarial principles, sound, accepted investment theory, and solid historical evidence.
  - Will enable consumers to understand the risks and rewards of the product.
- **ACLI believes that the alternative proposal**
  - Is inconsistent with existing regulation.
  - Is inconsistent with observed experience.
  - Does not provide sought-after consistency.

In **Appendices A through E**, we provide:

- A case study showing actual risk premium credits exceeding 400 basis points.
- An industry history of steady rate setting despite tumultuous market conditions.
- Analysis showing the ACLI’s proposal is calibrated with other UL products on the market.
- A demonstration showing the alternative proposal would cause incongruous disparity between insurers.
- Analysis demonstrating that the last 20 years were not ideal for IUL.

**The value of IUL**

IULs are a type of universal life insurance product, with flexible premiums and long expected duration. Unlike Traditional Universal Life (TUL), where policy value earns a fixed interest rate declared by the company, IUL provides the opportunity to earn interest based on the performance of a market index. Unlike Variable Universal Life (VUL), where policy value is invested in “subaccounts” that may increase or decrease due to market index changes, IUL is a general account product that provides an interest rate floor (e.g., 0% or higher) that protects against market index losses, and applies index parameters (e.g., caps, participation rates) that may limit the indexed interest earned. Thus, the average level of IUL interest crediting can be thought of as being between TUL and VUL.3

Consumers who purchase an IUL choose to trade the relatively stable fixed account return for a more risky and uncertain return based on an index. IULs provide consumers the ability to earn interest based on a market index, while providing downside protection against market losses.

Because market indexes bear more risk than traditional general account bond portfolios, IUL index options are expected to provide a long-term average return that is higher than the general account rate consistent with capital market theory and practice.

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3 Although IUL credits indexed interest, it is not a security; its value cannot decrease due to market index changes.
IUL Study: Theory, Practice, and Experience

Risk premium: theory and practice
Many insurers use a derivatives-based strategy to back their IUL products. By using call options, these insurers can offer their policyholders a responsible balance between principal protection and market exposure.

Investment portfolios with similar expected volatility (risk) have similar expected returns, and portfolios with higher expected risk will have higher expected reward. This theory is called arbitrage pricing theory, is reflected in the capital assets pricing model (CAPM), and it has been supported by historical experience.

Analysis from 1996-2013 has demonstrated a typical IUL portfolio comprised of bonds and call options has close to 300 basis points of risk premium over a portfolio consisting solely of bonds. Depending on the asset assumptions used, a back-tested one-year S&P IUL index interest option would have credited between 9-10% compared with a typical 6-7% general account portfolio yield during the same time period.

One company’s actual weighted average payoff on their option positions from September 2005 to August 2014 was 9.14%, compared with a weighted average option cost of 4.94%.

The investment mechanics supporting IUL
IUL companies could use a number of strategies to support index-linked interest. The following two strategies would generate returns to match the index-linked interest with floor guarantee:

1. Invest in equities and buy put options for downside protection
2. Invest in fixed income instruments and buy call options for both upside potential and downside protection

Both strategies provide the same return profiles and therefore have similar, meaningful risk premium; strategy 2 is more capital efficient under RBC calculations.

Support for the ACLI’s proposed Actuarial Guideline
A life illustration is one of many tools used to facilitate consumer education. Ideally, the illustrated values in a life illustration would exactly match future policy performance; however, this cannot be accomplished for TUL, IUL, VUL, or whole life products due to nonguaranteed policy features such as interest rates, policy charges, dividends, and bonuses. Because of this, it is inappropriate to imply that any aspect of an illustration should be used to project or predict the future; illustrations are intended to show how different policy features work.

Although both Model 582 and ASOP 24 apply to IUL illustrations, IUL illustration actuaries have lacked clear guidance for illustrated rates, so the ACLI formed the ACLI IUL Task Force to develop guidance. The task force identified the following five goals, and then drafted a proposed Actuarial Guideline that meets those goals.

Goal 1. Create consistency in illustrated rates for similar IUL products
The ACLI’s proposal will result in identical maximum illustrated rates for IUL products with the same index, crediting method, and index parameters. Illustration actuaries will benefit from that clarity of the ACLI’s proposed guideline, and consumers will gain a better understanding of the product with this consistency.

Goal 2. Ensure consumer awareness of variability of returns
The ACLI’s proposed Actuarial Guideline includes three mechanisms to address this goal.

The first is the inclusion of a midpoint scenario in addition to the input scenario and guaranteed values. This additional scenario is unique to IUL, and will show the impact of lower interest rates to the various features of an IUL policy. It will also provide a safeguard

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4 Brealy and Myers, “Principles of Corporate Finance”
5 See Appendix A for the full case study.
6 30% Risk Based Capital (RBC) treatment for equities vs. 0.3% to 1% RBC treatment for derivatives

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when indexed loans are being illustrated—illustrated rates will typically be less than loan charges so the loan mechanics will become more transparent.

The second is the historical look back table. This table will illustrate the potential variability of returns from year to year so consumers know not to expect a level interest rate in all years.

The third is a table showing the sensitivity of the look back rate to index parameter changes, which will emphasize that index parameters are nonguaranteed.

**Goal 3. Align with existing regulations and other general account products.**

An Actuarial Guideline should clarify and build upon existing regulations and standards of practice. Section 3.4.1(a) of ASOP 24 prescribes the use of experience factors when determining the investment income for the disciplined current scale:

- **Investment income**, which is defined as an “experience factor,” should reflect the “recent actual investment experience, net of default costs, of the assets supporting the policy block.”

- **Investment income** should also “reflect the insurer’s actual practice for nonguaranteed elements with respect to realized and unrealized capital gains and losses, investment hedges, policy loans, and other investment items.”

The same section of ASOP 24 also requires the use of historical index data *specifically* for IUL:

- **Investment return factors**, which are used to determine investment income, should “be reasonably based on recent actual investment experience [...] the actuary should consider an appropriate time frame commensurate with such cycles and the characteristics of the underlying index in determining recent actual experience.”

The ACLI’s proposed 25-year look back aligns with ASOP 24 because it uses actual historical index experience and current nonguaranteed elements (i.e. the index parameters).

The use of current index parameters reflects the roughly 10 years of IUL carriers’ experience developing and selling IUL. Over that time period, most carriers’ index parameters have been reasonably stable.\(^9\) Proposals to use “historical” index parameters could result in index parameters that exceed an insurer’s current scale, would conflict with ASOP 24, and would be akin to showing historical fixed rates in a TUL illustration.

The ACLI’s proposed Actuarial Guideline builds on ASOP 24 by specifying an “appropriate time frame” to be used as the basis for the assumed investment returns. Since 1945, the average business cycle has been just over 5 years long\(^10\). As a result, a 25-year look back period would include 4-5 business cycles. Thus, the 25-year period proposed by the ACLI aligns with the guidance in ASOP 24.

**Goal 4. Uniform and expedient applicability**

Given the current lack of clear guidance, the ACLI *first* chose to address illustrated rates with an Actuarial Guideline, because Actuarial Guidelines:

- Apply to all carriers uniformly and immediately.

- Clarify practices for actuarial functions (in this case, the role of an illustration actuary).

- Align with existing regulations and standards of practice.

The ACLI established a process in the early spring to address market conduct-related illustration items – such as policy loans, variability of returns, and other disclosures – in a separate initiative. These market conduct items potentially impact non-IUL life insurance products, and are not actuarial items, so it was appropriate to separate them from the IUL Actuarial Guideline. Due to discussions on the illustration interest rates, work on the other issues has been deferred.

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\(^9\) Actual historical IUL caps are shown in Appendix B.

Goal 5. Adapt to product differentiation, future new product development, and future economic scenarios

The ACLI’s proposed Actuarial Guideline adapts to new product and emerging economic scenarios.

Many IUL products offer more than one interest option. These interest options fall on a wide continuum—from the stable fixed interest options (similar to TUL) to index options with more upside potential.

Figure 1 shows the impact that volatility of returns has on illustrated rates for various types of life insurance. The analysis to support Figure 1 is contained in Appendix C.

Figure 1: Maximum illustrated rates for various types of universal life products

Practical problems with the alternative proposal

The alternative proposal introduces the following problems:

Problem 1. The alternative proposal does not comply with ASOP 24

The alternative proposal does not use actual experience to determine investment income, does not use actual index experience, and does not reflect the current cap (the nonguaranteed element), in conflict with Section 3.3.4.a. of ASOP 24.

Problem 2. The alternative proposal would result in inconsistent illustrated rates

Under the alternative proposal, two companies with the same index parameters could have two different illustrated rates. The opposite could also be true: two companies with different index parameters could have the same illustrated rates. This inconsistency would cause confusion and hinder consumer understanding.\(^{11}\)

Problem 3. The alternative proposal does not provide guidance for the defined “indexed derivative return” (the proxy for equity risk premium)

Each illustration actuary would need to develop an individual evaluation methodology, resulting in ambiguity for compliance and inconsistencies across the industry.

Problem 4. Explanation of “indexed derivative return” within illustration would hinder consumer understanding of the IUL product.

Agents would be expected to explain the actuarial derivation of the “indexed derivative return,” which would be further complicated by the inconsistencies among insurers. This detail would confuse consumers and distract them from the relevant mechanics of their policy, rather than improve their understanding of how the policy operates.

In addition, this would cause inconsistencies with all other life insurance product types, which are not required to disclose investment return assumptions in their illustrations.

Problem 5. The alternative proposal applies an arbitrary 12% limit on the “indexed derivative return” without any evidence to support it. According, it would not permit reflection of differences between various index designs.

The 12% cap on the “indexed derivative return” does not allow for the illustration of a risk premium consistent with historical experience, nor does it differentiate between the risk profiles among the index options. For example, under the alternative proposal, an IUL with a 5% fixed interest rate would have a 5.60% maximum illustrated rate, meaning the maximum difference between a general account and any index options would be 0.60%, which is far less than the 300 basis points found in the IUL Risk Premium Analysis.\(^{12}\)

\(^{11}\) Appendix D demonstrates the disparity caused by the alternate proposal.
\(^{12}\) See attached IUL Risk Premium Analysis.
IUL Study: Theory, Practice, and Experience

Controversial items raised by the alternative proposal

Claim 1: BXM index proves that "options are generally profitable to the seller and are unprofitable to the buyer."

This assertion does not recognize the difference in risk profile between the covered call reflected in the BXM and the call spread reflected in IUL interest crediting.

A covered call is a strategy in which an investor has a long position in equity (i.e., owns stock) and then sells a call option on that same equity. In doing so, the investor gives up the potential for returns above a certain threshold in exchange for the certainty of the option premium.

A call spread is a strategy in which an investor buys a call at one strike price and sells a call at a different strike price. In the case of IUL, the strike price for the purchased call is typically at the level of the floor (e.g., 0% or 2%) and the strike price for the sold call is typically at the level of the cap. In doing so, the IUL carrier payoff structure matches the interest owed to the policy owner.

The payoffs for a covered call and a call spread purchase are shown in Figure 2.

Figure 2: BXM strategy vs. call spread payoffs

The BXM strategy maintains downside risk if the market decreases because the value of the equity decreases and the call option has no value. If the market increases, the investor must pay the increase to the call buyer; this is offset by the increase in the value of the equity and the investor keeps the call premium from the original sale.

Claim 2: Stochastic analysis proves the 25-year look back produces unsupportable rates

The analysis described in the alternate proposal support letter uses an Economic Scenario Generator (ESG) that was developed for variable annuity reserving valuation. As such, the ESG is calibrated to be conservative and produce a large number of low or negative equity scenarios relative to actual experience and reasonable assumptions. Thus, it is inappropriate to use these ESG scenarios to analyze the reasonableness of the 25-year look back methodology.

Claim 3: The expected return on a call option over time should be 0%.

One of the citations used to justify this position is academic literature describing risk-neutral valuation. However, the alternative proposal does not consider that risk neutral valuation is "merely an artificial device for obtaining solutions to the Black-Scholes differential equation."13 Options and derivatives are not risk neutral, and they carry more risk than general account bond portfolios and even equities.14

Claim 4: A 50% annual return assumption is “exorbitant.”

To some, a 50% expected return seems outrageous, especially considering the historical average annual return for the S&P 500 total return index was around 10%. But the letter ignores the fact that a position in a call option is riskier than a position in equity. If an index change is negative (even if only slightly negative) a call option will pay out $0 and the purchaser will lose the entire purchase price. So it would stand to reason that a purchaser of a call would expect a high upside in return for a chance of total loss.

Historical data supports this concept. Analysis of option prices obtained from Credit Suisse demonstrates a 54% historical average annual return for a one-year S&P 500 IUL interest option with a 12% cap and 0% floor.15 If the cap drops to 10%, the average annual return is still 52%.

Question 1: If call options are so profitable, why don’t insurers use them to generate higher returns in their own general accounts?

The purpose of an insurer’s general account is to provide a relatively stable fixed income return; the variable expected return of call options does not fit within that profile. Insurers’ match their assets with their liabilities, and buying call options beyond what is required to support policyholder interest crediting would result in an unmatched portfolio.

Question 2: Why would anyone sell a call if the long run expectation is negative?

Derivatives are rarely used as a sole investment, so one should use caution when analyzing derivatives use separately from the rest of an investment strategy. In addition, every investor’s goals are unique; often one cannot pinpoint the motivation behind an isolated decision.

Four examples of parties who sell call options:

- Short term speculators who are not interested in long run expectation.
- Owners of equity portfolios who earn fee income by giving up the upside in their holdings. The combined positions (known as covered calls strategies) give up expected upside return for a more reliable stream of fee income.
- Insurers who subsidize the cost of an at-the-money-call purchase by selling an out-of-the-money call (i.e. call spread).
- Index managers and fund managers who protect equity investments against market declines at a reduced cost.16,17

There are many observed examples of rational purchases made when the long run expectation is negative. Insurance in general is a prime example—anyone who buys insurance has a negative long run expectation, yet the benefits to the purchaser justify the cost.

One specific example of buying insurance is common within the variable insurance market. Although the long run expectation of buying a put is negative, variable insurance providers buy puts because they are willing to pay for protection. Another specific example: investment managers (whose fees are based on the value of customer accounts) will also pay for protection in exchange for the more certain income.

Claim 5: Investment professionals, endowments, and pension funds “sell options as a way to generate income.”

In reality, these professionals sell options as a part of the covered call structure described in the BXM analysis section of this paper; they are not sold alone as investments. Such parties who sell options to hedge their net long positions in equities remain net long. An IUL also has a net long position in equity.

---

15 Annual options purchased once per month (mid-month), covering index changes from 9/16/1994 through 7/18/2014

16 E.g., the CBOE S&P 500 95-110 Collar IndexSM (CLLSM): http://www.cboe.com/SPXMS/SP500/95-10CollarIndex.aspx

17 E.g., the Russell Strategic Call Overwriting Fund: http://www.russell.com/us/Investment_Products/Russell_Funds/Strategic_Call_Overwriting_overview.asp
IUL Study: Theory, Practice, and Experience

Claim 6: Index performance from 1994 through 2013 was “ideal” for an IUL look back.

An analysis of the S&P 500 price index since its inception shows that the most recent 20-year time period was not “ideal” when compared with other historical 20-year time periods in terms of average volatility, interest rates, and equity movements.\(^{18}\)

Since there is no such thing as a “typical” index period, it is important to follow ASOP 24 and find “an appropriate time frame commensurate with such cycles and the characteristics of the underlying index.” The ACLI’s proposed Actuarial Guideline defines this as a 25-year period. Historically, 25-year periods have been sufficiently long to include 4-5 business cycles, but are not so long as to understate the more recent results of an evolving marketplace.

Conclusion

In this paper, we have demonstrated:

- IUL products provide strong value for consumers looking for more growth potential without risk of loss of principal by enabling them to exchange their fixed account return for an index-based return.
- The ACLI’s proposal:
  - Is consistent with existing regulation.
  - Is supported by actuarial principles, established investment theory, and solid historical evidence.
  - Will enable consumers to understand the risks and rewards of the product.
- ACLI believes that the alternative proposal:
  - Is inconsistent with existing regulation.
  - Is inconsistent with observed experience.
  - Does not provide sought-after consistency.

Important analysis and additional information is contained in the appendices.

We welcome the opportunity to work with LATF to consider additional improvements that will further aid consumer understanding, while remaining consistent with existing guidance and established actuarial principles.

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\(^{18}\) Appendix E shows that 1994 through 2013 was unfavorable for IUL analysis.
Appendix A

Actual options experience demonstrates significant risk premium

Company XYZ case study

Company XYZ has invested in high quality bonds and equity index call spreads to back its IUL products since 2005, and has exhaustively tracked their historic investment activity. Company XYZ’s actual results for all of their products are far better than the levels the alternative proposal views as possible:

- The one-year S&P 500 product (12% - 13% cap, 0% floor) has produced attractive credits for policy owners, averaging 8.63% since inception.
- Their fixed-income portfolio has supported the options budget every year.
- As a percentage of account value, their average options cost has been 4.94%.
- The weighted average payoff on their option positions has been 9.14%.
- This translates to an 85% return on their options through a very difficult market cycle.
- The average fixed rate during that time was 5.15% with a range from 4.50% to 5.35%.

Company ABC case study

Company ABC has invested in high quality bonds and equity index call spreads to back its IUL products since January 2006, and has tracked their historic investment activity. Company ABC’s actual results are far better than the levels the alternative proposal views as possible:

- As a percentage of account value, their average options cost for all of their one-year S&P 500 products has been 4.64%.
- The weighted average payoff on their option positions has been 8.29%.
- This translates to a 78% return on their options through a very difficult market cycle.
- The average fixed rate during that time was 5.10% with a range from 4.00% to 5.80%.
Appendix B

Actual historical IUL caps were steady despite an unsteady market

IUL products have been on the market since 2002. During that time, caps have been reasonably stable despite tumultuous market movements.

Please note: Both IUL and TUL have nonguaranteed rates, such as crediting rates, mortality charges, and expense charges, and various product designs may result in different rates or different updates to those rates. Thus, an appropriate evaluation of any product considers the entire product, and not one rate alone (e.g., index parameters).

STEADY: Actual historical caps for one-year S&P 500 annual point to point index option with 0% floor

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Company A Product 1</th>
<th>Company B Product 1</th>
<th>Company C Product 1</th>
<th>Company C Product 2</th>
<th>Company D Product 1</th>
<th>Company D Product 2</th>
<th>Company E Product 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>11.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>11.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>12.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>12.00%</td>
<td>12.50%</td>
<td></td>
<td></td>
<td>11.50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>12.00%</td>
<td>12.00%</td>
<td></td>
<td></td>
<td>12.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>12.00%</td>
<td>12.50%</td>
<td></td>
<td></td>
<td>11.50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>12.00%</td>
<td>12.00%</td>
<td>14.00%</td>
<td></td>
<td>11.50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>12.00%</td>
<td>13.00%</td>
<td>14.00%</td>
<td></td>
<td>11.50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>12.00%</td>
<td>13.50%</td>
<td>13.50%</td>
<td></td>
<td>12.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>13.00%</td>
<td>14.00%</td>
<td>13.50%</td>
<td>13.00%</td>
<td>12.00%</td>
<td>13.00%</td>
<td>10.50%</td>
</tr>
<tr>
<td>2012</td>
<td>13.00%</td>
<td>14.00%</td>
<td>13.50%</td>
<td>13.00%</td>
<td>12.00%</td>
<td>13.00%</td>
<td>10.25%</td>
</tr>
<tr>
<td>2013</td>
<td>13.00%</td>
<td>13.50%</td>
<td>13.50%</td>
<td>12.00%</td>
<td>11.00%</td>
<td>12.00%</td>
<td>9.75%</td>
</tr>
<tr>
<td>2014</td>
<td>12.00%</td>
<td>13.50%</td>
<td>12.00%</td>
<td>11.50%</td>
<td>11.00%</td>
<td>12.00%</td>
<td>9.75%</td>
</tr>
</tbody>
</table>

UNSTEADY: Actual historical market data for the same period

Figure 4: Significant historical swings in implied volatility

Figure 5: Significant historical downward interest rate trend
Appendix C

The ACLI’s proposal is calibrated with other UL products on the market

There is a wide variety of IUL indexed interest options available in the marketplace today.

<table>
<thead>
<tr>
<th>Crediting type</th>
<th>Crediting periods</th>
<th>Index parameters</th>
<th>Floor guarantees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual point to point</td>
<td>1-5 years</td>
<td>Caps with participation rates, participation rates only, uncapped with spread, uncapped with participation rate</td>
<td>0% to 2%</td>
</tr>
<tr>
<td>Monthly sum</td>
<td>1 year</td>
<td>Monthly caps with participation rates</td>
<td>0%</td>
</tr>
<tr>
<td>Trigger</td>
<td>1 year</td>
<td>NA (trigger interest rate)</td>
<td>0%</td>
</tr>
<tr>
<td>Monthly average</td>
<td>1 year</td>
<td>Participation rates only</td>
<td>0% to 2%</td>
</tr>
</tbody>
</table>

The differences in these interest options are compounded when paired with a variety of underlying indexes with different characteristics (e.g. expected volatility, expected return, correlation, etc.).

Each interest option presents a unique risk profile. Some interest options tend to produce steady, more consistent interest crediting from year to year, while other interest options tend to be more volatile with higher average credits at lower frequencies.

Consistency across UL products

The maximum illustrated rate should be set at a level that is consistent with other products and allows IUL illustrations to illustrate these differences. The 12% maximum illustrated rate was selected for VUL because it was unlikely that an average would exceed 12%. The maximum for IUL illustrations should be set with a similar goal.

The most risky interest option available for an IUL today is the uncapped 5-year option with a 100% participation rate; based on arbitrage pricing theory, it is also the option with the highest expected return. Since this option is uncapped, it should have a similar expected return as the underlying index, with some risk premium lost as a result of the 0% floor guarantee.

This uncapped 5-year interest option is currently available based on the S&P 500 price index. Many VULs available today offer the S&P 500 total return fund. The two differences between the returns in these options are (1) dividends, and (2) the 0% floor. The difference between the maximum VUL illustrated rate and the maximum IUL illustrated rate reflects these differences.

Setting a maximum illustrated rate

The 10% maximum illustrated rate is set at a level where it is unlikely that an IUL average would exceed it, and allows appropriate room for the look back mechanism to allow different indexes with different index parameters to be compared and contrasted in terms of historical performance.

While the 10% maximum is one guardrail, the look back uses a 25-year average that further limits the maximum illustrated rate. The 10% guardrail will be redundant for most interest options—the look back rate for the most common products will be approximately 7.5%.
Appendix D
The alternative proposal would cause disparity between insurers

Table: Comparison of two proposals

<table>
<thead>
<tr>
<th>Company</th>
<th>General account yield</th>
<th>Option budget</th>
<th>Index cap</th>
<th>Index floor</th>
<th>ACLI’s proposal (25-year look back)</th>
<th>Alternative proposal (112% of GA yield)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company 1</td>
<td>5%</td>
<td>5%</td>
<td>12%</td>
<td>0%</td>
<td>7.6%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Company 2</td>
<td>4%</td>
<td>5%</td>
<td>12%</td>
<td>0%</td>
<td>7.6%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Company 3</td>
<td>5%</td>
<td>4%</td>
<td>8%</td>
<td>0%</td>
<td>5.6%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Company 4</td>
<td>5%</td>
<td>3%</td>
<td>6%</td>
<td>0%</td>
<td>4.4%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

Observations:

1) Although Company 1 and Company 2 can use the same illustrated rate under the ACLI’s proposal, to comply with disciplined current scale (DCS) the underlying policy charges would need to be higher for Company 2 so their illustration would perform worse. Under the alternative proposal the impact of the higher charges would be compounded by being forced to use a lower maximum illustrated rate than other companies, despite identical index returns.

2) Under the alternative proposal, Company 3 and Company 4 could theoretically pass DCS testing with lower insurance charges than Company 1, which would provide them higher illustrated values despite their lower caps. The customer would not understand the impact of caps on returns over a long time horizon.
IUL Study: Theory, Practice, and Experience

Appendix E

1994-2013 was not “ideal” for IUL

Claim/Null Hypothesis: The most recent 20-year period (1994-2013) was “ideal” for IUL.

Process: Evaluate the most recent period against all other 20-year periods on the following measures:

- Equity returns
- Volatility
- Interest rates

If the most recent period was ideal for IUL, equity returns will be relatively high, volatility will be relatively low, and interest rates will be relatively high. Analysis uses data from 1953 through 2013.19

Conclusion: Reject the Null Hypothesis. The most recent 20 calendar year period was not ideal for IUL. Equity returns were near average, volatility was medium to high, and interest rates were at all time lows.

EQUITY RETURNS

Equity returns during the most recent 20-year period were neither atypical nor ideal for IUL:

Figure 8: 20-year period S&P 500 price index analysis

<table>
<thead>
<tr>
<th>Percentile</th>
<th>0</th>
<th>0.25</th>
<th>0.5</th>
<th>0.75</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>All periods</td>
<td>2.73%</td>
<td>4.33%</td>
<td>6.75%</td>
<td>9.60%</td>
<td>13.95%</td>
</tr>
<tr>
<td>Most recent</td>
<td>7.13%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Calendar year data was used for equity return analysis (1/1 to 12/31).

VOLATILITY

Volatility during the most recent 20-year period was atypical, but not ideal for IUL:

Figure 9: Historical realized volatility

Realized volatility was generally the same or higher during the last 20-year period with a huge spike in 2009. Thus, volatility was atypical, but was not ideal for IUL during that period.

Note that actual option costs depend on implied volatility, not realized volatility, but there is not enough implied volatility data to determine a trend by looking at implied volatility alone. The following graph shows the relationship between realized volatility and implied volatility since the early 1990’s. The strong correlation between the two implies we can use historical trends in realized volatility to infer trends in implied volatility.

Figure 10: Historical realized volatility and implied volatility

---

19 1-year CMT data first available in 1953.
INTEREST RATES

Interest rates during the most recent 20-year period were atypical, but not ideal for IUL:

Figure 11: 20-year period one-year CMT rate analysis
Arithmetic average annual interest rate

<table>
<thead>
<tr>
<th>Percentile</th>
<th>0</th>
<th>0.25</th>
<th>0.5</th>
<th>0.75</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>All periods</td>
<td>3.84%</td>
<td>4.94%</td>
<td>6.85%</td>
<td>7.93%</td>
<td>8.27%</td>
</tr>
<tr>
<td>Most recent</td>
<td>3.84%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 12: 20-year historical averages – one-year CMT rates
Arithmetic average annual interest rate
AG49 Comment Letter

Mr. Fred Andersen
Chair, NAIC IUL Illustration (A) Subgroup

Re: ACLI proposed draft of Actuarial Guideline 49-A

Dear Mr. Andersen:

Equitable appreciates the opportunity to submit this follow-up to our proposal regarding AG49-A on prospective requirements for IUL illustrations.

This follow-up proposal integrates select elements of the Independent and Equitable proposals into the ACLI proposal structure. The resultant “Integrated Proposal” leverages the effort to develop the ACLI proposal but adjusts features required to satisfy our understanding of regulator objectives – including several valid concerns raised by non-ACLI commentators about the ACLI proposal that, if not addressed, jeopardize the durability of the AG49 revisions. Critical features of the Integrated Proposal are its greater clarity and simplicity.

A draft of the Integrated Proposal, redlined from the ACLI proposal, is attached for reference.

The remainder of this letter is organized to accomplish the following objectives:

1- Articulate our (refined) understanding of the regulator governance objectives
2- Propose an “integrated proposal” that accomplish regulator objectives
3- Suggest next steps for regulators to finalize AG49 revisions

I. Our (refined) understanding of the IUL illustration governance objectives

The stated goals of AG 49 are to (i) guide the determination of maximum illustrated crediting rates and earned interest rates for the disciplined current scale and (ii) require additional side-by-side illustrations and disclosures to aid consumer understanding. As noted in our prior letter, we believe this reflects the overarching regulator desire to ensure policy illustrations depict a realistic projection of long-term policyholder returns upon which a current or prospective policyholder can establish realistic expectations for account performance and funding requirements.

From a technical perspective, we bifurcate the elements of the illustration that require governance into the:

a) **Size of the “option budget”**: the amount of total contract value “put at risk” by investing in equity options or other risky investments.
b) Rate-of-return on the “option budget”: the illustrated long-term return of the instruments in which the option budget is invested.

Figure 1: Elements of the IUL illustrated return and associated regulator concerns

With respect to the size of the option budget, we understand the foremost regulator concern to be option budgets that are substantially larger than what can be supported by investing the contract value at yields on prevailing high-quality investments – especially given the expected decline of current portfolio NIERs given far lower prevailing investment yields. This concern has not been addressed by the ACLI proposal, which was developed before interest rates declined to their present level and the examples for which continue to reflect assumed NIERs of 4.5%.

With respect to the rate-of-return on the option budget, we understand the foremost regulator concern to be illustrated returns well in excess of high grade investment yields – i.e. overly optimistic assumptions about the realization of market risk premia.

These concerns manifest in the ultimate regulator concern that consumers predicate decisions on unrealistic expectations of contract performance, irrespective of whether the option budgets themselves are overstated or the rate-of-return on the option budget are overstated.

II. Proposed “Integrated Solution”

In order to address these concerns in a manner that builds upon the time and thought invested into the ACLI proposal, Equitable proposes to integrate elements of the Independent Proposal and prior Equitable proposal into the ACLI proposal structure. The table below summarizes the principal adjustments to the ACLI proposal that we believe are necessary to accomplish the regulator objectives. The table includes a description and rationale for each adjustment.
The key beliefs behind the Integrated Proposal adjustments to the ACLI proposal are below:

- **Past performance is no guarantee of future returns**: The Integrated Proposal reduces the reliance on backtesting to forecast long-term future returns. Equitable believes backtesting of a given strategy can be part of the product sale process – as reflected in the section 7 table of historical index returns – but has a limited role in the illustration of long-term returns given their unproven predictive power for future returns over multiple decades.

- **A 45% annual excess return is an imprudent basis for long-term return expectations**: The Integrated Proposal reduces the maximum long-term realization of risk premia to 20% per year. Equitable believes this level could still be viewed as overly optimistic – but strikes a compromise relative to the existing 45%. To be sure, a 45% annual return over a multi-decade illustration timeframe leads to significant levels of
projected contract outperformance (three-fold account levels over 50 years), as summarized in the table below.

**Table I: Long-term accumulated returns of $1 by proposed annual return cap**

<table>
<thead>
<tr>
<th>Return cap (5% hedge budget)</th>
<th>Contract return</th>
<th>Projection length (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>5.00%</td>
<td>4</td>
</tr>
<tr>
<td>120%</td>
<td>6.00%</td>
<td>6</td>
</tr>
<tr>
<td>145%</td>
<td>7.25%</td>
<td>8</td>
</tr>
</tbody>
</table>

Of paramount importance to the success of AG49 is that the policyholder expectation for contract performance does not rely on excessive long-run outperformance of the instruments in which the option budget (of whatever size) is invested. The table above demonstrates the considerable outperformance that is assumed in current proposals.

- **The size of the option budget should be governed distinctly from the rate-of-return of the option budget**: The prior belief notes the significant impact of high annual illustrated risk premia. Better governance of the rate-of-return enables more latitude in the illustration of option budgets that rely, in part, on supplemental charges (not investment returns). This view reflects a belief that (a) a policyholder may reasonably seek a contract with greater market exposure than what can be created by an option budget supported only by prevailing yields on high quality investments – and hence who desire a larger option budget and (b) an outsized (e.g. 145%) rate-of-return on the supplemental charges is not illustrated given more strict governance of the rate-of-return.

To reinforce this point, we consider Indexed UL as offering a spectrum between fixed UL and Variable UL – and a VUL policy has a 100% market exposure since all contract value can be invested in equities, far above the proposed 5% cap for IUL illustrations.

- **Standardization of option budget sizes is critical to consistency of illustrations**: The Integrated Proposal embraces the Independent Proposal use of Black-Scholes to determine option budget size. Use of a Black-Scholes methodology will ensure consistent inputs are used to size the illustrated option budgets. The prospect of two companies with substantially similar index crediting features and NIERs that illustrate different returns is an objectionable feature of the ACLI proposal.

- **Black-Scholes is the best available method to ensure consistent option budgets**: Black-Scholes is simply another term for market pricing – and is a practical and robust method to size long-run option budgets. First, Black-Scholes inputs are readily accessible (the ACLI analysis demonstrates this). Second, any market risk premia in Black-Scholes has been demonstrated to be modest over time and, to be sure, any conservatism is far more than offset by the allowance of up to 20% annual excess returns on the option budget investments. Third, any concerns about rate stability year-over-year are irrelevant given (i) rates are, by nature, not stable given fluctuations in market risk from year-to-year and (ii) rate stability has not been identified as a regulator objective.
Realistic ‘downside scale’ performance add valuable transparency to consumers:
The requirement to include an equally prominent, side-by-side illustration of the downside (aka “alternate”) scale that differs only in the rate-of-return of the option budget offers consumers valuable insight into contract performance and potential funding requirements should risk premia not be realized. Holding constant all other elements of the illustration helps to ensure such alternate illustrations are not disregarded as overly conservative by consumers.

III. Suggested next steps for regulators to close out AG49 revisions

Equitable believes the Integrated Proposal represents a pragmatic solution that leverages the investment of time in the ACLI proposal with critical adjustments to ensure its durability.

To bring the AG49 revisions to a close we suggest the regulators confirm or reject the concerns outlined in Section I and the associated key beliefs behind the “integrated proposal” in Section II. This will enable a more rapid convergence on the final features of the AG49 revision and use of the Integrated Proposal (practical given it starts with the structure of the ACLI proposal).

Thank you once again for the opportunity to share our thoughts with you on this important issue. Please do not hesitate to contact me should you have any questions or concerns regarding our proposal.

Aaron Sarfatti, ASA
Chief Risk Officer
The Life Actuarial (A) Task Force met via conference call May 21, 2020. The following Task Force members participated:
Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Ricardo Lara represented by Perry Kupferman and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain and Vincent Tsang (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Adopted the IUL Illustration (A) Subgroup Minutes

The IUL Illustration (A) Subgroup met March 3 and Jan. 28 to discuss proposed revisions to Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49).

Mr. Yanacheak made a motion, seconded by Mr. Weber, to adopt the Subgroup’s March 3 (Attachment Six-A) and Jan. 28 (Attachment Six-B) minutes. The motion passed unanimously.

2. Exposed Amendment Proposal 2020-07

Paul Graham (American Council of Life Insurers—ACLI) said the Heroes Act, a bill passed recently by the U.S. House of Representatives, contains a revision to Section 7702 of the Internal Revenue Code (IRC), which for tax purposes provides the definition of life insurance. The definition uses the cash value accumulation test (CVAT) to determine whether a policy qualifies as life insurance, allowing it to avoid being taxed as an investment. The interest rate used in the Section 7702 CVAT is currently floored at 4%. He noted that the 4% nonforfeiture interest rate floor in the Standard Valuation Law and the Valuation Manual was set to match the 4% floor in the Section 7702 CVAT.

Mr. Graham further explained that the Heroes Act changes the CVAT by replacing the interest rate floor from the 4% static rate to an indexed rate. He said the change necessitates a similar change in the Valuation Manual for policies issued after the congressional bill is adopted by the U.S. Senate. He said the challenge is that the timing of the Senate adoption is uncertain.

Brian Bayerle (ACLI) said amendment proposal 2020-07 (Attachment Six-C) removes Valuation Manual references to the 4% interest rate floor and replaces it with language that sets the nonforfeiture rate floor in the Valuation Manual to the rate determined by Section 7702, eliminating the need for future adjustment to align the two sets of requirements. He reiterated that the change will not affect any existing policy.

Mr. Tsang said lowering the nonforfeiture rate will result in higher cash values. He asked if there is a business reason for lowering the rate.

Mr. Graham said that as interest rates decline, premiums on new policies will increase. He said providing higher cash values as premiums increase is a matter of equity.

John Norton (Globe Life) said Globe Life is not in favor of the change recommended in amendment proposal 2020-07. He said Globe Life is concerned the change will lead to higher costs that will affect the affordability of basic life protection. He said Globe Life is supportive of comprehensive reform of the nonforfeiture laws.

Jim Hodges (National Alliance of Life Companies—NALC) said that the NALC agrees with the Globe Life viewpoint.
Mr. Yanacheak made a motion, seconded by Mr. Tsang, to expose amendment proposal 2020-07 for a 21-day public comment period ending June 10. The motion passed unanimously.

3. Accepted Amendment Proposal 2020-04 As an Editorial Change

Bill Wilton (unaffiliated) said amendment proposal 2020-04 (Attachment Six-D) recommends reordering the rows of the Exhibit 7 reserve table in Section 3.A.5 of VM-30, Actuarial Opinion and Memorandum Requirements, to match the rows of Exhibit 7 in the life and health annual financial statement.

The Task Force agreed, without objection, to accept the recommendation in amendment proposal 2020-04 as an editorial change.

4. Exposed Amendment Proposal 2020-05

Jason Kehrberg (PolySystems) said amendment proposal 2020-05 (Attachment Six-E) recommends modifying VM-20, Requirement for Principle-Based Reserves for Life Products, to clarify that in Section 3.C.4, the net premium reserve reflects death claims and assumes continuous deaths and immediate payment of claims.

Mr. Leung made a motion, seconded by Mr. Yanacheak, to expose amendment proposal 2020-05 for a 21-day public comment period ending June 10. The motion passed unanimously.

5. Exposed Amendment Proposal 2019-58

Mr. Bock said amendment proposal 2019-58 proposes revising Section A.1 of the Valuation Manual, Introduction, Section I, Process for Updating, to require that updates to templates prescribed by the Valuation Manual be considered substantive and, therefore, subject to the Valuation Manual change requirements.

Mr. Robinson made a motion, seconded by Mr. Chou, to adopt amendment proposal 2019-58 (Attachment Six-F). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The IUL Illustration (A) Subgroup of the Life Actuarial (A) Task Force met via conference call March 3, 2020. The following Subgroup members participated: Fred Andersen, Chair (MN); Ted Chang (CA); Andrew Greenhalgh (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Rhonda Ahrens (NE); Bill Carmello (NY); Peter Weber (OH); Mike Boerner, John Carter and Rachel Hemphill (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Comments on the IUL Illustration Jan. 28 Exposure

Brian Bayerle (American Council of Life Insurers—ACLI) proposed revisions to Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49). He said the revised guideline, titled AG 49-A (Attachment Six-A1), is designed to be prospectively applied to new business. He noted that the ACLI is not in favor of retroactive application of AG 49. He said the revision uses a single benchmark index account (BIA), and it proposes several new or revised definitions. The revision attempts to address the major concerns of state insurance regulators, while avoiding unnecessary complicated language.

Mr. Tsang asked whether a product with a multiplier will illustrate better than a non-multiplier product under the ACLI proposal.

Mr. Bayerle said the net effect on the account values should be the same. He said the ACLI’s hope is to provide examples at the Spring National Meeting.

Seth Detert (Securian Financial) discussed the proposal (Attachment Six-A2) jointly submitted by Mutual of Omaha, Nationwide, Penn Mutual, Prudential and Securian Financial. He said the ACLI proposal potentially allows policies that use charges to increase cap rates to illustrate better than policies that do not allow charges to increase cap rates, which is inconsistent with the request of the Life Actuarial (A) Task Force to have the products illustrate the same. He said the language in the joint proposal does a better job of closing that loophole than the ACLI proposal. He said the five companies generally agree with the ACLI changes to the illustrated scale, but they have questions related to Section 4.B. He said the five companies are generally in favor of the changes, with possibly a few minor tweaks, to the disciplined current scale proposed by the group represented by Scott Harrison (High Point Strategies).

Graham Summerlee (Lincoln Financial) said the IUL Coalition proposal (Attachment Six-A3) adds language for the process of selecting the BIA. He said the ACLI proposal is ambiguous about which account one would select for the BIA. The IUL Coalition proposal also proposes revisions for the language related to the determination of the illustrated rate.

Tom Doruska (Global Atlantic) said Global Atlantic’s proposal (Attachment Six-A4) stresses that designs with more index growth potential should have higher illustrated rates. He said the proposal differentiates itself from the ACLI proposal in the treatment of cap buy-ups and multipliers and the determination of the portion of assets backing the product that should be subject to the earned interest rate.

Tom Love (Valmark Financial) read comments (Attachment Six-A5) from a group of independent life insurance professionals concerned about the state of indexed universal life (IUL) illustrations. He said illustrations can be used to display the mechanics of the product (type A) or used as means to show performance projections (type B). The group is concerned that Task Force decisions are designed to address type B illustrations without regard for the education of the consumer on the functioning of the product. He said the group recommends using the fixed indexed annuity (FIA) illustration standards for AG 49 and using a Black-Scholes model to determine the intrinsic value of the options strategies instead of the historical lookback approach to providing the index credits for the illustration.

Mr. Andersen said the current work on AG 49 is just a single step in a multi-step process. He said after addressing the IUL illustrated rate issue by revising AG 49, other issues, such as disclosures and potentially opening the model regulation for long-term changes, could be addressed by the Subgroup, as directed by the Life Insurance and Annuities (A) Committee.
Mr. Chupp asked if Securian Financial could comment on its reasons for advocating a single BIA instead of multiple BIAs.

Mr. Detert said Securian Financial understood the Task Force direction on buy-up and multiplier accounts to mean that any type of charge could not be used to enhance the crediting rate or create multiple benchmark accounts.

Austin Bichler (Allianz) said the Allianz comment (Attachment Six-A6) expressed its agreement with the ACLI and IUL Coalition proposals as bases for revising AG 49.

Mr. Tsang said his comment (Attachment Six-A7) supports having products with multipliers illustrate no better than non-multiplier products. He suggested setting the crediting rate and account value for the non-multiplier product as an upper bound for all illustrations.

Mr. Andersen suggested that those developing future drafts of AG 49 should note when they have included or omitted Mr. Tsang’s recommendations.

Donna Megregian (American Academy of Actuaries—Academy) said the Academy comment (Attachment Six-A8) focuses on the historical background of illustrations. She the Society of Actuaries’ (SOA) Task Force for Research on Life Insurance Sales Illustrations, which defined the type A and type B uses for illustrations, noted that while type A usage can be handled well with illustrations, type B usage cannot. She said the Academy is concerned that the Subgroup decisions may result in limits on type A usages while trying to address issues related to type B usages. She said the Academy comment letter recommends a number of principles through which to evaluate potential changes to AG 49.

Mr. Andersen said that during Subgroup’s Oct. 17, 2019, conference call, it was determined that multiplier products should illustrate no better than non-multiplier products (possibility 2). He said the Subgroup was directed to address the crediting rate for loans in a manner reflecting possibility 2. He said industry members have said their perception is that the loan issue had not been decided.

Mr. Weber said addressing loans using possibility 2 is appropriate as a current solution. He said a better, longer term solution can be considered in the future. Mr. Boerner agreed.

Mr. Harrison said industry members believe that ample opportunity to discuss the decision was not provided.

Mr. Andersen said any revisions submitted to the Subgroup should reflect the use of possibility 2 or add commentary on why it is believed that possibility 2 should not apply.

Having no further business, the IUL Illustration (A) Subgroup adjourned.
March 24, 2020

Mr. Fred Andersen
Chair, NAIC IUL Illustration (A) Subgroup

Re: ACLI proposed draft of Actuarial Guideline 49-A

Dear Mr. Andersen:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following draft of AG49-A on prospective requirements for IUL illustrations.

During the March 3rd call of the Subgroup, multiple commenters suggested possible language to revise the Guideline. ACLI reviewed the various proposals and attempted to harmonize a version that both addresses concerns raised by regulators while providing consumers with the information necessary to make informed decisions on products they are considering for purchase.

The attached revisions (Attachment One) borrow concepts raised by the various drafts, and we’re appreciative of all the thought that went into each of these efforts. We note that, while this draft reflects our best-effort, there remain items that require additional consideration.

Consistent with the ACLI’s established opposition to retroactivity, AG49-A assumes that these new requirements are applicable on a prospective-only basis, and solely for policies issued after the guideline’s effective date.

ACLI notes the following in this best-effort draft:

- Definitions in Section 3 were refined from the earlier ACLI 02-21-20 draft.
- Language in Section 4 and 5 were largely borrowed from the Securian et al draft, with several modifications. We note the language in Section 5 requires additional consideration.
- For the treatment of Policy Loans (Section 6 and within the definition of “Alternate Scale”), industry is offering two proposals for regulators to consider. We note that the language in this section may require additional modification. This language attempt to capture the two main approaches previously submitted.

Indexed UL products may allow the loaned amount to remain in the index and earn index credits. When the index return is higher than the loan charged rate then the loan is “leveraged”. IUL products are the only product type where actuarial guidelines endorse this type of leveraging in

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1 The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at www.acli.com.
illustrations. An objective for regulators in tightening this language is to ensure that the Supplemental Hedge Budget is not double counted.

During a straw poll at the end of the October 17 conference call, the vote favored language similar to Option 2. However, some of the language proposed subsequent of this call was similar to Option 1. We lay out arguments below for each approach, and we recommend further discussion on the topic.

We note there are advantages of each approach:

- **Option 1:** 100 bp loan leverage limit only applies to index credits:
  - Provides consistent treatment of illustrated bonuses between fixed UL and indexed UL, as well as consistent treatment of standard loans and indexed loans within an indexed UL.
  - Is consistent with the original scope of AG49, which was to apply to index-linked credits.
  - Allows for the illustration of consistent maximum crediting rates between IUL policies with a loan and IUL policies without a loan.
  - The Option 2 language may pose technical difficulties to implement.
  - The Option 2 language may be read to disadvantage innovative product designs, such as policies that offer wellness credits to customers who engage in activities that help them live longer and healthier lives.

- **Option 2:** 100 bp loan leverage limit applies to index credits and other types of bonuses:
  - If the limit only applies to Index Credits, loan leverage may exceed 100 bps using fixed rate bonuses or other innovative product designs.
  - Since all index accounts will illustrate similarly under the new AG 49, other bonus types may become more common.
  - This is a maximum illustration limit to prevent illustrations that are overly optimistic.
  - Products could still offer other bonus types and demonstrate how they work at lower interest rate illustrations or when loans are not illustrated.

We look forward to a discussion of our proposed language. Thank you.

Sincerely,

cc Reggie Mazyck, NAIC
THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST SOLD AFTER [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption*]

Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for inforce illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective as follows: for all new business and in force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption*].

i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:
The policy is subject to Model #582.

Interest credits are linked to an external index or indices.

The policy offers Indexed Credits

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The credited rate (total annual percentage rate of Indexed Credits) for each Index Account does not exceed the lesser of the maximum credited (total percentage rate of Indexed Credits) for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the credited rate (total annual percentage rate of Indexed Credits) for each Index Account shall not exceed the average of the maximum credited (total percentage rate of Indexed Credits) for the illustrated scale and the guaranteed credited (total percentage rate of Indexed Credits) for that account. However, the credited rate (total annual percentage rate of Indexed Credits) for each Index Account shall never be less than the guaranteed credited (total percentage rate of Indexed Credits) for that account.

ii. If the illustration includes a loan, the illustrated rate credited to the loan balance does Policy Loan Interest Credited Rate shall not exceed the illustrated loan charge for the policy. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding hedges for Indexed Credits), less provisions for investment expenses and default cost, allocated to support the policy. Charges of any kind are not included in the Annual Net Investment Earnings Rate.

B.C. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4(B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.

vi. Additional amounts credited The amount used to determine the cap in 3 (C) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind are not included when determining the applicable cap rate.
vii. There are no less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 1 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account that are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values linked to an index or indices in excess of the interest calculation, including but not limited to experience refunds or multipliers and bonuses.

eighth. There are no limitations on the portion of account value allocated to the account.

ix. A single Benchmark Index Account will be determined for each policy. A policy shall have no more than one Benchmark Index Account.

C.D. Fixed Account: An account where the amounts credited are not tied to an external index or indices.

D.E. Index Account: An account where the amounts credited are tied to an external index or indices.

F. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Credits to the policy resulting from a floor are included.

G. Hedge Budget: For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This amount should be consistent with the hedging program of the company.

H. Loan Balance: Any outstanding policy loan and loan interest, as defined in the policy.

I. Policy Loan Interest Rate: The annual interest rate that is charged on any Loan Balance. This does not include any other policy charges.

J. Policy Loan Interest Credited Rate: The annual interest rate credited that applies to the portion of the account value backing the Loan Balance, as defined in the policy.

i. For the portion of the account value backing the Loan Balance that is in a Fixed Account, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate, as defined in the policy.

[OPTION FOR CONSIDERATION: Please see commentary on these approaches in the ACLI Comment Letter; language for Option 1 and Option 2 may need to be tightened up:

Option 1: ii. For any portion of the account value backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage rate of Indexed Credits, net of any applicable Supplemental Hedge Budget for that account, as defined in the policy.

Option 2: ii. For any portion of the account value backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage rate of Indexed Credits and all illustrated bonuses, charge reductions or other enhancements that impact the portion of the account value backing the Loan Balance, net of any applicable Supplemental Hedge Budget for that account, as defined in the policy.]

K. Supplemental Hedge Budget: For each Index Account, the Hedge Budget minus the Annual Net Investment Earnings Rate. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

4. Illustrated Scale

The credited rate, total annual percentage rate of Indexed Credits, for the illustrated scale for each Index Account shall be limited as follows:
A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).

ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of the Benchmark Index Account, and shall use that cap in 4 (A).

B. For each applicable Benchmark Index Account, the total Indexed Credits illustrated as a percentage of the account value in the Index Account shall not exceed the minimum of (i) and (ii):

iii.i. the arithmetic mean of the geometric average annual credited rates calculated in 4 (A) shall be the maximum credited rate(s) for the illustrated scale.

B. D. For purposes of compliance with Section 6 (C) of Model #582, the credited rate for Supplemental Hedge Budget may cause the illustrated rate to exceed the earned interest rate underlying the Disciplined Current Scale.

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale

The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for index-based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed 145% for the policy, inclusive of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the all general account assets (excluding hedges for index-based credits) allocated to support the policy and hedge assets that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed:

iii. the Annual Net Investment Earnings Rate, plus
iv. 45% of the lesser of the Hedge Budget minus any floor and the Annual Net Investment Earnings Rate, adjusted for timing differences to ensure that fixed interest is not earned on the hedge cost.

The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate.

For a product with multiple Index Accounts with different Hedge Budgets that are less than or equal to the NIER, a maximum rate in 5.A. should be calculated for each set of accounts with different Hedge Budgets.

B. If an insurer does not engage in a hedging program for index-based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy Annual Net Investment Earnings Rate.

C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy’s account value.

D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support test under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

Policy Loans

If the illustration includes a loan, the illustrated rate credited to the loan balance Policy Loan Interest Credited Rate shall not exceed the illustrated loan charge Policy Loan Interest Rate by more than 100 basis points. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 5%.

Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical interest rates Indexed Credits using current index parameters for the most recent 20-year period.
February 21, 2020

Fred Andersen  
Acting Deputy Commissioner of Insurance  
Minnesota Department of Commerce  
85 7th Place East, Suite 280  
St. Paul, MN 55101

Dear Fred,

The undersigned companies present this proposal and the attached AG49 with examples, in response to the NAIC IUL Illustrations (A) Subcommittee request for comments on AG49 on the January 28, 2020 call. We would be happy to discuss the revisions and examples at your convenience and on the next Subcommittee call.

Respectfully,

Seth Detert, Securian Financial  
Pete Rothermel Life CFO, Nationwide  
Jacqueline Fallon, Penn Mutual Life Insurance Co  
John Ponte, Prudential  
Seth Harlow, Mutual of Omaha

We believe that the proposed revisions accomplish the main tasks set forth by the Subcommittee to date:

- That products with charged for multipliers and/or buy up accounts illustrate substantially similar to those products without the additional charges.

- That there is consistent illustrative treatment of policy features such as multipliers, index bonuses, participating loan crediting, and non-benchmark indices across the industry.

During this comment period the majority of our revisions were to Sections 3 and 4 to accomplish the Subcommittees’ goals in a transparent manner and clarify existing issues. We also made revisions to Section 5 for clarity and consistency throughout AG49.

At this time, we have declined to comment on the applicability to policies sold before the effective date of the new revisions. We believe that the applicability to inforce policies is a conversation better served when we understand the impact of the revisions.

In the attached draft of AG49 we recommend these changes:

- In Section 3 we have added definitions for Annual Net Investment Earnings Rate, Index Credits, and Supplemental Hedge Budget.

- We have modified the definition of Benchmark Index in 3 (C)
  - We believe that there should only be ONE Benchmark Index for any given product.

  - As such we modified Section (C) (vi) to clearly state that only the Annual Net Investment Earnings Rate can be used when determining the Cap for the Benchmark Index account.
We modified Section (C) (vii) to identify that for the Benchmark account that no additional credits through bonus or multipliers apply.

- In Section 4 we changed the focus of the section from the illustrated credited rate to be concerned with illustrated Index Credits.
  - We believe this is important because as we have seen products with similar credited rates can produce significantly different illustrated values due to the Index Credits produced through multipliers and bonuses.
  - In section 4 (A) and 4 (A) (i & ii) we made small modifications to align with the concept of only having one Benchmark Index per product.
  - In Section 4 (B) we changed the wording to define the maximum Index Credits for the Benchmark Index (versus the maximum illustrated credit rate) and we implemented an additional limit to the maximum Index Credits to be 145% of the Annual Net Investment Earnings rate.
  - In Section 4 (C) we defined how an illustration actuary would determine the maximum Index credited rate for non-benchmark indices.

- In Section 5 (A) & (B) we updated the language to be clearer and consistent with the rest of the revisions to the guideline.
  - We believe Section 5 (D) can be eliminated due to the change to limit to one Benchmark Index per policy.

- In Section 6 we added language to clarify that the 100 bps of loan arbitrage of should be inclusive of any policy credit that increases the account value of the policy.

The attached examples are included to show the impact of the proposed revisions on illustrated Index Credits. The examples are hypothetical, however they do provide a good representation of the types of products currently available in the industry.
Proposed AG 49 edits to reflect 1) multipliers illustrating the same as non-multipliers and 2) subject cap buy-ups and index return enhancements to constraints reasonably similar to the constraints applied to multipliers

Actuarial Guideline XLIX
THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST

Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective as follows:

i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

i. The policy is subject to Model #582.

ii. Interest credits The policy offers interest credits, multipliers, factors, bonuses, or other enhancements to policy values any of which are linked to an external index or indices.
3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The credited rate for each Index Account does not exceed the lesser of the maximum credited rate for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the credited rate for each Index Account shall not exceed the average of the maximum credited rate for the illustrated scale and the guaranteed credited rate for that account. However, the credited rate for each Index Account shall never be less than the guaranteed credited rate for that account.

ii. If the illustration includes a loan, the total amount credited as a result of the loan balance, including Index Credits and all other illustrated benefits and bonuses that impact the policy’s account value, shall not exceed the illustrated loan charge.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate, less provisions for investment expenses and default cost, of the general account assets (excluding hedges for Index Credits) allocated to support the policy. Policy charges of any kind are not included in the Annual Net Investment Earnings Rate.

B.C. Benchmark Index Account: A policy shall have only one Benchmark Index Account, which has the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Only the Annual Net Investment Earnings Rate is used to support the cap in 3 (C) (ii). Policy charges of any kind are not included when determining the applicable cap rate. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered within the policy, only one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of S.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.

vii. There are no additional amounts credited that are linked to an index or indices in excess of the interest calculation, including but not limited to multipliers and bonuses.

viii. There are no limitations on the portion of account value allocated to the account.
C.D. **Fixed Account**: An account where the credited rate is not tied to an external index or indices.

E. **Index Account**: An account where the credited rate is tied to an external index or indices.

F. **Index Credits**: Any interest credit, multiplier, factor, bonus, or other enhancement to policy values that is linked to an index or indices.

D.G. **Supplemental Hedge Budget**: For each Index Account, the annualized amount available to generate the Index Credits as determined by the illustration actuary minus the Annual Net Investment Earnings Rate, not less than zero. This amount is expressed as a percent of the account value in the Index Account and adjusted for timing to align with when the Index Credits are applied.

**Illustrated Scale**

The total Index Credits credited rate for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for the each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

   i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).

   ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account, and shall use that cap in 4 (A).

B. For each applicable the Benchmark Index Account, the total Index Credits illustrated as a percentage of the account value in the Index Account shall not exceed the minimum of (i) and (ii):

   i. The arithmetic mean of the geometric average annual credited rates calculated in 4 (A).

   ii. 145% of the Annual Net Investment Earnings Rate.

C. For other any Index Accounts that does not meet the definition of the Benchmark Index Account in 3 (C) using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the total Index Credits illustrated as a percentage of the account value in the Index Account shall not exceed the minimum of (i) and (ii):

   i. The maximum Index Credits for the Benchmark Index Account calculated in 4(B) plus the Supplemental Hedge Budget for the Index Account

   ii. The total Index Credits that the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. The determination shall reflect the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. In no event shall the credited rate for the illustrated scale exceed the applicable rate calculated in 4 (B). The illustration actuary shall use actuarial judgment to determine this value using methodology consistent with 4 (A) and 4 (B) where appropriate.

D. At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. **Disciplined Current Scale**

   The earned interest rate for the disciplined current scale shall be limited as follows:
A. If an insurer engages in a hedging program for index-based interest Index Credits, the assumed earned interest rate underlying the disciplined current scale, inclusive of all general account assets and hedge assets that support the policy, net of default costs and investment expenses, including the amount spent to generate the Index Credits of the policy shall not exceed 145% of the Annual Net Investment Earnings Rate, (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-based credits) allocated to support the policy.

B. If an insurer does not engage in a hedging program for index-based interest Index Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy.

C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all benefits including illustrated bonuses.

D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

6. Policy Loans

If the illustration includes a loan, the illustrated rate total amount credited to as a result of the loan balance, including Index Credits and all other illustrated benefits and bonuses that impact the policy’s account value, shall not exceed the sum of illustrated loan charges and the Supplemental Hedge Budget by more than 100 basis points.

7. Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period.
### Example 1/IRA *

<table>
<thead>
<tr>
<th></th>
<th>Multiplier</th>
<th>Cap Buy-Up</th>
<th>Cap Buy-Up w/Multiplier</th>
<th>Included bonus</th>
<th>Smaller Included Bonus</th>
<th>1% floor</th>
<th>1% floor &amp; Included Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Net Investment Earnings Rate</strong></td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
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<tr>
<td><strong>Cap</strong></td>
<td>10%</td>
<td>18%</td>
<td>18%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td><strong>Index Bonus (Multiplier)</strong></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Index Changes</strong></td>
<td></td>
<td></td>
<td></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Historical Credited Rate for Benchmark Index Account (A)</strong></td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
</tr>
<tr>
<td><strong>Historical Credited Rate for Index Account</strong></td>
<td>6.2%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total Indexed Credits @ Index Account Load Back Rate (B)</strong></td>
<td>6.2%</td>
<td>9.3%</td>
<td>13.3%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
</tr>
<tr>
<td><strong>Minimum Indexed Credits</strong></td>
<td>6.2%</td>
<td>9.1%</td>
<td>11.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
</tr>
<tr>
<td><strong>Implied Non-Illustrated Indexed Rate</strong></td>
<td>6.2%</td>
<td>9.2%</td>
<td>12.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
<td>6.2%</td>
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</table>

### Policy Loans

<table>
<thead>
<tr>
<th></th>
<th>5%</th>
<th>5%</th>
<th>5%</th>
<th>5%</th>
<th>5%</th>
<th>5%</th>
<th>5%</th>
<th>5%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Loan Charge Rate</strong></td>
<td>6%</td>
<td>9%</td>
<td>11%</td>
<td>11%</td>
<td>0%</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Maximum Amount Credited on Loan Balance, including all policy features</strong></td>
<td>6% + 0% + 1%</td>
<td>5% + 0% + 1%</td>
<td>5% + 0% + 1%</td>
<td>5% + 0% + 1%</td>
<td>0% + 0% + 1%</td>
<td>5% + 0% + 1%</td>
<td>0% + 0% + 1%</td>
<td>0% + 0% + 1%</td>
</tr>
<tr>
<td><strong>Illustrated Loan Credits less Charges</strong></td>
<td>6% + 0% + 1%</td>
<td>5% + 0% + 1%</td>
<td>5% + 0% + 1%</td>
<td>5% + 0% + 1%</td>
<td>0% + 0% + 1%</td>
<td>5% + 0% + 1%</td>
<td>0% + 0% + 1%</td>
<td>0% + 0% + 1%</td>
</tr>
</tbody>
</table>
March 25, 2020

Fred Andersen  
Deputy Commissioner of Insurance  
Minnesota Department of Commerce  
Chair, NAIC IUL Illustration (A) Subgroup

Re: Proposed Changes to Actuarial Guideline 49

Fred:

On behalf of the companies listed below (the “IUL Coalition”), we are submitting this letter in response to proposed changes to Actuarial Guideline 49 (“AG 49-A”) submitted by the ACLI to the Indexed Universal Life Illustration (IUL) Subgroup (“IUL Subgroup”). These proposed changes are intended to implement regulators’ stated intent over the last several months.

- Lincoln Financial Group  
- Pacific Life Insurance Company  
- National Life Group  
- John Hancock  
- Sammons Financial Group

The IUL Coalition has worked closely with ACLI as it drafted AG49-A and sincerely appreciates the effort to collaborate and compromise up to this point.

First, the IUL Coalition strongly agrees with ACLI that AG49-A should be applied on a prospective-only basis to policies issued after the effective date of changes. We refer you to prior comments we have made on this issue.

Second, the IUL Coalition concurs with the ACLI comment letter where a consensus was reached. The IUL Coalition provides further comment below on the one area of the ACLI letter where a consensus was not reached.

**The Coalition Supports ACLI Option 1 Regarding the Treatment of Policy Loans**

While the ACLI was able to reach a consensus on most provisions, one exception was with respect to the treatment of policy loans. As a result, the AG49-A draft contains two proposals for the treatment of policy loans: Option 1 and Option 2. Both Options limit the maximum crediting rate on the portion of the policy that is collateral for an index loan to a rate that is not higher than 100 bps above the illustrated loan interest charge rate (the “1% limit”). The difference between these options is that Option 1 applies the limit on Index-related performance while Option 2 applies the limit on all credits, regardless of whether they are tied to an index or not.
We agree with the ACLI that further discussion on this topic is warranted. Below we provide more clarification and education to the regulators beyond the comment letter distributed by the ACLI and describe why we support Option 1.

In evaluating the two proposed options as well as the arguments supporting each, it is the IUL Coalition’s belief that there are flaws and inconsistencies in Option 2 as described below:

1. **Applying loan “leverage” to Non-Indexed Credits.** One of the purposes of AG49 was to limit the loan leverage shown in the illustration. While the term “leverage” is not defined within AG49 itself, it is defined within the comment letter provided by the ACLI. Within that document, it defines loan “leverage” as when the index return is higher than the loan charged rate. Option 2 indicates that the loan leverage may exceed 100 bps via means of fixed rate bonuses or other innovative product designs. We respectfully disagree. Since non-indexed credits do not impact the index return nor the loan charged rate, the loan leverage remains consistent between Option 1 and Option 2.

2. **Inconsistent treatment of Indexed Loans.** Option 2 creates various inconsistencies as outlined below:

   a. **Loan vs. Non-Loaned within IUL product.** Option 2 allows the Non-Indexed Credits to be fully illustrated on non-loaned values but they may be limited on loaned values. The leads to difficulties for an applicant to compare and understand the costs associated with a loan and the impact on benefits under the policy.

   b. **Standard Loans vs. Indexed Loans within IUL product.** Option 2 allows the Non-Indexed Credits to be fully illustrated on Standard Loans but they may be limited on Indexed Loans. This creates confusion to the policyholder when determining which type of loan would be best suited for them.

   c. **Varying by Index Return.** Option 2 advocates that “products could still offer other bonus types and demonstrate how they work at lower interest rate illustrations or when loans are not illustrated.” The implication is that at higher illustrated returns, the Non-Indexed Credits cannot be illustrated since the true loan leverage is already at 100 bps. However, at lower return scenarios, they are allowing you to illustrate the bonus as you would no longer be illustrating any leverage. To illustrate items such as fixed credits differently across the return scenario is inconsistent, arbitrary and misleading as it gives the impression that the bonus amount truly varies by index performance.

   d. **UL vs. IUL.** UL policies illustrated with a loan can include Non-Indexed Credits (subject to self-support/lapse-support tests) while the IUL policies illustrated with the loan will only be able to reflect the Non-Indexed Credits that don’t cause the 1% limit to be exceeded. This difference will make it more difficult for the applicant to understand which product better suits his or her needs and will also make it more difficult to compare the mechanics of each product. The ACLI letter cautions that non-Index bonuses may become more common. We note, however, that these bonuses have been in common use for many years and have proven beneficial to many policyholders. There are no negative implications associated with a possible increase in the use of these bonuses.
To summarize, and for additional clarity, when a simplified example is shown to demonstrate how Option 1 and Option 2 would illustrate a Non-Indexed Credit under various scenarios, the inconsistency becomes apparent:

<table>
<thead>
<tr>
<th>Fixed Persistency Bonus (% of Policy Value)</th>
<th>0.50%</th>
<th>Illustrated Fixed Persistency Bonus</th>
<th>Illustrated Fixed Persistency Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illustrated Policy Value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UL Product</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed Account (no loan)</td>
<td>1,000</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Index Account (no loan)</td>
<td>1,000</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Standard Loan - Fixed Account</td>
<td>1,000</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Indexed Loan - Indexed Account (lower index return)</td>
<td>1,000</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Indexed Loans - Indexed Account (higher index return)</td>
<td>1,000</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

3. **Innovative products will be disadvantaged.** Many innovative products are designed to add Non-Indexed Credits that could increase a customer’s policy value. The best way for a customer to understand the benefits derived from these types of products is in the illustration. By applying the 1% limit to Non-Indexed Credits, illustrated values for the product when a loan is taken will reflect the full charge associated with the innovative feature but may not be permitted to reflect the full potential benefit. This would create a disadvantage for innovative product designs, such as policies that offer wellness credits to customers who engage in activities that help them live longer and healthier lives.

4. **Option 1 does not provide any undue “optimism” compared to Option 2.** Within the comment letter distributed by the ACLI, one of the arguments provided for Option 2 is that it “prevents illustrations that are overly optimistic.” The implication is that Option 1 is allowing overly optimistic illustrations. This is not true. The inclusion of an item like a fixed bonus is not adding any additional optimism in that the bonus will be paid regardless of index performance. Therefore the level of “optimism”, in projecting uncertain items like indexed return, is identical between the two options.

The IUL Coalition feels that Option 1 as outlined in the ACLI draft and comment letter is the appropriate direction. The IUL Coalition believes that Option 1 provides consistent treatment of Non-Indexed Credits to allow a policyholder to properly understand the implication of a loan. In addition, Option 1 limits illustrated index loan leverage while encouraging innovative product designs. And, while each of the points above get into detail as to why we prefer Option 1, it’s also wise to step back and remember the overall goal of AG49. It was created to prevent over-illustrating indexed performance within IUL illustrations. Option 2 restricts the illustrations beyond index-related items which we don’t believe aligns with the objectives of AG49.

**Comments on other changes to AG49-A**

The revisions in AG49-A accomplish the main objectives of the IUL Subgroup’s request. The guideline establishes a maximum level of index credits based on hedge budgets that are no greater than the earned rate on assets supporting the product. At maximum levels for illustrated rates and hedge budgets,
features like multipliers or higher caps illustrate at a similar level as products without those features. We don’t believe there are openings to illustrate a net value for a BIA that is higher than the limits shown by the examples submitted by the ACLI.

We note that the ACLI is continuing discussions on a few remaining items and may have some additional changes to propose. Once the ACLI has completed discussions on any remaining changes, we plan to provide more detailed comments at that time.

The IUL Coalition is committed to working with stakeholders to promptly implement the intent of regulators, even during this time of economic and social uncertainty. We note that, over the coming months, regulators may need to consider providing increased flexibility regarding comment deadlines and decision-making as regulators and companies operate under emergency plans in response to the COVID-19 pandemic. While IUL Coalition members’ first priority is to maintain essential services to our policyholders during this public health emergency, we stand ready to continue progress on this issue as appropriate.

We appreciate the opportunity to provide input to the IUL Subgroup and look forward to further discussions.

Respectfully Submitted,

Scott R. Harrison
High Point Strategies, LLC
scott@highpointstrategies.llc

cc: Reggie Mazyck, NAIC
February 14, 2020

Mr. Fred Andersen  
Chair, NAIC IUL Illustration (A) Subgroup  
Mr. Reggie Mazyck  
Life Actuary, NAIC

Re: Questions on IUL Illustrations

Dear Mr. Andersen and Mr. Mazyck,

Global Atlantic supports the continued review of Actuarial Guideline XLIX (AG49) considering new policy designs which have once again brought a lack of uniformity in illustrated values that can be confusing to potential buyers, in addition to creating uncertainty for the illustration actuary. We continue to believe that all index product designs should illustrate consistently and within the spirit of the current guideline. The current guideline provides for illustrated values based on the product’s index growth potential, using restrictions on the credited rates, earned interest rates within the disciplined current scale and loan leverage.

Global Atlantic is submitting a draft update that, we believe, develops illustrated value uniformity across index products while maintaining the spirit of AG49. The attached draft addresses the issues within the January 2020 exposure document as follows:

**Issue #1**
Section 3.B.ix. of the draft requires all sources of index credits to be included in the Benchmark Index Account. The different maximum AG49 lookback rates are therefore eliminated.

Additionally, the draft does not utilize the “Supplemental Option Budget” term, thereby eliminating the issues raised with defining that item.

**Issue #2**
The current AG49 allows for more than one Benchmark Index Account to be used. The attached draft builds on this through:
1. Section 3.B.ix requiring all sources of index credits to be included in the Benchmark Index Account.
2. Section 4.A.iii. providing guidance on determining the maximum credited rate for Index Accounts that differ from the Benchmark Index Account.

**Issue #3**
The attached draft specifies utilization of policy values subject to index interest, eliminating the interpretation differences of dollar amount and interest rate approaches listed in the exposed document.

**Issue #4**
AG49 applies to policies that have interest credits linked to an external index or indices. The attached draft requires all credits linked to an external index or indices to be considered within the 100 basis point limit. This consistent definition clarifies the 100 basis point differential applies to all sources index-based credits as Global Atlantic has suggested in our previous comment letters. Other policy credits, such as a reduction
in policy charges for those who lead a healthy lifestyle, are not derived from an external index and thus are not considered.

We look forward to continued dialogue on this important topic and the suggested revisions we are submitting with this comment letter.

Thomas A. Doruska  
Head of Life Product Development

David P. Wilken  
President - Life
Fred,

Thank you for the opportunity to comment on potential revisions to AG49. While we see merits in the Supplemental Option Budget approach, we believe that it is unable to address the full spectrum of designs that could lead to effective illustrated rates well in excess of the AG49 maximum illustrated rate for the Benchmark Index Account (BIA). For example, it is not effective for dealing with the implications of alternative crediting strategies and hybrid indices that have higher imputed option profits based on the hypothetical historical lookback methodology in AG49 Section 4(A), which already provide for means of illustrating returns well in excess of the BIA maximum illustrated rate in products available for sale today. It is also not clear how the concept of a Supplemental Option Budget would interact with persistency funded multipliers, bonuses or cash infusions, as are commonly found on Indexed UL products currently in market.

As a result, we believe that alternatives to the Supplemental Option Budget approach should be considered that will better align Indexed UL illustrations to Fixed Indexed Annuity illustrations and address the full spectrum of potential indexed crediting and product designs. This letter outlines an alternative methodology with specific AG49 language recommendations. We believe that the changes we are proposing to AG49 will accomplish the goals set forth by the regulators while maintaining the ability for life insurers to clearly differentiate crediting strategies and products on the basis of risk and return characteristics using historical index return data.

Our recommendation is for two primary modifications to AG49. The first is to move the hypothetical historical lookback methodology currently used in 4(A) to the crediting rate reports described in Section 7. We also recommend that Section 7 be augmented to encompass best case, worst case and most recent case historical returns over 10 years, aligning Indexed UL illustrations with Fixed Indexed Annuity illustrations. Finally, we recommend that Section 7 be clarified to allow any additional credits or charges contractually related to providing indexed interest which, again, is in accordance with Fixed Indexed Annuity illustrations. Taken together, these changes will augment the insurer’s ability to show how variability of returns can impact crediting performance in a variety of scenarios for each indexed crediting option, thereby increasing consumer understanding of the crediting mechanics and potential risks and returns of the strategies.

Second, we recommend using an option valuation methodology for Section 4(A) with pricing inputs being drawn from the previous calendar year. We recommend using the Black-Scholes formula, a universally accepted valuation methodology for derivatives, including call options, and is commonly applied to the valuation of financial products containing derivatives-based payoffs, such as warrants and retail structured products. Replacing 4(A) with an option valuation formula aligns the maximum illustrated rate with the denominator for all indexed-linked credits in the contract, regardless of whether they are funded through the insurer’s portfolio yield, additional policy charges or persistency. This modification to 4(A) will eliminate the illustrated benefits of multipliers and buy-up caps.

It would also align the illustrated benefits of alternative crediting strategies and hybrid indices with the Benchmark Index Account. There would be differences in the illustrated rates for the various accounts based solely on the fair market value of the options, which is a true and reasonable indicator to consumers of the current intrinsic value of the indexed crediting option. However, consumers would still be able to see the potential risks and rewards of these strategies in the hypothetical historical crediting reports described in Section 7 based on historical index returns. By combining these two approaches, consumers will be able to make an informed decision about choosing an indexed crediting strategy based on both the current fair-market valuation of the replicating options for the strategy (Section 4(A)) and its potential to deliver performance in a variety of historical return scenarios (Section 7).
The changes to the AG49 language proposed herein would accomplish the following goals stated by regulators:

1. Standardizing illustrated rates across Benchmark Index Account options, in accordance with the stated goals of the original Indexed UL Illustration Subgroup in 2013.
2. Limiting the ability for alternative crediting strategies and indices to illustrate more advantageously than traditional indices and crediting strategies, in accordance with the stated goals of the original subgroup.
3. Ensuring that products with multipliers illustrate similarly to products without multipliers, in accordance with the recent vote taken by the IUL Illustration Subgroup.
4. Ensuring that products with buy-up caps illustrate similarly to products without buy-up caps, in accordance with the vote taken at the most recent NAIC meeting in Austin.
5. Bringing Indexed UL illustrations into alignment with Fixed Indexed Annuity illustrations.
6. Maintaining the majority of the current AG49 language, including the 145% factor for illustration actuary testing, thereby avoiding a time-intensive rework of the guideline.

The language proposed herein would also satisfy the following concerns raised by life insurers:

1. Continuing to provide for the ability of life insurers to differentiate their products and crediting methodologies by demonstrating the potential for different indexed crediting options to offer different risk/return profiles, including multipliers, buy-up caps and proprietary/hybrid indices.
2. Providing for illustrated loan arbitrage to a similar degree as Whole Life, thereby ensuring that Indexed UL is not at a competitive disadvantage to Whole Life in terms of illustrated loan treatment.
3. Providing for the continued illustration of persistency-based, embedded multipliers and bonuses, thereby ensuring that Indexed UL is not at a competitive disadvantage to other types of Universal Life products.

Specific AG49 language changes, with accompanying comments, are appended. We appreciate the opportunity to comment and respectfully submit our proposal.

Signed,

Bobby Samuelson, Executive Editor, The Life Product Review
Larry Rybka, President & CEO, Valmark Financial Group
Joseph M. Belth, professor emeritus at Indiana University
Chris Hause, FSA, President, Hause Actuarial Solutions
Richard M. Weber, President, The Ethical Edge, Inc
Barry Flagg, President, Veralytic
Stephen R. Leimberg, Publisher, Leimberg Information Services, Inc
Bill Boersma, President, OC Consulting Group
Tom Love, VP, Insurance Analytics, Valmark Financial Group
Mike Brohawn, President, Your Life Insurance Solution
Steven Roth, President, Wealth Management International, Inc., Licensed Life & Disability Insurance Analyst
Ben Baldwin Jr
Suggested AG49 Language Modifications

1. Replace 4(A) with:

   A. Calculate the value of the replicating option trades for the Benchmark Index Account over the preceding calendar year, based on the Black-Scholes formula using the following inputs calculated on each trading day:
      i. Average closing implied volatility for 12-month, at-the-money S&P 500 call options
      ii. Average closing implied volatility for out-of-the-money 12-month S&P 500 call options with a normalized strike price equal to the currently declared cap
      iii. Average dividend yield on the S&P 500
      iv. Average 12-month LIBOR

   This section is designed to replicate the reasonable price of replicatively hedging the current index parameters in the Benchmark Index Account. An alternative approach may be for the NAIC to publish standard tables of the estimated price for hedging index participation parameters at defined intervals (0.25%, for example) with allowance for insurers to interpolate between the datapoints. This would limit the degree to which insurers with identical index participation parameters would have different illustrated performance. LIBOR may also be exchanged for another measure of Risk Free Rates.

2. Replace 4(B) with:

   B. The value calculated in 4(A) shall be the maximum credited rate(s) for the illustrated scale.

3. Remove 3(A) – The Alternate Scale

4. Replace 4(C) with:

   C. For other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgement to determine the maximum credited rate for the illustrated scale. The determination shall reflect the fundamental characteristics of the Index Account as relates to the inputs for the Black-Scholes valuation formula, including realized volatility, implied volatility, volatility targets (if applicable), embedded fees (if applicable), deduction of an interest rate component (if applicable), dividend participation (if applicable) and other factors that may apply.

   This section is designed to ensure that products using different crediting methodologies, indices or combinations of the two illustrate in the same methodology as the Benchmark Index Account in accordance with their fundamental, underlying characteristics

5. Replace 7 with the following:

   A. A table showing the minimum and maximum of a geometric average for any available Benchmark Index Account using the following methodology:
i. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

ii. Calculate the arithmetic average of the geometric average annual returns in all 25-year periods

B. For each Index Account illustrated, a table showing actual annual historical index changes and corresponding hypothetical interest rates using current index parameters, including any applicable asset-based charges and asset-based interest bonuses or index credit multipliers paid within the first 10 years of the policy:

i. The 10-year period with the lowest calculated returns within the period referenced in 7(A)(i)

ii. The 10-year period with the highest calculated returns within the period referenced in 7(A)(i)

iii. The most recent 10-year historical period as calculated on the final trading day of the preceding calendar year

C. If an index has not been in existence for 10 years, the table shall replace the figures with the maximum available back-tested performance.

This section is designed to bring Indexed UL illustrations into alignment with Fixed Index Annuity illustrations. These demonstrations will also provide latitude for insurers to demonstrate the potential risk and return profiles of various crediting strategies, indices and policy mechanisms.

The following sections of AG49 were not altered for the following reasons:

5. There is no need to change the 145% provision in 5(A) as it will provide a cushion for the inevitable mismatches between the standardized illustrated price of the replicating options calculated in 4(A) and the insurer’s own pricing for options, expectations of prices or cap-setting process. Retaining the 145% will allow insurers who have economies of scale in hedging, are supporting higher caps with higher policy charges or other designs to illustrate benefits and costs accordingly. However, it may be advisable to adopt some of the clarifications to this language previously proposed in other comment letters.

6. There is no need to change the 100 basis points allowance for illustrated loan arbitrage. As with Section 5, there are inevitable mismatches between what an insurer is willing to charge on a loan and the value of what it may credit by providing current index participation parameters. This section preserves the ability for insurers to reflect those changes. However, it may be prudent to add clarifying language about the inclusion of illustrated bonuses and multipliers for the 100bps allowance.
February 21, 2020

Mr. Fred Andersen, Chairperson, IUL Illustration (A) Subgroup
National Association of Insurance Commissioners

Re: Proposed Changes to Actuarial Guideline 49

Mr. Andersen,

Allianz has had the opportunity to preview a number of different proposals for changes to Actuarial Guideline 49 and we appreciate the opportunity to provide our comments on the matter.

In the spirit of gaining industry consensus, we support using the ACLI and IUL Coalition proposals as the foundation for the revised guideline. The companies represented by the ACLI and IUL Coalition offer a variety of product designs and serve a broad range of consumer needs, and these proposals accomplish the goals set forth by regulators while also being clear, direct, and broadly applicable.

Where there are differences between the proposals, we support the approach that is more broadly applicable to the various product designs offered throughout the industry.

Thank you for the opportunity to provide these comments.

Regards,

Austin Bichler, FSA, MAAA
Senior Director Actuary & Illustration Actuary
Allianz Life Insurance Company of North America
Dear Fred;

Thank you for the opportunity to comment on the proposed Actuarial Guideline 49 (AG 49) “The Application of The Life Illustrations Model Regulation to Policies with Indexed-Based Interest.”

Members of the Life Actuarial Task Force (LATF) Indexed Universal Life (A) Subgroup had previously voted to promote the general principle of “not allowing multiplier products illustrate better than products without multipliers.” The objective of revising the AG 49 is to clarify the guidance and applicability for this general principle. Examples noted in the current version of the proposed AG 49 also demonstrate the essence of this general principle. During the 2019 NAIC Winter Meeting, members of the subgroup voted to further expand this general principle to cover the “cap buy-up” feature of Indexed Universal Life (IUL) products.

As indicated in the provided document for the Jan 28, 2020 conference call, both Option A and Option B for Sections 3.G and 4.E of the proposed AG 49 leave rooms for companies to illustrate higher net credited rates for multiplier products than non-multiplier products. As both options violate the general principle of “not allowing multiplier products illustrate better than products without multiplier,” we prefer neither Option A nor Option B.

Regardless of the final option (A, B or others) being adopted, no regulations or actuarial guidelines may cover all future product innovations and terms used in insurance contractual provisions. Innovative IUL products or contractual provisions may gradually limit the effectiveness of the final AG 49 on IUL illustration. It is also not practical for regulators to continually revise the definitions of the AG 49.

While we should continue to revise the language of AG 49 to achieve the general principle, we may also consider implementing a supplementary approach of defining the net credited rates and the projected account values of the base IUL product (without multipliers, cap buy-up or other credit enhancing features) as the upper bounds for the net credited rates and the projected account values of IUL products with multipliers, cap buy-up or other credit enhancing features. The combination of the two approaches may minimize the loopholes of AG 49 and reduce the frequency for updating AG 49.

In conclusion, we do not prefer either Option A or Option B on a stand-alone basis. Besides revising the languages for Section 3.G and 4.E, we encourage the subgroup to consider amending the AG 49 by defining the net credited rates and the projected account values of a base IUL product as the upper bounds for the IUL product with multipliers, cap buy-up or other enhancing product features.

Thank you.

Very truly yours,

Vincent Tsang, FSA, MAAA

Illinois Department of Insurance
February 21, 2020

Mr. Fred Andersen
Chair, IUL Illustration (A) Subgroup
National Association of Insurance Commissioners (NAIC)

Dear Mr. Andersen,

On behalf of the American Academy of Actuaries\(^1\) Life Illustrations Work Group (the “Work Group”), I appreciate the opportunity to provide comments to the IUL Illustration Subgroup regarding the illustrations of Indexed Universal Life (IUL) insurance policies under Actuarial Guideline XLIX (AG 49).

In the early 1990s, the Task Force for Research on Life Insurance Sales Illustrations researched life insurance sales illustrations and published a report of its findings in the *Transactions of the Society of Actuaries* 1991–1992 Reports (see attachment). We believe this report is important because it formed part of the basis for the Life Insurance Illustrations Model Regulation (adopted later that decade) and much of it continues to be relevant today.

The research indicated there are two major uses of illustrations:

- **Type A Usage** is intended to show the consumer the mechanics of the policy being purchased and how the policy values or premium payments change over time. The emphasis is a matter of *how and what* rather than *how much*.
- **Type B Usage** tries to project likely or best estimates of future performance and compare cost or performance of different policies. It attempts to show *how much* on the premise that the *hows and whats* are comparable enough for this to be meaningful.”

Although the Task Force concluded that “illustrations handle Type A requirements well,” the report states that “Type B usage for illustrations is fundamentally inappropriate” and “illustrations are structurally incapable of handling Type B questions.”

During subsequent development of the Life Insurance Illustrations Model Regulation, a majority of regulators agreed with the conclusions of the Task Force:

“A regulator suggested that a provision be added to refer to comparison between policies, recognizing that people will compare policies whether the working group thinks it is

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
appropriate or not. The majority decided the NAIC should not go on record in any way encouraging what they consider an inappropriate use of illustrations.” (*Proceedings of the NAIC*, 1995 Proc. 2nd Quarter 537.)

We are concerned that the recent direction from the Life Actuarial Task Force (LATF) will result in the inability to show the consumer the mechanics of the policy being purchased (i.e., inhibit Type A usage). We understand LATF’s concern that illustrations could be misleading if consumers believe the illustrated rates are best estimates (Type B usage), but it is also misleading to deprive consumers of the ability to see how certain product features work (Type A usage).

Therefore, the Work Group offers the following principles for evaluating potential changes to AG 49:

1. Product features are adequately disclosed and reasonably demonstrated in all illustrated scenarios, to support Type A usage and educate consumers on what they are buying (e.g., costs, functionality, benefits/risks/limitations, impact on illustrated values, etc.).
2. Discourage Type B usage through disclosures in the illustration and through consumer education.
3. Illustrated values that are supportable through DCS testing.
4. Maximum illustrated rates that are reasonably related to the product features and also reflect the economic environment.

In addition, we suggest that Section 7.C. of AG 49 be reviewed to improve disclosure of total credits and charges (not only credited rates).

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The Work Group appreciates the efforts of the IUL Illustration Subgroup to review AG 49. If you have any questions or would like further dialogue on the above topics, please contact Ian Trepanier, life policy analyst, at trepanier@actuary.org.

Sincerely,

Donna Megregian, MAAA, FSA
Chairperson, Life Illustrations Work Group
American Academy of Actuaries
TRANSACTIONS OF SOCIETY OF ACTUARIES
1991-92 REPORTS

FINAL REPORT* OF THE TASK FORCE†
FOR RESEARCH ON LIFE INSURANCE SALES ILLUSTRATIONS
UNDER THE AUSPICES OF THE
COMMITTEE FOR RESEARCH ON SOCIAL CONCERNS

EXECUTIVE SUMMARY

Purpose
The Task Force for Research on Life Insurance Sales Illustrations reports to the Society's Committee for Research on Social Concerns. The Task Force was formed in recognition of the declining level of consumer confidence in the life insurance industry and, in particular, to investigate how sales illustration practices can add to, or detract from, consumer confidence.

In developing this report, the Task Force surveyed life insurance company illustration practices, reviewed available literature and regulatory requirements, held open forums at Society of Actuaries (SOA) and Canadian Institute of Actuaries (CIA) meetings, and considered the methodology applied to other financial products.

Situation Analysis
Sales illustrations have been developed to meet a variety of needs from a variety of consumers, all placing different requirements on an illustration. There are two major uses of illustrations:

• **Type A Usage** is intended to show the consumer the mechanics of the policy being purchased and how policy values or premium payments change over time. The emphasis is a matter of how and what rather than how much.

• **Type B Usage** tries to project likely or best estimates of future performance and compare cost or performance of different policies. It attempts to show how much on the premise that the hows and whats are comparable enough for this to be meaningful.

Illustrations handle Type A requirements well, especially if several illustrations are used to show different scenarios. Illustrations inherently do not

*Opinions expressed herein are those of the Task Force for Research on Life Insurance Sales Illustrations and of the Committee for Research on Social Concerns. This report does not purport to represent the views of the Society of Actuaries or of its Board of Governors.
† Judy A. Faucett (Chairperson), Benjamin J. Bock, Bruce E. Booker, John W. Keller, John R. Skar, Linden N. Cole, Staff Liaison, W. Steven Prince, CIA Liaison, and Michael J. Roscoe, AAA Liaison.
handle Type B requirements well. How credible are any nonguaranteed numbers projected 20 years into the future, even if constructed with integrity? How does a consumer evaluate the credibility of two illustrations if they are from different companies or even from the same company if different products with different guarantees are being considered? Most illustration problems arise because illustrations create the illusion that the insurance company knows what will happen in the future, and that knowledge has been used to create the illustration.

In many countries, Type B usage of life illustrations is prevented, in effect, through use of standardized assumptions. It is acknowledged that there are real differences in performance between companies, but such differences cannot be described through illustrations. Within North America in other financial products such as mutual funds, it is recognized that future performance cannot be illustrated. The emphasis of these illustrations is to disclose expense charges, not the performance of the underlying fund.

Life insurance policies are complex financial contracts. There is no simple measure or analysis to compare future performance of unpredictable events. This fact is well understood in the securities industry and needs to be assimilated into the life insurance industry as well.

CONCLUSION: Illustrations are a valuable tool for the consumer and third-party advisors when used properly. Most companies are making a good-faith effort to comply with the regulatory requirements and disclose material facts on the illustration. However, the consumer would benefit from illustrations that demonstrate the sensitivity and operation of nonguaranteed elements and better methods/measures to compare policies and companies.

Alternatives to Current Practices

The Task Force considered a number of alternatives to current practices for illustrations. Specific recommendations are contained in Sections VI and VII of the report. The recommendations fall into these main categories:

- **Educational Efforts:** A large educational effort should be undertaken with consumers, agents and head office personnel concerning the limitations of illustrations for Type B purposes. The sales process should emphasize selling of the product, not the illustration.

- **Standards, Disclosures and Regulations:** The CIA and American Academy of Actuaries (AAA) should consider developing specific standards
on what assumptions should be used in illustrations or on required disclosure of assumptions used. It should be required that unique product features are prominently disclosed as well.

- **Optional Improvements:** Companies could require a consumer signature on illustrations. Historical data could be provided separately from the illustration. Illustrations could be accompanied by graphs or quinquennial summaries to avoid the illusion of precision.

- **Continuing Research:** The proposed alternatives are not a complete solution to the problem of properly explaining a policy to a consumer and allowing an informed choice to be made. Research on methods to achieve this should continue.

### 1. Scope of Research

A life insurance policy illustration is a mathematical calculation of benefits and values over time under specific, simplified, and generally static assumptions. Illustrations have evolved into relatively sophisticated marketing tools. Their popularity and importance have increased not only with easier access to fast, powerful computers, but also as the result of heightened consumer need to understand what is being purchased and how much it will cost.

Consumers and their advisors use illustrations to understand how a policy operates and its expected cost over time. When a consumer is comparing several products, illustrations are often used to determine relative performance or cost. While current practices may have some flaws, illustrations are an important source of information to the consumer.

The Task Force on Life Insurance Sales Illustrations was formed to research life insurance company sales illustration practices from the perspective of the consumer. Much of the motivation for this research was based on the perception that:

- Serious problems exist with respect to the use of life insurance sales illustrations in the U.S. and Canada.
- More than two decades of regulations and required disclosures have not solved the problems; if anything, the situation is getting worse.
- Actuaries are familiar with these problems and should be involved in the solutions. Our goal is to encourage an efficient market by applying principles of actuarial science. These principles include:
  - Appropriate and consistent recognition of the time value of money.
- Use of probability to measure uncertainty or risk.
As part of this research, the Task Force undertook to investigate:
  ● Current illustration practices, including regulatory requirements and the
    flexibility that companies provide agents to customize illustrations in the
    field
  ● Alternatives to current illustration practices
  ● Advantages and disadvantages of current and alternative practices
  ● Appropriate uses for illustrations.
  To support these efforts, the Task Force considered:
  ● How consumers currently use illustrations
  ● How to make illustrations more intelligible to the consumer
  ● The appropriate disclosures to the consumer
  ● How to maintain credibility with the consumer in the illustration process
  ● What data and assumptions should be displayed on the illustration
  ● Illustration practices in other countries
  ● Illustration practices for other financial products.
  While the following items may have an impact on the illustrations delivered to the consumer and merit study, they are beyond the scope of this research paper:
  ● How agents modify illustrations beyond the flexibility provided by the company
  ● The setting of profit standards and pricing assumptions within a company
  ● The appropriateness of policy provisions and their conformance with regulatory or actuarial standards
  ● Variable life insurance.
  Further, we focused primarily on life insurance. Annuities and health insurance were not generally considered. While our comments are specific to sales illustrations, many of them apply equally to in-force illustrations. We did not consider variable product illustrations, except as an example of alternative illustration methodology. While we primarily focused on the situation in the U.S., we believe our research and conclusions are equally appropriate to Canada.
  It may be useful to describe our research activities.
  ● We surveyed 87 life insurance companies regarding their current illustration practices and sought their ideas on positive change. These companies were selected as being major writers of participating insurance policies, universal life and/or innovative life insurance policies in the U.S. and Canada. Their responses are summarized in Appendix I.
LIFE INSURANCE SALES ILLUSTRATIONS

- We compiled a bibliography from actuarial literature, which is shown in Appendix IV.
- We reviewed the work of other organizations and state regulations.
- We talked with actuaries from other countries to gain an understanding of their illustration practices and the associated strengths and weaknesses.
- We talked with our counterparts in other financial services to determine whether their illustration practices were adaptable to life insurance.
- We sought input from our colleagues: actuaries, legal counsel, compliance officers, agents, marketing officers, regulators, and others.

The result of these efforts is this white paper. To those who contributed, we appreciate your input. The development of regulations and standards of practice is beyond the purview of the Society of Actuaries. However, we hope that this paper will provide input, and serve as a catalyst, to the organizations that can effect such changes.

II. REGULATORY REQUIREMENTS FOR LIFE INSURANCE ILLUSTRATIONS

The policy performance and features illustrated to the buyer have been an issue with regulators for at least a century. At the turn of the century, there was concern about the tontine dividends that companies illustrated to their customers. An outgrowth of the Armstrong Commission was the required annual distribution of dividends and the elimination of tontines based on survivorship.

During the 1930s, there was again concern about illustrations because dividend scales were decreasing due to the economic environment. Among the issues discussed were:

- The appropriate number of years for dividend illustrations (20 years was common but thought too long, given the uncertainties of the 1930s)
- Display of year-by-year dividends or 3–5 year totals
- Disclosure to the buyer of the nonguaranteed nature of dividends and the assumptions underlying the current scale.

More recently, there has been concern about the impact of policy illustrations on the industry’s credibility in the context of changes in interest rates, asset quality and policy features. Policies are more flexible and more complex than in the past and place greater emphasis on nonguaranteed values.

The insurance code of each state has certain requirements that apply to illustrations. While these requirements vary by state, the following are generally applicable:
• If dividends are illustrated, the illustration must use the insurer’s current dividend scale.
• If nonguaranteed elements other than dividends are illustrated, the illustration must use the insurer’s current interest rate, mortality charges and expense charges.
• If the policy provides for a separately identified interest credit, the interest rate used in the illustration must be displayed. If the interest rate is linked to an index, the index must be described. Any limitations on the crediting of interest must also be described.
• Any reference to dividends or nonguaranteed elements must include a statement that such elements are not guaranteed.
• Illustrations of nonguaranteed values must display, with equal prominence, the comparable guaranteed values. If nonguaranteed and guaranteed values are shown combined as a single sum, they must also be shown separately in close proximity thereto.
• For policies providing for flexible premiums and/or death benefits, all data shall be displayed assuming the schedule of anticipated premiums and death benefits.
• Interest adjusted cost indexes must be displayed for specified durations. These indexes are the net payment cost index and the net surrender cost index. If the policy is participating, the interest-adjusted equivalent level annual dividend also must be displayed.
• If the guaranteed policy cost factors or the initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy’s maturity date, such fact shall be disclosed.

Additionally, for U.S. business, Exhibit 8, Question 3 of the Annual Statement requires a company to opine on its ability to support the nonguaranteed elements currently illustrated for new and existing business. This applies only to illustrations authorized by the company. Schedule M requires an attachment that describes the precise methods by which dividends are calculated. In Canada, the valuation actuary must comment on the appropriateness of the dividend scale but not any other nonguaranteed elements.

The purpose of these illustration requirements is to ensure that both the guaranteed and nonguaranteed performance of the policy are disclosed to the buyer. The cost indexes are intended to help the buyer judge the relative value or cost of an insurance policy. However, the Life Insurance Buyer’s Guide points out that cost comparisons should only be made between similar plans of insurance. Further, it states that other information, such as company financial strength and historical performance, will be needed on which to
base the purchase decision. When the cost indexes were originally developed, they were perhaps more useful than they are now. Policies had, at that time, fixed premium patterns with fairly consistent design features and profit margins. This is not the case with most permanent, cash value life insurance being sold today.

Regulations and requirements must change to remain appropriate and effective. Evolving marketplace and economic conditions necessitate periodic updating of regulations, including rescinding requirements that are no longer helpful. The regulations of the early 1980s did not anticipate the product features, payment options and anomalies of the succeeding decade. As examples:

- Illustrations of a vanishing premium for a fixed-premium product depend upon the nonguaranteed policy factors to support premium payments after the vanish year. Should the accompanying guaranteed values be based on the illustrated premium outlay by the buyer or the payment of full premiums in all years?

- Companies are required to illustrate the current dividend scale or the current scale of nonguaranteed factors as appropriate. At a time when interest rates, mortality experience and expenses may not be improving, current scale may provide an overly optimistic projection of future results. Many companies currently provide agents with the flexibility to illustrate performance under alternative dividend scales or scales of non-guaranteed factors. While such sensitivity analysis is not explicitly provided for by most states, we believe it provides valuable information to the buyer.

- There is a great deal of discretion given to companies in the development of current dividends or nonguaranteed factors. There is no regulation, or any required disclosure, of the degree of risk or contingency associated with those nonguarantees.

- When a company increases its current dividend scale to distribute accumulated surplus over a specified period of years, there is no required disclosure of the likelihood of lower dividends at the end of that period.

- There is no regulation or disclosure of policies that are lapse supported, that are not self-supporting or that are based on assumptions that are inconsistent with a company's experience. Each of these items increases the performance risk to the buyer.

- The Internal Revenue Code in the U.S. contains sections which may have an impact on the tax treatment to the buyer or beneficiary of death proceeds, policy surrenders and partial withdrawals of policy values.
Most companies alert the buyer to possible tax implications through some disclosure on the illustration, although such disclosure is not required.

III. CURRENT PRACTICES

A. General

To better understand current illustration practices, we surveyed 87 companies; 56 responded. A sample questionnaire with responses summarized is contained in Appendix 1.

The first section of the survey provided companies with an opportunity to present their perspective on life insurance sales illustration practices. Over 95 percent of the companies responding to our survey perceive a problem with current industry sales illustration practices in terms of successfully communicating with the potential buyer in a good-faith manner. Of these, 65 percent thought that the problem was serious but could be fixed.

Based on the comments from respondents, the perceived problems are:

- The typical consumer does not understand which values in 50-year projections are guaranteed.
- The consumer cannot determine if the underlying assumptions are realistic.
- The consumer cannot evaluate the relative conservatism of the nonguaranteed policy values illustrated by different companies.
- Footnotes and other narrative disclose assumptions and other important facts, but they are often not carefully reviewed by the consumer.
- Providing agents with the ability to run their own illustrations limits the control companies have over what the consumer is shown.
- Companies have too much discretion in illustrating nonguaranteed elements.

Some companies provide the agent with tools to customize illustrations to particular client needs, or agents can buy or develop these tools on their own. The tools that companies provide allow flexibility with respect to column selection and formats, variations on nonguaranteed elements, and different premium patterns. Many companies that allow this flexibility require that the client also be given a ledger illustration in an approved format.

Companies are generally opposed, or neutral, to such complete flexibility. Respondents are concerned about outside programming that alters policy values or eliminates required columns or footnotes. There is also concern as to whether the consumer receives the complete illustration package, including the pages of caveats and footnotes.
While information regarding company size and financial strength is important to the consumer, most companies do not provide this as part of the illustration.

Respondents believe that the best features of their illustrations are flexibility, completeness and conservatism. Completeness includes disclosure of the contract’s operation and the tax consequences to the buyer. Basing non-guaranteed elements on current experience and lack of “gimmicks” were cited by several companies as examples of the conservatism built into their illustrations.

Respondents offered a number of suggestions regarding how illustrations could be improved to the benefit of the consumer.

- Simplify illustrations; there are too many numbers and too much “legalese.”
- Educate the consumer that an illustration demonstrates the operation of a contract under only one scenario and that there is a range of possible outcomes as to nonguaranteed benefit levels.
- Establish standards for illustration practices; in particular, provide more specificity in the definition of current experience and require disclosure of assumptions.
- Require that scenario testing with defined assumptions be part of the illustration package.

B. Dividend-Paying Policies

Of the 56 companies responding to the Task Force survey, 35 write participating policies.

When asked the question, “Which, if any, of the following dividend factors as illustrated anticipate a change from current experience, either by projecting trends or on some other basis? . . . Mortality, Interest, Expense,” one company indicated that it used mortality projections in its current illustrations. Three companies responded positively regarding interest and two reported anticipated changes in expense.

The comments accompanying this question indicate that only one company is anticipating lower expenses in its illustrations. One company occasionally anticipates higher expenses in its illustrations. At least two of the three companies projecting interest rates are companies that only allow agents to select a lower-than-current rate for illustration purposes. The company using mortality projections is assuming improved mortality in the future.

To the question, “Are such changes disclosed to the consumer?” three of these companies answered affirmatively.
Seventeen companies, or almost half of the 35 responding, answered yes to the question, “Do your agents have the flexibility to run illustrations at dividend interest rates or mortality rates higher or lower than the current scale?” All 17 companies indicated that they allow fluctuations in the dividend interest rate only. Fourteen of the companies stated that they only allow dividend interest rates to be illustrated that are lower than the current scale. Only two companies allow either higher or lower interest rates to be illustrated. Eight companies cap the maximum variance from current scale at 2 percent. Two of the companies allow the variance to be as much as 3 percent. One company allows agents to choose the average interest rate from the past 8, 12, 20, or 40 quarters.

Ten of the 35 responding companies answered “yes” to the question “Has your company received an increasing number of policyowner complaints about dividends paid versus dividends illustrated?” Eight companies indicated that the largest number of complaints concerned the vanishing point of premiums. Typical comments included:

“Most misunderstandings relate to vanishing premium illustrations and dividend scale changes. Policyholders mistake a vanishing-premium illustration for a promise of a paid-up policy.”

“Policyowner complaints have increased as dividend scales have decreased. [Policyowners] do not always comprehend the nonguaranteed nature of dividends.”

The Task Force also asked three state insurance departments whether or not they had observed an increase in complaints regarding dividend illustrations. Two (New York and Wisconsin) indicated that very few of the complaints they received were related to life insurance and, further, that they did not keep records in sufficient detail to respond to our questions. However, both expressed great interest in our research and voiced the concern that complaints may become more significant in the future. The third (California) noted that, based on a random sample of recent complaints, illustration complaints arose from decreasing dividend scales which affected total policy values and the vanishing point.

In addition to asking companies to fill in the questionnaire concerning their current practices, the Task Force also asked them to send samples of policy illustrations currently being used. Exhibits A–H are examples, as described below. All exhibits are in Appendix 11.
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Exhibit A

Exhibit A is an example of a traditional illustration for a participating whole life policy. It shows dividends, paid-up additions, guaranteed and total cash values and death benefits, increase in total cash value and guaranteed paid-up insurance for each policy year from the date of issue until age 100. It also includes the interest-adjusted surrender and payment cost indexes for 10 and 20 years.

Although the sheer volume of numbers may be overwhelming, the footnotes are kept to a bare minimum. They simply mention that the first dividend is contingent upon the payment of the second-year’s premium, that dividends are affected by policy loans, that dividend figures are based on the current scale assuming no loans, and that dividends are not guaranteed.

Exhibit B

The illustration shown in Exhibit B builds on the traditional model but gives the prospective buyer fewer numbers and a great deal more text material. The first page is a summary of the numerical results at the end of 20 years and at attained age 65. This is followed by two pages of numbers showing year-by-year values from the year of issue to attained age 98. Footnotes are again kept to a minimum, but a statement at the bottom of page 3 warns that two other forms must be enclosed with the illustration. These forms add two more pages of explanatory material.

One form is a listing of all the optional benefits that are available with the policy. The second form contains the dividend caveat, an explanation of illustrative life income figures, a brief explanation of term plans, and some information about the policy loan provision and interest-adjusted indexes.

Exhibit C

Exhibit C is another fairly traditional illustration, but it is included here because of its unusually forthright dividend caveat. Page 1 is a complete illustration showing 20 years of values plus values at attained ages 65 and 75. It has a very brief dividend caveat but refers the prospect to an attached page of footnotes.

Page 2 gives the year-by-year values through age 95. Page 3 is the footnote page. The first footnote assures the client that the policy is not a modified endowment contract. The second footnote pertains to dividends. It first gives the usual statement that dividends are based on the current scale and are not guaranteed. However, it then goes on to say, “Due to new federal taxes and
economic conditions including declining interest rates, dividends based on the 1992 dividend schedule are expected to be lower than those shown in the illustration.” Among all the illustrations submitted to the Task Force, this one surely deserves an award for its candor! Several more footnotes follow, including a statement that the illustration does not recognize the time value of money and should not be used to compare policy costs.

Finally, the bottom of page 3 shows the interest-adjusted surrender cost and net payment cost index numbers, and gives an explanation of them.

Exhibits D and E

Exhibits D and E show how two different companies handle illustrating dividend interest rates which differ from the current scale. The illustration in Exhibit D simply takes the standard illustration format and runs it at an alternate dividend interest rate. The actual rate used and the fact that it is less than the current rate are disclosed at the very top of the illustration on each page.

The illustration in Exhibit E compares the results of the current dividend scale and an alternative dividend scale in the same illustration. The first page shows values for the first 20 policy years and at attained ages 65 and 70. Page 2 is an illustration based on the alternative dividend scale showing a vanishing-premium scenario. This page also includes a comparative rate of return. Page 3 gives some summary figures at the end of 20 years and shows the interest-adjusted costs and payments.

The fourth page of the illustration contains several footnotes, including a statement about the hypothetical dividend interest rates and an explanation of the comparative rate of return. At the bottom of the page are listed the actual hypothetical interest rates used in the illustration.

Exhibit F

Since several companies indicated that vanishing-premium illustrations were their largest source of policyowner complaints, it was natural that many of these illustrations were sent in as samples. It is obvious that some companies are trying hard to find ways to educate policyowners to the fact that the vanish point depends on the dividends that will be paid in the future.

The illustration in Exhibit F is a case in point. It illustrates policy values on a vanishing-premium basis but places a full-pay illustration right alongside the vanishing-premium illustration for comparison purposes. The footnotes state that “the term ‘vanish’ does not mean that the premiums are no
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longer due, but that the cash premium due reflects the payments of future gross annual premiums through the use of current dividends. If future dividends are reduced from the current, results of the vanish may differ from that illustrated. Additional premium payments may be required if the current scale of dividends is reduced."

Exhibit G

The illustration in Exhibit G is another example of an attempt at complete disclosure. The first page, labeled 1 of 4, shows the vanishing premiums, together with the paid-up additions that need to be surrendered in years 12 through 15. Page 2 shows a guaranteed ledger assuming all premiums paid. Pages 3 and 4 contain explanations, including an explanation of vanishing premiums and a suggestion that an alternate proposal be requested on a lower dividend interest rate. Finally, the policyowner and agent must sign a statement to the effect that they have received and reviewed all four pages of the proposal, including the footnotes.

Exhibit H

Exhibit H represents an innovative approach to showing a vanishing premium plan on both the current scale and 1 percent less than current scale, all on the same page. From the wording in the first footnote, we can see that it is designed to be shown along with a full-pay ledger and is to be accompanied by an explanation of the vanishing premium concept.

C. Universal Life

From the beginning, a necessity for successful marketing of universal life has been the ability of the seller to illustrate the performance of a policy tailored (within policy limits) to the needs and resources of the prospective purchaser. The agent and prospect have the ability to choose almost any pattern of benefits and premiums. No longer is the sale limited to one of several fixed plans of insurance from a ratebook. Each one is different.

Any system of policy illustrations will have some limitations on this flexibility. For instance, few can illustrate off-anniversary changes. Besides such practical constraints and the policy’s inherent restrictions, how should the illustrations be limited? What interest rates can be shown? What cost of insurance rates can be used?

Most observers would agree on the appropriateness of current rates of interest and cost of insurance deductions along with guaranteed rates. But
what about other than current rates of interest and cost of insurance, such as lower or higher interest rates? Should the buyer be able to factor in his or her own conservatism, or optimism, about future economic conditions?

In our survey of insurance company practices in this area, 49 of 56 responding companies reported that they allow the agent or consumer to vary interest rates. Four of these allow higher interest rates than the current scale, usually with a footnote disclosing this fact. Others show both the current rate and another lower rate chosen by the agent. Most of the companies allowing cost-of-insurance variations reported offering a choice of only current or guaranteed deductions.

Since any life insurance policy is a long-term contract, its performance depends more on what happens in the future than on current credits and deductions. Some companies will pay more interest than others. Some companies will charge lower cost-of-insurance rates or loads than others. How can these differences be discerned and/or illustrated at the time of sale? The premiums on this policy have not been invested yet. There is no experience on the mortality and persistency of this year’s sales yet. How can the company show that it is different, and how can a consumer judge differences?

From an actuarial point of view, there is guidance. In the U.S., Actuarial Standards of Practice No. 1, “The Redetermination (or Determination) of Non-Guaranteed Charges and/or Benefits for Life Insurance and Annuity Contracts” (ASOP 1), sets a standard of using anticipated experience factors, that is, “those elements in the redetermination (or determination) of non-guaranteed charges and benefits that reflect expected future experience.” ASOP 1 states that “anticipated, or projected, experience of a factor class means experience expected in the future as determined by the actuary through the application of sound professional judgement.” It should be based on recent experience and expected trends, where applicable. ASOP 1 also explicitly recognizes that current company experience may be of limited value in projecting future experience.

ASOP 1 thus allows a company to use its best judgment in estimating its future experience factors to use in setting parameters for determining illustrative policy values.

Of the 56 responses to the survey, five use mortality assumptions which differ from current experience, eight use different interest rates, and two use different expenses. Since policy illustrations may go for as long as 100 years, and the oldest universal life policy is only 12 years old, some projections of future experience from current are obviously necessary.
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The question remains: To what degree will the illustrated differences in policies actually occur? Currently, there are no recognized yardsticks for the consumer to use. At best, a comparison of credited interest rates with bond yields, and a comparison of actual to illustrated cost-of-insurance rates, may show how the company's customers have fared in the past.

Separate from the questions of the ultimate realization of illustrated interest and cost-of-insurance factors is that of "persistency bonuses." For this purpose, a persistency bonus is a retrospective or prospective credit structure which provides enhanced values to a long-term policyowner compared to a short-term one. If guaranteed, persistency bonuses are limited in most states by the workings of the smoothness test in the Standard Nonforfeiture Law. Simply put, this test requires that policy values grade smoothly within each successive five-year period, so that large, one-time bonuses are not allowed. Most states do not restrict the crediting of properly disclosed nonguaranteed bonuses.

Ten of the 56 survey respondents reported bonuses. The existence of a bonus in the illustrated values is disclosed in footnotes by these companies, along with disclosure of its nonguaranteed nature, if appropriate.

We are aware of at least one company which displays the current cash surrender values in a footnote; only the accumulation values are shown in the body of the illustration.

Companies responding to the survey also provided us with sample illustrations for universal life and interest-sensitive whole life products. The representative illustrations that we selected dealt with policy features that are unique to these products. These are shown in Exhibits I-M.

Exhibits I-M

Exhibit I is an illustration showing values on three different bases: current, illustrative and guaranteed. The interest rates associated with each set of values are clearly displayed on the first page. A footnote at the bottom of the page indicates that the policy has a prospective interest rate bonus that is applicable after 20 years. We assume that it is not guaranteed since it is included for only the current values.

For each rate basis, account value, cash value and death benefit are shown. Footnotes describe the assumptions for each rate basis. Cost indexes are shown for all three bases.

A footnote indicates that the policy terminates in year 31 based on guaranteed values. This is a year not displayed on the illustration.
Disclosure of persistency bonuses is a key feature in these illustrations. Exhibit J is an example of a guaranteed bonus. Values are shown on three bases, with both the implicit and nominal interest rates displayed. Pages 4 and 5 describe the assumptions underlying each set of values, as well as the impact of the persistency bonus at each bonus point.

Exhibit K contains several variations. The assumptions, including those for mortality and expense, for both guaranteed and current values are part of the column caption. There is a footnote on page 3 alerting the consumer to a number of tax issues and citing the need for professional advice. Page 4 describes certain product features, including a prospective persistency bonus. The comments on the persistency bonus do not mention whether it is guaranteed.

Exhibit L is included for its use of graphics. Displaying key values graphically is certainly easier for the typical consumer to grasp than seven columns of numbers. The graphic display is based on projected values.

Exhibit M is an example of a product with an accelerated death benefit, or living benefit. The cover page describes how the living benefit works. There is no reference to the tax treatment of the living benefit although the tax treatment of death proceeds is mentioned. This is followed by one illustration page of values and two pages of explanatory notes.

This policy has two types of bonuses: interest and mortality. The consumer is referred to the policy for a complete description of factors affecting the mortality bonus.

D. Term and Term Look-Alikes

Approximately three-fourths of the companies responding to our survey sell these types of products. None of the responses to our survey questions pointed to any potentially abusive or questionable illustration practices on these kinds of products, nor did contact with state regulators turn up any. We were particularly interested in whether the conversion privilege (or lack thereof) was being adequately explained, and it appears that it is.

However, a couple of problems have been observed. One is that a company will display a cost comparison of its term plan with another company's permanent plan strictly on the basis of premium. Clearly, this is inappropriate. Another problem is that illustrations of indeterminate-premium term plans do not always display the corresponding guaranteed premiums. When the term plan includes a deposit fund, guaranteed values are not always displayed.
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Companies provided us with several representative illustrations, which are contained in Exhibits N and O.

*Exhibits N and O*

These are two basic term illustrations, displaying current and guaranteed premiums. Exhibit N shows the death benefit, current premium, accumulated premium, and maximum premium for an indeterminate yearly renewable term plan. Interest-adjusted cost indexes are displayed. The only footnote references the nonguaranteed nature of current premiums.

Exhibit O is an illustration of a 10-year re-entry term product. Current premiums are displayed for the second 10-year period, both with and without re-entry. A footnote discloses that re-entry is subject to evidence of insurability.

*E. Second-To-Die Policies*

Of the 56 responding companies, 39 indicated that they sell a second-to-die product. Only six of the 39 companies offer a product that provides for a cash value increase at the first death. Of those six, only one company answered “yes” to the question, “Are the values shown on your illustration always based on the assumption that both lives remain alive?” Three companies mentioned that agents could choose the year of death for the first death for illustration purposes.

To the question, “Does the illustration contain an explicit statement that there is no death benefit payable on the first death?”, 12 companies answered yes.

Exhibits P and Q are examples of illustrations of second-to-die policies.

*Exhibits P and Q*

Exhibit P is a survivor life ledger showing a traditional policy with dividends used to purchase paid-up additions. The final footnote makes it clear that no death benefit is paid until the second death. Although a term rider is mentioned in the footnote, it does not seem to be included in the illustration. Also, without further analysis, it is not readily apparent whether or not this policy provides a cash value increase on the first death.

Exhibit Q offers perhaps the ultimate in full disclosure. The first illustration, consisting of six pages, shows a 10-year vanishing premium and both insureds alive. Note that the policy is a combination of permanent whole life and term insurance.
Pages 4 through 6 show results on an alternative dividend scale, but do not include the vanishing-premium concept. Following this six-page illustration is a three-page illustration which assumes that the male insured dies at age 64. All premiums are assumed to be paid. This is followed by another three-page illustration assuming both insureds are alive and also assuming an alternative dividend scale. Then there is another three-page illustration that assumes the male dies at age 64 and that premiums vanish in the eleventh year.

Presumably, in addition to all these alternatives, one could request still more illustrations on different alternative dividend interest rates and different years of death for the first death.

F. Two-Tier Products

A two-tier product is one that has different cash surrender and annuitization values. Typically, the annuity value cannot be commuted and surrendered; it is available only as an income stream. Only five of the 56 companies answering our survey sell two-tier products. Most of these five companies feel that their illustrations clearly indicate that the policyholder who surrenders will receive less than the amount that would be applied toward annuitization at the same point in time. In some cases this is emphasized with additional statements on the illustration.

Another area of concern is whether the annuity income figures shown on the illustration are calculated only using current annuitization rates, or on both current and guaranteed annuitization-rate bases. Again, most but not all companies are showing the results on both bases.

A nonstandard illustration practice we encountered on two-tier products was that of a company whose illustration included a footnote naming its reinsurer—a large, well-known company—and stating that the reinsurer approved of the product.

G. Special Issues for Corporate Buyers

Corporate buyers of insurance are concerned about the accounting and tax impact of the purchase, as well as the product’s operation. Illustrations may be for individual insureds, but it is quite common for the corporation to be given illustrations that include all insureds, either on an actual or modeled basis.

Illustrations typically show all cash flows: premiums, use of dividends or other nonguaranteed elements, policy loans or withdrawals, benefits paid to
employees, annual expected death proceeds paid to the corporation, and the tax impact. The cash flows and asset (cash value) development are summarized to reflect the impact on the corporation’s balance sheet and the profit and loss statement. The illustration might also demonstrate the development of the benefit liability and its impact on the company’s accounting statements.

There are two common ways of reflecting the impact of deaths in the illustration. One is to assume that each insured dies at a specified age, such as 75 or 80. The other method is to adjust for mortality based on an appropriate table; this is known as fractional mortality or partial mortality. Based on discussions with several companies, there is concern that corporate buyers do not appreciate that the timing of the death proceeds is not guaranteed.

Traditional interest-adjusted cost indexes may be shown, but buyers focus on performance measures such as Internal Rate of Return and Net Present Value of Gain. Net present value of gain is usually calculated at the corporation’s after-tax cost of capital. These measures are usually calculated on a basis consistent with the expected death proceeds.

Guaranteed values are not usually displayed prominently next to current values although companies may require an accompanying ledger illustration. There are some group experience-rated contracts used in this market that do not have guaranteed maximum mortality charges and therefore do not have guaranteed values.

As with individual illustrations, illustrations for the corporate buyer are subject to company discretion as to the timing of certain events.

Illustrated funding patterns are more aggressive or flexible in this market than for individual purchases. The most aggressive is a 7-pay contract with premiums paid by policy loan in policy years 1–3 and by the surrender of nonguaranteed values in policy years 4–7, with the only illustrated outlay from the corporation being the payment of policy loan interest. This gives the perception that insurance can be purchased without real premium outlay by the buyer.

Because the products and the benefit plans being funded are very complex, companies attempt to disclose pertinent tax issues such as the impact of TAMRA, TEFRA, etc. Many include footnotes stating that buyers should seek their own tax counsel and not rely on the illustration for any tax advice.

H. Current Practices—Other

Other noteworthy illustration practices that we found included the following: (a) a Product Features Page which gives the answers item by item to
the questions posed in the CLU Professional Practices guidelines; (b) a full page dedicated to the 7-pay test, including the company’s interpretation of some of the aspects of TAMRA; (c) a place for the client to sign the illustration signifying that he or she has read and understands all the disclaimers; and (d) page numbering schemes that inhibit removal of footnote pages (for example, “Page 1 of 5”). We also found: (a) unclear column headings, for example, lack of clarity as to whether benefits and values shown reflect valuation for loan, and (b) vanishing-premium illustrations in which the guaranteed figures shown alongside the current figures assume premiums paid all the way to maturity.

Survey and preliminary report respondents also expressed the following concerns:

- Whether products that are a blend of whole life and term insurance are in some cases being improperly portrayed as simply “whole life”
- The impropriety of Company X printing comparisons of its nonguaranteed values to Company Y’s guaranteed values
- The appropriateness of calculating net outlay as the premium less the dividend payable at the end of the same policy year, that is, not recognizing the time value of money during the year.

IV. USES OF LIFE POLICY ILLUSTRATIONS

An extensive body of literature already exists on this subject. However, most previous work deals with symptoms, rather than with underlying causes. For example, many articles decry aggressive assumptions, unrealistic nonguaranteed elements, lapse-supported pricing, and question the integrity of some illustrations. However, there is very little written about what caused the symptoms.

One way to get at root causes is to examine appropriate and inappropriate uses of illustrations. If an illustration is used for addressing questions it inherently cannot answer, problems will occur, even if the illustration is built with integrity.

The primary users of life insurance illustrations are:

- Consumers
- Life Insurance Agents/Brokers
- Companies (actuarial and marketing departments)
- Outside Advisers/Third-Party Analysts.

Each of these may have multiple needs which they hope to satisfy with an illustration. In general, these needs are of two primary types:
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Type A usage tries to:
- Demonstrate how policy values change over time under specified premium payment and experience (for example, interest rate) scenarios.
- Demonstrate how a particular financial design or concept works, such as deferred compensation or vanishing premium.

Type A usage helps the consumer understand what is being purchased. It focuses on a single contract and its contractual features and mechanisms. It shows how a particular contract responds to illustrative conditions. Multiple illustrations of a single contract demonstrate how contractual values change in response to variations in assumptions.

Type B usage tries to:
- Project likely or best estimate future performance.
- Evaluate comparative cost or performance of several policies.

Type B usage helps the consumer understand which policy is the best buy. It evaluates comparative cost or performance among competing alternatives. It also focuses on projecting most likely estimates of cost.

Type B questions are of great interest to all user groups. Therefore, an objective, credible, inexpensive and quantitative means of answering these questions is highly desirable. Illustrations are quantitative and relatively inexpensive. But are they objective and credible? What can actuaries say about the ability of illustrations to accommodate Type A and B usage?

Illustrations appear well suited for Type A questions. In particular, multiple illustrations run under different premium patterns and interest rates are very helpful in explaining contractual mechanisms.

Type B usage is a different story. Today’s life insurance and annuity products are complex financial instruments, whose ultimate future cost and performance depend on macroeconomic and demographic factors, individual company performance and individual consumer behavior. Type B questions necessarily involve many factors, including:
- Evaluation of the likelihood of future economic events
- Measurement of company-specific performance risks
- Measurement of product-specific performance risks
- The individual consumer’s likely response to various future events.

For today’s individual life insurance products, reliable answers to Type B questions are not possible using illustrations. The footnotes, caveats and disclosures on a typical illustration are already overwhelming for most consumers. Yet this information adds little value in terms of developing a reliable estimate of future performance.
It can be seen that Type B usage is inappropriate unless the illustrations include a measure of relative risk. For example, if one illustration shows 15 percent lower premiums but has 60 percent greater risk of not achieving projected values, then lack of risk disclosure renders the comparison meaningless. Since relative risk cannot be calculated, Type B questions assume similar degrees of relative risk. Regulations try to assure “consistency” between illustrations as a way to keep relative risk equal. However, since there are really no practical means of assuring similar relative risks, Type B usage for illustrations is fundamentally inappropriate.

The incentives associated with Type B questions are considerable. However, an objective actuarial evaluation must conclude that typical life insurance products are too complex and the number of unknowable events is too great to allow for simple answers to questions of this type. Even when developed appropriately and with integrity, illustrations are structurally incapable of handling Type B questions. Illustrations, by their nature, cannot answer these questions. Problems arise because of the illusion that they can.

Many people believe that although illustrations aren’t perfect, they are the best available indicator of future performance. They may believe, for example, that all illustrations are somewhat optimistic, but then conclude, “Even if they’re all high by 15 percent, I’ll still do better with the one which shows the highest values on these illustrations.” Actuaries should oppose this myth.

V. OTHER ILLUSTRATION PRACTICES

It is easy to forget that sales illustrations in the U.S. and Canada have a unique history. Life insurance products sold in other countries, and other financial products sold in North America, do not share the same illustration practices. A review of these practices is helpful before evaluating alternatives for our system.

A. Other Countries

A quick survey of illustration practices in other countries reveals the importance of a historical and cultural context. In countries where insurance products are standardized by law, there is little controversy with respect to illustrations. This is the case for much of the Far East and Europe. Where product standardization is the rule, there is little product competition as we know it, and illustrations are naturally limited to noncontroversial Type A usage.
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The United Kingdom and Australia have relatively competitive life insurance markets, with many similarities to the North American market. As in our market, ledger illustrations have been employed for Type B comparative cost and performance evaluation. Not surprisingly, these countries have also encountered problems with sales illustrations.

Japan

Currently, sales illustrations in Japan are based on the "current" dividend scale. There is increasing concern that this practice may cause the consumer to believe that the current scale will remain unchanged in future years. Consequently, procedures will be revised to show the effect of a 0.1 percent decrease in the dividend interest rate. Disclosures will emphasize the variable nature of dividends and the fact that the illustration is based on current scale. In addition, special maturity dividends will be identified and shown separately from regular dividends.

U.K.

Sales illustrations are heavily regulated in the U.K. Regulations were influenced by a number of perceived abuses which developed during the 1980s. Currently, illustrations are constrained in at least three major ways:

(a) Upper-level performance constraint (maximum interest rate)

(b) Risk disclosure, by means of two alternative scenarios at significantly different interest rate levels. The regulators believe that two scenarios are better than either one or three at conveying the basic uncertainty of the investment performance assumption. Low and high investment rates are specified, and only change occasionally, based on underlying inflation expectations. There is a deliberate emphasis against specifying a "best estimate" rate.

(c) Standardized expense and mortality assumptions. All companies are required to use the same nonguaranteed expense and mortality assumptions. These are set by regulation based on current industry averages. While conceding that actual expense and mortality differences could influence the choice of a life carrier, the regulators felt that they should not be reflected in projections. This emphasizes their strong belief that illustrations have a limited scope, and should not be used for comparative performance measurement.
**Australia**

In early 1991, the Insurance and Superannuation Commission Circular #291 promulgated completely new guidelines for benefit illustrations in Australia. This was the first major change since 1985 and followed growing concerns about overly optimistic assumptions and a lack of consistency in the approach to long-term benefit projections.

The circular takes note of the situation in the U.K., where illustrations have been “ruthlessly standardized” and “serve only to create a generalized impression of the order of magnitude of benefits.”

Under the Australian approach, companies have some latitude, through their Appointed Actuary, to reflect individual circumstances in their projections. There is a clear threat that this remaining privilege will disappear if these new guidelines do not work.

Australian companies are required to ensure that agents, brokers or other intermediaries representing them do not alter their benefit projections in any way.

Principal provisions of the Australian regulations are:

- A specified maximum assumption basis, with lower rates permitted if appropriate.
- Specific standards of practice to follow for all promotional material, aimed at avoiding ambiguity or false impressions.
- Two illustrations are normally required. The higher rate cannot be greater than \((CB + 3) \times (1 - t)\) where \(CB\) = the 3-year average 10-year Treasury bond yield, and \(t\) is the maximum tax rate on the type of business in question. The lower rate is no more than 80 percent of the higher rate. If only one illustration is shown, it must be at the lower rate. If more than two rates are illustrated, the third and subsequent cannot exceed the higher rate.
- Projections are required to include an illustration of the effects of inflation, for the term of the projection, with an inflation rate of 60 percent of \(CB\).

In summary, regulation of illustrations in both the U.K. and Australia has been structured to emphasize their suitability for Type A usage only. To enforce this, illustrations are highly standardized and provide little or no opportunity for comparative performance or cost evaluation.

**B. Other Financial Products**

A review of other financial products’ illustration practices provides interesting comparisons to life insurance.
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The securities industry has many complex financial products. The risk and uncertainty of future performance in these products are so well accepted by the public, however, that it is difficult to imagine Type B usage in ledger illustrations. For example, try to imagine a stockbroker advising a consumer on whether to buy IBM or AT&T stock, using a 30-year projection of last quarter’s dividend and change in stock price!

For most securities, the consumer must use something other than illustrations to make judgments about performance. The prospectus is the primary document for this purpose. It is both highly structured and complex. It is difficult, if not impossible, for a consumer to have a quick, easy-to-understand, numerical basis for doing comparative performance evaluation for mutual funds or securities.

The *NASD Manual on Investment Company Securities* gives detailed guidance on what must be done if comparison of investment products or services is to be done.* The essence of this guidance is that comparisons should not be performed unless all factors which could possibly be considered relevant are disclosed.

**Mutual funds** may be illustrated on a “hypothetical” basis, with full disclosure of all expense charges and a statement that the illustration is based on past performance and is not indicative of future performance. The relative simplicity of a mutual fund product structure makes it feasible to use illustrations for this purpose. There are no “nonguaranteed elements” or “participating” expenses and mortality charges to muddy the waters. The prospectuses for both mutual funds and variable annuities include fee table examples, so that buyers can compare expense levels among different products.

**Variable life insurance** illustrations are regulated by the SEC and the NASD. Investment returns must be specified as gross yields. At least one investment return assumption must be 0 percent, and no return can be higher than 12 percent. All expense charges and loads must be shown explicitly in the prospectus. It is easier to attempt Type B comparisons on variable life, particularly since one of the most important factors, investment return, is assumed constant between products. In a more fundamental sense, however, Type B analysis of variable life illustrations may have limited value, since differences in expenses and cost of insurance could be overwhelmed by differences in investment performance. Some observers see a trend toward more nonguaranteed bonuses and charges in variable life products. If this is

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true, it may be progressively more difficult to use sales illustrations to answer Type B questions for variable life insurance, as is true today for nonvariable products.

In general, a review of relevant practices for other countries and other financial products reveals an understanding that illustrations should not be used for comparative performance measurement. This is particularly true for the more complex products containing nonguaranteed performance elements.

VI. ALTERNATIVES TO CURRENT PRACTICES

Our Task Force presented 23 alternatives to current illustration practices in our preliminary report. During the exposure period, we received a number of comments on these alternatives, and suggestions of other alternatives that we might consider.

We categorized the alternatives that were identified during our research as follows:

- Reduce or limit numbers
- More stringent requirements for nonguaranteed elements
- Product or market specific issues
- Consistency of illustrations
- Strategic/educational efforts.

Our Task Force was charged with researching illustration practices from the perspective of the consumer. Therefore, we evaluated alternatives on these criteria:

- Will it improve the consumer’s understanding of the life insurance policy being considered?
- Will it improve the consumer’s understanding of life insurance generally?

A. Reduce or Limit Numbers

The road to full disclosure has some pitfalls. In showing as many numbers on illustrations as most companies already do, a couple of phenomena occur. First, consumers who are simply not numbers-oriented, and there are many such people, may tune out or be misled; they may be more interested in a careful verbal explanation of the basic concepts. On the other hand, there are consumers who will fixate on the numbers, particularly the current account value column on a typical universal life illustration or the total value column on a dividend-paying whole life illustration, which marches mesmerizingly toward a 6- or 7-figure number. Compounding this problem is the fact that the prevailing practice is to show these account values to the
nearest dollar, which, perhaps unwittingly, ascribes a level of credibility to the numbers that is quite inappropriate, especially for durations in the murky future beyond the 10th or 20th year. These account values are purely illustrative figures that, at best, are based on convenient, reasonable working assumptions as to what future mortality charges and interest rates might be like. Small differences between the assumptions and actual experience will compound to a very large “error” before very many years go by. In short, our Task Force sees a need for the industry to take some definitive steps away from selling our packaging (the illustration) and toward selling products, by reducing the focus on raw numbers.

There are several possible remedies to this general problem:

1. If possible, supplement numeric information with a presentation in graph form. Technical advances now make this feasible in many instances. This approach addresses the need to emphasize concepts more and numbers less, and the problem of “extra” significant digits in the account values disappears. Safeguards against the misleading scaling of graphs may be needed, however. Graphics, if done well, can be an excellent tool for conveying information to the average person. One reason often cited for the tremendous success of the newspaper USA Today is its very popular and informative graphs.

CONCLUSION: We would encourage actuaries to work with their colleagues in systems and sales/marketing to find new and more customer-friendly ways to present illustration information in graphic form.

2. Limit illustrations of current values to 20 years and every fifth duration thereafter. This, we think, would help to make it clear that we have a sketchier picture of the distant future than of the near future. Also, it reduces the degree to which the client is overwhelmed by numbers and leaves more room on the page for useful narrative. It is important that values be shown to maturity or lapse so that the consumer is aware of any changes in benefits over time. However, if there is a change in premium or if a policy provision first manifests itself after the twentieth year, the illustration should display all durations.

CONCLUSION: Companies should consider adopting this convention on a voluntary basis.

3. Show current values to the nearest $10 per thousand of initial face amount. This rule could apply at all durations, or perhaps just after the fifth or tenth year.

CONCLUSION: Companies should consider adopting this convention on a voluntary basis.
B. More Stringent Requirements on Nonguaranteed Elements

The Task Force identified five alternatives that deal with nonguaranteed elements.

1. More Complete Definition of “Current Experience” or “Current Dividend Scale”

At present, confusion exists as to what is meant by current experience or current dividend scale. For example, a current-dividend-scale illustration may assume mortality improvements built into it, but those improvements are not reflected in the dividends of older duration in-force policies. Is the illustration really based on the company’s “current scale”? Some may define current-scale illustrations much more stringently as only those on a dividend scale having the same experience factors as are currently being paid to in-force policyholders.

In 1978 a paper appeared in the Transactions of the Society of Actuaries (Volume XXX, pp. 447–475) entitled “Choice of Basis for Dividend Illustrations” by Russell R. Jensen. In it Jensen states,

“The simplest definition of current experience would be in terms of those factors of mortality, interest, and expense used in determining dividends currently payable (current allocation). Yet at times this type of definition may not be valid or applicable. There may be no such factors that are appropriate for the illustration of dividends because anticipated mortality, lapses, or expenses of the new business are clearly different from those now experienced on any block of business in force. Or, a company may use different investment yield rates for different eras of business, and there may be a question as to the rate to be applied to current issues.”

A company entering a new market will not have any past experience to illustrate. A new product may require a different investment pattern from anything the company currently has. These and other situations would mean that showing current experience can be more misleading than using currently anticipated experience.

CONCLUSION: We believe that further study and research into this issue would be worthwhile. Therefore, we encourage the AAA and the CIA to:

- Review existing regulations requiring the use of current experience or current dividend scales in life insurance sales illustrations;
- Suggest revisions to those regulations which would clarify the meaning of “current,” and
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• Recommend modifications to the regulations which would allow the use of both current experience and deviations from current experience, but, if the latter, only with appropriate and mandated disclosure of the assumptions used.

2. Standards of Practice for “Illustration Actuary”

As part of his response to our survey of current illustration practices, Armand de Palo suggested that the time has come to consider the concept of an “Illustration Actuary.” This individual would be responsible for informing senior management whenever illustrations with unrealistic assumptions are being used. This might be considered as part of the enhanced standards for nonguaranteed elements.

CONCLUSION: We are not ready to endorse this concept at this time, but we agree that it is an idea worth pursuing. Therefore, we encourage the AAA and the CIA to study this concept further.

3. Furnish Historical Data

This alternative would require agents to furnish clients with dividend histories, and dividend history comparisons with other companies, in addition to current illustrations. These would show clients how the company performed over the last 20 years, information similar to that supplied to buyers of mutual funds.

The argument is often made that dividend histories are not subject to manipulation and, therefore, are a more reliable gauge of a company’s performance than are current illustrations. Certainly for those companies included in Best’s annual 20-year history study, the information is readily available, including rankings and comparisons with other companies.

Companies have reasons for arguing that historical comparisons are not pertinent. Today’s products are much different from products issued 20 years ago. For example, 20-year histories of universal life policies are not yet available. A company may argue that it has changed its approach to underwriting, its investment philosophy or its expense controls. Also, the formation of new companies, mergers and acquisitions pose practical problems for presenting 20-year histories.

One danger in using histories is that often the historical results are compared with the illustration provided at the time of issue. Over the past 20 years, of course, actual results have been much better than the illustrated results of 20 years ago. This could give both buyers and agents the false impression that they could expect the same pattern of results in the future,
that is, that illustrations are always conservative and actual results will always be significantly better.

CONCLUSION: We believe there is value to illustrating historical performance and in providing buyers with a company’s actual record of dividends or experience rates credited over the past 10 or 20 years. However, given the fact that many of today’s products were not being issued 10 or 20 years ago, and that linking past performance of significantly different products with today’s products may be misleading, we do not recommend that historical data be made a required part of illustrations.

4. Disclosure of Underlying Assumptions and Current Experience Supporting Illustrated Performance

Complete disclosure would include publication of interest rates, mortality charges, lapse assumptions, expenses (home office, field, investment, etc.), taxes, and profit assumptions that support current values. Most companies disclose the current interest rates used in their illustrations and some disclose mortality charges. Many companies, however, would object to such full disclosure on the grounds that the information is proprietary and disclosure would be competitively damaging.

Even the information being disclosed today is suspect in that the interest rates disclosed may be before or after investment expenses and taxes, mortality charges may or may not reflect actual experience, and expense charges may or may not cover actual expenses. Would a consumer be able to sort out all of the different experience factors and assumptions used in an illustration to determine if the illustrated values are in fact reasonable or not?

CONCLUSION: We believe that the idea of requiring more complete disclosure deserves further study. Therefore, we recommend that the AAA and the CIA pursue this topic further.

5. Identification of, or Special Reserving Requirements for, Unusual Features Such as Lapse-Supported or Two-Tiered Products, Terminal Dividends, Interest Rate Kickers, Persistency Bonuses

We wholeheartedly support complete and clear disclosure of unusual policy or pricing features, particularly if they result in inconsistent treatment of one group of policyholders relative to another group (for example, persisters versus early terminators).

CONCLUSION: We would encourage the AAA and the CIA to work toward development of appropriate disclosure requirements for such
practices and to determine whether or not special reserves should be required.

C. Specific Product Issues

Based on the illustrations available to us, we believe the following product-specific issues must be resolved.

1. Vanishing Premium Illustrations of Fixed-Premium Products

There should be consistency between the premium patterns assumed for guaranteed and nonguaranteed values, particularly when they are shown next to each other. If the underlying premium pattern is not consistent, the illustration should explicitly show both premium patterns. This is not an issue for flexible premium policies since both current and guaranteed values must be based on the same premium pattern.

Many consumer complaints relate to vanishing-premium illustrations. Consumers do not understand what is guaranteed or the sensitivity of illustrated performance to changes in the nonguaranteed policy factors.

CONCLUSION: The AAA and the CIA should both consider and recommend improvements to these illustrations which will communicate the sensitivity and the associated guarantees. The result should be consistent with the illustration requirements for flexible premium policies.

2. Second-To-Die Products

Second-to-die product illustrations should be required to disclose whether or not there is a cash value increase on the first death. If there is, the illustration should include examples of values after a first death occurs.

For second-to-die products that include a term portion—usually paid for through dividends—it is especially important to illustrate values all the way to the end of the mortality table. It is also crucial to show how these policies perform at lower than current dividend interest rates. While current scales may support the policy adequately for 20 or 30 years, the insureds could be faced with very large premiums due at very advanced ages.

CONCLUSION: We believe that important policy features must be disclosed to the consumer. Further, modular policy design may increase the sensitivity of nonguaranteed policy features. The AAA and the CIA should consider appropriate disclosures and/or standards for sensitivity analysis that will help the consumer understand these features and their impact on performance.
3. Two-Tier Products

The difference between the tiers can be quite large. The tier differential could be viewed (and is viewed, by some regulators) as a surrender charge, so certainly one alternative to current practice is to format the illustration accordingly, possibly even including a column that explicitly displays this surrender charge. Another alternative is to add language to the illustration that provides the needed additional emphasis of the important point that needs to be made to the client: the cost of rolling the funds out of this product to another one is unusually high, that is, the client needs to feel highly committed to staying with this company. Also, as life expectancies and expenses increase, annuitization rates may become less favorable, so a case could be made for using something more conservative than current annuitization rates on the illustration for someone who is not going to annuitize until several decades from now.

Another idea worthy of consideration, which comes from the California Department of Insurance, is to require that the account value column heading say “not available in cash.”

Mandating that the tier differential be explicitly characterized as a surrender charge may be a bit severe and could unduly limit a company’s freedom to illustrate its products in a reasonable way. Adequate disclosure is really the key point. Thus, for example, the idea of requiring the words “not available in cash” for the annuitization account value column heading seems like a good one.

Good-faith disclosure also clearly calls for showing monthly incomes on both a current and guaranteed annuitization-rate basis. As to the idea of using slightly conservative current annuitization rates for this purpose, in anticipation of future increases in life expectancy, this may be laudable but it does not seem necessary, since the juxtaposition of the corresponding guaranteed figure next to the current figure should convey the sense that things may not work out as favorably as the current figure suggests. Furthermore, this could create additional unneeded complexity and could even be latched onto as a defense of using future mortality improvements on life illustrations. Likewise, monthly incomes should be shown based on both the current and guaranteed annuitization account values.

CONCLUSION: The Task Force believes that the AAA and the CIA should consider the appropriate disclosures for two-tier products and appropriate changes to the values displayed.
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4. Concept Illustrations

These illustrations demonstrate a concept or a program, such as split dollar or executive benefits. The focus is typically the accounting or tax impact rather than the operation of the insurance policy. Concept illustrations usually do not meet the regulatory requirements for policy illustrations. To demonstrate both concept and policy operation in the same illustration would overwhelm the consumer with numbers.

The Task Force believes that concept illustrations are appropriate. However, these illustrations should be clearly labeled “Concept Illustration Only.” Unless guaranteed values are prominently displayed next to current values, the footnotes should disclose that this is not a policy illustration. This would allow agents to demonstrate concepts while alerting the consumer that the illustration does not demonstrate the operation of the policy.

CONCLUSION: We would recommend the recognition of concept illustrations and would encourage the AAA and the CIA to develop the appropriate disclosure to differentiate concept illustrations from policy illustrations.

D. Consistency of Illustrations

A somewhat more standardized approach to illustrations could make it easier for a buyer to understand the illustration. The Task Force identified five possible areas of standardization.

1. Standard Definition of Terms

Commonly used terms should have the same meaning in all companies’ illustrations. For example, the column labeled “Current-Year’s Death Benefit” should have data that are consistent for all companies. There should be no discretion as to whether it is the death benefit at the beginning of the year, end of the year or some interim value. Standard definitions of terms would increase the clarity of illustrations to all users, not just to consumers.

CONCLUSION: We encourage the AAA and the CIA to consider pursuing this suggestion with industry trade groups, professional organizations and regulatory bodies.

2. Standardized Notes

There are probably too many notes on illustrations today, and they are not consumer-friendly. Furthermore, given today’s product features, regulatory requirements for notes do not keep current with the need for disclosure
of how a product operates. Since the notes are at the end of the illustration, it is not clear how much attention they are given by the buyer. It would seem appropriate that important notes should be placed at the beginning of the illustration.

**CONCLUSION.** While the complete standardization of notes is most likely unattainable and perhaps not even desirable, we would encourage the AAA and the CIA to determine what degree of standardization might be helpful to consumers.

3. **Different Print Sizes**

Currently, all the data and notes on an illustration are given equal prominence. To the extent that it is technologically possible, the Task Force believes there is merit in using boldface or different print sizes for emphasis. This would help to ensure that the buyer reads important notes such as the nonguaranteed nature of illustrated values.  

**CONCLUSION:** We encourage the AAA and the CIA to pursue this concept.

4. **Standard Assumptions**

Three possible models have been described in this paper: the illustration of variable life and the illustration practices in the United Kingdom and Australia. These models for standardization of assumptions help the buyer to understand that the illustrated performance varies with the underlying assumptions and is not guaranteed. The Australian requirement that effects of inflation also be demonstrated for the term of the projection has considerable appeal to the Task Force.  

**CONCLUSION:** We encourage the AAA and the CIA to consider pursuing this alternative with industry trade groups, professional organizations and regulatory bodies.

5. **Range Approach/Specified Scenarios**

The range approach was advanced by the American Council of Life Insurance to the National Association of Insurance Commissioners in 1988. As proposed, it would apply to both life insurance and annuity illustrations. Use of the approach would have been elective, not compulsory. It would have allowed a range of interest rates only—not of mortality or expense assumptions. Finally, it would have allowed interest rates up to two percentage points higher and two percentage points lower than the interest rates underlying the company’s current scale.
The assumption behind this approach was that the agent would actually show three complete illustrations to the client. One would be on the current scale, one up to two percentage points higher than the current scale and the third based on an interest rate up to two percentage points lower than the current scale. The current-scale illustration would always be required. The other two would be optional, but if an illustration based on an interest rate higher than current scale is shown, then the correspondingly lower-interest-rate illustration must also be shown. The NAIC did not adopt this approach.

An advantage of the range approach is that it allows clients to see how the policy performs under different interest rate assumptions. More importantly, it demonstrates powerfully that variations are likely. In his presentation to the NAIC, Anthony T. Spano, Actuary with the American Council of Life Insurance (ACLJ), said,

"Use of the range approach would demonstrate to the insurance buying public that illustrations are merely examples of how a product may perform rather than benchmarks on how it will perform. An undue focus on the company’s current scale, which would result if illustrations were restricted to current scale, would be a disservice to the consumer in that it may create the impression that there is something magical or permanent about a company’s current scale. This could lead the consumer to feel that current scale figures are tantamount to guarantees."

Needless to say, companies were not unanimous in their support of the ACLJ in advancing the range approach. The most controversial aspect of this proposal was that companies would be allowed to illustrate policies at higher than current interest rates for the first time. The counterbalance to this, of course, was the requirement to also show an illustration at a rate lower than current scale. The fear, however, was that agents would not always show the lower-interest-rate illustration, or even the current-scale illustration, but instead would concentrate only on the higher-interest-rate numbers.

Another concern was that only the interest rate could be varied and not mortality or expenses, which could also be expected to change over time.

Although the NAIC did not adopt the range approach, the industry seems to have gone part way towards it on its own. Several companies are allowing agents to show illustrations at dividend interest rates lower than current scale, while very few allow illustrations at higher than current scale. Most illustrations of products with explicit interest credits allow the interest rate to vary, either up or down.
The Task Force strongly believes that consumers should be made aware of a product’s sensitivity to changes in the environment. The range approach is one approach that might be considered.

CONCLUSION: We think further discussion on the range approach within the industry and within our profession is warranted. As stated in Section B-1 above, we encourage the AAA and the CIA to:

- Review current regulations requiring the use of current experience or current dividend scales in life insurance sales illustrations;
- Suggest revisions to those regulations which would clarify the meaning of “current,” and
- Recommend modifications to the regulations which would allow the use of both current experience and deviations from current experience, but, if the latter, only with appropriate and mandated disclosure of the assumptions used.

E. Strategic/Educational Efforts

1. Change Use of Illustration in Sales Process: Consumer Disclosure

Consumer education efforts should focus on appropriate uses for illustrations. Usage disclosure should be clear and simple. It should indicate that illustrations are only useful for Type A questions, as defined in this paper. Required disclosures should make clear that it is inappropriate for agents, companies or advisers to use illustrations for Type B questions, regardless of the integrity of the illustrations involved.

This is not a ban on illustrations. Over time, however, such disclosure should reduce the occurrence of abusive practices. Previous regulations and disclosures have not been effective, because it has been possible to design around a rule while still using illustrations for comparative cost purposes.

Sample usage disclosures, for display at the top of the illustration:

a. **Sales illustrations should not be used for comparative policy performance purposes.** Life insurance policies are complex financial instruments, which generally contain both guaranteed and nonguaranteed elements. A sales illustration may be helpful in understanding how a particular policy performs under specified circumstances. It is generally not feasible, however, to use sales illustrations to determine whether one policy is a better buy than another.

b. The only promises a life insurance company makes when it sells a policy are the contractual guarantees. Policy illustrations are not promises. Rather, they are hypothetical examples of what might happen if certain assumptions are met.
c. Policy illustrations should not be used for comparing the relative cost or performance of life insurance products.

d. Most life insurance policies are complex financial contracts which contain both guaranteed and nonguaranteed features which depend on unpredictable future events. Consequently, the amount of risk associated with a particular sales illustration cannot be determined.

If illustrations cannot be used as a comparative performance measure, many people will demand to know, “What can be used?” The honest answer is that there is no simple measure or analysis which can be done for such complex financial products. The consumer bears a degree of future performance risk, and this cannot be readily estimated, especially for competing policies. This fact is already well understood in the securities industry. It needs to be assimilated in the life insurance industry.

Of course, there are other factors to consider, including rating agency analyses and retrospective cost measures. There are also many service and quality factors. Contractual features which have value to the consumer’s individual situation may be more important than generalized cost estimates. Finally, an evaluation and recommendation by the agent or broker may be of critical importance. Ultimately, although many factors may be considered, the final decision on the best policy must be based on individual judgment.

CONCLUSION: The AAA and the CIA should encourage their respective regulatory bodies to mandate inclusion of sales illustration disclosures of the type shown above. At least one of the disclosures should be prominently displayed at the top of every page.

2. Consumer Brochure

A small, easy-reading brochure, developed by an industry or professional association, could supplement the proposed disclosures and explain proper and improper uses of policy illustrations in more detail. It could also cover other due diligence questions which a consumer might want to ask before making a decision. The brochure should be offered in every situation in which an illustration is used as part of a decision to buy, lapse or replace life insurance coverage. It should be designed as a way to educate the consumer about both insurance and illustrations.

CONCLUSION: There are many associations that could sponsor or contribute to this effort, including the ACLI and the Canadian Life and Health Insurance Association (CLHIA). We believe that it is important to have active actuarial sponsorship of this publication. We recommend
that the AAA and the CIA take the lead in developing the text. The brochure could replace the current buyers' guides used in the U.S. and Canada.

3. Consumer Hotline

Though it would be a logistic challenge to set up, an industry-funded consumer hotline could be established, staffed by actuaries or other industry personnel interested in addressing the illustration problem on a one-on-one basis with the public. Consumers would call in (or fax) their questions.

This approach would be the most proactive of all the methods of addressing the illustration problem discussed in this paper, since it is a direct, hands-on approach rather than just another report or regulation. The concept is similar to that of the Legal Aid hotlines set up by various bar associations.

CONCLUSION: We do not recommend proceeding with this approach. In our opinion, most questions of this type are best handled by the individual company or the servicing agent.

4. Consumer Signature

There is value in having the consumer acknowledge something about the process used in deciding to buy, lapse or replace life insurance coverage. This is similar to the requirement that a consumer receive a prospectus prior to buying securities. The acknowledgment should be simple and short enough that it actually gets read before it is signed.

A sample might be: "I understand that my decision to buy/lapse/replace this life insurance policy should not be based on illustrations of nonguaranteed future performance or cost. If I was shown an illustration, I was given a copy of the brochure, Life Insurance Illustrations."

CONCLUSION: Companies should implement such disclosures on a voluntary basis.

5. Illustrations as Road Maps

As technology advances, it may soon be possible to store the illustration upon which the sale was made in the home office's computer. Then each year on the anniversary, the total current value would be compared to the value originally illustrated for that anniversary and, if it is less, the policyholder would be given (a) the reason(s) why it is less, and (b) the chance to make up the difference via an additional premium payment, if feasible. Illustrations would thus be used as road maps instead of just as point-of-sale
projections, credibility would be enhanced, and the workings of the policy would be clearer to the buyer on an ongoing basis.

CONCLUSION: Companies should consider providing “in-force illustrations” on a voluntary basis to help educate and inform their customers.

6. Agent and Home Office Education

A knowledgeable, well-informed agent is critical to ensuring that illustrations are used and interpreted properly. Our industry already invests a great deal of money in home office and field training of agents. With respect to illustrations, this effort is currently focused principally in two areas: (a) how to explain the “performance” of their own illustrations in a positive way; (b) how to discover and discredit “unreasonable” assumptions in competing illustrations. The sense of our Task Force is that agent education about illustrations should refocus on proper and improper usage, as described previously in this paper.

Once the concept of Type A and Type B usage is widely understood and accepted, agents will have more time to spend on activities which truly benefit themselves and their clients. For example, they can try to understand and explain the contractual differences between two policies (Type A), rather than trying to infer which policy will have the lowest cost over the next 40 years (Type B).

Educational efforts should not be limited to agents. Home office marketing, sales and product areas must understand and accept the concepts involved before meaningful progress can be made among agents.

CONCLUSION: The effort to refocus agent and home office education should start with the industry’s professional societies and trade associations, including SOA, AAA, CIA, ACLI, CLHIA, Life Underwriters Association of Canada (LUAC), Association Des Intermediaries en Assurance de Personnes du Quebec (AIAPQ), and The American College. Trade publications, such as the National Underwriter and Best’s Review, are important educational forums which should be used to further this effort.

VII. SUMMARY OF RECOMMENDATIONS AND NEXT STEPS

To summarize, the Task Force endorses the use of illustrations for Type A purposes. We do not believe they are appropriate for Type B purposes. Educating the consumer and others on the appropriate uses for illustrations
is a long-term effort. In the interim, we must deal with the Type B uses, and our report makes recommendations specific to these uses. The need for some of these recommendations may diminish as consumers understand the uses for, and limitations of, illustrations.

Several persons commented that we must provide consumers with a basis on which to compare different policies and companies. Past committees of the SOA and others have grappled with this issue, and have “tolerated” the use of illustrations and interest-adjusted indexes for this purpose. We would recommend that the actuarial profession renew its efforts to develop appropriate methodologies or indexes on which to compare products and companies. Our recommendations are in four areas:

- Educational Efforts
- Standards, Disclosures and Regulations
- Optional Improvements
- Continuing Research.

_Educational Efforts_

Educational efforts represent a long-term strategy for the industry. These efforts will necessarily involve insurance professionals from a number of disciplines, including agents, actuaries, regulators and company management. Without management commitment, these efforts are not likely to succeed. We would recommend that the AAA and the CIA consider the educational efforts that have been identified and develop a strategic plan for development and implementation. These organizations would determine the appropriate forum for bringing in other insurance disciplines.

Among the alternatives that we believe have particular merit for further consideration are:

- Agent education and licensing
- Home office education
- Consumer brochures.

_Standards, Disclosures and Regulations_

These recommendations represent the short-term approaches to deal with the problems arising from Type B uses. They also deal with the changes needed to support and enhance Type A uses. The AAA and the CIA should be charged with the development of an integrated program of standards, disclosures and regulations to improve illustrations in the near term. This Task Force believes that the following have considerable potential:
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- Standard assumptions, following the variable life or Australian model
- Disclosure of underlying assumptions
- Review of actuarial standards for establishing nonguaranteed factors
- Disclosure of unique product features
- Display of alternative scenarios or sensitivity testing.

The Task Force strongly recommends the adoption of changes to vanishing premium illustrations in order to properly communicate the concept and its nonguaranteed nature, to the consumer.

Optional Improvements

The Task Force identified several alternatives that could improve illustrations that companies could implement on an optional basis. These would include:

- Consumer signatures on illustrations
- Presentation of historical data, separate from the illustration
- Use of graphs to supplement numerical data
- Display only quinquennial durations after year 20
- Round current values to nearest $10 per 1000 of initial face amount
- Illustrations as road maps.

Continuing Research

We would recommend that the SOA form a task force to research an appropriate methodology for comparison of products. The Task Force believes that in the current product environment, a measure that is not adjusted for risk is not helpful to the consumer or any reviewer of life insurance illustrations and contracts.

CONCLUSION: The illustration practices of most companies are consistent with regulatory practices and attempt to communicate in a good-faith manner with the consumer. However, there is room for improvement. Life insurance policies are complex, and consumers often do not understand which benefits are guaranteed and which benefits are not.

The Task Force strongly encourages the AAA and the CIA to consider our recommendations and to work with the other industry groups and regulatory bodies to improve illustration practices and to develop educational materials that will aid consumers.
APPENDIX 1
SAMPLE SURVEY AND SUMMARY OF RESPONSES

I. GENERAL

A. To what extent does your company feel that a problem exists within the industry regarding life illustration practices today, in terms of successfully communicating with the potential buyer in a good-faith manner?

(5) We think there is a serious problem but the nature of today's products makes it unavoidable.

- Problem is that the people selling them (producers, agents, reps, etc.) oftentimes will do and say anything to make the sale. Product differences and volatility of interest rates, etc. make it difficult for the consumer to compare products and understand all the pieces.
- The trend in the industry seems to be a return to more responsible illustrations. But illustrations still create a strong visual impact. Footnote, disclaimers, and ledger have trouble competing for the buyer's attention.
- So long as agents are allowed to run their own proposals, there will never be assurance that what the company intended is shown. Also, differences between companies will never be able to be accurately portrayed.

(35) We think there is a serious problem which can be fixed.

- We do not, however, believe that policies with adjustable elements will ever be completely understood by the buying public.
- Many agents sell on the basis of a 40–50 year projection of policy values as if these had a reasonable probability of materializing. Furthermore, they frequently misunderstand some of the fundamentals (that is, they often compare UL policies at a fixed rate of interest for several products even though companies take margins differently and may actually be paying very different rates at the time the illustration was prepared).
- We feel that some companies are misleading their customers by showing unrealistic illustrations, for example, a rate of interest which the agent knows will never be attained. This raises the issue of integrity because the individual agent and company are left to decide how to illustrate nonguaranteed elements, so long as the guaranteed elements are shown. The industry should develop, and the state regulators should adopt, a
standard by which all companies must conform when illustrating non-guaranteed elements. This would eliminate the practice of companies and agents competing by way of misleading sales illustrations which give the customer unrealistic expectations.

- It is important to disclose what is being illustrated rather than restrict or complicate the illustration.
- Many aggressive companies do not want to fix this problem and choose to illustrate values that are not likely to be paid, or will be paid only to a very few policyowners. These companies, in general, cannot be competitive on actual performance. However, there are still a few quality companies doing the right thing, although they are considered old fashioned since they believe in giving good value to the policyholder and in paying out real value, rather than illusions.
- The lowering of dividend scales has helped agents finally understand that dividends really are not guaranteed!
- Many companies show unrealistic interest rates and have great flexibility in making products look better. Disclosure statements and footnotes should be required to improve situation.
- The fix will require a realignment of some companies’ fiber of integrity and a decision to include guidelines in full disclosure.
- Our company position is that the insurance industry must take steps to begin monitoring the practices of its representatives and initiate consistent regulation of the industry throughout the country.
- We have been working on consumer education pieces to supplement illustrations which provide additional information on the nature of illustrations.
- Illustrations of unrealistic projection of mortality and bonuses.

(13) We think there is a problem, but it's not serious.

- In Canada, some UL illustrations may use unrealistic interest rates. Major complaints arise from (name of company)’s unbelievable Par illustrations.
- Most agents and companies are OK, the bad cases get a lot of attention.
- Some illustrations need improvement in both stock and mutual companies; however, most companies do an adequate job.
- As the marketplace becomes more sophisticated, so must products sold in these markets. Illustrating complex products in a simple fashion causes unavoidable problems for the consumer.
• Overall practices are acceptable. Very few problem areas. TAMRA should be handled better. Handful of copies allow illustration at much higher interest rates than current credited rates, and some companies do utilize projected improvements in future mortality rates.

• I don’t see how to enable the prospective policyowner to judge the relative value of nonguaranteed policies from different companies.

• Any attempt to fix may make the cost of doing business too high.

(2) We think current practices are acceptable.

B. Software packages are available that enable an agent to take the numerical output from a company produced illustration program and “recast” the results into a format individually tailored by the agent. Examples include the ability to rearrange, add or delete columns, and to change headings and footnotes. Also, some agents have sufficient programming skills to accomplish this on their own. What is your company’s position on this?

(9) We promote it (for example, we make such software available).

• However, we strongly discourage any alterations and/or deletions of information.

• We don’t like it, but competition has forced us to make it available.

(4) We condone it.

• Some flexibility is necessary to meet the needs of sophisticated markets.

(10) We are neutral.

(19) Officially we’re opposed, but there’s little enforcement.

• Difficult to enforce in brokerage environment. Can control branch offices easier, but it still happens.

• We do everything we can to ensure that this doesn’t happen, but you can never have 100 percent control of software running on a PC.

(6) We oppose these practices and vigorously enforce this.

• But it is difficult to catch individuals that doctor illustrations. We fire any that are caught.

• Officially we’re opposed . . . however, we do encourage agents to have Head Office review proposals.

• Our software is designed to prevent these practices.
(8) Other.

- It is available, but we don't promote it—those that find it are capable and we work with them.
- We allow agents to add additional information by adding columns to the standard illustration.
- Allow specified adjustments.
- Currently we make available a software package which translates our company-produced illustration into a different format. The format is chosen by the agent from a menu of formats, and so the individual agent cannot modify or otherwise rearrange the output to suit his/her needs. The software company, however, has the ability to add or modify formats, and we have basically trusted them not to abuse or misrepresent our products. Only one area of disagreement has arisen to date: the software’s treatment of a MEC is different from ours, and our solution is to not pass the data over from our company’s system if the policy turns out to be a MEC. Hopefully, solutions for all disagreements can be accomplished as easily.
- We promote use of (name of company), but our illustration is required.
- Different marketing channels follow different approaches. The largest one opposes. Other channels encourage or attempt to limit to company-approved programs. In any case it is very difficult to control agents who are computer-literate and can design their own spreadsheets.
- We have asked our field to show us their special charts for review. While we do not receive many, we do review all that come in and we have requested changes where appropriate.
- Agents have the ability to customize columns but not numerical values. We condone customization of this type and oppose agent programming that allows altering values in any manner.

Please indicate the illustration flexibility, if any, that your company provides to your agents, or explicitly allows them to use.

- Graphic interfaces.
- We provide ability to download data and reformat it using commercial graphics packages. This facility is used by relatively few agents. Minimum disclosure requirements for such presentations are being developed.
- An agent may edit a print file created from the illustration. However, we feel that this is a better option than allowing an agent the flexibility of typing his own error-prone illustration.
• Customize column selection from a predetermined list, output to an ASCII file, limited interest rate flexibility, and input Universal Life in-force information.
• Cannot alter form or format of proposal. May only change the current credited rate and this should be done only when company declares a change in rate.
• We allow the agent to use a lower interest rate than the current rate.
• We use a company called (name of company). We require all agents to show the company-produced illustration; it is automatically printed, but the agent can always throw it away (that is, enforcement may be impossible).
• Illustrations can not be modified. Agents can incorporate them in their sales package, but they must include “all” pages generated by our proposal system.
• We offer the (name of company) system.
• We allow agents to use a software package that reformats columns and rewords headings and footnotes in whatever manner the agent desires, so as to produce a snazzier-looking illustration. However, company policy is that this second illustration is to be provided to the client in addition to (not instead of) the regular company-approved illustration.
• Choice of interest rate for some products; no choice on others.
• Headings and footnotes cannot be changed. A variety of pre-set and user-defined illustrations may be selected from a menu.
• Ability to illustrate with their own interest rate assumptions as well as the current rate. Some flexibility as to what output is produced—optional graphs, additional notes, etc.
• Our illustrations can be converted to (name of company). Agents then can produce whichever numbers they choose. Footnotes are not converted, however.
• Our software allows agents to rearrange or delete columns, or add columns from a group of columns that are available through the software. VUL is an exception, however, as no alterations may take place.
• Our software allows column add/deletion only—no footnote or header editing.
• Company provided software with fixed formats; other formats require our ledger to be attached.
• We allow customization of illustration output; however, we strictly maintain footnotes that require a standard illustration that provides all guaranteed values.
LIFE INSURANCE SALES ILLUSTRATIONS

- A limited range is \( \pm \frac{1}{2} \) of 1 percent on interest rate assumptions.
- We support an Interface to Advanced Underwriting Software but do not provide such software.
- An agent can always retype any illustration, even without a PC. We take strict action if we find erroneous numbers or an outrageous illustration that is not company-produced. All software has flexibility and the market demands this flexibility, but we always require a ledger and footnote to precede any summary. However, no one is with the agent to ensure that he gives it to the customer. All pages are numbered as “x” of “y” pages, that is, page 1 of 4, etc. Company illustration system has over 200 available columns of information that can be displayed, but standard formats exist. The results of the PC version can be captured by agent-owned software that we have little control over. Outside independent vendors, who we cannot control, have our rate files.
- None for company-provided computer system. If outside PC software is used, we have no control.
- Minimal flexibility is provided.
- Lower dividend interest rate, first-death scenarios for survivorship, optional columns to show, for example, face amount of PUA’s, cost of 5th div rider.
- [name of company], cash needs analysis, advanced needs analysis, split dollar.
- We require agents get pre-approval on any special format illustrations.
- Planners have only the ability to select the pages that are included in the sales presentation. They must always include the ledger (numerical) illustration.
- We have little or no flexibility.
- Ability to add, delete and customize columns; however, we require a “compliance” page which shows GTD values. Portfolio rates may be illustrated with lower assumptions—not higher.
- Difficult to summarize briefly. Column selection is available to some agents and brokerage offices. Changing headings and footnotes is generally not condoned.
- For our universal life product, we allow agents to select an interest rate for illustration from 4–14 percent inclusive. Current rates are, however, disclosed.
- We allow download into prearranged packages.
- We support [name of company].
- None, except for illustrative rate flexibility.
Ability to vary interest rates, and specify premiums (within policy limits).
Some column selection and report writing capabilities; (name of company) download conversion.
All life products (including UL) are participating, and only current dividend scale can be shown. Agents have flexibility to show various interest rates for annuity illustrated.
Agent can enter interest rate but not change format.
Flexibility about what pages to produce, what columns to output.
Any illustrated rate between 4½ percent and 14 percent can be shown, but whatever is illustrated is disclosed. Mortality and expenses are only shown at current levels with no option to vary. Of course the premium and face amounts in a UL illustration may also vary.
Column customization, funding flexibility, optional report selections.
The agent can illustrate changing premium patterns, death benefits and interest rates, but footnotes, column headings, guarantees cannot be altered.
Agent can download for graphics. Once downloaded, however, the possibility of rearrangement exists.
C. Do your illustrations routinely contain text about:
   (5) Your company’s ratings from the various rating agencies.
   (5) Company size.
   (4) Company financial strength.
Yes. Yes. Yes. Marketing page that is available.
Yes. Yes. Yes, but do not explicitly state our surplus.
This information can be produced as an OPTION on the software.
Yes. Yes. Yes. But agent has to request.
No. No. No. Separate sales publications are used for above.
(1) Optional on some products.
This is an area we are exploring.
D. What do you consider to be the best feature of your illustrations?
Electronic data transfer to (name of company)/graphics.
Illustrated values are generally based upon reasonable assumptions. Volatility disclosed by way of mandatory conservative rate illustration.
The fact that it is maintained “in-house” and has a large degree of flexibility.
Flexibility to customize to consumer’s own situation.
Strong vendor who produces the software, comprehensive system that is state-of-the-art and accurate.
LIFE INSURANCE SALES ILLUSTRATIONS

- The menu of options on our flexible UL allows agents to be very flexible in illustrating deposit and withdrawal scenarios. Proposals may almost appear custom-tailored.
- Checks for DEFRA, TAMRA, etc.; can vary premium, death benefit, etc.
- We have no gimmicks (COI give-backs, retroactive interest rate bonuses, etc.).
- Our alternative illustration demonstrates the impact of IIT, AIDS, etc. No other Canadian company illustrates lower dividend rates even when the IIT was introduced and everyone knew it would decrease dividends by 50–75 bps on the investment return.
- Consistency.
- User-friendliness of input screens; speed of calculations, especially on solve-for-the-premium requests.
- Our sales illustrations are developed to comply with state laws and regulations. While the expiration date of the policy is not required by law, it is an important feature because it lets the customer know how long the policy will remain in-force, based on guaranteed factors and planned premiums.
- Meaningful disclosure of contract guarantees and current values.
- Illustrate specific products well. Flexible enough to assist an agent in selling with different marketing strategies (U-Life).
- We feel that our illustrations present a fair, conservative picture. We do not overstate values, and these values are based on our current experience.
- The column add/delete feature allows the agent to adjust the complexity of the illustration to suit his client.
- Honest, straightforward, no gimmicks.
- Readability and easy to understand.
- Our illustration systems are very flexible.
- The completeness.
- User-friendly input.
- They are clear, concise, and complete.
- Flexibility.
- A decoupled dividend interest scale can be run showing dividend interest lower than currently payable. The allowable range is between current and guaranteed. Also complete and extensive footnotes exist. Note: This is very unusual. Most companies cannot do this.
- Accurate/complete including benefits.
Integrity through promotion of conservatism in assumptions and well-documented disclosure of assumptions and guarantees.

Pertinent and accurate information and dividends are based on current experience.

Simple to understand.

Flexibility in showing premium payment options (borrow or surrender PUA's only in certain years, use paid-up add riders to achieve quick pay in targetted years), and in showing cash distributions from policies.

Integration of products on one software piece.

Can illustrate flexibility of the products (for example, future changes); footnotes regarding compliance with tax laws.

Simplicity of basic input; marketing support including graphics and concepts display.

The fact that it can be easily read and understood by our prospects as well as our field force.

Simplicity of use.

User-friendly system with no “trick” illustrations or assumptions.

Flexibility; accuracy compared with administrative system (ties in very well).

The large number of available page formats, and the flexibility to tailor new formats to a specific need.

Alternate interest rate scenarios. On vanishing premium illustrations, a “low side” illustration is now produced automatically by our major systems.

They are short and easy to read.

Flexibility, user-friendliness.

Flexibility of sales presentations.

Ease of use, flexibility, supplement pages with text explaining product and marketing concept.

TAMRA and TEFRA premium checks.

Interest-sensitive products show intermediate values from use and an illustrative interest rate. In addition to current and guaranteed.

Ease of use for agent.

The disclosure regarding the nonguaranteed elements.

Variability of interest/premiums to match prospects’ outlook and needs.

Simplicity, user-friendliness, speed.

Ease of use to agent, easy to read.

Their flexibility.

User-friendly.
LIFE INSURANCE SALES ILLUSTRATIONS

• Flexibility relative to formats and supporting reports.
• Completeness and correctness. We check for TEFRA and TAMRA.
• Uniformity of presentation on all products, straightforward presentation.
• Straightforward, easy-to-use software, which does not project improvement in any factors except possibly interest with disclosure. There are also a lot of options to allow the agent to solve for solutions to the client needs.

E. How, if at all, would you change illustrations to improve them from the consumer's standpoint?

• Show the consumer how his needs are being solved, ask for signature.
• Reduce the amount of data presented which tends to suggest more accuracy and higher probability of realization than is warranted. More emphasis should be placed on the volatility of future results.
• Try to make them more efficient from a time perspective (that is, make them faster). Greater disclosure with respect to variable products.
• Better disclosure about proper use—should not be used as a prospective cost measure.
• Standardize footnotes for all companies so consumer can make a fair comparison.
• Use graphics.
• No illustration of “gimmicks” unless guaranteed and reserved for. Greater clarity and explanation of the fluctuation of interest (particularly the down side). Include a couple of interest rate indexes such as 5-year treasuries and Moody’s AAA bonds with explanation of the companies interest rate margins and the risks of crediting too high a rate.
• 1. Simplify them. The total volume of numbers intimidates many clients.
   2. Deemphasize the importance of illustrations to the sale. In many cases the agent uses the 40th-year CSV as the key selling point as if it were a given.
• Use the illustrations to explain the product rather than just show numbers.
• Only show first 10 years of values, and quinquennial thereafter. More disclosure. In short, fewer numbers and more words, as it should be for a “concept” sale.
• Companies should not be allowed to show illustrated values which are greater than those currently being credited. As the rates change, the customer should be notified accordingly.
• Require disclosure if illustration does not reflect current assumptions.
• Require disclosure of improved lapse, mortality and/or expense assumptions shown in the illustration, and require an alternative illustration showing results if the improvements are not realized.
• More explanation aimed at the “average person,” not just legalese. Perhaps also cut down on the level of technical detail that is presented in our standard illustrations.
• As it happens, we are undertaking some research to establish the answer to that very question.
• Should explain unusual features. Remove the requirement to show guarantees on the same page. (Still must show them.) Space could be used to make numbers easier to follow.
• Consumers need education about products to understand them before illustration changes will help—anyway, an interest cap will help.
• From the consumer’s standpoint, all of our illustrations are very well caveated.
• In the same way a valuation actuary needs to sign off on reserves, require an actuary to sign off on illustration procedures.
• Similar terminology; more graphic illustrations.
• Make them more clear, concise and complete.
• Better caveats and explanations, more control over “current experience” requirements, better agent education.
• Require a standard ledger be run with all of the other possible variations.
• No change.
• We attempt to stay current with enhancements and modifications which improve the usefulness of our illustrations; no improvements are outstanding at this time.
• Ideally, limit illustrations to 10 or 20 years.
• Disclose all important information in an easy and understandable format.
• Illustrate true performance of product; use of graphics; require financial ratings of at least two rating agencies; indicate investment quality.
• More accurate depiction of expenses and mortality, especially in later years. Showing the impact on policy values, when expense and mortality assumptions are kept at current.
• The illustrations are easy to read and understand in the format they are currently in. I wouldn’t change them at all.
• Require a standardized format for traditional, UL, interest-sensitive products. Use would be in addition to customized format.
• Accuracy of mid-year projections; too much verbiage.
LIFE INSURANCE SALES ILLUSTRATIONS

- Require more disclosure of the assumptions behind each illustration. Give the consumer the necessary information to properly evaluate the risks involved. (For example, 1, possible consequences of future tax law changes; for example 2, current mortality charges assume future improvements in underlying mortality; for example 3, current interest rate would be X percent if company could earn Y percent after investment expenses.)
- This subject is under constant discussion within our marketing and actuarial organizations. We would like to simplify illustration outputs, so that people are not confused by masses of numbers and multiple pages of footnotes. At the same time, we would like the customer to be thinking about a range of possible outcomes. Our new vanishing premium ("abbreviated payment plan") may help us meet this goal. Another idea which is under discussion and has not been implemented is to round nonguaranteed cash values and death benefits to the lower multiple of say, $100 or $1,000. Numbers with six or eight significant digits have an aura of precision which can’t be overcome by footnotes or other disclaimers.
- More restrictions regarding disclosure.
- Clear explanation of product features.
- Decrease amount of footnotes on each page by putting clearer notes on a required extra page.
- Provide a page of comparison values: that is, assuming current interest and current mortality project the premium and values, the same assuming guaranteed mortality and guaranteed interest, current interest and guaranteed mortality, etc.
- 1. Bar retroactive mortality or interest credits. 2. Mandate illustrative rate showing results at lower than current interest.
- 1. Require a historical angle to the output. 2. Regulate what is being used in the assumptions or disclose what’s used currently (fully disclose).
- Highlight or emphasize (large print) that illustration is nothing more than a sample of how the contract MAY work.
- Include brief definitions of terminology used on illustrations. Include graphics.
- Use graphics rather than tables of numbers to show results.
- Wouldn’t.
- Yes, I would include company ratings and financial strength.
- Limit number of years that could be illustrated.
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- Automatically include variations of CSV and DB development, less numbers, more verbiage.
- We would prefer to provide easy-to-understand supplemental brochures describing important issues since footnotes on illustrations are not effective.

F. (7) Does your company have an illustration that you regard as a positive innovation in terms of format, content, or concept, from a consumer standpoint?

- We produce a policy illustration and include it in the policy. Differences between this independently produced projection and the one originally provided by the agent can and has identified misunderstandings right at the outset when they can most easily be corrected.
- Edit screen on UL.
- We’re the only Canadian company to illustrate an alternative (lower only) dividend scale, but this is common in the U.S. (I believe) so it’s not really a great innovation.
- Signature page; various columns for INN calculations; three scenario pages.
- Screen graphics are available—easier to visualize.
- We examine our illustrations regularly to see what improvements we can make. While they may not be “innovative,” we believe that they do an excellent job of fairly presenting the product.
- No. But we do allow interest rate modeling, and we have an extensive re-illustration (in-force ledger) system.
- Question is not clear—we have a typical big company type of system, except for our decoupled illustration, and an in-force system.
- The ability to illustrate dividends less than the current scale.
- This is a vanishing premium illustration that automatically produces a low-dividend-interest-rate scenario. Also, the zero premium has been replaced by a special character that references a footnote.
- It isn’t so much an illustration, rather that we have adjusted our products to include investment income tax (as stated in the footnotes).

II. DIVIDEND-PAYING PRODUCTS

A. (35) Does your company sell this type of product? (If no, skip to III).

B. Which, if any, of the following dividend factors as illustrated anticipate a change from current experience, either by projecting trends or on some other basis? Please explain the general nature of such changes.
LIFE INSURANCE SALES ILLUSTRATIONS

(1) Mortality.
(2) Interest.
(3) Expense.

- Mortality. Projected improvements.
- Company does not illustrate dividends higher than our current scale.
- We are aggressively attacking the expense issue.
- Performance of our pool fund is more than enough to support dividends this year, and our projections suggest we’ll be fine in 1992. However, a continued deterioration in the economy could accelerate that occurrence. A few years ago when the AIDS issue was heating up and the IIT was about to be implemented, we specifically showed a reduction to reflect the potential impact. Currently, we simply show a 1/2 percent reduction in interest rate to illustrate the effect of a drop in yields. Our field force hates our doing this at all.
- Use current dividend assumptions. For projections, don’t try to anticipate change.
- The standard illustrated scale is the actual payable scale with no projection. The agent has the option to run any lower dividend interest assumption the client wants to see.
- Illustrations reflect current experience.
- (This was a response to II-B. and II-C.) Unless otherwise requested, the dividend factors which produce the illustrated dividends will be based on the following: (a) The mortality and expense factors will reflect the current-dividend-scale assumptions. (b) The interest factor will reflect the current-dividend-scale assumptions unless it has been determined that the scale which applies to the policy will in fact contain a lower-interest-rate assumption. If this is the case, this lower rate will be used. If the reverse is true, however, and it is anticipated that the actual interest rate will be higher than the current value, we do NOT reflect this higher rate but instead remain at the current level. Lower only. We do not allow dividends to be illustrated in excess of the current scale. Agents have the flexibility to run illustrations where the interest component can range from zero to a maximum which assumes the default rate as defined in (b) above. The mortality and expense components currently cannot be adjusted. However, an upcoming enhancement will provide the flexibility to completely zero out the dividends. Our illustrations contain a supplementary page which illustrates all nonguaranteed elements otherwise buried within the illustration.
• Current scale is projected to continue—no changes in experience are anticipated.
• In aggregate the current experience reflects actual; by blocks they don’t. DAC has not been reflected.
• Currently illustrated refunds are calculated using expense factors which have become out-of-date. This will be corrected on next change.
• We illustrate current scale only; in 1998, when tax laws were changing, we temporarily illustrated a lower-than-current scale.

(3) Are such changes disclosed to the consumer?
• Dividends are not guaranteed on the illustration. Values illustrated may vary depending upon actual experience.
• Yes, though the change is not imminent, it is shown as an alternative scenario.
• Advise consumer that these factors affect dividends and changes may occur.
• Not specifically, but reproposals are available as requested.

C. (17) Do your agents have the flexibility to run illustrations at dividend interest rates or mortality rates higher or lower than the current scale?

If yes, please indicate the degree of flexibility they have.

• Select interest rate to be assumed within a range rate assumed disclosed on illustration along with actual recent experience.
• Interest only. Higher or lower. Illustration will say “hypothetical.”
• Lower, but not higher.
• Only lower.
• −1%, −2% and −3%.
• Illustrations can be run up to 200 basis points below the current gross crediting rate. Our conservative illustration practices do not allow us to show an increase in dividends.
• We allow up to a 200-basis-point reduction. We do not allow illustrations of a dividend increase.
• Current scale, reduce interest factor 1 percent or 2 percent.
• Interest rate less than current scale only.
• Lower dividend interest rates only may be run.
• At lower rate only. May decrease dividend interest rate by up to 200 basis points.
• Yes—lower only; 200 basis points lower than current.
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- Agents can illustrate dividend interest rates lower than the current rate. (As low as three percentage points below current.) Mortality rates cannot be varied.
- Up to 2 percent lower than current scale, average of 8, 12, 20 or 40 prior quarter interest rates.
- Can show results of lower interest factor (higher not sanctioned by company).
- Lower interest only. Two percent interest drop, no change in mortality assumption. Maximum differential is 2 percent.

D. (10) *Has your company received an increasing number of policyowner complaints about dividends paid versus dividends illustrated?*  
(1) *Have these complaints indicated any common misunderstandings of illustrations furnished at the time of sale? Please explain.*

- No. Consumers thought of dividends as guaranteed.
- No. These plans are relatively new. Track record thus far has been pretty good—dividends have generally exceeded expectations.
- Same. Only in terms of the “vanish” if dividends are decreased and have more premiums will need to be paid prior to “vanish.”
- The problem has not been dividends paid versus dividends illustrated, but how the changes in the dividend scale affect the vanish point of the contract. That is, the way they see it, if you had a 1 percent reduction in your dividend scale, total cash to vanish should only increase by 1 percent!
- Policyowner complaints have increased as dividend scales have decreased. They do not always comprehend the “nonguaranteed” nature of dividends.
- The nonguaranteed nature of dividends was not well understood nor presented well.
- Normal level. Most complaints are minor. The majority of the questions concern vanishing outlay or values less than originally projected. However, once the policyowner understands that he/she is still being credited a competitive return versus available options, then the policyowner in general is satisfied.
- Yes, but relatively few so far. Impression, belief, or hope that dividends only increase.
- Many complaints deal with misunderstandings that quick-pay years were guaranteed, or at least highly unlikely to change.
Most misunderstandings relate to vanishing-premium illustrations and dividend scale changes. Policyholders mistake a vanishing-premium illustration for a promise of a paid-up policy.

Policyholders believed dividends would cover premiums by a certain date, and due to a decrease in the dividend scale this is not so.

People seem to think insurance dividends should be unaffected by expense changes and interest swings. They remember the 15–16 percent interest rates of 10 years ago.

We had some complaints immediately following scale drops in 1987 and 1988, but fewer than expected.

The consumer did not understand the relationship of investment yield to product performance.

"Vanish" illustrations are frequently misunderstood regardless of the agent's explanation at the time of sale.

Most complaints pertain vanish year increasing due to reduction in dividend scale.

III. UNIVERSAL LIFE AND INTEREST-SENSITIVE LIFE PRODUCTS

A. (52) Does your company sell these types of product? (If no, skip to IV.)

B. Which, if any, of the following experience factors as illustrated anticipate a change from current levels, either by projecting trends or on some other basis? Please explain the general nature of such changes.

(5) Mortality.
(8) Interest.
(2) Expense.

• Mortality—can illustrate based upon current or guaranteed maximum scale. Interest—select rate from an allowable range. Mandatory lower rate projection also produced. Expense—administrative fees subject to fixed inflation factor.

• An input assumption.
• All current values are based on company experience.
• Mortality on juvenile issues. Illustrations for juveniles assume conversion to nonsmoker product at minimum allowable attained age.
• Mortality—no, have priced for AIDS. Interest—no, based on current interest rate. Expense—no, have priced for IIT, AST, etc.
• Bonus interest.
LIFE INSURANCE SALES ILLUSTRATIONS

- Negative anticipated changes are not considered when the illustrations are developed. We see this as part of the integrity problem because, while there is no legal obligation to forewarn customers of anticipated negative changes, the company and/or agent may be aware of such changes. For example, a decrease in interest rates may be imminent, but until it’s effective, the agents continue to illustrate the higher rate as if that rate will remain in effect for 20 years. Although agents should not be required to provide predictions, they should be honest with the customer if it appears that a change is about to occur.
- All factors reflect current assumptions.
- Projections may be done using an interest table based on anticipated future changes.
- We don’t anticipate changes.
- We are opposed to future enhancements in these factors.
- Current level projected to continue—can lower interest assumptions over time.
- Alternate interest rate projections are available.
- Illustration values are based on (1) current assumed interest and mortality and (2) guaranteed rates.
- Mortality—OK in aggregate; in process of repricing. Interest—too high on new premiums; managed down over time. Expense—doesn’t reflect DAC, otherwise OK.
- Expense factors are out of date and need to be updated.
- We expect mortality to continue to improve as it has in almost every period in the past.
- Rates are adjusted for the guaranteed added interest credits at the end of years 10, 15, 17, 18, 19 and 20.
- Use of a higher credited rate (i.e., lower spread) after 5 years.
  (9) Are such changes disclosed to the consumer?
- Mortality and interest.
- Footnotes/guaranteed values illustrated.
- Before the full level of the IIIT was known, we advised new clients of the potential range of the impact.
- Not on illustration; in Exhibit interrogatories.

C. Which, if any, of the following experience factors can the agent vary from current levels in your illustrations?
(49) **Interest.**
(6) **Cost of insurance.**
(2) **Minimum premium.**

( ) **Policy loads.**

- Interest. Cost of Insurance—guaranteed and current, only.
- Interest. Cost of Insurance—choice is current rate or guaranteed maximum scale only.
- None. Our branch offices only can go 3 percent above current interest rate and this is footnoted.
- Interest in a separate section of proposal labelled “projected values.”
- Interest—but *must* show current rates and a minimum rate illustration.
  The current rate is the upper limit the agent can use in the projection.
- Interest. Agents are permitted to vary interest rates up or down (up to a maximum of 14 percent). Due to good training and (to some extent) a fear of litigation, more of our agents vary the interest rate downward than upward.
- Interest, from 4 percent to 10 percent. Cost of Insurance, illustration can be run with guaranteed mortality charges.
- Interest, but *never more* than current rate.
- Interest, additional page only.
- Interest—This is done so we don’t have to provide new software when interest rates change.
- Interest—Our illustrations show Universal Life values on a current basis allowing for an alternate interest rate either higher (subject to a maximum) or lower if desired. In addition, values are illustrated on a guaranteed basis which are based on the guaranteed minimum interest rate and the guaranteed maximum cost of insurance charges.
- Interest—this is an agency input item.
- Interest—but only a lower rate than current, only available on some illustrations systems.
- Interest—However, the current illustration is automatically printed in addition to the assumed-rate illustration.
- Cost of insurance, guaranteed only.
- Cost of insurance, show current and/or guaranteed.
- Interest, range of values. Cost of Insurance, choice: guaranteed or non-guaranteed cost. Minimum Premium, compensation is not based on the premium chosen but on the cost of insurance and policy fees.
D. (10)  *Does your policy include any contingent credits or persistency bonuses? If yes, how are they disclosed?*

- Some policies guarantee a higher credited rate from year 11+ on. Footnote explains.
- Bonus interest credited once policy reaches a certain duration. This feature is fully disclosed and is contractually guaranteed.
- Footnote. Illustration of credits is optional—agent may decide not to show it.
- Contractually guaranteed bonus interest is disclosed in a footnote.
- No. We believe most of these "gimmicks" will be taken away from the consumer unless persistency is lousy. Most "gimmicks" are designed to encourage persistency.
- The bonuses are guaranteed, so they are reflected in both the current and guaranteed values shown on the illustration. In some cases there is further explanation in footnotes also.
- Within the footnotes.
- As a company practice in a footnote.
- They are disclosed in footnotes on the illustration.
- A paragraph describing the requirements to receive the benefit, the amount, and any other restrictions is included.
- A footnote provides the method of calculation and notes that the bonuses are "nonguaranteed."
- They are illustrated only if they apply in situation illustrated. Caveats explain requirements to get credits.
- On the summary page of the illustration.
- By footnote at bottom of illustration.
- Payroll deduction UL discloses higher interest beginning years 11 and 21 if premiums are paid pro-rata thru 10 years.
- They are disclosed in a footnote in the summary page.
- In the page of notes following the illustration.
- In footnotes.
- Reduced COI after specified cumulative amount of insurance purchased; asterisk on ledger once lower COIs are being charged.
- Bonus interest, described in footnote at bottom of sales proposal, cost disclosure.
- No. We will, however, soon introduce a UL product that includes an interest rate bonus of 1.25 percent after 10 years provided cumulative...
target premiums have been paid. This will be fully disclosed in the explanatory notes section of illustration.

- Interest rate bonus is listed in ledger and in the footnotes.

IV. TERM AND TERM-LIKE (FOR EXAMPLE, GRADED PREMIUM WHOLE LIFE) PRODUCTS

A. (41) Do you sell this type of product? (If no, skip to V.)

B. (13) Can your agents illustrate conversion to universal life, participating life or interest-sensitive life plans on a term or GPWL proposal?

(12) If yes, does the conversion illustration show both current and guaranteed values?

C. (8) Do you sell nonconvertible term?

(10) Or term with a very short conversion period?

(9) If yes, does the illustration prominently disclose that the product is nonconvertible or very limited in its conversion rights?

- No illustration.
- Very short, first 3 years only on a 20-year decreasing term plan.
- We do not provide illustrations for our NCT product.
- No, but the illustration is entitled ‘‘. . . Nonconvertible Term.’’
- Covered in brochure and contract. The term illustration shows rates on a guaranteed and current basis with and without re-entry.

V. SECOND-TO-DIE PRODUCTS

- These are the wrong questions to ask on this product. You need to consider both the base policy and the term riders.

A. (41) Do you sell this type of product? (If no, skip to VI.)

- No. We offer a beneficiary insurance rider. It gives the insureds a guaranteed right to purchase an additional amount of insurance at the first death.

B. (6) Does your product provide for a cash value increase on the first death?

(1) If yes, are the values shown on your illustration always based on the assumption that both lives remain alive?
LIFE INSURANCE SALES ILLUSTRATIONS

- Yes. Yes. Agents can illustrate death and illustration does prominently disclose the death scenario.
- Yes. No. Agent can choose both alive or first death in any duration.
- Yes. No, can be run to choose year of death of either life.
  
  ( ) If yes, is this assumption prominently disclosed on the illustration?

C. (14) Does the illustration contain an explicit statement that there is no death benefit payable on the first death?
- Company has death benefit payable on 1st death Rider approach. Two separate policies are issued.
- No, but the illustration is entitled “...Second-to-Die.”
- No—but it shows that cash value increases.
- N/A. We offer a guaranteed insurability option that, upon the first death, allows for the use of the death benefit as premium for a Universal Life policy payable upon the death of the second life.

VI. TWO-TIER PRODUCTS
A. (6) Do you sell this type of product? (If no, skip to VII.)
B. (5) Does the illustration clearly indicate the amount payable if the policyholder surrenders rather than annuitizing?
- Additional verbiage also emphasizes this fact.
C. ( ) Are the illustrated monthly incomes (upon annuitization) shown using both current and guaranteed annuitization factors?

VII. OTHER
A. (20) Are there other specialty products on the market for which you feel illustration practices should be researched? If so, please indicate which products:
- First-to-Die, Variable Universal.
- Registered Life, Variable Life.
- Variable Life products.
- Disability Income.
- Living benefits.
- Term-to-100 (basically low premium whole life with no nonforfeiture values and is sold in Canada only). Often assume very high lapses in pricing and illustrations.
- Annuities; lapse-supported illustrations.
TSA 1991-92 REPORTS

- Yes, UL and VUL products.
- Annuities.
- Accelerated benefits.
- Renewable health product with low initial rates may be worth considering.
- Two-tier Universal Life, 10-year indeterminate level premium which becomes 1-year term thereafter, and deferred annuities where interest rate for the initial period and renewal period are different.
- Realism of second to die product pricing/illustration; use of projections of improving experience in combination WL/term illustrations.
- Products that are stated to be whole life but are actually blends of base and term.
- No, except (name of company) shows their projections against others' guarantees.
- Annuities.
- Universal life products with equity side funds, in relation to credited interest rates and tax status.
- Universal life maturing as an annuity.
- Interest-sensitive whole life.
- Group UL especially for executive purchases.

B. (35) Are there specific illustration practices that you believe should be researched? If so, please indicate which practices:

- On traditional WL illustrations, “guaranteed” values should never include any dividends.
- 1. Use of nominal interest rates. 2. Disclosure of only the gross fund value before surrender charge for UL products. 3. Ability to illustrate temporary coverage (say to life expectancy) without adequate disclosure.
- Producers creating their own illustrations via (name of company), etc. Telling consumer wrong information about guarantees.
- Are graphs easier to understand than columns of numbers for the consumer.
- Projecting continual improvement in mortality for UL policies.
- I believe agents put too much emphasis on illustrations during the sale process and some companies go too far in selecting optimistic assumptions to make long term values look good.
- Lapse-supported illustrations; increasing interest rates, mortality improvement. As somewhat already addressed in this survey, the issue of an agent’s ability to manipulate figures in the illustration is of importance because of the potential to mislead customers by illustrating unrealistic interest rates. Further research is needed to ascertain how often such
practices occur. Also of importance is compliance with state disclosure regulations. This issue should be researched and the insurance departments made aware of any widespread noncompliance, so that appropriate action can be taken at a state level to enforce the laws and regulations that govern disclosure.

- Necessity of illustrating at a low interest rate even for asset products like the RRIF.
- Failure to disclose guaranteed charges/costs (mortality, expenses, etc.) and illustrating improved lapse, mortality experience, etc.
- Any illustrations that show the extent to which funds may be attached to and accumulate tax-free within an insurance policy. There is a propensity to liberally interpret the Canadian Income Tax Act.
- Refunding cost of insurance and other bonuses.
- Any illustration practices which have incomplete disclosure, are ambiguous or are confusing, should be examined. Though these concepts are difficult to formalize, some guidance should be codified.
- Failure to illustrate to age 100, or to such duration where coverage may decrease under current assumptions.
- Persistency or lapse supported illustrations should be made illegal. We should urge the adoption of an IRR approach, a modified Linton-type yield with cost of mortality. There should also be a standardization of decoupled formats. Some companies blend lower new money rates into their portfolio that will not reach a 200 basis point cut for 10–20 years. However, these companies claim they are using the lower rate.
- Concern that some companies are not reflecting current costs (for example, expenses, IIT) in their illustrations.
- Practices which do not adequately disclose nonguaranteed assumptions and values.
- Premium offset.
- Projected improvements in mortality.
- Placing disclosure statements within the illustration, not on a separate sheet that can be discarded.
- List assumed improvements in experience, and bonuses and how they impact the illustration.
- Practice of illustrating improving expenses or mortality assumptions.
- Interest rate kickers, terminal dividends and persistence bonuses, interest rate improvements, assumed mortality improvements, unlabeled columns, that is, BOY/EOY death benefit. Unidentified rider blends.
• Illustrations should not anticipate mortality improvement. In the past guaranteed minimum value used guaranteed interest but current mortality for some companies.
• Mortality improvement in pricing or in illustrations. Declared interest rates that cannot be supported. Vanish on a current basis by surrendering PUAs and put these columns next to guaranteed columns (based on a full pay) with the result that the guaranteed values look like they are based on the vanishing premium. Agents compare illustrations at a common declared interest rate—it is not obvious to them or the consumer why this is not a fair comparison.
• Nonguaranteed persistency bonuses for which no reserve is held. Also, illustrating mortality improvement. What disclosure is needed if better than current mortality is assumed in a traditional product, or better than current mortality changes is a UL product?
• More explicit disclosure of nonguarantees.
• Current interest rates and validation.
• 1. Tontine credits. 2. Interest far in excess of earnings.
• Abuse in the super select illustrations. Misuse of annual versus monthly premiums.
• Lapse supported bonus arrangements, disclosure.
• Reduction in future mortality charges (guaranteed and nonguaranteed). Dividends on universal life, lump sum and accumulated mortality charge persistency bonuses.
• Projected improvement in mortality.
• Nonguaranteed terminal dividends and bonuses, particularly those that are retroactive.
• Illustration of long-term values when product is not expected to persist that many years.
• Enhanced mortality and bonus rates—especially higher interest rates than company currently earning.

C. Undoubtedly all companies get an occasional question or complaint about an illustration from a consumer. What is the most common kind of illustration complaint received in your Home Office?

• Contract performance not as illustrated and additional premiums needed. Surrender charges not understood.
• Illustrated policy values are at policy anniversaries. Annual statements based on actual data after anniversary processing so differences occur that require explanation.
LIFE INSURANCE SALES ILLUSTRATIONS

- Why can't the illustration be run faster?
- Sold on a "vanish" premium, and dividends decreased.
- Don't understand where the numbers are coming from, "Vanish" year discrepancies when dividends are changed.
- Discrepancies between proposals and "Statement of Policy Benefits & Costs" required by state regulations, which is provided with the policy. These are easily explained. Usually the reason is due to monthly premiums on the proposal versus annual premiums used in the disclosure statement.
- We haven't any major complaints from our consumers.
- Illustration doesn't match contract summary pages—usually because policy was not illustrated (mode, riders) as issued.
- Interest rate illustrated versus paid, or premium vanish illustrated versus actual.
- Quick pay illustrations (for example, at 11 percent interest in 1984) not being fulfilled as originally illustrated.
- Specific statistics regarding complaints received concerning sales illustrations are not available. However, our group that handles customer complaints has indicated that the most common kind of complaint involving sales illustrations is the misunderstanding of the surrender charges and their effect on cash values.
- Illustration differs from cost disclosure due to change in interest rates.
- No overall common complaints that I know of.
- Policyowners frequently do not understand that illustrations are projections, subject to change, and they especially are unaware of the results of a dividend change.
- 1. Vanish illustrated at issue differs from current vanish. 2. Want more flexibility, for example, show what happens if dividends fall 25 basis points in each of the next five years, then begin to rise again.
- Vanishing premiums, but using side-funds rather than dividends. Interest rate changes cause the payment stream into the fund to be altered or some "spillover" into a taxable fund.
- Too much compliance information.
- Only that did not understand not all premium earning interest—not illustration itself.
- Dividend scale reduction.
- Premium cease date is later than initially illustrated so client needs to continue paying premiums.
Illustration too difficult to understand and compare with other company’s products/illustrations.

We do not get complaints about proposals. We believe that this is a direct result of our philosophy of clear, complete, concise wording. My experience is that agents are usually the people that complain about illustrations.

Actual performance falls short of illustration—for example, premium vanish period is longer than illustrated.

Misunderstanding of what the policyowner purchased. Our agents have a good relationship with their clients. We have few real complaints.

Customer not fully understanding that it is an “illustration.”

Interest rates on UL policies less than that illustrated.

Premium offset.

Consumers don’t understand quick pays; don’t understand effect of loans on policy values.

Consumers assume the illustration is a “guarantee” of what their policies will look like.

Removal of detailed illustration from back of annual report for universal life contract.

Effect of increase or decrease in assumed interest rates especially in relation to vanish.

We typically do not hear consumers’ complaints first hand. Planners’ complaints about our competitor’s illustrations usually involve the fact that they are often difficult to read and understand. Many times, pages are missing from the presentation.

Extended vanish period due to dividend/interest rate decreases.

Regarding unfamiliarity with UL, which is labeled “Flexible Premium.” Term information also shows “end of year” to be consistent with cash value products.

Actual policy configuration or performance did not match the illustration given by agent.

That the originally illustrated premium vanish point has not been realized.

Our most common illustration question is, “What happens after age 75?”

Illustration does not always match materials received at issue.

Having to pay more premiums before vanishing the premium with dividends.

Rarely receive a complaint. Most often they involve the premium illustrated which does not hold when interest falls.
• Vanishing premium.
• Lower values (dividends) than illustrated.
• Policyowner believes illustration was a guarantee.
• Don’t understand why “current” projection goes to maturity but “guaranteed” stops after a few years. Guaranteed is too conservative or too costly.
• The numbers in the policy don’t match the illustration. This is because the policy does not reflect any future changes to premiums or face amounts except as required by tax law, and the illustration can reflect changes that may be contemplated.
• Required to pay more premiums than anticipated to vanish policy (due to drop in interest rates).
• Vanish delays.
• Calculation of settlement options.
• Agent does not show footnotes.

D. (21) Has the number of illustration complaints your company receives increased over the past five years?

• Yes—use and volume have significantly increased during past five years.
• Slightly, due to pricing assumptions used and the decline of rates from 11 to 7–8 percent which affect UL, dividends, other interest-sensitive products.
• No, hardly ever get any from clients. Generally get them from agents who complain that our 40th-year CSV is less than some other companies’ 40th-year value given the same premium and death benefit.
• No. The number of such complaints have actually decreased over the past five years. While the exact reason for the decrease in such sales illustration complaints is unknown, we believe that both the agent and customer service representatives are doing a better job of explaining the surrender charges so that the customers are more aware of the implications of surrender charges.
• Yes, due to falling interest rates as well as changing tax legislation.
• Most complaints are handled by the agencies. We have an 800 number, but the volume of complaints and questions is not that large—maybe a few thousand on an in-force of 500,000 (that is, low percentage).
• Not significantly in relation to increase in volume.
• Not markedly.
Yes, due to software systems that are now obsolete, product sold was interest-sensitive whole life which was sold when interest rates were much higher.

- Yes, although the number of complaints from consumers continues to be small.
- This is probably more from an increase in-force business and lower interest crediting rates than from poor illustrations, or improper sales concepts.
- Only because we write a lot more business than 5 years ago.
- Decreased.

E. Please use this space for any comments you'd like to offer regarding life insurance illustrations from the consumer's perspective.

- Regrettably we have let the ease of production push us in the direction of providing the consumer more and more data that clouds basic understanding of the policy being purchased. With the numbers based upon assumptions that are inconsistent between companies, this puts the focus on noncomparable possible values scores of years in the future. More properly, illustrations would provide clearer illustration of the product's main features with as few numbers (and pages) as is reasonably possible.

- 1. Producers, Home Office personnel, salespeople, all need to have a clear and concise understanding of the products they are selling. Consumers need to fully understand what they are buying. Better training and education of salespeople and insurance people is necessary. 2. Illustrations contain lots of numbers, not all people are numbers people and understand what the numbers represent. 3. Insurance terminology, what does “Vanish” mean, paid-up mean? That is, “if I paid 10 years of premiums on my Universal Life policy, then I will be paid up,”’ is what people are told when they have an illustration that solved for a 10-year premium paying period to carry the policy to maturity. However, if rates decline, more premiums could be due to sustain the contract.

- We have a concern regarding illustrations of an income stream generated by policy cash values. In some cases that we have seen, the policy lapses within five years or less after the income has been paid. The assumption is that the insured will die before that (based on normal life expectancy). However, if insured lives and policy lapses, this triggers a significant taxable event. This (the tax implications) is not disclosed to the insured.

In some cases, the insured is not informed that the policy could terminate prior to death.
LIFE INSURANCE SALES ILLUSTRATIONS

- No gimmicks should be illustrated unless guaranteed and reserved for. The impact of lower interest rates needs to be more fully disclosed. The risks of crediting too high an interest rate need to be more fully explained. Perhaps, a comparison of an industry acceptable (probably not possible) index, such as Moody’s AAA bonds less an assumed interest spread (profit margin), with the current rate would tend to bring more realistic rates into the marketplace. Today, my company’s ULs are crediting 8 percent. This is probably a little too high. Yet, we are 75–100 basis points below most of our competitors. We think we can earn about 9 percent in today’s market, but there are products out there crediting 9 percent. What gives?

- The majority of consumers find illustrations confusing and have no concept as to the long-term achievability of the numbers, let alone what they actually mean. Personally, I believe we need very strong guidelines regarding illustrations and what can be shown, either at the professional or legislative levels. Otherwise, consumers are likely to view them as little more than smoke and mirrors which will further damage the public’s general view of the insurance industry.

- In-force projections should be provided at anniversaries, allowing the customer to see if the policy will behave as intended, based on new nonguaranteed elements and past premium payment patterns and cash value accumulations. In many instances, the consumer’s attention is drawn to the current illustrated values without mention of the guaranteed values. Although the guaranteed values are required by regulation to be included in the illustration, the agents often fail to mention the fact that there are minimum guaranteed. The consumer should be informed of the “worst-case scenario,” so that there are no misconceptions as to the accumulation of cash values. In other words, the agent should give equal time during the sales presentation to explaining what the minimum guarantees are and what effect they may have on the policy values.

- Illustration practices vary considerably from one company to the next, for example, beginning or end-of-year cash values? Beginning or end-of-year death benefit? How are internal rates of return calculated? This is particularly a problem in later years, when large dividends are typically paid, since the point in time illustrated can have a substantial impact on illustrated value. This is a key concern in highly competitive markets, such as the second-to-die marketplace.

- The main problem is that aggressive companies are illustrating values not likely to be paid. The illustrations of most mutual companies do not
have this problem. It is mostly a problem found in the UL illustration of a stock company. There is no easy solution, but the problem is getting worse, not better. The Annual Statement disclosures of dividends and other nonguaranteed elements are either not given to the consumer or the responses are not meaningful. Few companies state that their nonguaranteed elements are not based on realistic assumptions. Historic performance is useful, but many companies do not have good track records and new products may not be comparable. Dividend history IACs are subject to manipulation if noncomparable products are used or if very little of the "historical" product is still in-force. The only solution to the problem that I can foresee is to provide the client with an illustration using standard assumptions, in addition to the company's regular illustration. The standard assumptions used could be as follows: 1. assume no lapses and accumulate net premiums underlying cash values by: 2. crediting an interest rate equal to 10 percent less actual investment expenses and priced for the spread of the product; the spread should be disclosed; 3. never charging mortality less than 100 percent of S/NS 75–80 S&U table; the company can disclose if current experience is better; 4. using a realistic expense assumption; 5. charging a defined profit margin. If these assumptions and accumulated premium less expense and mortality charges are used, the values are much less than the illustration. (The client should also ask more questions.)

- 1. Illustrations are only one piece of a sales/disclosure process and should not be used to select companies without considering such things as actual dividend history, financial strength, etc. 2. Illustration assumptions should be modified as soon as possible after new schedules of credits or charges are authorized. Additional Comment: In general, our company does not believe in letting distributors do "what-if" illustrations which: (a) assume future improvements in interest, mortality, expenses; (b) "solve" for loan or other transaction patterns which cannot be supported administratively. However, some producers do use the output from our illustrations as input to spreadsheet applications, massaging the data as they see fit. Although we are uncomfortable with this practice, we recognize that it is basically beyond our control.

- We believe that life insurance sales illustrations should be easy to understand and to read. In addition, they should provide complete disclosure regarding the assumptions that are used in the generation of the numbers.
• There should be enough information available for a consumer to figure out the risks of buying life insurance based on the illustration.

• Consumers are in a very vulnerable position. They don’t look at illustrations until they are ready to buy. They are too often sold a vanishing premium illustration as a “paid-up” policy without understanding that it is really a source of PUAs or other type of use of policy values to carry the premium in the future. Carriers must recognize that the people who sell insurance products usually do not feel comfortable asking for a lifetime commitment of significant premiums, so they resort to overselling the possibility of a reprieve (via vanish) as a certainty. A new “lesson in life insurance” easy to understand and to explain should be part of every sales presentation. It should be worded in such a way that agents will want clients to see it rather than keep it from them.

• Nonguarantees too commonly seen; consumers end up depending on these nonguarantees for long term.

• A due diligence type of approach should be used to illustrate products for the consumer. Show all possible combinations of factors subject to change, from worst-case scenario to best-case scenario and some in between.

• Illustrations should only be a part of the sales process. They should be fair and should provide the consumer with a sense of the range of values possible over the future from guaranteed to current scale. Excessive footnotes and mandated exculpatory working should be guarded against.

• The two-tier, superman and kicker abuses are the most flagrant. We’d like to see historical data included much like Mutual Fund hypotheticals.

• Computer projections have reduced life insurance sales to a ledger sale, not a needs sale, the higher ledger numbers or lower premium gets the sale. Insurance sales emphasize investment performance rather than protection, tax deferral, safety and needs satisfaction or completion. Illustrations have not done our business much good in the last five years. All illustrations are not alike but the customer can’t tell the difference. We have to level the playing field.

• In order to protect themselves, companies list numerous disclosures and disclaimers. This coupled with the ability to show almost unlimited changes during the years illustrated, causes the client/prospect to be unsure of what he/she expects of the product and will often cause the prospect to delay making a decision. Illustrations need to be used as supportive material in the sales process rather than being used to sell future projected values.
### APPENDIX II

**SAMPLE ILLUSTRATIONS**

**EXHIBIT A: PAGE 1 OF 2**

#### LEDGER ILLUSTRATION PREPARED FOR INSURED

<table>
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<tr>
<th>$100,000 Traditional Life</th>
<th>Male Age 45 yrs</th>
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<td>Cash</td>
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5% interest adjusted cost indices for base plan only

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The dividend payable at the end of the first year is contingent upon payment of the second year’s premium.

The amount of the dividend is affected by any policy loans outstanding. The dividend figures are based on the current scale assuming no loans. Dividends are not guaranteed.

This policy is based on male rates.
### Exhibit A: Page 2 of 2

<table>
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<tr>
<th>Yr</th>
<th>Total Dividend Income (Calculation)</th>
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5% interest adjusted cost indices for base plan only

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<td>20 Yrs</td>
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The dividend payable at the end of the first year is contingent upon payment of the second year's premium.

The amount of the dividend is affected by any policy loans outstanding. The dividend figures are based on the current scale assuming no loans. Dividends are not guaranteed. This policy is based on male rates.

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EXHIBIT B: PAGE 1 OF 5

Plan: Whole Life  
Insured: Classification: Preferred Non-smoker  
Age: 35  
Sex: Male  
Basic Policy  
Amount of Insurance: $100,000  
Premium Mode: Annual  
Annual Premium: $1,245.00  
Yes Payable: Lifetime

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Dividends based on Jan. 1991 scale that uses current interest, mortality and expense rates. Illustrative monthly income based on May 1991 settlement option rates. Illustrative figures are not guarantees or estimates for the future.

Initial Prem:  
Annual $1,245.00;  
Semiann. $670.00;  
Monthly $112.00
### EXHIBIT B: PAGE 2 OF 5

Plan: Whole Life  
Insured: Classification: Preferred Non-smoker  
Age: 35  
Sex: Male  
Premium Mode: Annual  
Premium: $1,245.00  
Amount of Insurance: $100,000

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**EXHIBIT B: PAGE 3 OF 5**

Annual dividends used to buy paid-up additional insurance

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*Guaranteed cash value, cash value of additional insurance and any terminal dividend.

†Paid-up insurance available if you stop paying premiums and reduced paid-up insurance option is chosen. Illustrative paid-up insurance includes paid-up insurance bought by dividends. Any remaining optional benefits and riders end when paid-up option takes effect.

‡Benefit applicable to principal insured, includes basic insurance, additional insurance, any terminal dividend and any rider insurance value.

§Age at life expectancy, U.S. population life tables.

Dividends based on Jan. 1991 scale that uses current interest, mortality and expense rates. Illustrative figures are not guarantees or estimates for the future.

Explanatory notes form —— and form ——— must be enclosed.
EXHIBIT B: PAGE 4 OF 5

BENEFITS THAT MAY BE AVAILABLE

Following are descriptions of benefits provided by riders that may be included with your policy. These benefits are subject to certain limitations and exclusions which are not described below. For full details, ask to see a specimen form.

DISABILITY WAIVER OF PREMIUMS BENEFIT. Provides that, if you become totally disabled as described in the rider, before your age 60 and your disability lasts for at least six months, you will not have to pay premiums while totally disabled. There is also a limited waiver benefit for total disability which occurs between the ages 60 and 65.

ACCIDENTAL DEATH BENEFIT. Provides additional insurance, usually equal to the face amount of insurance, if you die from an accident. An amount equal to twice the A.D.B. amount is paid if the accident occurred while you were a fare-paying passenger in a licensed public conveyance being operated by a common carrier for passenger service.

FAMILY INCOME BENEFIT. Provides a monthly income to your family if you die before the end of a specified period (10, 20 or 30 years). The monthly income is paid for the balance of the period and is in addition to the amount payable under the basic policy. A similar income benefit on a spouse is also available.

ONE-YEAR TERM INSURANCE BENEFIT. Provides renewable and convertible level term insurance payable if you die before the end of the specified one-year period. This benefit is also available on a spouse.

10-YEAR LEVEL TERM INSURANCE BENEFIT. Provides renewable and convertible level term insurance payable if you die before the end of the specified 10-year period. This benefit is also available on a spouse.

GUARANTEE TO ISSUE NEW INSURANCE WITHOUT EVIDENCE OF INSURABILITY. Guarantees you the right to buy a new policy on your life without evidence of insurability for an amount of insurance up to the specified option amount. The new policies may be purchased only on an option date.

CHILDREN’S TERM INSURANCE BENEFIT. Provides term insurance on each covered child to the policy anniversary at the child’s age 25, or to the policy anniversary at the insured’s age 65 if earlier. An insured child may obtain a new policy without evidence of insurability.

ONE YEAR COST OF LIVING TERM INSURANCE BENEFIT. Provides one-year term insurance which varies annually to match yearly fluctuations as indicated by the CPI.

PAID-UP ADDITIONS RIDER. A permanent additional insurance rider that provides supplemental growing cash values. This rider also provides the potential for enhanced premium flexibility and for advancing the year when out of pocket premium payments are no longer required under the Accelerated Premium Payment plan, or when the policy can be fully paid up or matured for its face amount.

ACCELERATION OF POLICY BENEFITS FOR LONG-TERM-CARE RIDER. Provides for the acceleration payment of a portion of the death benefit for the long-term care of the insured. Such care can be provided either in a qualified convalescent facility or at home when the insured has a qualified disability. The benefit payments are made each month and continue as long as the insured remains disabled and the maximum benefit under the rider has not been paid. The size of the monthly payments and the maximum benefit are stated in the rider (subject to state approval).
EXHIBIT B: PAGE 5 OF 5

EXPLANATORY NOTES

ACCELERATION OF DEATH BENEFIT RIDER. Provides for a one-time discounted payment of all or a portion of the death benefit to the policyowner once the insured has been determined to be terminally ill with 12 months or less to live. The size of the benefit payments and the maximum benefit are stated in the rider. There are no premiums or fees for this rider (subject to state approval).

DIVIDEND INFORMATION. Dividends paid by ______ depend on future experience as to investment earnings, operating expenses, claims paid, and taxes. All of these factors may so that dividend scales will change from time to time. The dividends shown in this proposal are an illustration of our current dividend scale and are not a guarantee or estimate of future results.

Terminal dividends may be paid on Whole Life, Life Paid Up at 95, and Life Paid Up at 98 policies. There are no terminal dividends payable on term life insurance plans.

ILLUSTRATIVE LIFE INCOME. Any illustrative life income figures shown in this proposal are based upon our life income plan rates currently in effect. These rates are not guarantees or estimates for payments starting in the future. After monthly life income payments begin, the amounts will be fixed.

TERM PLANS. Term Life insurance plans and term insurance riders provide insurance protection only. They do not provide cash or loan values.

The POLICY-LOAN provision provides for an adjustable policy loan interest rate that is charged daily at the rate we set from time to time. This rate will never be more than the maximum allowed by law and will not change more often than once a year on the policy anniversary. Loan interest is due at the end of each policy year. Interest not paid within 31 days after it is due will be added to the loan principal.

INTEREST-ADJUSTED INDEXES. These indexes, if shown in this proposal, provide a means for evaluating the comparative cost of the policy under stated assumptions. They can be useful in comparing similar plans of insurance, a lower index being better than a higher one. Indexes are approximate because they involve assumptions, including the rate of interest used, the dividends being paid in cash and the continuation of current dividend scales. Indexes apply to the basic policy only. They exclude any optional riders such as accidental death.

"Total premiums less illustrative cash value," "total premiums less total dividends," "net increase or decrease in business surplus," etc., should not be used in policy cost comparisons because they do not consider the effect interest could have on payments made at different times. They can sometimes be helpful for accounting purposes.

Any application for insurance will be subject to underwriting rules.
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Dividends are not guaranteed and are subject to significant fluctuations. Changes in dividends will change all nonguaranteed values.
**EXHIBIT C: PAGE 2 OF 3**

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Dividends are not guaranteed and are subject to significant fluctuations. Changes in dividends will change all nonguaranteed values. See page 3 for footnotes, assumptions and explanations.
EXHIBIT C: PAGE 3 OF 3

Proposed Insured: Society of Actuaries
Plan: Whole Life Policy
Basic Policy Amount: $100,000
Dividend Option: Dividends used to purchase paid-up additions

Footnotes:

As illustrated, this policy would not become a modified endowment contract (MEC) under the Internal Revenue Code. Loans and distributions from a MEC are subject to income tax and may also trigger a penalty tax. Changes made to the policy may cause the policy to become a MEC.

*This footnote pertains to column(s) 3, 4, 5, 6, 7:
Based on the 1991 dividend schedule. Dividends are not guaranteed. Due to new federal taxes and economic conditions including declining interest rates, dividends based on the 1992 dividend schedule are expected to be lower than those shown in the illustration. Transfer of policy ownership to a qualified pension or profit-sharing plan would result in a different dividend schedule. The first year dividend, although included in this illustration, is contingent on payment of the entire second year premium. The first year dividend is not used in the calculation of first year paid-up insurance and first year monthly life income.
*This policy is available at issue with a policy loan rate of either 8% or an annually adjustable rate. This illustration assumes no policy loans. For the 8% policy, loans will affect dividends.
*This footnote pertains to column(s) 4, 6:
The components of this column are depicted separately in this illustration.
*This footnote pertains to the monthly income figures shown:
   Based on total cash surrender value using the current rate which is not guaranteed.
*This footnote pertains to the monthly income figures shown:
   Monthly income shown assumes the right to commute unpaid payments has been waived.

This illustration does not recognize the time value of money and should not be used to compare policy costs.

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The interest-adjusted cost comparison indexes provide two means of comparing the relative cost of similar plans of insurance issued by the same company or different companies. A low index number represents a lower cost than a higher one. These indexes reflect the time value of money by applying a 3 percent interest factor to policy premiums, dividends, and for the surrender cost index, the 10- and 20-year cash values. The dividends used in calculating these indexes are based on current year’s scale and are not guarantees nor estimates of future dividends.

The indexes do not consider: (1) the value of the services of an agent or company; (2) the relative strength and reputation of the company and its actual dividend performance; or (3) differences in the policy provisions.
**EXHIBIT D: PAGE 1 OF 3**

Based on 3.00% dividend interest rate, which is less than the current dividend interest rate
$100,000 Life Plan
For Age 35 Male
Annual Premium $9,355.00

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**Premiums**

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Subject to underwriting limits

Dividends assume no loads; loans will reduce dividends. Illustrated dividends (1991 scale) reflect claim and expense experience and are not estimates or guarantees of future results. They may be larger or smaller than those illustrated. This illustration does not reflect that money is paid and received at different times. 8% loan provision.
### EXHIBIT D: PAGE 2 OF 3

Based on 8.00% dividend interest rate, which is less than the current dividend interest rate

100,000 Life Plan
For Age 35 Male
Annual Premium $1,333.00

Dividends used to purchase paid-up additions

<table>
<thead>
<tr>
<th>Year</th>
<th>Initial Insurance</th>
<th>Dividend*</th>
<th>Annual Cash Oustay</th>
<th>Cash Value Increase*</th>
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<th>Mon.</th>
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<tr>
<td>75,000 Additional Purchase</td>
<td>126.75</td>
<td>11.03</td>
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*Dividends assume no loans; loans will reduce dividends. Illustrated dividends (1991 scale) reflect claim and expense experience and are not estimates or guarantees of future results. They may be larger or smaller than those illustrated. This illustration does not reflect that money is paid and received at different times. 8% loan provision.
### EXHIBIT D: PAGE 3 OF 3

Based on 8.00% dividend interest rate, which is less than the current dividend interest rate $100,000 Life Plan

For Age 35 Male
Annual Premium $1,233.00

Dividends used to purchase paid-up additions

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<td>Increase*</td>
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**Premiums**

<table>
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<th>Mon.</th>
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</thead>
<tbody>
<tr>
<td>Insurance</td>
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<td>Waiver</td>
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<tr>
<td>100,000 Accidental Death</td>
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</tr>
<tr>
<td>75,000 Additional Purchase</td>
<td>126.75</td>
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</tr>
</tbody>
</table>

Subject to underwriting limits

*Dividends assume no loans; loans will reduce dividends. Illustrated dividends (1991 scale) reflect claim and expense experience and are not estimates or guarantees of future results. They may be larger or smaller than those illustrated. This illustration does not reflect that money is paid and received at different times. 0% loan provision.*
### Exhibit E: Page 1 of 4

<table>
<thead>
<tr>
<th>Age at Year of Dividend</th>
<th>Guaranteed Dividends</th>
<th>Current Dividends</th>
<th>Alternative Dividends</th>
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<td>Total Cash Value</td>
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<tr>
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<tr>
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<tr>
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This illustration compares the cash values and death benefits that would be provided by the basic policy if dividends are used to purchase paid-up additions in each of the following future scenarios:
1. No dividends are ever paid, guaranteed values
2. The current dividends scale is maintained indefinitely
3. Dividends are paid based on the alternate dividend scale described in the footnotes to the following illustration.

This illustration is merely intended to demonstrate the effect of our current dividend scale and variations in the interest rate underlying that scale. It is not an illustration of the coverage you have selected. This illustration assumes that no premiums are paid in addition to the base policy premium.
## EXHIBIT E: PAGE 2 OF 4

Dividends based on alternate dividend scale described in footnotes.

<table>
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<tr>
<th>Age at Start of Year</th>
<th>Annual Outlay</th>
<th>Annual Dividend</th>
<th>Total Dividend</th>
<th>Guar Cash Value Yr End</th>
<th>Cash Value of Annuity</th>
<th>Net Cash Value Yr End</th>
<th>Death Benefit</th>
<th>Compar Rate of Return</th>
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Please see attached sheets with important footnotes.
## EXHIBIT E: PAGE 3 OF 4

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<td>5% Interest-adjusted costs (2):</td>
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<td>at 10 Years</td>
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<td>at 20 Years</td>
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<td>5% Interest-adjusted payments:</td>
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<td>at 10 Years</td>
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<td>at 20 Years</td>
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Exhibit E: Page 4 of 4

Guaranteed cash values as shown on this illustration are only available if all premiums have been paid. The annual rate of interest underlying the computation of these guarantees is 4.00%.

All cash values shown are end-of-year values.

All illustrations for individual life insurance products are tested for the possibility of classification as a modified endowment for the purposes of federal income taxation. This test applies to policies entered into after June 20, 1988 and may not be used for policies in force before that date.

The illustrated outlays shown on this illustration would not cause it to be classified as a modified endowment. This test is not a guarantee that a particular policy will not be classified as a modified endowment in the future.

Figures depending on dividends are neither estimated nor guaranteed, but are based on a hypothetical dividend scale. That scale has the same factors as the 1991 dividend scale, except for the interest return. The interest return is based on assumed rates that would credit, which may vary by policy year. These rates are shown in the end of those footnotes, and do not exceed the current rate of 10.50%.

Actual future dividends may be higher or lower than those illustrated depending on the company's actual future experience.

The cost of the above policy over a period of years cannot be determined without taking into account the interest that would have been earned had the premiums been invested rather than paid to the insurer.

Net death benefit on all permanent plans means the face amount plus riders, if any, plus the end of year dividend less policy loans. A full dividend is not generally paid upon death during the policy year. Other variables are possible. Your agent will define the rules upon request.

The policy loan interest rate shown on your illustration is payable in advance at a discount rate equivalent to an annual rate of 8.00%. Dividends are affected by policy loans. To the extent the dividend scale is based on an interest rate greater than 7.00%, in any given policy year the greater the amount of loan, the smaller the dividend.

(This does not apply to term, which has no loan value.)

The number of years of required cash outlays depends upon age at issue, policy class, face amount, and continuation of current dividend scale, and assumes no policy loans. This is not an automatic dividend option. Policy owners must request change of dividend option at policy year indicated. He may pay the balance of premium by surrendering a portion of paid-up insurance.

This is not a paid-up policy, premiums are due and payable in all policy years.

(1) The comparative rate of return shown represents the rate, not considering the effect of taxes, which the policyholder would have to earn on an adjusted series of outlays to accumulate to the total cash value at the end of the period. The adjusted series of outlays equals the actual outlay in each year less the cost of insurance protection for that year, which is based on the 1980 CSO Basic Table (K).

(2) Interest adjusted cost indexes are based on the policy excluding riders and are useful in comparing policies of similar types.

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EXHIBIT F: PAGE 1 OF 2

VANISHING PREMIUM PLAN PREPARED FOR CLIENT

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<th>CV Increase Less Net Payment</th>
<th>Total Cash Value</th>
<th>Total Death Benefit</th>
<th>Cash Premium Due</th>
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This is an illustration and not a contract.
Dividends are not guaranteed and are based on the current scale.
Cash values and death benefits may vary depending on actual experience.
This illustration assumes that recommended premium deposits are always made.
This illustration is only valid if all pages are included.
### EXHIBIT F: PAGE 2 OF 2

#### Summary Values at Age(s) 60, 65, and 70

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#### Cost Indexes

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This is an illustration and not a contract.

Dividends are not guaranteed and are based on the current scale.

Cash values and death benefits may vary depending on actual experience.

This illustration assumes that recommended premium deposits are always made.

(Name of company) does not give legal or tax advice. Please consult your professional tax advisors regarding any items which involve the interpretation of applicable tax laws.

Because of long-term interest rate trends, all policyholders should be aware that dividend scales at (name of company) and throughout the industry will likely be reduced at some point in the future. (Name of company) believes in providing full disclosure to our prospective policyholders, and we, therefore, suggest you consider obtaining additional illustrations to demonstrate the sensitivity of product values to potential reductions in dividends.

The term "vanish" does not mean that premiums are no longer due, but that the cash premium due reflects the payment of future gross annual premiums through the use of current dividends. If future dividends are reduced from the current, results of the vanish may differ from that illustrated.

Additional premium payments may be required if the current scale of dividends is reduced.

*Guaranteed values do not reflect any loans, surrenders or dividends from the policy.

Cash values are illustrated at the end of the year.

The actual beginning of year cash value will be lower when the dividends are surrendered to pay the premium.

This illustration is only valid if all pages are included.

This illustration assumes the surrender of paid-up values; these may be deemed as taxable income under I.R.C. sections 72(E) and 7702 and others. Please consult your professional tax advisor.

If this policy, in combination with any other insurance policies in-force or applied for, exceeds _______ dollars, special underwriting, reinsurance or commissioning may be required which could affect the premium and values illustrated.

The insured's tax bracket is 28%.
## EXHIBIT G: PAGE 1 OF 4

### VANISHING PREMIUM PLAN PREPARED FOR

**Male Non-smoker, Age 35**

$500,000

Initial Annual Premium $4,625.00

Dividends by PUIAs for 11 years, thereafter dividends reduce premiums with excess applied to purchase PUIAs

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<th>PUIAs Due</th>
<th>Total Cash</th>
<th>Cash Value of PUIAs</th>
<th>Total Cash Value Increase</th>
<th>CV Increase</th>
<th>Total Cash Value Less Net Payment</th>
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This proposal is valid only if all pages are included.
**EXHIBIT G: PAGE 2 OF 4**

**GUARANTEED LEDGER PROPOSAL PREPARED FOR**

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This proposal is valid only if all pages are included.
EXHIBIT G: PAGE 3 OF 4

IMPORTANT INFORMATION ABOUT THIS PROPOSAL

(Name of company) has a reputation for its financial integrity and for providing solid, long-term value to our policyholders. In keeping with that tradition, we encourage our clients to fully examine and understand the assumptions used in a life insurance proposal. We have provided the following information to help you make an informed purchase decision.

This proposal is not a contract; we recommend that you refer to your policy for a complete explanation of your policy benefits.

GUARANTEES
Only those premiums and values labeled as “guaranteed” in this proposal will be contractually guaranteed in your policy.

DIVIDENDS
Illustrated dividends, and all values depending on illustrated dividends, are based on the July 1990 dividend scale. They are neither guarantees nor estimates of future dividends.

The first dividend is dependent upon payment of the first premium due in the second year.

PREMIUM
Premiums due, when reduced by dividends, may vary substantially from the illustrated premiums due, depending on the actual dividends paid in future years.

VANISHING PREMIUMS
The policy illustrated requires that premiums be paid each year without limitation. However, it is possible that at some future date, dividends, and if necessary, the surrender of paid-up additions may become sufficient to pay current and future premiums due. The proposal shows this by indicating a time when premiums “vanish.”

If actual dividends are lower than illustrated, you would have to pay premiums beyond the date at which this proposal shows that premiums might “vanish.” For policies where premiums have already “vanished,” future premiums could be required.

LOANS AND SURRENDERS
The dividends shown in this proposal reflect the loans and loan interest rates as illustrated. Actual policy dividends will vary according to actual loan interest rates and loan activity.

This proposal is valid only if all pages are included.
TAXATION
This proposal may not fully reflect your actual tax or accounting situation. We suggest that you consult your professional advisors regarding the interpretation of current and proposed tax laws and accounting principles. The individual’s illustrated tax bracket is 28%.

PROPOSAL DESIGN
Internal Rates of Return on death have been calculated assuming that death takes place: (1) at the beginning of the year, and (2) at the end of the year (prior to the payment of the dividend). The two figures which result, represent the range of returns that will be delivered by the policy (based on the current dividend scale), depending on when during the year the insured dies. Internal Rates of Return on death are illustrated on a Traditional and Aggressive basis. While both assume that death occurs at the end of the policy year, the Aggressive basis makes the further assumption that the end of year dividends have been credited.

ALTERNATE PROPOSALS
In light of past interest rate trends, you should be aware that dividend scales at any company, including (name of company) could be reduced at any point in the future. Values illustrated are sensitive to changes in the dividend scale. If you wish to assess the sensitivity of the values illustrated to a drop in our current scale, you should review a second proposal prepared using a dividend scale lower than the scale currently being credited.

I have reviewed and reviewed four pages of this proposal, including footnotes. I also understand the implications of the above information on premium amounts and values illustrated.

Policyowner (For Trust: this should be signed by the Trustee)

Date

Presented by: Agent Date

This proposal is valid only if all pages are included
### EXHIBIT H

**ABREVIATED PAYMENT PLAN RESULTS**

<table>
<thead>
<tr>
<th>Policy Year</th>
<th>Results Based on the Current Dividend Scale</th>
<th>Results Based on a Divided Interest Rate 1% Less Than Current Scale</th>
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<td>303</td>
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<tr>
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*The Abbreviated Payment Plan uses dividend results to limit the number of premiums paid in cash. Results are not guaranteed. See Form 9-138 for details on how the Abbreviated Payment Plan works. Refer to the following "Full" Pay Ledger for a complete schedule of premium payments. †Based on the dividend scale reflected which is not guaranteed, no out-of-pocket cash outlay is required. Premiums are assumed to be paid by application of dividend credits. A reduction in the dividend scale could require you to make additional out-of-pocket cash outlays in one or more of these years.*
### EXHIBIT I: PAGE 1 OF 2

**UNIVERSAL LIFE**

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<th>Death Benefit (%)</th>
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<th>Death Benefit (%)</th>
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Total: 14,000

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Total: 21,000

The current rate is 8.50 percent for years 1–20, and 9.50 percent for years thereafter.
### EXHIBIT I: PAGE 2 OF 2

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#### 5% Interest-Adjusted Cost Indexes

| Guaranteed Values | 3.58 | 4.91 | 7.00 | 7.00 | 5 |
| 7.00% Illustrative Values | 1.60 | 1.24 | 7.00 | 7.00 | 381 |
| 8.50% Current Values | 1.09 | 0.01 | 7.00 | 7.00 | 391 |

Cost indexes are useful only for comparison of the related costs of similar policies. Charges for additional benefits have been removed from these indexes. The guaranteed columns reflect a guaranteed interest rate of 4.00% and guaranteed cost of insurance rates. Illustration for use in the state of __________. Initial guideline premiums: Net single 15,176 Net level 1,336 Maximum annual premium that complies with 7-pay test: 3,981

Columns other than guaranteed show values based on current cost of insurance rates and the interest rate indicated, and these columns are not guaranteed. Current interest rate is determined monthly. Using planned premiums this policy will terminate in policy year 31 based on guaranteed values.
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This illustration is only valid if all pages are included.
### EXHIBIT J. PAGE 2 OF 5

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<td>344,141</td>
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</tr>
</tbody>
</table>

This illustration is only valid if all pages are included.
IMPORTANT INFORMATION ABOUT THIS PROPOSAL

(Name of company) has a reputation for financial integrity and for providing solid, long term value to its policyholders. In keeping with that tradition, we encourage our clients to fully examine and understand the assumptions used in a life insurance illustration. We have provided the following information to help you make an informed purchase decision.

This proposal is not a contract; we recommend that you refer to your policy for a complete explanation of your policy benefits.

GUARANTEED COLUMN ASSUMPTIONS

Only those values labeled as “guaranteed” in this proposal will be contractually guaranteed in your policy.

Guaranteed values reflect the guaranteed cost of insurance charges which are not subject to change. Guaranteed values are illustrated using a guaranteed interest rate of 4% at any time and 5.5% over the life of the policy.

CURRENT COLUMN ASSUMPTIONS

Current values are illustrated using a current interest rate of 7.8% and are based on current cost of insurance charges, which are subject to change.

Additional interest is credited at the end of every 10th year and will be equal to 30% of the unborrowed interest credited during the previous 10 years. The additional interest feature is guaranteed.

The additional interest feature affects the current values in the following manner:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
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<tbody>
<tr>
<td>10</td>
<td>$2,105.37</td>
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<tr>
<td>20</td>
<td>$7,620.01</td>
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<tr>
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<td>40</td>
<td>$31,712.05</td>
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<td>50</td>
<td>$69,324.55</td>
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</table>

*The interest rate, credited from purchase, required to produce equivalent cash values every 10th year is 9.40%.

This illustration is only valid if all pages are included.
ASSUMED COLUMN ASSUMPTIONS

Assumed values are illustrated at an assumed interest rate of 7.55% and are based on current cost of insurance charges, which are subject to change.

Additional interest is credited at the end of every 10th year and will be equal to 30% of the unborrowed interest credited during the previous 10 years. The additional interest feature is guaranteed. The additional interest feature affects the assumed values in the following manner:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>10</td>
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<tr>
<td>20</td>
<td>$7,164.21</td>
</tr>
<tr>
<td>30</td>
<td>$15,513.62</td>
</tr>
<tr>
<td>40</td>
<td>$25,417.76</td>
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<td>50</td>
<td>$38,886.11</td>
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</tbody>
</table>

**The interest rate, credited from purchase, required to produce equivalent cash values every 10th year is 9.06%.

POLICY LOANS AND PARTIAL WITHDRAWALS

No policy loans or partial withdrawals of the cash surrender value are shown on this proposal.

CASE DESIGN ASSUMPTIONS

Your policy is illustrated on an assumed policy value basis.

You should carefully review the full proposal including the section entitled "Important Information About This Proposal."

I have received and reviewed all five pages of this proposal, including the section entitled "Important Information about This Proposal."

Policyowner (For Trust: this should be signed by the Trustee)

______________________________
Date

Presented by: ____________  ____________  ____________
### EXHIBIT K: PAGE 1 OF 4

**UNIVERSAL LIFE LEDGER**

<table>
<thead>
<tr>
<th>End of Year</th>
<th>Policy Values Based On</th>
<th>Policy Values Based On</th>
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<tbody>
<tr>
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<td>Cash Value</td>
<td>Death Benefit</td>
</tr>
<tr>
<td></td>
<td>Loan or Withdrawal</td>
<td>Cash Value</td>
</tr>
<tr>
<td>Age</td>
<td>Premium Outlay</td>
<td>For Year</td>
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This is an illustration, not an offer of insurance.
**EXHIBIT K: PAGE 2 OF 4**

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<th>End of Year</th>
<th>Age</th>
<th>Premium Outlay for Year</th>
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<td>Guar Max Expense Charge</td>
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<td>Cash Value</td>
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This is an illustration, not an offer of insurance.
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<th>End of Year</th>
<th>Male Age 45 Non-Smoker</th>
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<th>Annual Premium: $17,760.00</th>
<th>Additional Payment: $0.00</th>
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<td>Assumed Basis (5.95%)</td>
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<td>Total Premiums Paid</td>
<td>Total Loans/Withdrawals</td>
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<td>95</td>
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<td>5,454,605</td>
</tr>
</tbody>
</table>

The first year basic annual premium including riders is $17,760.00. WARNING/ TAX NOTICE: This illustration makes no representation or guarantees as to the tax treatment of life insurance transactions. The tax rules are complex and subject to change. This illustration is intended to comply with the rules limiting the amount of premiums (DEFRA) to meet the tax definition of life insurance. Loans or withdrawals may be taxable if premiums exceed allowances set forth under the law. The DEFRA and TAMRA premium limits are stated below only for the initial insurance amount. Any policy change would change these limits:

- DEFRA Single Premium Limit: $418,425.53
- DEFRA Annual Premium Limit: $55,568.30
- TAMRA Annual Premium Limit: $91,960.00

The information contained in this illustration is not intended to be legal or tax advice. Advice must be obtained from applicant’s own counsel.

This is an illustration, not an offer of insurance.
EXHIBIT K: PAGE 4 OF 4

EXPENSE DEDUCTIONS: An expense deduction is made from each premium paid on the policy. The present deduction is 3.5% on policies with attained specified face amount less than $1,000,000, and 2.5% on policies of $1,000,000 or above. These percentages may be changed by the company at any time but can never exceed 6%. In addition, a monthly expense deduction is assessed against policies with attained specified amount less than $1,000,000. This charge is $5 on policies between $25,000 and $99,999, and $3.50 on policies between $100,000 and $999,999.

CASH AND SURRENDER VALUE DEFINITIONS: Cash value is the policy value before the application of surrender charges. Surrender value is the policy value less any applicable surrender charges, withdrawals and outstanding loans. It is the amount actually available upon policy surrender.

PERSISTENCY BONUS, INSURANCE COSTS, EXPENSES AND INTEREST RATES: The current and assumed interest rate accumulations include an annual one half percent persistency bonus after the 10th year. The present insurance costs, expense charges and interest rates are subject to change by the company at any time. It may credit excess interest which may vary from time to time under a pattern that depends upon the date of premium payments. Variation may be caused by such factors as investment income, expenses, mortality and withdrawal experience under this series of Universal Life policies.

GUARANTEED BASIS: The expense charges and cost of insurance are illustrated at the maximum allowed. The guaranteed minimum rate of interest on policy cash values is 4.5%.

Loan amount is increased, each year, by the interest due on the loan. Premium payment in excess of the basic premium will be applied to reductions of any loan. The death benefit shown is the "net" after loans or withdrawal amounts. Interest on loans will be charged in advance at 8% and will be capitalized on the policy anniversary date, policy termination or loan repayment.

Values illustrated are end of year values. Premium payments, loans and withdrawals are assumed to occur at the beginning of the policy year.

<table>
<thead>
<tr>
<th>Indices</th>
<th>Guaranteed 10 year</th>
<th>Guaranteed 20 year</th>
<th>Assumed 10 year</th>
<th>Assumed 20 year</th>
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</thead>
<tbody>
<tr>
<td>Surrender costs:</td>
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<td>2.36</td>
</tr>
<tr>
<td>Net payment:</td>
<td>8.88</td>
<td>8.88</td>
<td>8.88</td>
<td>8.88</td>
</tr>
</tbody>
</table>

Indexes assume the time value of money to be 5 percent. An explanation of the cost indexes is provided in the "Life Insurance Buyer's Guide."

This is an illustration, not an offer of insurance.
<table>
<thead>
<tr>
<th>End of Year</th>
<th>Age</th>
<th>Gross Annual Outlay</th>
<th>Account Value</th>
<th>Cash Surm Value</th>
<th>Death Benefit</th>
<th>Account Value*</th>
<th>Cash Surm Value</th>
<th>Death Benefit</th>
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### EXHIBIT I: PAGE 2 OF 3

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**Summary**

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The current cost of insurance depends upon the premium payment pattern and the account value amount, and may increase or decrease accordingly.

**GUARANTEED VALUES:** Based on guaranteed interest, expense, and cost of insurance rates. The guaranteed interest rate is 7.5% of the 90 day CD rate, Chemical Bank of New York, but in no event less than 4.50%.

**PROJECTED VALUES:** Based on the projected interest rate, current expense and cost of insurance which are subject to change. Current interest rates are declared quarterly.

Projected and Guaranteed Values include guaranteed added interest credits on unborrowed values as follows: 0.25% at the end of year 10, an additional 0.25% at the end of year 15, and 0.125% at the end of years 17, 18, 19 and 20. The interest will be credited retroactively from the date of issue and prospectively while the policy is in force. Cash values equal to any outstanding loan balance will earn interest at 4.5%.

*Account Values subject to a graded surrender charge if policy is wholly or partially surrendered in first nine years.
†The Payments shown are not sufficient to maintain a policy in force under these assumptions.
The policy matures at age 100 on a projected basis with an Account Value of $2,093,184.
This is an illustration, not a contract.
This illustration has been checked against federal tax laws.
This illustration has been checked against the 7-pay test.
Illustrates total cash accumulation based on current interest rate. Net gain represents cash growth in excess of cumulative payments made into the policy. Net gain at age 65, $74,171. Net gain at age 75, $210,652.
EXHIBIT M: PAGE 1 OF 4

A LIVING BENEFIT UNIVERSAL LIFE PLAN

Living Benefit Universal Life Plan, described below, is one of the most versatile and comprehensive
life insurance programs available.

Most of us realize the need to provide additional dollars for our families in the event of our premature
death. However, in today's world of improved technology, the main concern has changed from
“What if I die prematurely?” to “What if I survive a serious illness?”
• “How do I pay for expenses not covered by health insurance?”
• “How do I pay for rehabilitation expenses?”
• “How do I make up for lost income?”

The solution to this new problem is “...” With this innovative
program, we will pay you a Living Benefit upon confirmed diagnosis of one of several specified
conditions. You do not have to die to collect!

Covered Conditions:
• Heart attack
• Stroke
• Life-Threatening Cancer
• Renal Failure
• Coronary Heart Surgery

Here is How It Works:
• You will receive $25,000 upon diagnosis of one of the specified catastrophic illnesses.
• If you die after receiving this Living Benefit, your beneficiaries will receive an additional
  $75,000.
• However, should you never experience one of these conditions, your beneficiaries will receive
  $100,000 tax-free and probate-free upon your death, plus any additional supplemental benefits.

Thank you for considering our exciting new Living Benefit plan. We hope you will agree that this
program offers the highest degree of protection and peace of mind for you and your loved ones.
### EXHIBIT M: PAGE 2 OF 4

**LIVING BENEFIT UNIVERSAL LIFE ILLUSTRATION**

**Policy Summary**
- **Issuer/Model**: [Details not specified]
- **Age**: 35
- **Premium Classification**: [Details not specified]
- **Prepared by**: [Details not specified]
- **Date**: 05/13/20
- **Total Death Benefit**: $100,000
  - **Death Benefit Option**: 1
- **Specified Amount**: $75,000
  - **Planned Payment Period**: 60 years
- **Accelerated Benefit**: $25,000
  - **Coverage Period**: 60 years
- **Planned Annual Premium**: $705.53
  - **Mode of Payment**: Annual
- **Initial Supp’l Premium**: $0.00
  - **Total Initial Premium**: $705.53

The annual deduction for $25,000 Accelerated Death Benefit: $76.82

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<th>Death Benefit at 8.00% Interest</th>
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**Federally Legislated Guideline Single Premium is** $20,369.44
**Federally Legislated Guideline Initial Premium is** $3,132.15

*Based on guaranteed values, policy coverage would terminate during policy year 36 unless planned periodic premiums are increased at that point. Additional contributions that increase the death benefit of the policy may require evidence of insurability.
NOTES TO THE UNIVERSAL LIFE ILLUSTRATION

Values are illustrated and based on premiums shown in the Total Premiums column of the Ledger Printout and are subject to policy provisions. Guaranteed values are calculated using the maximum cost of insurance factors that would be contained within the policy and a minimum guaranteed interest rate of 5.0%. Projected values are calculated using projected cost of insurance factors, and a current nonguaranteed interest rate of 8.00%, with an additional nonguaranteed persistency bonus of .5% of additional interest beginning in the sixth policy year. The current interest rate and projected cost of insurance factors are not guaranteed and may be changed by the company. Your actual values under the insurance program may change with variations in the interest rates, cost-of-insurance factors (mortality risk charges), and frequency, timing, and amount of your premium payments. As plan values may change in the future due to these factors, subsequent and similar illustrations may be furnished to you upon request.

Projected costs of insurance factors are based upon our current estimations of future mortality experience and are not guaranteed.

The amount of actual cash value available upon surrender of this coverage is subject to a surrender charge as described in your issued policy. During the first policy year, the amount of such charge would be $363.75. Charges for subsequent policy years are shown on Page 1 of this proposal as the difference between accumulation value and surrender value.

In the event of a policy loan, interest at the rate of 7.4% would be due annually in advance. The current rate of interest being credited to policy values impaired by policy loans is 6.0%

After the first policy year, withdrawals can be made against the net surrender value of the policy for a $25 administrative charge, as long as the amount is at least $500. After the withdrawal is made, at least $500 must remain in the surrender value. Withdrawals decrease the death benefit of the policy by the amount withdrawn.

Premium contributions, loans, and withdrawals are illustrated as of the beginning of the year. All other amounts are shown as of the end of the year.

Death benefits are shown as being reduced by any applicable withdrawals or loans. Any increases in coverage requested by the policyholder may require evidence of insurability, and are subject to the appropriate cost of insurance deductions.
A corridor amount of coverage, designed to comply with the current tax code, must be maintained in order for the coverage to enjoy favorable tax treatment. As such, any single premium, or other substantial additional premium tendered, or any request for a reduction in coverage that would violate the requirements of the tax code may result in the loss of this favorable tax treatment. The tax status of this policy as it applies to the owner of this contract should be reviewed each year.

Every effort has been made to comply with current tax law. However, due to the complexities and frequent changes in the tax code, premium patterns illustrated may not comply with all federal limitations. The content of this illustration should not be interpreted as assurance that premium tests have been satisfactorily met. In the event actual premiums received may adversely affect tax treatment, the policyholder will be notified. For complete information, it is recommended that a qualified tax advisor be consulted.

An explanation of the intended use of the cost indices is provided in the Life Insurance Buyer’s Guide. Such indices are useful only for the comparison of the relative costs of two or more similar policies. These indices have been calculated using the interest adjusted method with an assumed interest rate of 5%.

At the end of the 10th policy year, $1,500.94 was returned to the projected accumulation value by the UL-300 + Plus.

UL-300 + Plus is subject to guidelines which are numerous and complex. Please consult the policy form for complete details and information. Projected cost-of-insurance factors are based upon our current estimations of future mortality experience and are not guaranteed.

The schedule of premiums illustrated on this proposal would qualify the policy for the UL-300 + Plus return of mortality bonus through the 60th year, assuming there were no loans or withdrawals which violated the UL-300 + Plus guidelines. (See the policy for full details.)

This illustration includes an accelerated benefit rider which will pay a pre-death benefit for the conditions outlined in the policy. If the benefit is not paid sooner, it will be included as a death benefit.
### EXHIBIT N
STATEMENT OF CERTIFICATE (POLICY) COST AND BENEFIT INFORMATION
YEARLY RENEWABLE TERM ILLUSTRATION

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Cost Comparison Indexes—Based on 5.00% Interest

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An explanation of the intended use of these indexes is provided in the buyer’s guide.

*This May 30, 1991 illustration is based on the assumptions shown. Columns marked with an * are neither guarantees nor estimates. Actual experience may be different."
## EXHIBIT O

**PROTECTOR ILLUSTRATION**

**POLICY SUMMARY**

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### Projected, Re-entry

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The rates shown for the first 10 years are guaranteed. The re-entry rates shown are not guaranteed and are subject to evidence of insurability. The rates shown under the re-entry columns assume that you elect to re-enter and meet the necessary qualifications. This proposal is for illustration purposes only and is not a contract.
### EXHIBIT P: PAGE 1 OF 2

#### Coverage Summary: Amount 1,000,000 To Age 100

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**EXHIBIT P: PAGE 2 OF 2**

**SUMMARY**

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Interest Adjusted Indices @ 5.00%

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**Guaranteed Values**

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**Current Values**

Dividends buy paid-up additions to age 100.

Dividends in this Illustration are based on the current dividend scale and are neither guaranteed nor estimated for the future.

Issue of this policy at the rates illustrated is subject to underwriting approval.

Based on an initial seven pay premium of 35,900.00. This policy is not a modified endowment contract.

The death benefit shown is paid upon the second death. No insurance benefits other than the optional 1st-death term rider are payable at the first death. Age shown is based upon the joint equal age and is not necessarily the age of either insured.
**EXHIBIT Q: PAGE 1 OF 15**

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Please see attached sheets with important footnotes

Summary at 20 yrs

- Total Premiums: 101,191
- (Loss) Total Cash Value: 241,501
- (Guaranteed) Value of Dividends: 206,035
- (Value of Dividends): 35,466
- Difference: -140,310
- Average Difference per Year: -7,015
- Average Death Benefit: 1,006,626
- 5% Interest-Adjusted Costs:
  - At 10 Years: 3.85
  - At 20 Years: -1.76
- 5% Interest-Adjusted Payments:
  - At 10 Years: 16.64
  - At 20 Years: 10.11
Guaranteed cash values as shown on this illustration are only available if all premiums have been paid. The annual rate of interest underlying the computation of these guarantees is 4.00%.

All cash values shown are end-of-year values.

All illustrations for individual life insurance products are tested for the possibility of classification as a modified endowment for the purposes of federal income taxation. This test applies to policies entered into after June 20, 1988 and may not be used for policies in force before that date.

The illustrated outlays shown on this illustration would not cause it to be classified as a modified endowment. This test is not a guarantee that a particular policy will not be classified as a modified endowment in the future.

Figures depending on dividends are neither estimated nor guaranteed, but are based on the 1991 dividend scale.

Actual future dividends may be higher or lower than those illustrated depending on the company’s actual future experience.

The cost of the above policy over a period of years cannot be determined without taking into account the interest that would have been earned had the premiums been invested rather than paid to the insurer.

Net death benefits on all permanent plans means the face amount plus riders, if any, plus the end of year dividend less policy loans. A full dividend is not generally paid upon death during the policy year. Other variables are possible. Your agent will define the rules upon request.

The policy loan interest rate shown on your illustration is payable in advance at a discount rate equivalent to an annual rate of 8.00%. Dividends are affected by policy loans. Under current economic conditions, in any given policy year the greater the amount of loan, the smaller the dividend. (This does not apply to economix term, which has no loan value.)

The illustration is calculated assuming that the policy split option is included. The policy split option is included in a policy if it insures two lives married to each other. Your agent can supply details on the importance of this feature and details regarding its exercise.

The death benefit is payable only when both insureds have died.

The initial additional amount shown in this illustration is only available if PUA/PUI payments and OYD premiums illustrated are paid. If payments are not made, the target amount may be reduced.

The death benefits in this illustration, particularly in the later policy years, are sensitive to the schedule of PUA or PUI deposits as well as the current dividend scale. If the schedule of deposits is not maintained, or the dividend scale is decreased, the death benefit may not be maintained.

The initial number of years of cash outlays shown in this illustration may be less than the required number because of the manner in which the illustration was requested. If so, additional cash outlays will be required in later years.

The number of years of required cash outlays depends upon ages at issue, smoking classifications, policy class, face amount, and continuation of current dividend scale and one-year term rates, and assumes no policy loans. This is not an automatic dividend option. Policyowner must request change of dividend option at policy year indicated. He may pay the balance of premium by surrendering a portion of paid up insurance. This is not a paid-up policy; premiums are due and payable in all policy years.

1) Interest-adjusted cost indexes are based on the policy excluding riders and are useful in comparing policies of similar types.
While it may be possible to exclude the proceeds of this policy from the insured’s estates, legal advice should be obtained from qualified counsel.
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Please see attached sheets with important footnotes.

Summary at 20 Yrs

| Total Premiums: | 197,383 |
| (Less) Total Cash Value: | 309,312 |
| (Guaranteed) | 206,035 |
| (Value of Dividends) | 103,277 |
| Difference | -111,929 |
| Average Difference per Year | -5,596 |
| Average Death Benefit | 1,004,588 |
| 5% Interest-Adjusted Costs(1): | |
| At 10 years | 5.31 |
| At 20 Years | 1.85 |
| 5% Interest-Adjusted Payments: | |
| At 10 Years | 18.10 |
| At 20 Years | 13.72 |
EXHIBIT Q: PAGE 6 OF 15

This illustration is based on the plan, face amount, dividend option and underwriting class specified by the agent. However, results based on dividends are based on a modified scale. The interest rate factor of this dividend scale is assumed to be a level 8.000%, but other components of this scale are identical with the 1991 dividend scale. This illustration is intended to show what term insurance amounts and costs would be if the dividend scale decreases materially due to a reduction in interest rates.

Guaranteed cash values as shown on this illustration are only available if all premiums have been paid. The annual rate of interest underlying the computation of these guarantees is 8.000%.

All cash values shown are end-of-year values.

All illustrations for individual life insurance products are tested for the possibility of classification as a modified endorsement for the purposes of federal income taxation. This test applies to policies entered into after June 20, 1988 and may not be used for policies in force before that date.

The illustrated outlays shown on this illustration would not cause it to be classified as a modified endorsement. This test is not a guarantee that a particular policy will not be classified as a modified endorsement in the future.

Figures depending on dividends are neither estimated nor guaranteed, but are based on a hypothetical dividend scale.

Actual future dividends may be higher or lower than those illustrated depending on the company's actual future experience.

The cost of the above policy over a period of years cannot be determined without taking into account the interest that would have been earned had the premiums been invested rather than paid to the insurer.

Net death benefit on all permanent plans means the face amount plus riders, if any, plus the end-of-year dividend less policy loans. A full dividend is not generally paid upon death during the policy year. Other variables are possible. Your agent will define the rules upon request.

The policy loan interest rate shown on your illustration is payable in advance at a discount rate equivalent to an annual rate of 8.00%. Dividends are affected by policy loans. To the extent the dividend scale is based on an interest rate greater than 7.00%, any given policy year the greater the amount of loan, the smaller the dividend.

The illustration is calculated assuming that the policy split option is included. The policy split option is included in a policy if it insures two lives married to each other. Your agent can supply details on the importance of this feature and details regarding its exercise.

The death benefit is payable only when both insureds have died.

The target additional amount shown in this illustration is only available if PUA/PUI payments and DYT premiums illustrated are paid. If payments are not made, the target amount may be reduced.

The death benefits in this illustration, particularly in the later policy years, are sensitive to the schedule of PUA or PUI deposits as well as the current dividend scale. If the schedule of deposits is not maintained, or the dividend scale is decreased, the death benefit may not be maintained.

1. Interest-adjusted cost indexes are based on the policy excluding riders and are useful in comparing policies of similar types.

While it may be possible to exclude the proceeds of this policy from the insureds' estates, legal advice should be obtained from qualified counsel.
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Please see attached sheets with important footnotes.

Summary at 20 yrs:

| Total Premiums: | 202,383 |
| (Less) Total Cash Value: | 559,266 |
| (Guaranteed) | 255,440 |
| (Value of Dividends) | 303,826 |
| Difference | -356,883 |
| Average Difference per Year | -17,844 |
| Average Death Benefit | 1,012,351 |
Guaranteed cash values as shown on this illustration are only available if all premiums have been paid. The annual rate of interest underlying the computation of these guarantees is 4.00%.

All cash values shown are end of year values.

All illustrations for individual life insurance products are tested for the possibility of classification as a modified endowment for the purposes of federal income taxation. This test applies to policies entered into after June 20, 1988 and may not be used for policies in force before that date.

The illustrated outlays shown on this illustration would not cause it to be classified as a modified endowment. This test is not a guarantee that a particular policy will not be classified as a modified endowment in the future.

Figures depending on dividends are neither estimated nor guaranteed, but are based on the 1991 dividend scale.

Actual future dividends may be higher or lower than those illustrated depending on the company’s actual future experience.

The cost of the above policy over a period of years cannot be determined without taking into account the interest that would have been earned had the premiums been invested rather than paid to the insurer.

Net death benefit on all permanent plans means the face amount plus riders, if any, plus the end of year dividend less policy loans. A full dividend is not generally paid upon death during the policy year. Other variables are possible. Your agent will define the rules upon request.

The policy loan interest rate shown on your illustration is payable in advance at a discount rate equivalent to an annual rate of 8.00%. Dividends are affected by policy loans. Under current economic conditions, in any given policy year the greater the amount of loan, the smaller the dividend. (This does not apply to economic term, which has no loan value.)

The illustration is calculated assuming that the policy split option is included. The policy split option is included in a policy if it insures two lives married to each other. Your agent can supply details on the importance of this feature and details regarding its exercise.

The net paid up insurance shown is the amount that can be purchased with the end of year net cash value (remainder after loan has been repaid). Since repayment of the loan at this time may have tax consequences, you should consult your agent for alternatives.

Results in this illustration assume death of a specified insured in a certain policy year. Should death occur before or after that specified year, results will be different.

The death benefit is payable only when both insureds have died.

The target additional amount shown in this illustration is only available if PUA/PUI payments and OYT premiums illustrated are paid. If payments are not made, the target amount may be reduced.

The death benefits in this illustration, particularly in the later policy years, are sensitive to the schedule of PUA or PUI deposits as well as the current dividend scale. If the schedule of deposits is not maintained, or the dividend scale is decreased, the death benefit may not be maintained.

(1) Interest-adjusted cost indices are based on the policy excluding riders and are useful in comparing policies of similar types.

While it may be possible to exclude the proceeds of this policy from the insureds’ estates, legal advice should be obtained from qualified counsel.

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Please see attached sheets with important footnotes.

**Summary at 20 yrs**

- Total Premiums: 202,365
- (Less) Total Cash Value: 316,505
- (Guaranteed) 206,035
- (Value of Dividends) 110,470
- Difference -114,122
- Average Difference per Year -5,706
- Average Death Benefit 1,004,646
- 5% Interest-Adjusted Costs(1):
  - At 10 Years: 5.31
  - At 20 Years: 1.85
- 5% Interest-Adjusted Payments:
  - At 10 Years: 18.10
  - At 20 Years: 13.72

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EXHIBIT Q: PAGE 12 OF 15

This illustration is based on the plan, face amount, dividend option and underwriting class specified by the agent. However, results based on dividends are based on a modified scale. The interest rate factor of this dividend scale is assumed to be a level 8.00%, but other components of this scale are identical with the 1991 dividend scale. This illustration is intended to show what term insurance amounts and costs would be if the dividend scale decreases materially due to a reduction in interest rates.

Guaranteed cash values as shown on this illustration are only available if all premiums have been paid. The annual rate of interest underlying the computation of these guarantees is 4.00%.

All cash values shown are end of year values.

All illustrations for individual life insurance products are tested for the possibility of classification as a modified endowment for the purposes of federal income taxation. This test applies to policies entered into after June 20, 1988 and may not be used for policies in force before that date.

The illustrated outlays shown on this illustration would not cause it to be classified as a modified endowment. This test is not a guarantee that a particular policy will not be classified as a modified endowment in the future.

Figures depending on dividends are neither estimated nor guaranteed, but are based on a hypothetical dividend scale.

Actual future dividends may be higher or lower than those illustrated depending on the company's actual future experience.

The cost of the above policy over a period of years cannot be determined without taking into account the interest that would have been earned if the premiums been invested earlier than paid to the insurer.

Net death benefit on all permanent plans means the face amount plus riders, if any, plus the end of year dividend less policy loans. A full dividend is not generally paid upon death during the policy year. Other variables are possible. Your agent will define the rules upon request.

The policy loan interest rate shown on your illustration is payable in advance at a discount rate equivalent to an annual rate of 8.00%. Dividends are affected by policy loans. To the extent the dividend scale is based on an interest rate greater than 7.00%, in any given policy year the greater the amount of loan, the smaller the dividend.

The illustration is calculated assuming that the policy split option is included. The policy split option is included in a policy if it insures two lives married to each other. Your agent can supply details on the importance of this feature and details regarding its exercise.

The death benefit is payable only when both insureds have died.

The target additional amount shown in this illustration is only available if PU or PUI payments and OVT premiums illustrated are paid. If payments are not made, the target amount may be reduced.

The death benefits in this illustration, particularly in the later policy years, are sensitive to the schedule of PU or PUI deposits as well as the current dividend scale. If the schedule of deposits is not maintained, or the dividend scale is decreased, the death benefit may not be maintained.

(1) Interest-adjusted cost indices are based on the policy excluding riders and are useful in comparing policies of similar types.

While it may be possible to exclude the proceeds of this policy from the insured's estates, legal advice should be obtained from qualified counsel.

In _________this illustration must be accompanied by the following supplemental illustrations.
## EXHIBIT Q: PAGE 13 OF 15

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**Note:** Illustration assumes death of male, age 55 non-smoker at beginning of age 64.
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### Summary at 20 yrs

- **Total Premiums:** 101,191
- **Less Total Cash Value:** 581,726
- **Guaranteed Cash Value:** 255,440
- **Value of Dividends:** 126,286
- **Difference:** -280,534
- **Average Difference per Year:** -14.06
- **Average Death Benefit:** 1,010,208

**5% Interest-Adjusted Costs:**
- **At 10 Years:** -4.86
- **At 20 Years:** -8.28

**5% Interest-Adjusted Payments:**
- **At 10 Years:** 15.97
- **At 20 Years:** 6.44
EXHIBIT Q: PAGE 15 OF 15

Guaranteed cash values as shown on this illustration are only available if all premiums have been paid. The annual rate of interest underlying the computation of these guarantees is 4.00%.

All cash values shown are end of year values.

All illustrations for individual life insurance products are tested for the possibility of classification as a modified endowment for the purposes of federal income taxation. This test applies to policies entered into after June 20, 1988 and may not be used for policies in force before that date.

The illustrated outlays shown on this illustration would not cause it to be classified as a modified endowment. This test is not a guarantee that a particular policy will not be classified as a modified endowment in the future.

Figures depending on dividends are neither estimated nor guaranteed, but are based on the 1991 dividend scale.

Actual future dividends may be higher or lower than those illustrated depending on the company's actual future experience.

The cost of the above policy over a period of years cannot be determined without taking into account the interest that would have been earned had the premiums been invested rather than paid to the insurer.

Net death benefits on all permanent plans means the face amount plus riders, if any, plus the end of year dividend less policy loans. A full dividend is not generally paid upon death during the policy year. Other variables are possible. Your agent will define the rules upon request.

The policy loan interest rate shown on your illustration is payable in advance at a discount rate equivalent to an annual rate of 6.00%. Dividends are affected by policy loans. Under current economic conditions, in any given policy year the greater the amount of loan, the smaller the dividend. (This does not apply to economax term, which has no loan value.)

The illustration is calculated assuming that the policy split option is included. The policy split option is included in a policy if it insures two lives married to each other. Your agent can supply details on the importance of this feature and details regarding its exercise.

Results in this illustration assume death of a specified insured in a certain policy year. Should death occur before or after that specified year, results will be different.

The death benefit is payable only when both insureds have died.

The target paid-up amounts shown in this illustration is only available if premium payments and OYU premiums illustrated are paid. If payments are not made, the target amount may be reduced.

The death benefits in this illustration, particularly in the later policy years, are sensitive to the schedule of OUP or PUI deposits as well as the current dividend scale. If the schedule of deposits is not maintained, or the dividend scale is disrupted, the death benefits may not be maintained.

The number of years of required cash outlays depends upon ages at issue, smoking classifications, policy class, face amount, and continuation of current dividend scale and one year term rates, and assumes no policy loans. This is not an automatic dividend option. Policy owner must request a policy dividend option at policy year indicated. He may pay the balance of premium by surrendering a portion of paid-up insurance. This is not a paid-up policy; premiums are due and payable in all policy years.

[1] Interest-adjusted cost indices are based on the policy excluding riders and are useful in comparing policies of similar types.

While it may be possible to exclude the proceeds of this policy from the insureds' estates, legal advice should be obtained from qualified counsel.
LIFE INSURANCE SALES ILLUSTRATIONS

APPENDIX III
SUMMARY OF COMMENTS ON THE PRELIMINARY REPORT

The Task Force received a number of comments on the preliminary report, both in writing and at the open forums. These comments are summarized below. The Task Force carefully reviewed these comments in the development of our conclusions. Copies of all correspondence will be made available to the AAA and CIA for their consideration.

Applicability to variable life

Several commenters noted that the alternatives identified were not appropriate for variable life policies.

The Task Force agreed that our report focused on the illustration practices for general account policies. The first section was changed to exclude variable life policies from the scope of our research, other than as an alternative illustration model.

Define the problem and the role of the actuary

Several commenters suggested the need to define the problems with illustrations at an earlier point in the report and the role of the actuary in solving these problems.

The Task Force agreed and added these points to the first section.

Research methodology

Many commenters suggested that our research should include consumer interviews or focus groups.

The Task Force discussed this approach with market researchers associated with LIMRA. They indicated that focus groups would tell us how they think they should have used illustrations during the sales process, as opposed to how the illustration was actually reviewed and considered by the buyer. For this reason, we did not pursue this methodology.

What data should be on the illustration

One commenter noted that our Task Force does not define the data that every consumer should have available on the illustration.

The Task Force used current regulations to define a starting point. We recommended changes as we deemed necessary and appropriate.
Valuation

One commenter suggested that the underlying problem in the U.S. is its conservative valuation procedures. The Task Force believes the revision of valuation procedures is beyond the scope of our research.

Concerns with current practices

Several commenters brought what they considered unique or questionable illustration practices to our attention to ensure that the final report would encompass these practices. The Task Force considered these comments in developing our conclusions.

Alternatives to Type B usage

Many commenters agreed with the conclusion that illustrations cannot be used for Type B analysis in today’s environment. Those who disagreed argued that consumers require a tool to measure relative performance. Among their comments were:
- It should be possible to provide reasonable estimates of future performance based on credible assumptions
- Sensitivity analysis or the range approach should help the consumer determine variation
- Illustrations are the best indicator until some better measure is developed.

The Task Force acknowledges that a methodology for measuring and comparing products should be developed. We have added a recommendation that the SOA continue research in this area. We strongly support sensitivity analysis and the use of reasonable, credible assumptions, but that still does not address the variation among companies regarding relative conservatism in the choice of underlying assumptions.

Concerns with alternative practices

Many commenters pointed out concerns and problems with the suggested alternatives in the areas of implementation, helpfulness to the consumer, and potential for abuse. The Task Force considered these comments in restructuring the alternatives and developing conclusions on each.
LIFE INSURANCE SALES ILLUSTRATIONS

Disclosure and standards

Many commenters stated a preference for solutions involving improved disclosure or standards of practice, rather than increased regulation. Some even provided sample disclosures for the illustration.

These comments will be passed on to the CIA and AAA for their consideration in developing an implementation plan for changes to illustration practices.

Limited control by actuaries

Several commenters noted that the illustration practices are set by company management, with input from the actuaries. Further, neither the actuaries nor management are present when the agent meets with the buyer. Therefore, there is little that actuaries can effectively do to change industry practices.

The Task Force acknowledges the fact that the role of the actuary in the illustration process does not provide our profession with complete control. However, the actuary has a role in identifying shortcomings of current practices for management and others, and in developing appropriate and ethical standards of practice for the profession.
APPENDIX IV


“Illustrations Review,” LAUTRO, U.K.


LIFE INSURANCE SALES ILLUSTRATIONS

Discussions from Record of the Society of Actuaries


Articles from Transactions of the Society of Actuaries

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IUL Illustration (A) Subgroup
Conference Call
January 28, 2020

The IUL Illustration (A) Subgroup of the Life Actuarial (A) Task Force met via conference call Jan. 28, 2020. The following Subgroup members participated: Fred Andersen, Chair (MN); Ted Chang (CA); Andrew Greenhalgh (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Bill Carmello (NY); Peter Weber (OH); Mike Boerner, John Carter and Rachel Hemphill (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Comments on the IUL Illustration Questions Exposed on Nov. 1

Mr. Andersen said that in 2019, there were two Life Actuarial (A) Task Force conceptual votes on indexed universal life (IUL) issues. The Task Force voted to prohibit products with multipliers from illustrating better than products without multipliers and products with other product enhancements, such as cap buy-ups, from illustrating better than products without those features. He said there are a number of conceptual issues to be resolved, including the grandfathering of illustrations for previous policies, the handling of loans and the drafting of revised language for Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49) to reflect these concepts.

Mr. Weber recalled that the Subgroup had agreed by straw poll to put a 100-basis point limit on loan arbitrage.

Mr. Boerner had a similar recollection. He asked NAIC staff to review previous Subgroup minutes to confirm his recollection.

Scott Harrison (Harrison Law Office) said he met with several companies to attempt to reach consensus on language to capture the proposed AG 49 revisions. He said during those meetings, a number of interpretational issues were identified. The group decided to list those issues, identify some goals and attempt to provide additional context around the proposed language. He provided an industry document (Attachment Six-B1) intended to identify four issues with the proposed language that may require clarification.

Ernest Armijos (Pacific Life) said the first issue is to clarify whether state insurance regulators have a preference for either of the previously proposed versions of the language addressing the supplemental option budget (Option A or Option B). He said both versions achieve much of the Task Force’s objective of restricting the illustration of multiplier and buy-up features, but both still allow illustration of a smaller multiplier benefit. He said if state insurance regulators prefer neither option, industry is willing to pursue a different solution. He said Option A defines the option budget as a charge that explicitly increases the amount spent to generate index credits. It limits the indexed credits such that they can only be as high as the charges.

Mr. Armijos noted that there are still a few remaining interpretational issues, as indicated on page 2 of the industry document. He said the differences in interpretations indicate the difficulty in determining how a charge can be used in a given situation. Two examples were provided to demonstrate the variation in interpretations of how charges can be used.

Graham Summerlee (Lincoln Financial Group) said the examples in the industry document are attempting to point out instances that are contrary to the Subgroup’s premise that a product with a multiplier can illustrate no better than a product without a multiplier. He said industry wants the Subgroup to determine whether the results depicted in the examples are acceptable, or if the Subgroup requires its premise to be firmly upheld in all situations. He said the decision is needed in order for appropriate language to be proposed.
Mr. Andersen said it does not seem possible to draft language that would be applicable to all situations. He said if the new language results in maximum illustrated rates that are less than the 7% or 8% experienced prior to AG 49, the Subgroup will generally be happy.

Gayle Donato (Nationwide) suggested that a fully revised AG 49 be drafted that would address the multiple components that can be included in IUL policies.

Mr. Andersen asked for comments, due by Feb. 14, on the options related to the supplemental option budget presented in the industry document. He said comments that provide pros and cons of either option, provide an additional option, or include proposed draft revisions to AG 49 will be appreciated.

Having no further business, the IUL Illustration (A) Subgroup adjourned.
INDUSTRY FEEDBACK ON IUL EXPOSURE DRAFTS (10/29/2019 and 11/01/2019)

Since the LATF straw poll taken on October 17, 2019, insurers have submitted drafts of changes to AG49 that reflect their interpretation of the types of revisions that are needed to support LATF’s stated objective: That multiplier products illustrate no higher than non-multiplier products. Those proposed revisions are referred to in this document as the “11/01/2019 Exposure” or “the Nationwide letter”, and the “10/29/2019 Exposure.”

Despite these and other efforts to produce satisfactory changes to AG49, progress has been hindered because certain key provisions that have been proposed are subject to multiple interpretations over which the industry lacks consensus. The uncertainty over the treatment of buy-up accounts, which was resolved at the NAIC Austin meeting, is just one example of differing interpretations of draft AG49 changes requiring guidance from regulators.

To continue the progress that was made in Austin and move toward producing amendments to AG49 in line with LATF’s stated intentions, this document identifies four issues in the proposed language for potential clarification. With respect to each issue we (1) identify the relevant proposed language; (2) describe the possible interpretations; and (3) note the impact each interpretation will have on the illustration. We believe it is critical that any changes to AG49 be clear and unambiguous, which is why receiving clarification from regulators on these provisions is necessary before drafting of changes to the guideline can be finalized.

**Issue #1. Are either of the current options regarding the Supplemental Option Budget which are meant to restrict the illustration of multiplier and buy-up features acceptable to regulators?**

Two different versions of language addressing the Supplemental Option Budget have been proposed (described in more detail below as “Option A” and “Option B”). While both Option A and Option B achieve much of what LATF intended to accomplish on its October 17, 2019 straw vote, they do so in different ways. Both would still allow for some, albeit significantly smaller, multiplier benefits to be shown. Clarification is needed as to whether regulators have a preference between Option A and Option B, or another approach.
Option A: 11/01/2019 Exposure

The proposed language provides as follows:

3. **G. Supplemental Option Budget:** Any asset-based charges or other policy charges that are explicitly used to increase the total amount spent to generate the Indexed Credits of the policy. This amount is expressed as a percent of the policy’s indexed account value.

4. **E. If charges that fund a Supplemental Option Budget are deducted from the illustrated cash value, then Indexed Credits generated by the return from the Supplemental Option Budget within the scenario being illustrated may be illustrated in an amount up to, but not exceeding, such charges.

**Benefit:** Clearly identifies the Supplemental Option Budget as a charge that is explicitly used to increase the total amount spent to generate Index Credits. It is also clear that any Indexed Credits, by the return from the Supplemental Option Budget, can only ever be as high as the charges themselves.

**Interpretational Issues:** The draft language allows for at least two interpretations, each producing different outcomes:

**Interpretation A:** The draft language does not allow illustration of bonuses other than those funded through NIER to enhance the maximum AG49 values.

**Interpretation B:** The draft language allows a bonus without a charge to enhance the maximum AG49 values since it is already limited by DCS testing as modified in Section 5B.

The differences in interpretation result from the fact that policy charges in general can be used for a variety of purposes. Determining how a charge is being used in every situation could be extremely difficult to ascertain.

What follows are examples of how, working combination with section 5B, this section may still allow for bonuses that take the shape of a multiplier to be illustrated.

**Example 1:** Assuming a cap of 10% and a maximum AG49 lookback of 6.15%, suppose we assume that the cost of such an account is 4.5%. 145% of 4.5% is 6.525%. Based upon those assumptions it would be possible to Illustrate a persistency bonus not explicitly funded by charges but which provides a credit expressed as a percentage of index-linked credits and which is supported by hedges. The supporting hedges could increase the earned rate from 6.15% to 6.525% and still comply with this draft language.

**Example 2:** Assume with an option budget of 4.5%, a cap of 10% can be afforded with a multiplier of 0%, resulting in a maximum AG49 lookback rate of 6.15%. The option budget
of 4.5% could alternatively purchase a cap of <10% and a multiplier > 0%, such as a cap of 8% and a multiplier of 15%, resulting in a maximum AG49 lookback rate of 5.15%. The chart below shows the effective illustrated rates for these two indexed accounts.

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<tr>
<th></th>
<th>Index Account 1</th>
<th>Index Account 2</th>
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<tr>
<td>Option Budget</td>
<td>4.5%</td>
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<tr>
<td>Supplemental Option Budget</td>
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</tr>
<tr>
<td>Cap</td>
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<td>8%</td>
</tr>
<tr>
<td>Multiplier</td>
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<td>15%</td>
</tr>
<tr>
<td>Max AG49 Lookback Rate</td>
<td>6.15%</td>
<td>5.15%</td>
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<tr>
<td>Effective illustrated rate post multiplier (assuming 3% illustrated rate)</td>
<td>3% x (1+ 0% multiplier) = 3.0%</td>
<td>3% x (1+ 15% multiplier) = 3.45%</td>
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<tr>
<td>Effective illustrated rate post multiplier (assuming 4% illustrated rate)</td>
<td>4% x (1+ 0% multiplier) = 4.0%</td>
<td>4% x (1+ 15% multiplier) = 4.6%</td>
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<td>Effective illustrated rate post multiplier (assuming max AG49 illustrated rate)</td>
<td>6.15% x (1+ 0% multiplier) = 6.15%</td>
<td>5.15% x (1+ 15% multiplier) = 5.92%</td>
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**Other issues:** Many discussions have centered on the potential issues that defining the Supplemental Options Budget as a charge could create. Policy charges in general can be used for a variety of purposes and it could be difficult to ascertain whether a charge is being used explicitly for the purposes of generating indexed credits. For example, it would be difficult to know whether a portion of COI charges or per 1000 Face Amount charges is being used to increase the option budget. Another example would be that a source other than a charge could be used to fund a supplemental option budget, such as reducing a persistency bonus in later years to fund a supplemental option budget.

**Option B: 10/29/2019 Exposure**

The proposed language provides as follows:

3. **G. Supplemental Option Budget:** The total amount spent to generate the Indexed Credits of the policy minus the Annual Net Investment Earnings Rate. This amount is expressed as a percent of the policy’s indexed account value.

4. **E.** The total Index Credits illustrated shall not exceed the annual earned interest rate underlying the disciplined current scale as defined in 5 (A) and (B).
**Benefit:** This version bypasses the issue of where the budget for policy enhancements can come from by tying the maximum illustrated enhancement to the Net Investment Earned Rate. This would help close a potential loophole it is tied to a well-defined metric.

**What it still allows:** In combination with section 5B, this section may still allow illustration of charged for policy enhancements such as multipliers and buy-up accounts. A simple example of this would be to assume a cap of 10% and a maximum AG49 lookback of 6.15. Assume further an earned rate of 4.5% and a hedge cost of 4.5%. 145% of 4.5% is 6.525%

Here are two examples:

**Example 1:** Given that 4.E. does not mandate that charged for features only credit back the charges, there is an avenue that a charged for multiplier could exist to increase the credit up to 6.525% from 6.15%. The multipliers or buy-up features that result from this difference (6.525% - minus 6.15%) are significantly reduced from the multipliers that exist in the market today. In the example above, the resulting multiplier would be 6% and the charge for such a multiplier could be 27bps of Account Value. Although the enhancements and charges are significantly reduced in this scenario, they would still be illustratable.

Example 2: Assume with an option budget of 4.5%, a cap of 10% can be afforded with a multiplier of 0%, resulting in a maximum AG49 lookback rate of 6.15%. The option budget of 4.5% could alternatively purchase a cap of <10% and a multiplier > 0%, such as a cap of 8% and a multiplier of 15%, resulting in a maximum AG49 lookback rate of 5.15%. The chart below shows the effective illustrated rates for these two indexed accounts.

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<tr>
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<td>4% x (1+ 15% multiplier) = 4.6%</td>
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Effective illustrated rate post multiplier (assuming max AG49 illustrated rate)  

<table>
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<th>Illustration</th>
<th>Calculation</th>
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<tr>
<td>6.15% x (1+ 0% multiplier) = 6.15%</td>
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<tr>
<td>5.15% x (1+ 15% multiplier) = 5.92%</td>
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**Other issues:** Some concerns around the language in 4E should be converted to a return on assets to be comparable to the annual earned interest rate.

**Issue #2: What are the appropriate ways to set the maximum illustrated rate for Index Accounts that have a different risk profile than the Benchmark Index Account?**

This issue relates to the current language in Section 4.C, which states:

```
For other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. The determination shall reflect the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. In no event shall the credited rate for the illustrated scale exceed the applicable rate calculated in 4 (B).
```

**Why guidance is needed:**

Many index accounts have a different risk profile than the Benchmark Index Account. For example, certain index accounts use bonds, cash or commodities or use different crediting methods. AG 49 provides that the maximum illustrated rate for these index accounts is determined using actuarial judgment, subject to two requirements: the maximum illustrated rate (1) shall reflect an appropriate relationship to the expected risk and return of the applicable Benchmark Index Account and (2) shall not exceed the maximum illustrated rate for the Benchmark Index Account. The guideline provides little guidance for the first requirement. Are regulators okay with the fact that assessments of expected risk and return may vary in the industry? As an example, varying assessments could result in maximum illustrated rates that differ between products that have the same index, same crediting method, and same index parameters.
Issue #3: Clarification is needed as to whether the intent is to limit this to the dollar amount of earnings produced by the GA assets or the interest rate of earnings on the GA assets.

The direction provided by the IUL Subgroup is that the hedge cost that can assume a 145% return is limited to the earnings on the GA portfolio.

Example:

GA portfolio assets = $1000  
Earned rate on GA portfolio = 5%  
Dollar amount of GA earnings = $50

If the account value also equals $1000, using the dollar amount or rate allows the same hedge cost of up to $50 to assume a 145% return, resulting in a hedge return of $72.50.

However, when the account value is higher or lower than the assets, the two approaches can produce a different result.

Under the dollar amount approach, up to $50 of hedge cost can assume a 145% return, resulting in a hedge return of $72.50.

  If the account value is $800, the $50 hedge cost assuming 145% is 6.25% of the AV ($50 / $800)

  If the account value is $1,200, the $50 hedge cost assuming 145% is 4.17% of the AV ($50 / $1,200)

Under the interest rate approach, 5% of the account value can assume a 145% return, resulting in different amounts of hedge cost that assumes 145% than the dollar amount earned by the GA assets.

  If the account value is $800, 5% of the account value or $40 of hedge cost can assume 145%, producing a hedge return of $58.

  If the account value is $1,200, 5% of the account value or $60 of hedge cost can assume 145%, producing a hedge return of $87.
The Nationwide letter dated 11/12/2019 identifies two possible methods of incorporating hedge cost and return in DCS testing (Section 5.B.A) which can produce different results. Guidance is needed as to whether these differences are acceptable.

**ISSUE #4  Should any credits, such as a fixed bonus, that are not directly tied to the performance of an index account, be included within the 100 basis point limit?**

Proposed language for section 6.B in the 11/01/2019 Exposure indicates that credits, such as a fixed bonus, that are not tied directly to the performance of an index account, should not be included within the 100 basis point limit:

| If the illustration includes a loan, the total index credits to the policy loan balance shall not exceed the interest rate charged to the loan by more than 100 basis points. For example, if the loan charge is 4% of the loan balance, index credits to the loan balance cannot exceed 5%, regardless of product features available. |

However, the language above should include the following:

- Incorporating the pre-defined term “Indexed Credits” into the language above. From the “Definition” section of the 11/01/2019 exposure:
  - **Indexed Credits:** Any interest credit, multiplier, factor, bonus, or other enhancement to policy values that is linked directly or indirectly to an index or indices.
- How to incorporate charges used to fund a Supplemental Option Budget that apply to the loan balance
- Suggested revised language:

| If the illustration includes a loan, the total Indexed Credits as a result of the policy loan shall not exceed the illustrated rate charged to the loan by more than 100 basis points. The illustrated rate charged on the loan is inclusive of any asset-based fee or other policy charges used to fund a Supplemental Option Budget. For example, if the illustrated rate charged on the loan is 4% of the loan balance, Indexed Credits as a result of the policy loan cannot exceed 5%, regardless of product features available. |

Additionally, there are philosophical differences concerning whether credits, such as a fixed bonus, that are not directly tied to the performance of an index account, ought to be included within the 100 basis point limit. Guidance from regulators is therefore needed regarding the following two options:

- **Option #1:** The limit is absolute and therefore should apply to the total amounts credited to indexed account (inclusive of any non-indexed bonus).
Option #2: The limits should only apply to the credit that is tied to the index performance and the addition of a bonus that is not impacted by index performance should not be affected by the 100 basis point limit.

Once there is clarification around which option is preferred, additional language can be added to increase transparency around the issue.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

**Identification:**
Brian Bayerle, ACLI

**Title of the Issue:**
Remove 4% Floor from Life Standard Nonforfeiture Rate.

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

January 1, 2020 NAIC Valuation Manual – VM-02 Section 3.A

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

See attached.

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

Upon any possible tax code (IRC, S. 7702) modifications to remove the hardcoded interest rate floor starting in 1/1/2021, the life standard nonforfeiture rate is being updated to ensure the minimum funding under state requirements does not exceed the maximum funding under federal requirements for life insurance contracts issued starting in 1/1/2021.

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

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<td></td>
</tr>
</tbody>
</table>

**Notes:** VM APF 2020-07
VM-02

Version 1: Remove floor

Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the *Valuation Manual* shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the *Valuation Manual* for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the applicable interest rate used to meet the definition of life insurance in the Cash Value Accumulation Test under Section 7702 *(Life Insurance Contract Defined)* of the U.S. Internal Revenue Code 4%.

Guidance Note: For flexible premium universal life insurance policies as defined in Section 3.D of the *Universal Life Insurance Model Regulation* (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

William H. Wilton, FSA, MAAA
VM-30 – Reserve Table

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


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

The current reserve table for Exhibit 7 appears as follows:

<table>
<thead>
<tr>
<th>Statement Item</th>
<th>Formula Reserve (1)</th>
<th>Principle-Based Reserve (2)</th>
<th>Additional Reserve (3)</th>
<th>Analysis Method (4)</th>
<th>Other Amount (5)</th>
<th>Total Amount = (1)+(2)+(3)+(4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibit 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium and Other Deposit Funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guaranteed Interest Contracts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Contracts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annuities Certain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividend Accumulations or Refunds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Exhibit 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

However, the Annual Statement Blank is presented as:

```
EXHIBIT 7 - DEPOSIT-TYPE CONTRACTS

1  2  3  4  5  6
Total Guaranteed Interest Contracts Annuities Certain Supplemental Contracts Dividend Accumulations or Refunds Premium and Other Deposit Funds
```

I think our reserve table would be better presented in the order of Exhibit 7, i.e.

Guaranteed Interest Contracts
Annuities Certain
Supplemental Contracts
Dividend Accumulations or Refunds
Premium and Other Deposit Funds

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

In my opinion, the listing of items in the reserve table should be consistent with the presentation in Exhibit 7.

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

NAIC Staff Comments:

<table>
<thead>
<tr>
<th>Dates: Received</th>
<th>Reviewed by Staff</th>
<th>Distributed</th>
<th>Considered</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>

Notes: APF 2020-04
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

    Jason Kehrberg, Vice President, PolySystems, Inc.

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


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

    4. The NPR shall reflect the immediate payment of claims.

    Proposed VM-20 3.C.4:
    4. The NPR shall reflect continuous deaths and the immediate payment of death claims.

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

    I believe the intent was that 3.C.4 apply to death claims, e.g. not to payment of positive cash surrender values upon lapse, and that on a present value basis the calculated periodic death claim payments equate to immediate claim payment on deaths assumed to occur continuously.

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

NAIC Staff Comments:

<table>
<thead>
<tr>
<th>Dates: Received</th>
<th>Reviewed by Staff</th>
<th>Distributed</th>
<th>Considered</th>
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<tbody>
<tr>
<td>3/30/20</td>
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</tr>
</tbody>
</table>

Notes: VM APF 2020-05
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form

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

   Staff of Office of Principle-Based Reserving, California Department of Insurance – Address the topic of prescribed templates.

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

   Valuation Manual (January 1, 2019 edition), Introduction, Section I, A.1

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

   See attached Appendix.

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

   See attached Appendix.

---

NAIC Staff Comments:

<table>
<thead>
<tr>
<th>Dates: Received</th>
<th>Reviewed by Staff</th>
<th>Distributed</th>
<th>Considered</th>
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</thead>
<tbody>
<tr>
<td>APF 2019-58 (CA APF DN)</td>
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</tbody>
</table>
Appendix

ISSUE:

Now that the concept of a prescribed template has been introduced into VM-31, it should be made clear what the rules are surrounding making changes to such templates.

SECTIONS:

Introduction, Section I, Process for Updating the Valuation Manual, Section A.1

REDLINE:

1. Substantive Items

Substantive changes to the Valuation Manual are proposed amendments to the Valuation Manual that would change or alter the meaning, application or interpretation of a provision. All changes to the Valuation Manual or to templates prescribed for use by the Valuation Manual will be considered substantive, unless specifically identified as either a nonsubstantive item or an update to a table by simple majority vote of the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force. Any item placed on the Active List as substantive will be exposed by the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force for a public comment period commensurate with the length of the draft and the complexities of the issue, but for no less than 21 days. The comment period will be deemed to have begun when the draft has been placed on the appropriate public NAIC web page. The Life Actuarial (A) Task Force/Health Actuarial (B) Task Force will hold at least one open meeting (in person or via conference call) to consider comments before holding a final vote on any substantive items. Subsequent exposures of substantive items will be for a minimum of seven days. Meeting notices for Life Actuarial (A) Task Force/Health Actuarial (B) Task Force meetings will indicate if a vote is anticipated on any substantive items. Adoption of all changes at the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force will be by simple majority.

REASONING:

Help assure readers that there no back doors through which to create new requirements.
The Life Actuarial (A) Task Force met via conference call May 14, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Discussed Comments on the ACLI AG 49 Proposal

Mr. Andersen said in 2018, the Life Insurance and Annuities (A) Committee identified features of indexed universal life (IUL) products, including multipliers, that should be illustrated in a manner consistent with Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49).

Mr. Andersen said a series of public meetings of the Task Force and the IUL Illustration (A) Subgroup followed, resulting in several state insurance regulator decisions. The decisions included: 1) initially addressing issues related to the illustrated rate instead of focusing on disclosures; 2) not re-litigating current AG 49 concepts but focusing instead on newer product features, including multipliers and other product features that resulted in crediting rates greater than 6.75%; 3) prohibiting products with multiplier features from illustrating better than products without multiplier features; and 4) prohibiting products with cap buy up features from illustrating more favorably than products without cap buy up features.

Mr. Andersen said preliminary discussions also included the possibility of tightening guidance related to loan arbitrage. He reiterated that actions that may lead to disclosures or more drastic changes to the structure of life illustrations would be deferred. He said that leading into spring 2020, it was determined that industry experts should work together to coalesce their divergent thoughts on enhancing AG 49 requirements.

Mr. Andersen said the American Council of Life Insurers (ACLI) gathered a broad cross-section of companies to work on the effort, resulting in the currently exposed ACLI proposal (Attachment Seven-A), which combines the best efforts of previous proposals submitted by numerous entities. He expressed confidence that the ACLI proposal conforms to the direction provided by the Task Force and makes good progress in eliminating the problems that led to the charge from the Life Insurance and Annuities (A) Committee. He said the ultimate goal is to have a high likelihood that consumer expectations will be met, and the market will be fair and stable.

Brian Bayerle (ACLI) reviewed the highlights of the ACLI proposal. He noted that the document assumes the proposed changes are to be applied prospectively to minimize consumer confusion and to lessen the extent of the changes to AG 49. He pointed out that the industry participants did not reach a consensus on the treatment of policy loans. He said the proposal cover letter does offer a list of pros and cons of the two policy loan options. He provided a sample spreadsheet (Attachment Seven-B) that demonstrates the mechanics of the proposal. Mr. Bayerle acknowledged some outstanding commenter questions and agreed to attempt to address them later. He emphasized that the proposal does incorporate the earlier decisions made by the Task Force.

Bobby Samuelson (The Life Product Review) read prepared remarks (Attachment Seven-C) on behalf of the industry advocates, independent consultants and academicians who jointly authored an independent proposal (Attachment Seven-D). The independent proposal advocates the use of the Black-Scholes model to determine the maximum illustrated crediting rate.

Ms. Ahrens asked how the Black-Scholes model input will be controlled. Mr. Samuelson responded that suggestions on how to standardize the input would be solicited from insurance companies and other experts.

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Mr. Tsang said the Black-Scholes model assumes a risk-neutral environment. He asked how the accumulation rate will be determined from the model results. Mr. Samuelson said the equity risk premium will be determined as a factor of the volatility. He said another alternative is to get independent experts to opine on the appropriate equity risk premium.

Mr. Chupp asked if examples could be provided to demonstrate how the Black-Scholes model would be used. Mr. Samuelson agreed to provide examples.

Birny Birnbaum (Center for Economic Justice—CEJ) discussed his comment letter (Attachment Seven-E) submitted in support of the independent proposal. He expressed concern that the proposal would not be reviewed fairly. He also opined that any changes to AG 49 should be applicable to in-force illustrations for existing policies, as well as to new policies.

Mr. Andersen said some companies agree with many of Mr. Birnbaum’s comments but have agreed to compromise in support of the ACLI proposal in order to advance the issue.

Donna Megregian (American Academy of Actuaries—Academy) discussed the contents of the comment letter from the Academy’s Illustration Work Group (Attachment Seven-F).

Mr. Andersen said the Subgroup will consider the technical issues identified in the comment letter.

Aaron Sarfatti (Equitable) said the Equitable proposal (Attachment Seven-G) is designed to address two state insurance regulator concerns about illustrations, the size of the option budget and the returns on the option budget. He suggested that the proposal is simpler than the ACLI proposal and could be blended with the independent proposal to form a revised AG 49.

Neil Kulkarni (Global Atlantic) said the Global Atlantic comment letter (Attachment Seven-H) supports the ACLI proposal Option 1 method for addressing loan leverage.

Gayle Donato (Nationwide) said the ACLI proposal follows the guidance that the Task Force provided. She said its conformance with Task Force directives is the primary reason the Nationwide comment letter (Attachment Seven-I) expresses support for the proposal.

Scott Harrison (High Point Strategies) spoke on behalf of the companies comprising the IUL Coalition. He said the companies worked closely with the ACLI to develop the proposal. The IUL Coalition’s comment letter (Attachment Seven-J) reflects its support for the ACLI proposal.

Alex Silva (John Hancock) stated the IUL Coalition support for the ACLI proposal Option 1 method.

Seth Detert (Securian Financial) said his comments (Attachment Seven-K) represent a group of companies. The companies support the ACLI proposal and recommend adoption of the ACLI Option 2 method for loan leveraging.

Mr. Andersen said the Subgroup will incorporate some of the technical aspects of the comments into the ACLI proposal.

Gary Sanders (National Association of Insurance and Financial Advisors—NAIFA) said that while it will not change the performance of the policy, retroactive application of the AG 49 revisions will cause harm to the producer/client relationship, the agent’s reputation and the client’s trust in the agent.

Mr. Birnbaum asked for exposure of the independent proposal.

Subsequent to this conference call, the Task Force chair exposed the independent proposal for a 14-day public comment period ending May 27.

Having no further business, the Life Actuarial (A) Task Force adjourned.
April 14, 2020

Mr. Fred Andersen
Chair, NAIC IUL Illustration (A) Subgroup

Re: ACLI proposed draft of Actuarial Guideline 49-A

Dear Mr. Andersen:

The American Council of Life Insurers (ACLI)\textsuperscript{1} appreciates the opportunity to submit the following draft of AG49-A on prospective requirements for IUL illustrations.

During the March 3rd call of the Subgroup, multiple commenters suggested possible language to revise the Guideline. ACLI reviewed the various proposals and attempted to harmonize a version that both addresses concerns raised by regulators while providing consumers with the information necessary to make informed decisions on products they are considering for purchase.

The attached revisions (Attachment One) borrow concepts raised by the various drafts, and we’re appreciative of all the thought that went into each of these efforts. There are relatively small changes from the previously submitted March 24th draft, which are highlighted in the attachment. We note that, while this draft reflects our best-effort, there remain items that require additional consideration.

Accompanying the draft is a spreadsheet that walks through several examples of how the mechanics of this proposal are operating. One tab, ‘ACLI 04-14-20 Draft-BIA HB=NIER’, demonstrates how this works when the BIA hedge budget is equal to the NIER; these results should be consistent with the March 24th draft. Tab ‘ACLI 04-14-20 Draft-BIA HB<NIER’ shows the mechanics when the BIA hedge budget is less than the NIER, which shows the impact of many of the additional edits in this proposed version.

Consistent with the ACLI’s established opposition to retroactivity, AG49-A assumes that these new requirements are applicable on a prospective-only basis, and solely for policies issued after the guideline’s effective date.

ACLI notes the following in this best-effort draft:

- Definitions in Section 3 were refined from the earlier ACLI 02-21-20 draft.
- Language in Section 4 and 5 were largely borrowed from the Securian et al draft, with several modifications. We note the language in Section 5 requires additional consideration.
- For the treatment of Policy Loans (Section 6 and within the definition of “Alternate Scale”), industry is offering two proposals for regulators to consider. We note that the language in this

\textsuperscript{1} The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at \url{www.acli.com}.

American Council of Life Insurers
101 Constitution Avenue, NW, Washington, DC 20001-2133
(202) 624-2169  \texttt{briandbayerle@acli.com}
\url{www.acli.com}
section may require additional modification. This language attempts to capture the two main approaches previously submitted.

Indexed UL products may allow the loaned amount to remain in the index and earn index credits. When the index return is higher than the loan charged rate then the loan is “leveraged”. IUL products are the only product type where actuarial guidelines contemplate this type of leveraging in illustrations. An objective for regulators in tightening this language is to ensure that the Supplemental Hedge Budget is not double counted.

During a straw poll at the end of the October 17 conference call, the vote favored language similar to Option 2. However, some of the language proposed subsequent of this call was similar to Option 1. We lay out arguments below for each approach, and we recommend further discussion on the topic.

We note there are advantages of each approach:

- **Option 1**: 100 bp loan leverage limit only applies to index credits:
  - Provides consistent treatment of illustrated bonuses between fixed UL and indexed UL, as well as consistent treatment of standard loans and indexed loans within an indexed UL.
  - Is consistent with the original scope of AG49, which was to apply to index-linked credits.
  - Allows for the illustration of consistent maximum crediting rates between IUL policies with a loan and IUL policies without a loan.
  - The Option 2 language may pose technical difficulties to implement.
  - The Option 2 language may be read to disadvantage innovative product designs, such as policies that offer wellness credits to customers who engage in activities that help them live longer and healthier lives.

- **Option 2**: 100 bp loan leverage limit applies to index credits and other types of bonuses:
  - If the limit only applies to Index Credits, loan leverage may exceed 100 bps using fixed rate bonuses or other innovative product designs.
  - Since all index accounts will illustrate similarly under the new AG 49, other bonus types may become more common.
  - This is a maximum illustration limit to prevent illustrations that are overly optimistic.
  - Products could still offer other bonus types and demonstrate how they work at lower interest rate illustrations or when loans are not illustrated.

We look forward to a discussion of our proposed language. Thank you.

Sincerely,

[Signature]

cc Reggie Mazyck, NAIC
Actuarial Guideline XLIX-A – Draft [ACLI DRAFT APRIL 14, 2020]

THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST SOLD AFTER [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption*]

Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for in-force illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective as follows for all new business and in force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption].

i. Sections 1 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

i. The policy is subject to Model #582.
3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

i. The \(\text{credited-rate} \times \text{total annual percentage rate of Indexed Credits} \) for each Index Account does not exceed the lesser of the maximum \(\text{credited-rate} \times \text{total annual percentage rate of Indexed Credits} \) for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the \(\text{credited-rate} \times \text{total annual percentage rate of Indexed Credits} \) for each Index Account shall not exceed the average of the maximum \(\text{credited-rate} \times \text{total annual percentage rate of Indexed Credits} \) for the illustrated scale and the guaranteed \(\text{credited-rate} \times \text{total annual percentage rate of Indexed Credits} \) for that account. However, the \(\text{credited-rate} \times \text{total annual percentage rate of Indexed Credits} \) for each Index Account shall never be less than the guaranteed \(\text{credited-rate} \times \text{total annual percentage rate of Indexed Credits} \) for that account.

ii. If the illustration includes a loan, the illustrated \(\text{rate credited to the loan balance does policy loan interest credited rate shall not exceed the illustrated loan charge-policy loan interest rate. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.}

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding hedges for Indexed Credits), less provisions for investment expenses and default costs, allocated to support the policy. Charges of any kind are not included in the Annual Net Investment Earnings Rate.

B.C. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500\(^\circ\) Index value only, over a one-year period using only the beginning and ending index values. (S&P 500\(^\circ\) Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.

vi. Additional amounts credited The hedge budget used to determine the cap in 3 (C) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind are not included when determining the applicable cap rate.
vii. There are not less than three additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account that are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values linked to an index or indices in excess of the interest calculation, including but not limited to experience refunds or multipliers and bonuses.

viii. There are no limitations on the portion of account value allocated to the account.

ix. A single Benchmark Index Account will be determined for each policy. A policy shall have no more than one Benchmark Index Account.

C.D. Fixed Account: An account where the amounts credited are not tied to an external index or indices.

D.E. Index Account: An account where the amounts credited are tied to an external index or indices.

F. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Credits to the policy resulting from a floor are included.

G. Hedge Budget: For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This amount should be consistent with the hedging program of the company.

H. Loan Balance: Any outstanding policy loan and loan interest, as defined in the policy.

I. Policy Loan Interest Rate: The annual interest rate that is charged on any Loan Balance. This does not include any other policy charges.

J. Policy Loan Interest Credited Rate: The annual interest rate credited that applies to the portion of the account value backing the Loan Balance, as defined in the policy.

   i. For the portion of the account value backing the Loan Balance that is in a Fixed Account, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate, as defined in the policy.

[OPTION FOR CONSIDERATION: Please see commentary on these approaches in the ACLI Comment Letter; language for Option 1 and Option 2 may need to be tightened up:

   Option 1: ii. For any portion of the account value backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage rate of Indexed Credits, net of any applicable Supplemental Hedge Budget, for that account, as defined in the policy.

   Option 2: ii. For any portion of the account value backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage rate of Indexed Credits and all illustrated bonuses, charge reductions or other enhancements that impact the portion of the account value backing the Loan Balance, net of any applicable Supplemental Hedge Budget for that account, as defined in the policy.]

K. Supplemental Hedge Budget: For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the hedge budget that determines the Benchmark Index Account. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

4. Illustrated Scale

The credited rate total annual percentage rate of Indexed Credits for the illustrated scale for each Index Account shall be limited as follows:
A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

i. If the insurer offers applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).

ii. If the insurer does not offer applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of the Benchmark Index Account, and shall use that cap in 4 (A).

B. For each applicable Benchmark Index Account, the total Indexed Credits illustrated as a percentage of the account value in the Index Account shall not exceed the minimum of (i) and (ii):

iii. the arithmetic mean of the geometric average annual credited rates calculated in 4 (A) shall be the maximum credited rate(s) for the illustrated scale.

ii. 145% of the Annual Net Investment Earnings Rate.

C. For any other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate. Account that is not the Benchmark Index Account in 3 (C), the total Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii):

i. The maximum Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the illustrated scale. The determination shall Index Account.

ii. The total Indexed Credits that reflect the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. In no event shall the illustration actuary use actuarial judgment to determine this value using bookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.

B. For purposes of compliance with Section 6 (C) of Model #582, the credited rate for Supplemental Hedge Budget may cause the illustrated scale rate to exceed the earned interest rate underlying the Disciplined Current Scale. Applicable rate calculated in 4 (B).

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale.
The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for indexed based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed 145% for the policy, inclusive of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-based credits) allocated to support the policy and hedge assets that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed.
i. the Annual Net Investment Earnings Rate, plus

ii. 45% of the lesser of (1) and (2):

1. Hedge Budget minus any floor.

2. The minimum of the Annual Net Investment Earnings Rate and the hedge budget that determines the Benchmark Index Account.

These amounts should be adjusted for timing differences to ensure that fixed interest is not earned on the hedge cost.

The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate.

For a product with multiple Index Accounts with different Hedge Budgets that are less than or equal to the NIER, a maximum rate in 5.A. should be calculated for each set of accounts with different Hedge Budgets.

B. If an insurer does not engage in a hedging program for indexed-based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy Annual Net Investment Earnings Rate.

C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy’s account value.

D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5.(A), (B), and (C). All experience assumptions that do not directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

6. Policy Loans

If the illustration includes a loan, the illustrated rate credited to the loan balance Policy Loan Interest Credited Rate shall not exceed the illustrated loan charge Policy Loan Interest Rate by more than 100 basis points. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 5%.

7. Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical interest rates Indexed Credits using current index parameters for the most recent 20-year period.
<table>
<thead>
<tr>
<th>Annual Net Investment Earnings Rate</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
<th>Example 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cap</td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
</tr>
<tr>
<td>Index Bonus (Multiplier)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hedge Bonus</td>
<td>6.00%</td>
<td>6.15%</td>
<td>5.72%</td>
<td>6.15%</td>
<td>6.00%</td>
</tr>
<tr>
<td>Supplemental Hedge Budget</td>
<td>6.00%</td>
<td>3.30%</td>
<td>3.30%</td>
<td>4.25%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total Indexed Credits</td>
<td>5.96%</td>
<td>8.35%</td>
<td>10.19%</td>
<td>5.71%</td>
<td>5.96%</td>
</tr>
<tr>
<td>Maximum Indexed Credit</td>
<td>5.96%</td>
<td>8.35%</td>
<td>7.32%</td>
<td>10.19%</td>
<td>5.71%</td>
</tr>
<tr>
<td>Implied Max Illustrated Floor</td>
<td>5.96%</td>
<td>5.96%</td>
<td>5.96%</td>
<td>5.96%</td>
<td>5.96%</td>
</tr>
<tr>
<td>Earned rate under (D) assumption</td>
<td>6.66%</td>
<td>6.66%</td>
<td>6.40%</td>
<td>6.40%</td>
<td>6.39%</td>
</tr>
</tbody>
</table>

**Comment:** BIA† Lookback for Base Case

<table>
<thead>
<tr>
<th>Example 6</th>
<th>Example 7</th>
<th>Example 8</th>
<th>Example 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cap</td>
<td>4.50%</td>
<td>4.50%</td>
<td>4.50%</td>
</tr>
<tr>
<td>Index Bonus (Multiplier)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hedge Bonus</td>
<td>6.88%</td>
<td>6.68%</td>
<td>6.42%</td>
</tr>
<tr>
<td>Supplemental Hedge Budget</td>
<td>6.88%</td>
<td>0.39%</td>
<td>0.39%</td>
</tr>
<tr>
<td>Total Indexed Credits</td>
<td>6.46%</td>
<td>6.46%</td>
<td>6.46%</td>
</tr>
<tr>
<td>Maximum Indexed Credit</td>
<td>6.46%</td>
<td>6.46%</td>
<td>6.46%</td>
</tr>
<tr>
<td>Implied Max Illustrated Floor</td>
<td>5.96%</td>
<td>5.96%</td>
<td>6.00%</td>
</tr>
<tr>
<td>Earned rate under (D) assumption</td>
<td>6.40%</td>
<td>6.40%</td>
<td>6.40%</td>
</tr>
</tbody>
</table>
Thanks, Fred. I appreciate the opportunity present the comment letter on behalf of the twelve co-signers of the Independent Proposal. We have joined together for no purpose other than to voice our concern about the state of Indexed UL and to present a solution that we believe is in the best interest of our industry and all of its constituents.

Fundamentally, we believe that the ACLI proposal is a highly complex, overly engineered solution that requires significantly more disclosure, makes illustrations less understandable for consumers and leaves the door open for future product designs that will take advantage of its many grey areas and ambiguities. Our letter explores each one of these aspects of the ACLI proposal in detail and paints the contrast between the ACLI proposal and the Independent Proposal, which represents a simple but comprehensive solution to the mandate from LATF.

For context, it’s helpful to understand how we got here in order to also understand why the ACLI proposal is flawed. The original AG 49 prescribes a methodology for determining the illustrated value of the hedges used to create indexed credits in Section 4(A). This methodology is based on hypothetical historical backtesting – hypothetical in that the calculation assumes that the currently available, non-guaranteed indexed parameters based on today’s hedge costs never change. Historical in that the index returns used for the backtesting are actual historical index returns. The net result of combining a hypothetical assumption of constant index parameters with historical index returns is not a historically indicative valuation of the hedges – it is a purely hypothetical valuation. To our knowledge, this hypothetical historical hedge valuation methodology has no empirical or theoretical basis and is not used anywhere except in indexed insurance products.

This methodology is also at odds with how the hedges are actually valued in the marketplace. Life insurers purchase hedges at market prices that can be understood through the universally used and empirically validated Black-Scholes valuation methodology. For example, a 10% cap purchased last year would have cost approximately 4.6% of the notional value. That is the market valuation for the option. However, using the unique hypothetical historical backtesting methodology in AG 49, the illustrated valuation for the option would be 6.12%. This implies a perpetual illustrated valuation arbitrage between the empirically proven, universally used, market-driven Black-Scholes option valuation methodology and the unique, untested, entirely hypothetical option valuation methodology prescribed in AG 49.

This disconnect between the price of options and their illustrated value is what allows Indexed UL to illustrate superior performance to traditional fixed insurance products by a significant margin. It is also what allows Indexed UL products with multipliers and buy-up caps to produce superior illustrated performance to otherwise identical products without them. It also follows that, if the entirety of the account value were to have been used to purchase hedges, that the illustrated performance of that variant of product would have dramatically outperformed even the most aggressive multiplier-driven products on the market today.

As a result, it is clear that the problem with multipliers and buy-up caps is not actually multipliers and buy-up caps. The problem with multipliers and buy-up caps is the assumption of a hedge valuation arbitrage embedded into every indexed UL illustration, courtesy of the hypothetical historical lookback methodology employed by AG 49 in Section 4(A).

The ACLI proposal is a tacit acknowledgement of that fact. The way that the ACLI has proposed to satisfy the mandate from LATF to limit the illustrated benefits of buy-up caps and multipliers is by bifurcating Indexed UL illustrated rates into two segments – the Hedge Budget, which can illustrate with hedge valuation arbitrage, and the Supplemental Hedge Budget, which does not illustrate perpetual hedge valuation arbitrage.
This segmentation of the illustrated rate is both incongruous with the original letter and spirit of AG 49 and entirely artificial, created for the sole purposes of fulfilling the LATF mandate. This is why the ACLI proposal is so cumbersome, complex and opaque. In order to mechanically accommodate creating an artificial bifurcation of illustrated indexed credits and implement different solutions for each, nearly every clause in AG 49 had to be modified in some way, including the introduction of new definitions, formulas and clauses. By our count, 51 of the 61 clauses in AG 49 were modified by the ACLI proposal.

These modifications and additions to AG49 create their own set of problems. Virtually all of these new factors are uncertified rates determined internally by the life insurer and not disclosed on the illustration. Furthermore, because these factors will be interpreted, defined and set internally at the discretion of the insurer, there will be natural inconsistencies between how life insurers apply them. These inconsistencies will undo the chief goal of the original AG 49, which was to create consistency across illustrated rates for products with identical index parameters. The ACLI proposal manages to simultaneously make illustrations less transparent and less consistent, a combination that renders them almost unintelligible except to the company issuing the product.

But more importantly, the ACLI proposal leaves significant latitude to life insurers, providing them with ample opportunity to find new ways currently not contemplated by the drafters or LATF to generate higher illustrated performance while remaining in technical compliance with the guideline. In our letter, we have detailed at least 5 potential product designs that would produce outsized performance while remaining in compliance with the ACLI proposal, all of which already exist in some form in today’s market. It is only a matter of time before these designs are tuned for optimal illustrated performance under the new AG 49 in the same way that life insurers tuned designs for optimal illustrated performance after the original AG 49 was implemented.

As a result, we believe the ACLI proposal to be fundamentally flawed. It is a limited solution for the particular problem of multipliers and buy-up caps. It relies on internally inconsistent logic that is only tenuously bound together through overly complex and ambiguous language. It is not, by any stretch, a long-term holistic solution to the general problem of prolific, repeated and – most importantly – generously rewarded gamesmanship in Indexed UL illustrations, of which multipliers and buy-up caps are merely the most recent manifestation and hardly the last.

By contrast, the Independent Proposal is a simple and holistic solution. It requires that the illustrated value for the hedges be calculated using the Black-Scholes formula, which will roughly align the actual market price of the hedges with their illustrated value. This will eliminate the possibility for any sort of illustrated valuation arbitrage in the Indexed UL illustration, including excess interest from multipliers and buy-up caps. This simple alignment of actual market hedge valuation and illustrated hedge valuation will satisfy LATF’s mandate without any further modifications to the guideline. But more importantly, it will eliminate the ability for gamesmanship with future product designs for Indexed UL. The proposal is as simple as that. It requires a change to just one section of AG 49, Section 4(A).

We have also recommended that the supplemental crediting reports in Section 7 of AG 49 be augmented to allow life insurers to display the mechanics and potential return profiles of their various crediting strategy, but – and this is key – only in the context of the crediting rate and not in the illustrated scale. Our proposal recommends a methodology for these supplemental crediting reports that would align them to the crediting reports available in Fixed Index Annuity illustrations. This methodology was broadly supported by industry for the purposes of FIA illustrations and recognized as an effective way to educate consumers about the mechanics, variability and potential performance of indexed crediting. To be clear, these supplemental crediting reports are not a part of the illustrated scale and do not have any interaction with the illustration model regulation. The Independent Proposal
in its entirety is in conformity with the illustration model regulation. The augmentation of these supplemental reports also does not constitute “new disclosure” because they already exist in the guideline.

In summary, we believe that the basis for Indexed UL illustrations should align market hedge values with illustrated hedge values. This view is also shared by the ACLI’s proposal – but, in their view, only for the multipliers and buy-up caps specifically called out by LATF and only then because of the LATF vote. We would remind LATF that prior to the vote, many life insurers and their professional advocates voiced support for the continued illustration of multipliers and buy-up caps. These insurers have not changed their minds about the merits of these strategies. They’re simply complying with LATF’s request in order to keep the franchise going and, by that, I mean the franchise of illustrated valuation arbitrage that generates double-digit internal rates of return in Indexed UL illustrations even without multipliers and buy-up caps. As long as that exists, and it certainly will with the ACLI proposal, then gamesmanship in Indexed UL illustrations will continue unabated and we will certainly be revisiting AG 49 in the future.

The Independent Proposal, in contrast, is a simple, holistic solution that rests on a universally-used and empirically proven hedge valuation methodology that will end Indexed UL illustrated performance gamesmanship once and for all. Furthermore, the Independent Proposal maintains the ability for life insurers to demonstrate the mechanics and potential performance of indexed crediting methodologies, but only in the context of supplemental crediting reports that are not a part of the illustrated scale. The Independent Proposal strikes the appropriate balance between restricting illustrated gamesmanship while still providing life insurers a means to demonstrate the mechanics of their indexed crediting methodologies in a way that will both educate consumers as to their mechanics and highlight their potential to perform well in certain environments. We urge LATF to consider the Independent Proposal.

Finally, we would welcome any feedback and questions on the Independent Proposal and request the ability to respond on today’s call.

Thank you.
Not surprisingly, companies selling Indexed UL will voice concerns about some aspects of the Independent Proposal. Allow me to address some of those:

1. The Independent Proposal does not allow for the illustrated benefit of an equity risk premium.
   a. This is not true. The primary market input of the Black-Scholes formula is implied volatility, the market expectation for equity volatility over the same period of time as the option. Volatility is a proxy for risk. As described by the also universally used Capital Asset Pricing Model, more risk means more return. As a result, the expected return for the option until its expiration is explicitly accounted for through market pricing for implied volatility. This is why option prices are constantly changing in reaction to the risk-return dynamics in the marketplace.
   b. Furthermore, the methodology currently prescribed by AG 49 is not an appropriate or accepted measure of the equity risk premium. The burden of proof is on proponents of this obscure methodology to prove that it is empirically grounded. No proof of the robustness and accuracy of the methodology has ever been presented.
   c. However, the Independent Proposal recognizes the fact that over a certain period of time, perhaps even more than a decade, options may be consistently undervalued or overvalued in retrospect relative to their actual returns. For example, the last 10 years have produced stellar risk-adjusted returns in the S&P 500, meaning that option valuations have been consistently underpriced. As a result, we have recommended that Section 7 be expanded to allow more latitude for life insurers to demonstrate hypothetical historical performance of their crediting methodologies over specific period of times, including multipliers and buy-up caps. We believe this is a fair and informative way to demonstrate the mechanics and potential value of various crediting strategies. And, to be clear, this is only for Section 7 – these crediting reports are supplemental and are not a part of the illustrated scale. The Independent Proposal does not require any change to the Model Regulation for complete implementation.

2. The Independent Proposal will cause changes to illustrated rates even if the indexed parameter does not change.
   a. This is true and this currently happens with today’s AG 49 hypothetical historical methodology because the historical period is rolling and changes every year.
   b. The other side is also true – the illustrated rate using the Independent Proposal might not change even if the index parameter does. This will actually provide a more accurate picture to the consumer for setting expectations and a superior solution to the current AG 49 methodology.
      i. For example, if the cap drops from 10% to 9% because option prices increase, the current AG 49 maximum rate would decrease the illustrated rate from 6.14% to 5.67%. This would lead a consumer to believe that their product is now “underperforming” relative to the original expectation.
      ii. This is a false conclusion because the market value of the 10% cap previously is the same as the 9% cap is currently. The Independent Proposal takes actual market valuation into account and will correctly inform the consumer that their value has actually not changed and the product is not “underperforming.”
   c. Over time and taking index parameter changes into account, the Independent Proposal would actually produce more stable illustrated rates than the current AG 49 methodology and therefore enhance consumer understanding and expectations for the product.

3. Finally, and most importantly, the chief criticism of the Independent Proposal will be that it lowers the illustrated rate of Indexed UL products. Or, put differently, it no longer provides for Indexed UL to illustrate long-term perpetual arbitrage between the actual market value of the option and illustrated value of the option based on the untested and empirically unproven hypothetical historical lookback.
methodology. We fail to see why this is a concern for regulators. Furthermore, we fail to see why this is a concern for life insurers. Illustrations are used for explaining the mechanics of the product, not as performance projections. Therefore, a change to the illustrated rate should not change sales or the consumer appetite for the product. An informed consumer would not rely on the illustrated rate to make a decision. Our goal is to have informed consumers and we believe that the Independent Proposal will enhance their understanding of the product and its potential performance. The ACLI proposal, by contrast, will restrict it.

As long as perpetual riskless illustrated arbitrage exists in Indexed UL because of the disconnect between actual option values and the AG 49 hypothetical historical lookback values, there will be gamesmanship in Indexed UL.
Fred,

We have reviewed the ACLI proposal regarding revisions to AG 49 and appreciate the opportunity to comment on it. Overall, we believe that the ACLI proposal effectively fulfills LATF’s stated goals of eliminating the specific illustrated benefits of both Cap Buy-Ups and Multipliers but does so in an overly complex and engineered way that requires more disclosure, makes illustrations less understandable for consumers and leaves the door open for product designs that, if history is any indication, will be created in its aftermath to maximize illustrated performance for the express purpose of competitive positioning.

In stark contrast to the ACLI proposal, the Independent Proposal makes only one modification to the underlying structure of AG 49 to accomplish the goals outlined by LATF and does not, in any way, require changes to the Illustration Model Regulation. The Independent Proposal is far simpler – and far more effective – than the ACLI proposal. Furthermore, the Independent Proposal also includes revisions to Section 7 that will allow life insurers to fully demonstrate the mechanics and potential performance of indexed crediting strategies using supplemental crediting reports in an effort to further consumer understanding and provide a platform for life insurers to differentiate their products in a way that is consistent with Fixed Index Annuities. We fail to see why this approach would be any less appealing for Indexed UL than it is for Fixed Index Annuities, where it was widely supported by life insurers.

The remainder of this letter will detail the challenges with the ACLI proposal and contrasts them with the Independent Proposal.

Proposal Overview

Of the 61 independent clauses in the ACLI proposal, only 10 are unchanged from the original AG 49 language. The ACLI proposal introduces numerous and material new clauses, definitions and formulas. While many of the changes were clarifications to the original guideline, the ACLI proposal relies on the following material modifications to deliver an effective solution to LATF’s request:

1. 3(B) – The formal definition of the Annual Net Investment Earned Rate (NIER)
2. 3(G) – The introduction and definition of the Hedge Budget
3. 3(K) – The introduction and definition of the Supplemental Hedge Budget
4. 4(B)(ii) – The addition of NIER * 1.45 as a maximum illustrated Index Credit as a percentage of AV ("illustrated rate")
5. 5(A)(ii) – The addition of the Hedge Budget as a limitation for application of the 1.45 factor for DCS

Taken together, these material modifications form the mechanical changes to the guideline that limit the illustrated benefits of Buy-Up Caps and Multipliers. However, they also represent fundamentally new additions to the guideline that create their own new challenges that require a response.

By contrast, the Independent Proposal requires just one modification to Section 4(A) to accomplish all of LATF’s goals. The current AG 49 language for Section 4(A) uses a hypothetical historical lookback approach, applying today’s currently available index parameters based on highly dynamic option prices to long-term historical index data, a methodology only used (to our knowledge) in indexed insurance products. The Independent Proposal replaces this rare and untested methodology with the universally accepted and empirically supported Black-Scholes formula for option valuation. In doing so, any option-based strategy used inside of an indexed insurance product will always illustrate at its fair-market value, meaning that any augmentation of the option budget through policy charges will be neutralized for the purposes of the illustrated scale. For example, a 1% asset-based...
charge to buy a 20% multiplier for an account with a 5% Black-Scholes fair-market valuation will result in a net illustrated rate of 5% (5% * 1.2 = 6% - 1% charge = 5% illustrated rate). This simple modification entirely satisfies LATF’s stated goals and does not require any other changes to AG 49 to accommodate it.

Disclosure
In the original AG 49, the entirety of the illustrated scale was directly related to declared non-guaranteed elements or contractual provisions. However, in the ACLI’s proposal, the illustrated scale will be impacted by non-contractual, non-disclosed elements. For example:

1. The maximum illustrated rate for the product may be limited by NIER * 1.45 (Section 4)
2. The maximum illustrated rate for a product with a Supplemental Hedge Budget will be comprised of two separately calculated factors:
   a. 4(B) – Maximum illustrated rate, the minimum of 4(A) calculation and NIER * 1.45
   b. 4(C)(i) – Supplemental Hedge Budget, which is a function of both NIER and the Hedge Budget

In either situation, it will be impossible to calculate the maximum illustrated rate based solely on declared non-guaranteed elements and contractual factors because the NIER, the Hedge Budget and the Supplemental Hedge Budget are not disclosed and are not declared non-guaranteed elements. This is immensely problematic for consumer understanding of illustrated performance and product mechanics and represents a significant step backwards from the original guideline.

In order to remedy this problem, disclosure of the newly defined terms of Net Investment Earned Rate, Hedge Budget and Supplemental Hedge Budget for each offered indexed account, including the BIA, must be required and certified. These rates should be readily available in the illustration along with a description of how these rates formulaically relate to the maximum illustrated rate with numerical examples.

The Independent Proposal, by contrast, presents a simple and straightforward approach to determining the maximum illustrated rate in Section 4(A) using the Black-Scholes Formula, the most common options valuation formula in the world, and relying on externally verifiable pricing factors such as LIBOR and index implied volatility. The remaining inputs are the declared non-guaranteed elements of the product relating to indexed performance such as the cap or participation rate. As a result, the entirety of the illustrated scale under the Independent Proposal can be easily sourced using publicly available data or declared non-guaranteed elements, presenting a superior solution for furthering consumer understanding of illustrated performance and product mechanics.

Product Designs
While the ACLI proposal effectively addresses products currently in market using Buy-Up Caps and Multipliers, it leaves open the potential for other product designs created to maximize illustrated performance under the new guideline. These product designs may take many forms, but generally speaking, they may fall into the following categories:

1. Use of proprietary indices and alternative S&P 500 crediting strategies, which can have significantly higher lookback rates than the BIA, to reduce hedge costs without reducing illustrated performance and to reinvest the savings into other product features, including fixed interest bonuses or policy charge reductions. There are already products in market using proprietary indices to generate excess illustrated performance and many of these products would be unchanged under the ACLI proposal.
2. Development of product features that do not technically adhere to the definition of an Index Credit in 3(F) but allow the life insurer to generate an effective illustrated rate in excess of the BIA rate, but is still
3. Development of bonuses that exploit seemingly small timing differences to generate outsized performance. For example, a charge for the Supplemental Hedge Budget might be deducted based on the end of year values but its value credited based on the beginning of year values, effectively allowing excess interest from the Supplemental Hedge Budget to appear on the illustration. There are already products in market using timing differences to increase attractiveness of certain features.

4. Product designs that provide for actuaries to assume a higher Hedge Budget than is actually currently required to hedge the account, such as in the case of assuming a higher Hedge Budget today in order to account for the possibility of future increases in hedge costs. Using a higher Hedge Budget will allow for insurers to illustrate all the way up to the NIER * 1.45 limit in certain cases, allowing for higher illustrated performance simply by applying a different interpretation of what constitutes a Hedge Budget. Every company already uses a different methodology for determining their hedge budgets.

Each of these product designs represents a way for a life insurer to gain an edge in illustrated performance. However, these designs can also be combined in ways that could produce illustrated performance on par with the products driven by Multipliers and Buy-Up Caps prevalent in today’s market. There is no doubt that designs like these will become the next phase of the ongoing Indexed UL illustration war. Significant revisions and clarifications need to be added to the ACLI proposal in order to prevent the illustrated benefits of designs like these. Without those revisions and clarifications, we will certainly be revisiting AG 49 again in the future.

The Independent Proposal, however, does not leave open the possibility of any of these designs generating outsized performance because all effects of enhancing the option-based returns in the product are neutralized by using only fair-market option valuation for the purpose of the illustrated scale rather.

**Direct Illustration of Defined Hedge Profits**

In the original AG 49, the maximum illustrated rate defined in 4(B) was a function solely of the hypothetical historical lookback methodology (HHLM) prescribed in 4(A) and limited by the 1.45 factor in 5(A) for the purposes of DCS testing. In both the original guideline and the ACLI proposal, the 1.45 factor is only applicable to insurers that engage in a hedge program, which is an indicator that the factor is due to an implied average, long-term return from directly engaging in a hedge program.

In the ACLI proposal, the 4(B) maximum illustrated rate is now also limited directly by the NIER * 1.45 factor. In effect, the 1.45 factor has now become a visible limitation that directly impacts the illustrated scale as opposed to a DCS limitation that was created to accommodate the illustrated scale. Furthermore, the effective reduction of the factor to 1.0 for the Supplemental Hedge Budget is also a visible limitation.

Considering that the 1.45 factor is **solely attributable to a hedge program and therefore the assumed profits from engaging in the hedge program**, illustrated performance under the ACLI proposal will be sourced directly from illustrated returns attributable solely to the hedge program. This is fundamentally different than how asset returns are modeled in other fixed insurance products, where the declared illustrated rate is based on actual, currently paid returns in aggregate rather than assumed future returns of a specific asset class that directly and attributably impacts the illustrated rate in all years, as in the ACLI proposal.

The Independent Strategy, by contrast, uses the Black-Scholes option valuation methodology and therefore does not have any recognition of “profits” arising from hedging transactions. As a result, the 1.45 factor is repurposed in the Independent Proposal for inevitable temporary disconnects between the insurer’s NIER/hedge budget and...
the fair-market valuation of the indexed parameters. The 1.45 factor, therefore, does not need to be directly disclosed or explained in the illustration.

If LATF were to consider to the proposed ACLI framework, it is essential for LATF to consider and formally engage outside experts, including independent actuaries and finance academicians and practitioners, in determining:

1. Whether or not it is appropriate to illustrate directly attributable returns from specific asset classes or strategies, including hedge strategies, in a fixed, non-registered life insurance product
2. If it is appropriate, then what factor most accurately represents the average expected profit from engaging, generally, in hedging strategies that will replicate the various parameters of indexed crediting

The second question is of critical importance because of the central role that the 1.45 factor plays in the ACLI proposal and the fact that the magnitude of the factor itself was never publicly supported with external and independent empirical and theoretical evidence.

In closing, we ask that LATF consider the Independent Proposal on equal footing with the ACLI proposal and allow an exposure period for both proposals. For your reference, a blue-lined version of AG 49 with the suggested changes in the Independent Proposal is below.

Thank you.

Bobby Samuelson, Executive Editor, The Life Product Review
Larry Rybka, President & CEO, Valmark Financial Group
Joseph M. Belth, professor emeritus at Indiana University
Chris Hause, FSA, President, Hause Actuarial Solutions
Scott Witt, FSA, President, Witt Actuarial Services
Richard M. Weber, President, The Ethical Edge, Inc
Barry Flagg, President, Veralytic
Stephen R. Leimberg, Publisher, Leimberg Information Services, Inc
Bill Boersma, President, OC Consulting Group
Tom Love, VP, Insurance Analytics, Valmark Financial Group
Mike Brohawn, President, Your Life Insurance Solution
Steven Roth, President, Wealth Management International, Inc., Licensed Life & Disability Insurance Analyst
Ben Baldwin Jr
Actuarial Guideline XLIX

THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST

Background

The *Life Insurance Illustrations Model Regulation (#582)* was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an external index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective as follows:

i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.

ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.

iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.
2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

i. The policy is subject to Model #582.

ii. Interest credits are linked to an external index or indices.

3. Definitions

A. **Benchmark Index Account**: An Index Account with the following features:
   
i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

   ii. An annual cap is used in the interest calculation.

   iii. The annual floor used in the interest calculation shall be 0%.

   iv. The participation rate used in the interest calculation shall be 100%.

   v. Interest is credited once per year.

   vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the maximum illustrated crediting rates for the policy’s Index Accounts, subject to the requirements of 5.D. However, for each Index Account within the policy, only one Benchmark Index Account shall apply. Any rate calculated in 4 (B) shall not apply for an Index Account if the account charges for the applicable Benchmark Index Account exceed the account charges for that Index Account in any policy year. Account charges include all charges applicable to an Index Account, whether deducted from policy values or from premiums or other amounts transferred into such Index Account.

   vii. Additional amounts credited are not less than the additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in 4 (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values, including but not limited to experience refunds or bonuses.

   viii. There are no limitations on the portion of account value allocated to the account.

B. **Fixed Account**: An account where the credited rate is not tied to an external index or indices.

C. **Index Account**: An account where the credited rate is tied to an external index or indices.

4. Illustrated Scale

The credited rate for the illustrated scale for each Index Account shall be limited as follows:

A. **Calculate the value of the replicating option trades for the Benchmark Index Account over the preceding calendar year**, based on the Black-Scholes formula using the following inputs calculated on each trading day:
   
i. Average closing implied volatility for 12-month, at-the-money S&P 500 call options

   ii. Average closing implied volatility for out-of-the-money 12-month S&P 500 call options with a normalized strike price equal to the currently declared cap

   iii. Average dividend yield on the S&P 500

   iv. Average 12-month LIBOR or another appropriate interest rate measure
v. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration 
actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).
vi. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the 
illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual 
cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index 
Account, and shall use that cap in 4 (A).

B. For each applicable Benchmark Index Account, the value calculated in 4 (A) shall be the maximum credited rate(s) 
for the illustrated scale.

C. For other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, 
the illustration actuary shall use actuarial judgment to determine the maximum credited rate for the illustrated scale. 
The determination shall reflect the fundamental characteristics of the Index Account as relates to the Black-Scholes 
valuation formula, including realized volatility, implied volatility, volatility targets (if applicable), embedded fees (if 
applicable), deduction of an interest rate component (if applicable), dividend participation (if applicable) and any 
other factors that may apply. In no event shall the credited rate for the illustrated scale exceed the applicable rate 
calculated in 4 (B).

D. At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate 
for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale
   The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for index-based interest, the assumed earned interest rate underlying the 
disciplined current scale shall not exceed 145% of the annual net investment earnings rate (gross portfolio earnings 
less provisions for investment expenses and default costs) of the general account assets (excluding hedges for index-
based credits) allocated to support the policy.

B. If an insurer does not engage in a hedging program for index-based interest, the assumed earned interest rate 
underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general 
account assets allocated to support the policy.

C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, 
accounting for all benefits including illustrated bonuses.

D. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that 
correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests 
under Model #582, subject to the limitations in 5 (A), (B), and (C). All experience assumptions that do not 
directly relate to the Index Accounts as to expenses, mortality, investment earnings rate of the general account 
assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire 
policy.

6. Policy Loans
   If the illustration includes a loan, the illustrated rate credited to the loan balance shall not exceed the illustrated loan charge 
by more than 100 basis points.

7. Additional Standards
   The basic illustration shall also include the following:

A. A table showing the minimum, maximum and arithmetic average of a geometric average for any available Benchmark 
Index Account using the following methodology:
   i. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account 
for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current 
calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each
subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

B. For each Index Account illustrated, a table showing actual annual historical index changes and corresponding hypothetical interest rates using current index parameters, including any applicable asset-based charges and asset-based interest bonuses or index credit multipliers paid within the first 10 years of the policy:
   ii. The 10-year period with the lowest calculated returns within the period referenced in 7(A)(i)
   iii. The 10-year period with the highest calculated returns within the period referenced in 7(A)(i)
   iv. The most recent 10-year historical period as calculated on the final trading day of the preceding calendar year

C. If an index has not been in existence for 10 years, the table shall replace the figures with the maximum available back-tested performance.
Comments for the Center for Economic Justice

To the Indexed Universal Life Subgroup of the NAIC Life Actuarial Task Force

Proposed Revisions to AG 49

April 30, 2020

The Center for Economic Justice (CEJ) has reviewed the ACLI proposal to address loopholes in AG49 that have resulted in IUL products designed to game AG49 to produce unrealistic, deceptive and misleading illustrations. While CEJ appreciates the effort by ACLI, we urge LATF to reject the ACLI proposal and adopt the Independent Party (IP) proposal.

Our concerns with the ACLI proposal – and which are addressed with the IP proposal – are:

1. The ACLI proposal is complex extension of an already complex set of AG 49 calculations that will move illustrations further away from the core purposes of an illustration – to demonstrate how a product operates and to provide realistic expectations and understanding to the consumer about the product. The ACLI proposal is a classic example of losing sight of the forest because of the trees. In contrast, the IP proposal leads to illustrations and consumer disclosures that improve the outcomes for consumers compared to the current AG49

2. The ACLI proposal is a substantial re-write of large swaths of AG49 and introduces new terms undefined in the policy contract which would result in less accountability to and comprehension by consumers and regulators. In contrast, the IP proposal has revises minimal sections of AG49 to achieve the broader consumer protection and comprehension goals.
3. The ACLI proposal makes the 145% return on the option budget the de facto guardrail for crediting rates in illustrations. This is a radical departure from the current AG49 framework and effectively sets the key guardrail on an arbitrary value that is simply not supportable for a long-term investment horizon. Stated differently, it transforms AG49 compliant illustrations and incentives for product designs into life insurance as an option play. In contrast, the IP proposal does not rely upon an arbitrary value for long-term option return, but relies upon actual market values using the Black-Scholes methodology that has been the standard for nearly 50 years.

4. The ACLI proposal narrowly addresses some loopholes while creating incentives for other product designs to game AG49. In particular, the ACLI proposal encourages the use of data-mined proprietary indices instead of discouraging such practice. In addition, the ACLI proposal introduces new discretion for illustration actuaries that lessen accountability to consumers and regulators and promote disparity of illustration results across similar or identical product design. The IP proposal does not create these additional loopholes because no additional discretion is created and incentives for gaming AG49 through, among other things, proprietary indices is eliminated.

5. It is unclear why LATF would defer the design of fixing the loopholes in AG49 and deceptive nature of current IUL illustrations to the same industry participants who have abused IUL illustrations to create the need for AG49 and then further abused IUL illustrations to create the need for fixing loopholes in AG49. This is a classic example of what economist George Akerlof described as the market for “lemons” – products sold in markets with information asymmetry.¹ In such a market – like the market for IUL – those sellers seeking to provide realistic and comprehensible information (illustrations) to consumers lose out to sellers willing to employ unrealistic, deceptive and incomprehensible illustrations to consumers. Given the nature of a market in which competition rewards the bad players, it seems bizarre for regulators to defer the development of market problem solutions to those players benefiting from the current abuses.

   In summary, while we appreciate the efforts of the ACLI to respond to LATF’s directive, the problems with the ACLI approach are obvious and severe. In contrast, the IP proposal provides a better solution to the problems of multipliers and bonuses without creating new problems and while providing a more comprehensive solution for AG49 that will improve IUL illustrations in a manner consistent with the goals and purposes of those illustrations.

May 8, 2020

Mr. Fred Andersen
Chair, IUL Illustration (A) Subgroup
National Association of Insurance Commissioners (NAIC)

Dear Mr. Andersen,

On behalf of the American Academy of Actuaries1 Life Illustrations Work Group, I appreciate the opportunity to provide comments to the IUL Illustration (A) Subgroup regarding the illustrations of Indexed Universal Life (IUL) insurance policies under Actuarial Guideline XLIX (AG 49), and the American Council of Life Insurers (ACLI) proposal for AG 49-A exposed April 15, 2020.

We offer the following comments and note certain items that we believe warrant additional clarification as it pertains to AG 49-A as proposed by the ACLI. We have also made some observations related to Section 4 and would like to reserve comments on Section 6 and application to inforce.

Section 3: Definitions

1. 3.A.i.—We believe it is not clear as to what the total annual percentage rate is. We suggest making it clear how to do a “total annual percentage rate” calculation. Also, the definition in 3.A.i. uses “total percentage rate” and “total annual percentage rate” terminology, which leads to a question of the reason for this difference within the definition.

2. 3.B.—We suggest wording changes to last sentence to say “Charges of any kind cannot be used to increase the Annual Net Investment Earnings Rate,” which we believe would help clarify the intent.

3. 3.C.vi.—We suggest wording changes similar to 3.B. above, “Charges of any kind cannot be used to increase the annual cap.”

4. 3.C.vii.—We are unclear on how to do the “in excess of the interest calculation” that is specified in the definition and suggest examples or more wording to provide clarity.

5. 3.C.—We suggest adding clarity on what to do when Benchmark Index Account (BIA) definition is not met. Additional guidance could be to add into Item ix. the definition of Benchmark Index Account (BIA), which states that a hypothetical account needs to be developed using only Annual Net Investment Earning Rate to buy a cap.

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
6. 3.D.—We suggest modifying the definition of Fixed Account to be “An account where no amount credited is tied to an index or indices.”

7. 3.E.—We suggest modifying the definition of Index Account to be “An account where some or all of the amount credited are Indexed Credits.”

8. 3.F.—It is unclear in the definition of Indexed Credits how a company addresses the floor: for example, is this an annual floor or a cumulative floor? Also, is there a difference between interest credit vs. credit to the policy? To be consistent with previous language in the draft, using “Amounts credited to the policy” rather than “Credits to the policy…” when including the floor may be clearer.

9. 3.G.—We suggest modifying the second sentence in the definition of Hedge Budget to read “This total annualized amount should be…” to be clearer.

10. 3.I.—We suggest this should be defined as “The current annual interest rate as defined in the policy that is charged…”

11. 3.J.i.—We suggest modifying the first phrase in the definition of Policy Loan Interest Credited Rate to read, “For the portion of the account value in the Fixed Account that is backing the Loan Balance.”

12. 3.J.ii.—We also suggest modifying the first phrase in the definition of Policy Loan Interest Credited Rate to read, “For any portion of the account value in the Indexed Account backing the Loan Balance,”

13. 3.J.ii.—We note that it is difficult to understand the phrase “as defined in the policy” in Option 2 due to sentence structure.

14. 3.K.—We note that Hedge Budget is a defined term and should be capitalized consistently when relying on that definition.

Section 4

15. In general, we note that hypothetical BIAs may be developed more frequently as a result of the changes in AG49-A, which could make the maximum illustrated rate less transparent.

16. 4.D.—We are concerned that Section D is unclear with respect to the requirement to comply with Section 6(c) of Model #582. Noting an illustrated rate may exceed Section 6(c) of Model 582 does not seem to ensure the illustrated rate will be in compliance with the Model. We believe that AG49 should not contradict or override Model #582. We suggest that this section be clarified.

Section 5

17. 5.A.—The provision indicates the assumed interest rate underlying the Disciplined Current Scale (DCS) is inclusive of “All general account assets and hedge assets that support…” Hedge assets should already be included in “all general account assets,” and do not need separate mentioning. We suggest the following “…inclusive of all general account assets, both hedge and non-hedge assets, that support the policy…”

18. 5.A.ii.1.—We believe this should say “Hedge Budget minus any annual floor.”

19. 5.A.ii.—We believe the sentence starting with “The above approach…” should be guidance or drafting note because it does not provide instruction. Also, we believe the sentence could be made clearer by adding “underlying the disciplined current scale” after “assumed earned interest rate” at the end of the sentence.
20. 5.A.—The NIER abbreviation should be expanded to “Annual Net Investment Earnings Rate.”

Section 6
21. We would like to reserve comment on Section 6 until the Life Actuarial (A) Task Force (LATF) provides guidance on whether the 1% differential between the policy loan interest rate and the policy loan credited rate should or should not limit illustrated non-indexed credits to any policy loan balance. At that time, we will also review the definition of Policy Loan Credited Interest Rate, and Option 1 or Option 2 for completeness, clarity, and harmony with the rest of the draft.

The work group will also hold any comments on the application of the requirements to inforce policies until final revisions are made to AG49.

Drafters of the background section of AG 49 expressed the concern that, prior to AG 49, there was the possibility of confusing potential buyers when “two illustrations that use the same index and crediting method often illustrated different credited rates.” We note that the guidance from LATF and the resulting draft AG 49-A will cause two illustrations that use different indexes and crediting methods to illustrate similar credited rates. This may hinder consumers’ ability to understand the features of the product being considered. Additionally, with the dependence on an assumed Annual Net Investment Earning Rate in the draft AG 49-A, illustrations that use the same index and crediting method could again illustrate different credited rates.

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The work group appreciates the efforts of the IUL Illustration Subgroup to review AG 49. If you have any questions or would like further dialogue on the above topics, please contact Ian Trepanier, life policy analyst, at trepanier@actuary.org.

Sincerely,

Donna Megregian, MAAA, FSA
Chairperson, Life Illustrations Work Group
American Academy of Actuaries
AG49 Comment Letter

Mr. Fred Andersen

Chair, NAIC IUL Illustration (A) Subgroup

Re: ACLI proposed draft of Actuarial Guideline 49-A

Dear Mr. Andersen:

Equitable appreciates the opportunity to submit the following proposal regarding AG49-A on prospective requirements for IUL illustrations.

We believe that the ACLI draft represents quality work. However, we submit a distinct proposal from the ACLI for two reasons. First, the ACLI letter was developed prior to the recent decline in interest rates. A 10-year US Treasury yield of 0.65% interest rates does not align with the annual 4.5% net investment earnings rate assumption underlying the submitted numerical examples.

Second, we believe that the ACLI proposal has a narrow objective to ensure products with multipliers or other enhancements do not illustrate better than products without them. This has led to a result that, in our opinion, is rather extreme: that illustrated index credits reflect solely the options budget that can be supported by each company’s assumed annual net investment earnings rate. We do not believe the original goal of the AG 49 amendment was to eliminate the use of any policy charges to support illustrated indexed credits, but rather to limit the illustration of unrealistically high levels of indexed credits. We are concerned that the resulting proposal may not align well with the actual mechanics of the contracts being illustrated, which would reduce rather than enhance consumer understanding.

Our proposal has been informed by the discussions behind the ACLI draft but diverges in its form and substance in a manner that reflects our understanding of regulator objectives.

The remainder of this letter is organized to accomplish the following objectives:

1- Articulate our understanding of the regulator governance objectives for IUL illustrations
2- Propose a governance framework to accomplish each regulator objective
3- Outline specific parameters to calibrate the proposed framework

1. Our understanding of the IUL illustration governance objectives

The stated goals of AG 49 are to guide determinations of maximum illustrated crediting rates and to identify additional side-by-side illustrations to enhance consumer understanding. We
believe this reflects a broader regulator desire to ensure policy illustrations depict a realistic projection of long-term policyholder returns upon which a current or prospective policyholder can establish realistic expectations for account performance and funding requirements.

From a technical perspective, we bifurcate the elements of the illustration that require governance into the:

a) **Size of the “option budget”:** the amount of total contract value “put at risk” by investing in equity options or other risky investments.

b) **Rate-of-return on the “option budget”:** the illustrated long-term return of the instruments in which the option budget is invested.

**Figure 1: Elements of the IUL illustrated return and associated regulator concerns**

With respect to the size of the option budget, we understand the foremost regulator concern to be option budgets that are substantially larger than what can be supported by investing the contract value at yields on prevailing high-quality investments. Similarly, we understand the manifestation of that concern to be poor performance of large option budget investments which can lead to more rapid reductions in contract value beyond what clients expect.

With respect to the returns on the option budget, we understand the foremost regulator concern to be illustrated returns well in excess of high grade investment yields. Such returns are considered both volatile and unlikely to be sustained over long-periods, and any performance below illustrated rates-of-return may require the policyholder to contribute substantial premiums to maintain the policy in force.
II. Proposed illustration governance framework

In order to address these concerns, Equitable believes regulators should seek to govern both elements of the illustrated IUL return. That said, Equitable favors a more lenient “guardrail approach” that simply caps the size of the option budget. This would couple with stricter governance on the rate-of-return of the option budget. This approach reflects our beliefs that:

- A policyholder may reasonably seek a contract with greater market exposure than what can be created by an option budget supported only by prevailing yields on high quality investments – and hence who desire a larger option budget
- The policyholder expectation for contract performance should not rely on excessive long-run outperformance of the instruments in which the option budget (of whatever size) is invested

Equitable proposes a framework that governs distinctly each element of the illustrated return. We believe this approach offers the simplest governance framework for regulators and companies as well as aligns with the two aforementioned beliefs.

Table 1 below summarizes the proposed governance framework:

<table>
<thead>
<tr>
<th>Illustration element</th>
<th>Regulator concern</th>
<th>Governance approach</th>
<th>Rationale for approach</th>
</tr>
</thead>
</table>
| Size of option budget | • Budgets well in excess of levels supported by high quality fixed income assets | • “Guardrail”  
• Cap amount of option budget as % of contract value | • Allows adequate illustration of products designed to offer more/less market exposure  
• However, establishes an “upper bound” for the annual contract exposure |
| Return on option budget investments | • Returns on budgets which are unlikely to be sustained over long periods | • “Return limit”  
• Cap annual return on option budget investments | • Explicitly regulates the long-run returns on instruments in which option budgets are invested |

III. Proposed framework parameterization

Equitable believes the parameters for the proposed governance framework should permit illustration of products designed to suit customer needs, but also recognize the limits of downside risk expected for an IUL policy (before a Variable policy may become more appropriate). Moreover, we also seek to integrate the regulator feedback received during the preceding months of discussion on AG49.

The table below contains our proposed framework parameterization and the supporting rationale for the parameterization.
<table>
<thead>
<tr>
<th>Illustration element</th>
<th>Governance approach</th>
<th>Proposed parameter</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Size of option budget | • “Guardrail”  
• Cap amount of option budget as % of contract value | • Max(5%, Annual Net Investment Earnings Rate) | • Floors annual loss of value at 5% of CSV  
• Allows higher option budgets if prevailing investment yields rise  
• Permits carriers to offer meaningful market exposure even in low interest rate environments (e.g. point-to-point cap of 10%+) |
| Return on option budget investments | • “Return limit”  
• Cap annual return on option budget investments | • Cap set to [110%-130%]  
• Requirement to illustrate 100% | • Caps option budget performance at realistic levels  
• Zero outperformance (fixed account return) is a plausible yet prudent downside case |

The guardrail on the “size of the option budget” would be 5% in prevailing market conditions. We believe this cap balances the ability to create products with meaningful exposure market performance with the desire to limit contract value declines from underperformance. Moreover, to account for potential changes in prevailing investment yields we include a provision to increase the maximum option budget should prevailing investment yields rise in the future.

Governance over the illustrated rate-of-return on option budget investments contains two elements: a cap on the illustrated rate, and a requirement to project a “plausible but prudent” downside case. Equitable supports a prudent cap on the illustrated rate-of-return within the range of 110% - 130%. The 110% is a level advocated by NY DFS, which reflects the allowance of a prudent risk premium associated with converting the option budget into risky instruments (e.g., a 5% option budget is then illustrated to earn 5.5% in perpetuity). However, we also support a rate-of-return of up to 130%, which reflects the realization of a considerable risk premium (e.g., a 5% option budget is illustrated to earn 6.5% in perpetuity). We would not support levels above 130% on a sustained basis. Moreover, we believe levels close to 130% would require the parallel “downside” illustration of 85-100%. This level is consistent with no additional risk premium earned – a level consistent with a traditional fixed account. We support no lower than 85-100% to ensure the policyholder does not dismiss the downside case illustration as an unrealistic stress scenario. We believe that the existing Alternate Scale illustration could perform this role, if combined with a requirement for the prospective policy owner to acknowledge in writing that they have reviewed it and understand the downside risk.

Thank you once again for the opportunity to share our thoughts with you on this important issue. Please do not hesitate to contact me should you have any questions or concerns regarding our proposal.
Brian R. Lessing, FSA, MAAA
Senior Director-Actuarial

Aaron Sarfatti, ASA
Chief Risk Officer
May 1, 2020

Mr. Fred Andersen  
Chair, NAIC IUL Illustration (A) Subgroup  
Mr. Reggie Mazyck  
Life Actuary, NAIC

Re: Exposure of ACLI Comments and Draft AG49

Dear Mr. Andersen and Mr. Mazyck,

Global Atlantic supports the exposed Actuarial Guideline XLIX-A (AG49A) draft, as submitted by the American Council of Life Insurers (ACLI), to bring uniformity in illustrated values and aid potential buyers. Global Atlantic continues to believe that all index product designs should illustrate consistently and within the spirit of the current guideline. The ACLI’s cover letter presents two alternatives regarding loan leverage. Global Atlantic submits this comment letter in support of loan leverage Option 1 as listed in the ACLI submission.

AG49 limits the illustrated index return to no more than 100bps above the illustrated loan rate charged. The excess of index return over the loan rate charge is the leverage. AG49A Option 1 establishes the Policy Loan Interest Credited Rate as the total percentage rate of Indexed Credits, net of any applicable Supplemental Hedge Budget. Option 1 appropriately includes index-based provisions within the Policy Loan Interest Credited Rate and therefore leverage limit.

AG49A Option 2 establishes the Policy Loan Interest Credited Rate as the total percentage rate of Indexed Credits and all illustrated bonuses, charge reductions or other enhancements that impact the portion of the account value backing the Loan Balance. By including all illustrated bonuses, charge reductions and other enhancements, non-index provisions are included within the leverage limit. The background section of AG49, and in fact its title, indicate that its focus is the illustration of index-based benefits. Option 2’s inclusion of other provisions within the leverage limit will result in a lack of uniformity and consumer confusion.

Global Atlantic has for over a decade offered our Wellness for Life® product feature. That feature guarantees cost of insurance (COI) discounts when the insured leads a healthy lifestyle. We have offered the feature on both UL and IUL products. The feature is available on our IUL products regardless of whether policy funds are in the fixed or indexed accounts. The COI discounts are a reduction in policy charges. Option 2 would require that this COI discount be translated into a basis point interest benefit on a loan balance and reduce the loan leverage limit otherwise illustrated. The inclusion of such non-index provisions as included within Option 2 inappropriately restricts the leverage limit for non-index provisions. This was not the intent of AG49 and should not be included in AG49A. Option 2 creates an uneven market. It also creates complexity, if not impossibility, for the illustration actuary to translate non-index provisions that aren’t tied to interest crediting into interest rate benefit applied within illustrations involving loans.
We recommend that AG49A utilize the ACLI’s Option 1 wording to align with the intent of AG49, create a level playing field and provide consistent guidance to the illustration actuary. We look forward to continued dialogue on this important topic.

Thomas A. Doruska
Head of Life Product Development

David P. Wilken
President - Life
Mr. Fred Andersen  
Acting Deputy Commissioner of Insurance  
Minnesota Department of Commerce  
Chair, NAIC IUL Illustration (A) Subgroup  
85 7th Place East, Suite 280  
St. Paul, MN 55101  

Re: Life Actuarial Task Force request for comments on the ACLI draft AG49 by April 30, 2020.

Dear Mr. Andersen:

Broadly-speaking, we feel that the objective of life insurance product illustrations should be to help consumers make informed financial decisions by demonstrating how the product works and the potential risk and return opportunities. While we believe that sales professionals are accountable for reviewing the risk and return associated with indexed universal life insurance policies with consumers, we also see an opportunity for improvement in the way these products are illustrated. We look forward to continuing to work with the NAIC on longer-term, more holistic changes to provide better consumer clarity.

While additional changes may be important for the long term, the current ACLI AG49 draft dated April 14, 2020, represents a significant step forward for meeting the goals set forth by LATF. Within the ACLI AG49 draft, we support loan Option 2. This language will limit the illustrated loan leverage to 100 bp (1.00%), regardless of product design. Products could still offer additional bonus features and demonstrate how they work by illustrating at a lower index interest rate or when loans are not illustrated, however the loan leverage will never exceed 100 bp. We believe loan Option 2 fits with the spirit of AG49 and is in the best interest of consumers.

We would welcome the opportunity to discuss our position further with you. I can be reached at (614) 249-5947.

Regards,

Pete Rothermel  
VP, CFO – Individual Life

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April 30, 2020

Fred Andersen
Deputy Commissioner of Insurance
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: ACLI Proposed Draft of Actuarial Guideline 49-A and clarity on earned rate in the DCS and the percentage rate of Indexed Credits

Fred:

This letter is submitted on behalf of John Hancock, Lincoln Financial Group, Pacific Life Insurance Company and Sammons Financial Group. The purpose of this letter is to ask regulators to consider clarifying language on the relationship between the earned rate underlying the DCS in Section 5 and the percentage rate of Indexed Credits in Section 4 of the ACLI draft. The above noted companies have also submitted a separate letter that supports the direction of the ACLI’s proposed AG49-A including prospective-only application and Option #1 regarding the treatment of policy loans. This letter is meant to supplement that letter.

We believe that having clarity regarding the DCS and the rate of Indexed Credits is a minor but necessary change for the industry to have a common understanding of how to apply AG49-A. Different interpretations for this relationship were identified during discussions among carriers regarding potential changes to AG49.

**Interpretation 1:** The earned rate underlying the DCS in Section 5A is not restricted by the percentage rate of Indexed Credits in an illustration.

**Interpretation 2:** The earned rate underlying the DCS in Section 5A should be restricted by the percentage rate of the Indexed Credits in an illustration.

The ACLI examples represent the first interpretation. Example 1 on the tab with the hedge budget equal to the net investment earnings rate shows Indexed Credits at a level of 6.20%, while the Section 5A rate is calculated at 6.53%. In the illustration testing calculations for this example, Interpretation 1 could allow the earned rate underlying the DCS to be 0.33% more than the illustrated rate of Indexed Credits.

However, in a typical IUL design, the contract will state that the index-linked credits will equal the increase in the underlying index and if a carrier has perfectly hedged the amount of index credits, these amounts would be the same and there would be no additional return on the hedge. The hedge return would match the amount credited to the policy values.
Therefore, we believe that the correct interpretation is number 2, that the earned rate underlying the DCS should be limited by the illustrated Indexed Credits. Otherwise, the illustration tests could include margins that are not contractually realizable. For this reason, the IUL Coalition proposal dated February 21 contained the following in Section 5A:

The assumed return on hedges shall only be used in the disciplined current scale testing to support the illustrated Index Credits in the policy.

If regulators are comfortable with Interpretation 1, that the earned rate underlying the DCS need not be restricted by the level of Indexed Credits, it would be valuable to have AG49-A directly state this or include a drafting note that clearly allows an illustration actuary to use this interpretation. This will ensure there is consistent interpretation on this issue and clarity for actuaries certifying illustrations for these products.

Thank you for consideration of our comments and we are happy to answer any questions or concerns you may have.

Respectfully Submitted,

Scott R. Harrison
High Point Strategies, LLC
scott@highpointstrategies.llc

cc: Reggie Mazyck, NAIC
April 30, 2020

Fred Andersen
Acting Deputy Commissioner of Insurance
Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101

Dear Fred,

The undersigned companies present these comments in response to the NAIC IUL Illustrations (A) Subcommittee request for comments on the exposed draft of the ACLI recommended changes to AG49.

Respectfully,

Seth Detert, Securian Financial
Pete Rothermel Life CFO, Nationwide
Jacqueline Fallon, Penn Mutual Life Insurance Co
John Ponte, Prudential
Seth Harlow, Mutual of Omaha

We believe that the ACLI’s exposed revisions to AG49 accomplish the main tasks set forth by the Subcommittee:

- That products with charged for multipliers and/or buy-up accounts illustrate substantially similar to those products without the additional charges.

- That within an illustration there is consistent treatment of policy features such as multipliers, index bonuses, participating loan crediting, and non-benchmark indices across the industry.

We would like to commend the ACLI for the job they have done in facilitating the drafting sessions and allowing interested parties to comment on the proposed language. We believe that the ACLI has done an appropriate job of bringing the previous exposed recommendations to AG49 together in one draft and including new language to address the majority of the concerns raised during the drafting sessions.

We recommend the Subcommittee adopt Option #2 of the ACLI comment letter in regard to the applicability of loan leverage. We also recommend a slight modification to the ACLI’s current language. We would recommend either clarifying what was intended by “charge reductions” or to remove it. We believe that the impact of participating loans is unique to the IUL product and that in and of itself gives IUL products certain advantages over other product types in the industry. Thus, it is important that illustrations be inclusive of all types of credits in the loan leverage calculation and not over emphasize the impact participating loans can have on the illustrated values of IUL products.

We do recognize there are some ongoing concerns with the proposed ACLI revisions to AG49. We understand those concerns, however, we urge the Subcommittee to bring forward the current ACLI proposal for vote and ultimate adoption. The ACLI recommendation is a meaningful step forward in the consistent illustration of IUL products.
The Life Actuarial (A) Task Force met via conference call May 7, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman and Ben Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by William Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted its Minutes and the VM-22 (A) Subgroup’s Minutes**

    The Task Force met Feb. 27, Feb. 20, Feb. 13, Feb. 6, Jan. 30 and Jan. 23. During these meetings, the Task Force took the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) adopted an amendment to allow the use of different credibility methods for significantly different blocks of business; 3) adopted an amendment to clarify that policies with universal life policies with secondary guarantees (ULSG) business are excluded from the life principle-based reserving (PBR) exemption, whether provided in the base policy or in a rider when the secondary guarantee is material; 4) adopted an amendment emphasizing the requirement for increasing the reserve to reflect the increase in risk for policies resulting from term conversions; and 5) adopted an amendment providing a guidance note to reference Excel examples of mortality aggregation and the reporting of assumptions.

    The VM-22 (A) Subgroup met Feb. 26 to discuss potential revisions to VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities.

    Mr. Andersen made a motion, seconded by Mr. Weber, to adopt the Task Force’s Jan. 23 – Feb. 27 minutes (Attachment Eight-A) and the VM-22 (A) Subgroup’s Feb. 26 minutes (Attachment Eight-B). The motion passed unanimously.

2. **Agreed to Forward the Recommendation to Delay Collection of Company Mortality Experience Data**

    Pat Allison (NAIC) updated the Task Force on the status of the collection of company mortality experience data. She said the presentation (Attachment Eight-C) provides information on the schedule for planned communications with companies that have been selected to report their mortality experience. The communications are intended to keep the companies engaged even though the reporting of data for the 2018 observation year, which would normally be collected in 2020, will be delayed until 2021.

    Ms. Allison said a memorandum (Attachment Eight-D) proposing the delay was exposed by the Task Force in April. She shared that the NAIC began serving as experience reporting agent on Jan. 1. She said that at a June 25, 2019, Task Force meeting, NAIC life actuarial support staff presented information on the selection of companies required to submit mortality experience data in 2020. A total of 176 companies were selected, representing 31 states of domicile. Since then, all selected companies were notified, and the data call was planned to begin during Q2, 2020. The memorandum proposes the delay, at the request of the American Council of Life Insurers (ACLI), because of the disruption experienced by life insurance companies due to the COVID-19 pandemic and the corresponding impact on company resources required to support the collection efforts. The memorandum recommends the collection of data for the 2018 and 2019 observation years in 2021.

    Ms. Allison indicated that section 5.A.3 of VM-50, Experience Reporting Requirements, states that the experience reporting agent “may modify or enlarge the requirements of the Valuation Manual…… to accommodate changing needs and environments.” She suggested that the COVID-19 pandemic has resulted in “changing needs and environments.” She noted that collection of company mortality experience data remains a high priority regulatory issue for the NAIC. She said the proposed delay of data collection should not be interpreted as diminishing either the importance of the issue to the NAIC or the
role of experience reporting as the foundation for PBR. Therefore, insurers are admonished to ensure the continuity and quality of experience reporting data submissions.

Brian Bayerle (ACLI) said the ACLI comment letter (Attachment Eight-E) expresses support for the proposed reporting delay.

Mr. Kupferman made a motion, seconded by Mr. Leung, to forward the memorandum proposing the delay of the 2020 experience data collection until 2021 to the Executive (EX) Committee for its consideration (see NAIC Proceedings – Summer 2020, Executive (EX) Committee, Attachment One). The motion passed unanimously.

3. Heard an Update on the ESG

Ms. Allison gave a presentation (Attachment Eight-F) on the status of efforts to find a new economic scenario generator (ESG) to replace the American Academy of Actuaries’ (Academy) ESG. During the presentation, she reviewed the timeline of the request for proposal (RFP). She noted that six bids have been received, and they will be reviewed by the Task Force chair and vice chair and three NAIC PBR staff actuaries. Bids will be ranked based on the scoring criteria provided in the RFP. Ms. Allison said the review is expected to be completed by the end of May, and it will then be taken to the Executive (EX) Committee for funding approval in June. The implementation of the ESG is targeted for no earlier than 2022.

4. Discussed the Cessation of LIBOR

Ms. Allison provided a presentation (Attachment Eight-G) to raise awareness of the United Kingdom (UK) Financial Conduct Authority (FCA) intention to cease publishing the London Interbank Offered Rate (LIBOR) after 2021. She said the Alternative Reference Rates Committee (ARRC), formed in 2014 by the Federal Reserve Board and the Federal Reserve Bank of New York, is moving toward using the Secured Overnight Financing Rate (SOFR) as a replacement for LIBOR. She noted that insurance companies will need to inventory their products and processes that currently use LIBOR. She pointed out the need to revise the language in section 9.F.8.d of VM-20, Requirements for Principle-Based Reserves for Life Products, to eliminate the reference to LIBOR.

5. Exposed Amendment Proposal 2020-06

Mr. Bayerle discussed a slide presentation (Attachment Eight-H) on the interest rate swap spreads tables in the Valuation Manual. He said the Valuation Manual prescribes interest rate swap spreads for VM-20 and VM-21, Requirements for Principle-Based Reserves for Variable Annuities. He noted that the use of the NAIC published swap spreads increased substantially with the implementation of the new VM-21 reserve requirements for variable annuities. He said, while the NAIC three-month and six-month current swap spreads should track market observable data, there have been differences as large as 19 basis points. He recommended several actions to address this issue and other issues, including increased clarity of the rate calculation process and the need for a LIBOR replacement.

Ms. Allison said the NAIC’s published data is calculated as an average of data obtained from JP Morgan and Bank of America. She said market observable data is only available at selected tenors of the yield curve, requiring interpolation for the points in between the selected tenors. JP Morgan and Bank of America use proprietary processes to provide data at all points along the U.S. Department of the Treasury (Treasury Department) yield curve. Differences can be expected compared to market observable data because these firms calculate their own Treasury Department yield curve and their own LIBOR values.

Mr. Bayerle introduced amendment proposal 2020-06 (Attachment Eight-I), which provides Valuation Manual revisions that address the swap spreads issues by allowing companies to determine their own swap rates from market observable sources. He said the amendment proposal also requires the disclosure of the market observable sources in the PBR Actuarial Report.

Mr. Leung made a motion, seconded by Mr. Kupferman, to expose amendment proposal 2020-06 for a 21-day public comment period ending May 27. The motion passed unanimously.
6. **Exposed Revisions to Model #805**

Mr. Bayerle said the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805) currently sets the floor for the nonforfeiture interest rate at 1%. He said the current economic environment necessitates lowering the nonforfeiture interest rate to 0% to allow companies to support the nonforfeiture guarantees in their deferred annuity contracts. He submitted a proposal to revise Model #805 to lower the nonforfeiture rate.

Mr. Carmello made a motion, seconded by Mr. Weber, to expose revisions to Model #805 (Attachment Eight-J) for a 21-day public comment period ending May 27. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met via conference call Feb. 27, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Jason Wade (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman and Benjamin Bock (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Agreed to Distribution of the ESG RFP

Mr. Boerner said the need to replace the American Academy of Actuaries (Academy’s) economic scenario generator (ESG) was discussed during the July 16, 2019, joint call of the Task Force and the Life Risk-Based Capital (E) Working Group. The groups agreed, without objection, to have NAIC staff develop a request for proposal (RFP) for a replacement ESG. He said the proposed RFP (Attachment Eight-A1) was developed in response to that decision and in accordance with the direction provided to staff after discussions with a drafting group comprised of state insurance regulators and NAIC staff, Academy and industry representatives.

Mr. Boerner said the goal is to have the Task Force agree, without objection, to allow NAIC staff to release the RFP and provide a memorandum informing the Life Insurance and Annuities (A) Committee of the release of the RFP. Scott O’Neal (NAIC) said the memorandum to the Committee provides the background and history necessitating the RFP and summarizes the deliverables required of potential vendors.

Mr. Ostlund questioned the Task Force’s authority to issue the RFP without approval from the Committee.

Mr. Boerner said the information provided by NAIC staff is that Committee approval is not required.

Reggie Mazyck (NAIC) noted that the RFP was approved by both the NAIC chief operating officer (COO) and the chief financial officer (CFO), and it has been discussed with the Committee chair.

Mr. Boerner reiterated his understanding that Committee approval is not required, but he is willing to defer to Mr. Ostlund’s request to obtain Committee approval before recommending distribution of the RFP.

Mr. O’Neal said the RFP provides the minimum requirements expected from an ESG. He discussed the scope of the RFP, including the expected deliverables; ongoing production, maintenance and support requirements, including costs; and other contractual terms of the RFP.

Mr. Ostlund made a motion, seconded by Ms. Eom, to direct the Task Force chair to request permission from the Committee to issue an RFP for an ESG, noting that the ESG RFP memorandum serves as the request, while also providing information on the initiative (Attachment Eight-A2). The motion passed unanimously.*

*Editor’s Note: Subsequent to the conference call, it was determined that the RFP does not require Life Insurance and Annuities (A) Committee approval prior to distribution. The Task Force conducted an e-vote to agree, without objection, for NAIC staff to release the RFP and to provide the memorandum, as referenced in the minutes above, to the Committee.
2. **Adopted Amendment Proposal 2019-62**

Mr. Boerner said amendment proposal 2019-62 was exposed for 14 days after moving the proposed language from a guidance note into the text as an additional paragraph of VM-20, Requirements for Principle-Based Reserves for Life Products, Section 9.C.4.

Mr. Leung made a motion, seconded by Mr. Chupp, to adopt amendment proposal 2019-62 (Attachment Eight-A3). The motion passed unanimously.

3. **Exposed Amendment Proposal 2020-03**

Ms. Hemphill said there were differing interpretations of the treatment of the premium mode when calculating the VM-20 net premium reserve (NPR). She said amendment proposal 2020-03 clarifies that the actual modal premium may be reflected directly in the NPR calculation. Ms. Fenwick suggested modifying the language proposed for VM-20 Section 3.B.3.a to read, “Directly within the calculations” instead of, “Through direct adjustments to the calculations” because the latter may be subject to judgment.

Ms. Hemphill said that change works for the direct calculation, but it may not work if using an unearned premium approach. She recommended adding a note to the exposure asking commenters if the revised language proposed for Section 3.B.3.a might necessitate an additional requirement to cover calculations utilizing an unearned premium approach.

Ms. Fenwick made a motion, seconded by Mr. Ostlund, to expose amendment proposal 2020-03, including the change to Section 3.B.3.a, and the proposed cover note, for a 21-day public comment period (Attachment Eight-A4). The motion passed unanimously.

4. **Exposed Amendment Proposal 2019-58**


Mr. Bock made a motion, seconded by Ms. Eom, to expose amendment proposal 2019-58 for a 21-day public comment period (Attachment Eight-A5). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

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The Life Actuarial (A) Task Force met via conference call Feb. 20, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce. R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Bill Carmello (NY); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Adopted Revisions to AG 48

Mr. Boerner said changes were made to Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) to reflect changes to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) (Attachment Eight-A6) adopted by the Reinsurance (E) Task Force.

Mr. Leung made a motion, seconded by Mr. Chou, to adopt the revisions to AG 48 (Attachment Eight-A7). The motion passed unanimously.

2. Agreed to Forward Revisions to the VM-20 Reserve Supplement

Jennifer Frasier (NAIC) discussed proposed changes to the VM-20 Reserve Supplement blank. She said the major changes to the blank include: 1) changing the reporting units from thousands to dollars to be consistent with other annual statement reporting formats; 2) splitting Part 1 into Part 1A and Part 1B to provide the necessary space to accommodate the reporting unit change to dollars; and 3) removing Part 2, which was required only for the three-year transition period.

Ms. Frasier discussed proposed changes to the VM-20 Reserve Supplement instructions to reflect the revisions to the blanks. She noted receiving feedback that the sentence in the instructions for reporting the net premium reserve (NPR) in Part 1B, which reads “Report the floored amount,” may be unnecessary or confusing. She said the sentence was added after reviewing reserve supplements in which companies did not report the floor. She agreed to remove the sentence to provide clarity.

Ms. Frasier discussed the changes to the Variable Annuities (VA) Supplement blanks and instructions that reflect the VA Framework changes effective in the 2020 Valuation Manual. She said some feedback she received suggested adding a reference to Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43). She agreed to add that reference by changing the scope-related sentence to read: “Complete this supplement for contracts and certificates subject to VM-21 or AG 43.” She said other feedback suggested breaking proposed line for “Reserves Ceded” into two lines showing the amount of reinsurance ceded to captives and the amount of reinsurance ceded to other non-captive companies. There was no objection to the change.

The Task Force agreed, without objection, to forward the VM-20 Reserve Supplement blank and its instructions (Attachment Eight-A8), and the VA Supplement blank and its instructions (Attachment Eight-A9), including the agreed-upon edits, to the Blanks (E) Working Group.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met via conference call Feb. 13, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Linda A. Lacewell represented by Bill Carmello (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Re-Exposed Amendment Proposal 2019-62**

Mr. Boerner presented two options for editing amendment proposal 2019-62. The first option provides leading language to add context to the wording of the guidance note. The second option moves the guidance note language into the text to create a new VM-20, Requirements for Principle-Based Reserves for Life Products (Section 9.C.4.d.)

Mr. Chupp said that while either option is acceptable, his preference is for option 2. Mr. Carmello concurred with a preference for option 2.

Mr. Boerner suggested exposing the amendment proposal with option 2 and an explanatory note calling attention to the language in Section 9.C.4 and noting that the proposed language was extracted from the previously exposed guidance note.

Mr. Chupp made a motion, seconded by Mr. Ostlund, to expose amendment proposal 2019-62 for a 14-day public comment period ending Feb. 26 (Attachment Eight-A10). The motion passed unanimously.

2. **Exposed Amendment Proposal 2020-02**

Pat Allison (NAIC) said amendment proposal 2020-02 clarifies VM-20 Section 2.H and adds a new Section 2.I to address the skipping of steps mandated in VM-20 on the grounds of materiality or reliance on the allowance of approximations provided in Section 2.G. She said the proposal includes a guidance note that provides examples of steps that cannot be omitted.

Mr. Chupp made a motion, seconded by Mr. Leung, to expose amendment proposal 2020-02 for a 21-day public comment period ending March 4 (Attachment Eight-A11). The motion passed unanimously.

3. **Rejected Amendment Proposal 2017-51**

Mr. Boerner said the amendment proposes allowing final expense policies to be treated similar to pre-need policies, which are exempt from principles-based reserving (PBR). He said pre-need policies have a clearly defined boundary that distinguishes them from other policy types. He said the broad categorization of final expense policies could allow various product designs to fit under the final expense umbrella. Allowing final expense policies an exemption similar to that granted to pre-need policies might allow a PBR exemption to some policies inappropriately. He recommended the rejection of the amendment proposal.

Mr. Carmello indicated that if there were a limit on the face amount of the policies characterized as final expense dollar, he might be more amenable to the proposal, but he could not support it in its current form.

Mr. Carmello made a motion, seconded by Mr. Weber, to reject amendment proposal 2017-51 (Attachment Eight-A12). The motion passed, with Alabama and Iowa dissenting.
4. Discussed Amendment Proposal 2019-33

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comments (Attachment Eight-A16) on amendment proposal 2019-33 note concerns with the scope of the definition of “individual risk selection process” and practical implementation concerns. He said in addition to the written comments, the ACLI is also concerned that companies that issue very small group business may be doing more underwriting than is normally done for a group contract. He suggested the consideration of a minimum group size if there is a scope revision. He said consideration should also be given to the appropriateness of the mortality and lapse rates compared to the rates used in the net premium reserve (NPR). He recommended that the Task Force defer consideration until the concerns are addressed.

Len Mangini (Academy) said the proposal has a three-year phase-in, which would allow time for edits to the amendment proposal after Task Force adoption.

Mr. Chupp said the use of the term “ordinary life” might be problematic because the Valuation Manual uses the term to apply only to individual policies. He said his comment (Attachment Eight-A13) questions whether the proposed language is appropriately placed within the Valuation Manual. The comment recommends a new section to accommodate the language.

Mr. Robinson said his comment (Attachment Eight-A14) suggests that the proposal will require changes to VM-51, Experience Reporting Formats.

Mr. Mangini said the Academy Life Reserve Work Group will consider the comments.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met via conference call Feb. 6, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted its 2019 Fall National Meeting Minutes**

   Mr. Ostlund made a motion, seconded by Mr. Yanacheak, to adopt the Task Force’s Dec. 5–6, 2019, minutes (see NAIC Proceedings – Fall 2019, Life Actuarial (A) Task Force). The motion passed unanimously.

2. **Discussed Amendment Proposal 2019-62**

   Leonard Mangini (American Academy of Actuaries—Academy) said amendment proposal 2019-62 (Attachment Eight-A15) clarifies the treatment of additional mortality risk arising from the conversion of term life policies. He said the proposed language also requires a description of the conversion privileges and how the mortality was factored into the aggregation and segmentation.

   Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment Eight-A16) supports the proposed amendment.

   Mr. Chupp said his comment letter (Attachment Eight-A17) suggests that, given the use of the word “must” in the proposed language, the language should not be relegated to a guidance note, but it should be a part of the text. He suggested that the proposed guidance note should become Section 9.C.4.d of VM-20, Requirements for Principle-Based Reserves for Life Products.

   Mr. Mangini said the Academy’s Life Reserves Work Group proposed using a guidance note because they did not want to give the impression that they were changing existing requirements.

   Mr. Boerner said the guidance note could be revised to point to the specific section of VM-20 containing the existing requirements. He recommended deferring action on the proposal until it could be determined whether the guidance note can appropriately point to Section 9.C.4 without requiring revisions to the language in that section.

3. **Adopted Amendment Proposal 2019-61**

   Ms. Hemphill said amendment proposal 2019-61 clarifies that all universal life policies with a material secondary guarantee are ineligible for the life principle-based reserves (PBR) exemption, regardless of whether the secondary guarantee is a part of the base policy or a rider.

   Mr. Bayerle said the ACLI comment letter expressed support for the proposal.

   Mr. Leung made a motion, seconded by Mr. Weber, to adopt amendment proposal 2019-61 (Attachment Eight-A18). The motion passed unanimously.
4. **Adopted Amendment Proposal 2019-60**

Ms. Hemphill said that while the *Valuation Manual* requires a company to use one credibility method for all of its business, the lack of industry factors for 2008 Valuation Basic Table (VBT) is a practical constraint that does not allow application of the Bühlmann method to business issued on the 2008 VBT. She said amendment proposal 2019-60 allows a company using the Bühlmann method for its fully underwritten business to use the Limited Fluctuation method for its business issued on the 2008 VBT. She said it also clarifies that claims using different credibility methods cannot be aggregated for the purpose of determining credibility and the sufficient data period.

Mr. Chou made a motion, seconded by Mr. Leung, to adopt amendment proposal 2019-60 (Attachment Eight-A19). The motion passed unanimously.

5. **Accepted Amendment Proposal 2020-01 as an Editorial Change**

Ms. Hemphill explained that amendment proposal 2020-01 provides two guidance notes that point to documents on the NAIC website to assist users of VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, by providing examples. She said the first guidance note points to mortality aggregation examples provided in the Mortality Aggregation excel spreadsheet, and it includes a Mortality Aggregation Presentation from the 2019 Summer National Meeting. The second guidance note points to the Sample Assumptions Summary for PBR Actuarial Report, which may be a useful reference document to individuals developing reporting in accordance with VM-31 Section 3.D.l.a.

Mr. Boerner noted that the guidance notes only provide the location of examples and do not change any requirements.

Reggie Mazyck (NAIC) said that because the guidance notes are only informational and no requirements are changed, he recommends that the Task Force accept the amendment proposal as an editorial change.

Mr. Boerner asked if any Task Force members objected to accepting amendment proposal 2020-01 (Attachment Eight-A20) as an editorial change to the *Valuation Manual*. The proposal was accepted without objection from Task Force members.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met via conference call Jan. 30, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair, represented by Peter Weber (OH); Jim L. Ridling represented by Steve Oslund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou and Jim Jakielo (CT); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Bruce Sartain (IL); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce. R. Range represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal represented by Mark Hendrick (NM); Linda A. Lacewell represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Discussed the Oliver Wyman YRT Reinsurance Reserve Credit Long-Term Solution

Chris Whitney (Oliver Wyman) reviewed the yearly renewable term (YRT) reinsurance reserve credit slide deck discussed on the Jan. 23 Task Force call (Attachment Eight-A22). He acknowledged a request from a Task Force member for an example of how the YRT rates used in the analysis were derived. He said the example will be provided to NAIC staff for distribution to Task Force members. Mr. Whitney reiterated that key takeaways from the previous discussion were:

1) Principles-based projections of reinsurance ceded can allow for scenarios reflecting reinsurer reactions that can produce reserve credits in excess of \( \frac{1}{2} c_x \).

2) The relative impact of each solution changes over time as the level of margin and remaining projection years change.

Mr. Whitney said because initial field test results are at a point-in-time, they will provide limited information. He said the longer-term projections, expected to be available at the end of February, will be more informative.

Dylan Strother (Oliver Wyman) said the long-term solution supplement document (Attachment Eight-A23), providing the assuming reinsurer’s perspective, was developed in response to mirror reserving questions posed at the 2019 Fall National Meeting. He said mirror reserving is not expected under the principle-based reserving (PBR) approach, primarily due to the differing assumptions of the direct writer and the reinsurer. He noted that the mix of business and the mechanics of the PBR calculation also contribute to the unlikelihood of having mirror reserves.

Katie van Ryn (Oliver Wyman) discussed examples where differing assumptions lead to the implausibility of mirror reserving. She noted that for the graphs on slide 6, the credibility assumptions for the ceding and assuming companies differ, with the lower ceding company credibility resulting in a higher PBR mortality margin. A similar comparison is provided on slide 7, except the YRT premium rates are modeled as the current scale plus 105% of the increase in PBR mortality. The adjustment to the YRT premiums reduces the difference between the reserve credit and the assumed reserves.

Mr. Robinson noted that the graphs show instances where the ceded reserve credit is greater than the assumed reserve. He asked Task Force members if it is permissible for the reserve credit to exceed the assumed reserve. He requested that Mr. Whitney provide revised graphs comparing the reserve credit, the assumed reserve, the assumed net premium reserve (NPR) and \( \frac{1}{2} c_x \).

Mr. Boerner said that unless the Valuation Manual prohibits it, the calculated PBR reserve credit may be different from the calculated PBR assumed reserve.

Mr. Jakielo said that when reviewing the reserve amounts resulting from the testing of three amendment proposals, the Task Force should consider not only the comparison of the reserve credit and assumed reserve, but also it should consider the differences in the assumed reserve under each amendment proposal.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met via conference call Jan. 23, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Jillian Froment, Vice Chair; Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Robert H. Muriel represented by Bruce Sartain (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Steve Kelley represented by Fred Andersen and John Robinson (MN); Chlora Lindley-Myers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Linda A. Lacewell represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Heard a Status Update on the YRT Field Test**

Jason Kehrberg (American Academy of Actuaries—Academy), representing the Academy’s YRT Field Test Project Oversight Group, provided a status update on the yearly renewable term (YRT) field test (Attachment Eight-A21). The update included discussion of the timeline for the project workstreams and the dates of the project milestones.

Mr. Boerner noted that the date for the Plenary adoption milestone should be corrected to Tuesday, Aug. 11.

2. **Discussed the Oliver Wyman YRT Reinsurance Reserve Credit Long-Term Solution**

Chris Whitney (Oliver Wyman) provided an overview of the YRT reinsurance reserve credit slide deck presented at the 2019 Fall National Meeting (Attachment Eight-A22) and the supplement developed in response to mirror reserving questions (Attachment Eight-A23). He said questions from Task Force members and interested state insurance regulators indicated that a more targeted review of the presentation would be beneficial.

Dylan Strother (Oliver Wyman) said the Executive Summary of the slide deck seemed to be clearly understood by participants at the 2019 Fall National Meeting. He said one of the questions points to the need for a high-level overview of how the nested modeling and projection modeling depicted on slide #7 work. He clarified that best estimate assumptions are outer loop assumptions, and prudent estimates assumptions are inner loop assumptions.

Mr. Strother reminded the Task Force that as the projection moves forward to the next valuation date, the sufficient data period will increase, and inner loop assumptions must be updated for historical mortality improvement up to that point. He said such things are reflected in the Oliver Wyman modeling.

Mr. Strother said the major goals of the Background section were to set up a baseline analysis comprised of two straightforward base cases for modeling YRT premiums. The base cases will be used to analyze the various amendment proposals being presented. He said the first base case increases the YRT premium to equal the principle-based reserving (PBR) mortality. The second base case sets the current scale equal to the PBR mortality. One goal of the section is to compare the base cases, one conservative and the other aggressive, to the approach using \( \frac{1}{2} c_0 \). Another goal was to look at how the different approaches compare over a projection horizon.

As Mr. Strother discussed the graph of the mortality and PBR margins, he noted that the lack of future mortality improvement is an implicit margin that is a large part of the total margin in the early years, and reduces to a less significant portion of the total margin in later years.

Pat Allison (NAIC) said the graph shows that, assuming that no adjustments are made to the YRT reinsurance premium scale, reserve credits are driven by the difference between the PBR mortality and the best estimate mortality.

Mr. Strother noted that the impact of reinsurance on the reserve is largely dependent on whether the reinsurer chooses to adjust the premium to reflect changes in PBR mortality.
Katie van Ryn (Oliver Wyman) said the purpose of the Initial Insights and Analysis section is to frame the discussion within the context of amendment proposal 2019-40, amendment proposal 2019-41 and amendment proposal 2019-42, which are being evaluated as part of the field test. She discussed the results of each amendment proposal on the reserve credits under various assumptions of mortality improvement and reinsurer reactions.

Having no further business, the Life Actuarial (A) Task Force adjourned.
March 4, 2020

Re: RFP #2053 – **Economic Scenario Generator (ESG)**

The National Association of Insurance Commissioners (NAIC) is soliciting proposals from vendors to provide, maintain, and support an ESG producing real-world interest and equity scenarios to be prescribed for use in calculations of life and annuity Statutory reserves according to the *Valuation Manual* (e.g. VM-20, VM-21) and capital under the NAIC RBC requirements (e.g. C3 Phase 1, C3 Phase 2).

The chosen vendor will deliver an ESG and supporting tools that meet requirements set by regulators, along with robust documentation and training materials. On an ongoing basis, the vendor will produce the scenarios, support end users of the ESG, research changes considered by NAIC’s Life Actuarial (A) Task Force and Life Risk-Based Capital (A) Working Group and implement those that are adopted.

To receive consideration, proposals should be sent electronically to Proposals@naic.org by 5 PM Central on Friday, May 1, 2020. In addition to ensuring your proposal addresses all items within the scope of work, the proposal should clearly state the price plus any service charges or fees that could be incurred in the delivery of this service.

**Request for Proposal Schedule**

<table>
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<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>Wednesday, 03/04/20</td>
<td>Release of RFP</td>
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<tr>
<td>Friday, 03/13/20</td>
<td>Notification of intent to bid to <a href="mailto:Proposals@naic.org">Proposals@naic.org</a></td>
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<tr>
<td>Wednesday, 03/25/20</td>
<td>Submission of questions to <a href="mailto:Proposals@naic.org">Proposals@naic.org</a></td>
</tr>
<tr>
<td>Wednesday, 04/08/20</td>
<td>Responses to questions provided via email and the NAIC website</td>
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<tr>
<td>Wednesday, 04/15/20</td>
<td>Discussions held with vendors</td>
</tr>
<tr>
<td>Friday, 05/01/20</td>
<td>Proposal due to NAIC to <a href="mailto:Proposals@naic.org">Proposals@naic.org</a></td>
</tr>
<tr>
<td>May 2020</td>
<td>Vendor Selection and Award of RFP</td>
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Please submit questions regarding any aspect of this project to Jim Woody via Proposals@naic.org by close of business on Wednesday, March 25, 2020. All questions will be consolidated and answers provided to all potential vendors and posted to the NAIC website by close of business on Wednesday, April 8, 2020.

**Selection Criteria**

A committee of NAIC staff will review the proposals and award the project.

The selection will be based on the following criteria:

- Completeness of the proposal
- Qualifications of staff dedicated to developing and supporting the ESG
- Professional reputation of the firm
- Ability to deliver the items listed in Section II
• Capability to perform updates to economic scenario generator (ESG) features, parameters, and tools in a timely manner
• Flexibility in being able to work through the NAIC process to customize ESG features, parameters, and tools as needed
• Robustness of ESG and calibration documentation
• Quality of training materials and other means for providing support
• Price, including one-time and ongoing costs

NAIC reserves the right to reject any or all proposals, request new proposals, or request additional information. NAIC reserves the right to further negotiate with any or all bidders. The NAIC also reserves the right to cancel this RFP at the direction of its membership. Thank you for your consideration.

Sincerely,

James W. Woody
NAIC Chief Financial Officer

CC: Andy Beal, NAIC Chief Operating Officer/CLO
    Donna Powers, NAIC Strategic Business Initiatives Assistant Director
I. BACKGROUND AND PURPOSE

The American Academy of Actuaries (Academy) has developed an Economic Scenario Generator (ESG), which may be found on the Society of Actuaries website at https://www.soa.org/tables-calcs-tools/research-scenario/ and https://www.naic.org/cmte_e_lrbc.htm. The ESG is currently used by the life insurance industry in calculations of life and annuity reserves and capital.

Beginning in early 2017, the Academy notified the Life Actuarial (A) Task Force (LATF) that it did not have the resources to maintain the ESGs, except in their current form until a suitable replacement can be found. Since the NAIC does not currently have the resources or expertise to develop and maintain an ESG, a third-party ESG vendor is needed for these functions. In an open meeting held on 7/16/19, LATF and the Life RBC Working Group (LRBC WG) requested that NAIC staff consider issuing a Request for Proposals (RFP).

The purpose of this RFP is to solicit proposals from vendors to provide, maintain, and support an ESG producing real-world interest and equity scenarios to be prescribed for use in calculations of life and annuity Statutory reserves according to the Valuation Manual (e.g., VM-20, VM-21) and capital under the NAIC RBC requirements (e.g., C3 Phase 1, C3 Phase 2). The chosen vendor will deliver an ESG and supporting tools that meet requirements set by regulators, along with robust documentation and training materials. On an ongoing basis, the vendor will produce the scenarios, support end users of the ESG, research changes considered by LATF and LRBC WG and implement those that are adopted.

II. DELIVERABLES

This project requires an initial set of deliverables, as well as ongoing maintenance and support. As noted in Section III below, bids should include a detailed breakdown of costs for each of the initial and ongoing items listed in A-P below.

Initial Deliverables (Items with One-Time Costs)

A. An existing ESG capable of producing, at a minimum, real-world interest rate, equity, and bond fund return scenarios for use in calculations of life and annuity Statutory reserves according to the Valuation Manual (e.g., VM-20, VM-21) and capital under the NAIC RBC requirements (e.g., C3 Phase 1, C3 Phase 2). If the ESG can produce additional variables beyond the minimum requirements (e.g. inflation rates, risk-neutral scenarios, corporate bond spreads, implied volatility scenarios,
credit defaults, credit rating migrations, etc.), indicate if there is an additional cost for these features.

B. Meetings with NAIC staff and regulators as needed to discuss the vendor’s existing economic scenario generator (ESG) features and parameters, as well as potential modifications.

C. Customization of ESG features and parameters to reflect any modifications adopted by regulators.

D. A scenario reduction tool to allow companies to choose a specific number of representative scenarios (e.g. 100, 500, 1000, etc.) from a universe of 10,000 scenarios. Scenario subsets provided by the tool as of a valuation date must contain the same scenarios for all users of the tool.

E. Calibration criteria used to determine whether stratified scenario subsets are sufficiently dispersed relative to the universe of 10,000 scenarios.

F. A tool to generate scenarios for the VM-20 Stochastic Exclusion Ratio Test.

G. A tool to generate the VM-21 Company-Specific Market Path method scenarios.

H. A tool to generate statistics on the output of the ESG.

I. Full documentation on the ESG specifications, calibration, and tools.

J. Robust training materials for regulators and industry end-users.

Ongoing Production, Maintenance and Support (Items with Ongoing Costs)

K. Run the ESG as of each month-end and produce the required scenarios on the first business day of the following month. The process to generate the scenarios must be completed in time to post scenarios on business day one of each month. Statistics on the output of the ESG are expected to be delivered simultaneously with the scenarios. Note that NAIC staff intends to provide the scenarios on the NAIC website to ensure they are available to all companies regardless of whether they have licensed the vendor’s software.

L. Develop parameter updates at a frequency determined by the regulators. The process to update the ESG will include the following steps:
   1. Perform research on potential changes as requested by regulators.
   2. Document and present potential changes to regulators for exposure and adoption. Attend regulator meetings as needed to respond to questions/comments received during the exposure period. Materials to be provided for consideration of changes should include a) discussion on how changes were vetted for complex interactions between parameters, b) attribution analysis showing the impact of each change, and c) documentation on the above in sufficient detail to allow independent review.
   3. Modify the ESG to reflect final adopted updates in a timely manner and provide evidence to NAIC staff that they were made appropriately.
4. Update documentation on the ESG specifications.

M. Update training materials for regulators and industry end users.

N. Provide full support to end users of the economic scenario generator (ESG) scenarios who have licensed the ESG software.

O. Provide help desk support to end users of the ESG scenarios who have not licensed the ESG software.

P. Provide scenarios to support field testing of the new ESG under regulatory reserving and capital frameworks.

III. CONTENT OF PROPOSAL

For final evaluation of proposals, it is important that vendors provide the information requested below:

A. A breakdown of the number of staff dedicated to ESG development by division (e.g., parameterization, software development, documentation, training, etc.) along with the resumes of key staff members.

B. The number of life insurance and annuity companies that are currently licensed to use the ESG for real-world liability valuation. Additionally, please provide at least three named clients to act as references along with their contact information.

C. Description of the ESG indicating the type of model (e.g. stochastic log volatility, independent log normal, regime switching lognormal with number and frequency of regimes, stochastic volatility jump diffusion, other etc.). The vendor should also include a discussion of the benefits and limitations of their recommended ESG model.

D. Description of the ESG parameters and how they are determined (e.g. fitting model to actual historical data using maximum likelihood estimation, etc.).
   1. If model fitting is done using historical data, detail the source of the data and length of the period used and whether any adjustments are made to the source data.
   2. Describe how any parameters, including mean reversion parameters, are derived and whether they are static or dynamic.
   3. Provide information on the level of customization available to regulators in specifying ESG features and parameters. For example, regulators may want to specify a certain type of mean reversion formula, the historical period used to determine parameterization, or other items.

E. Description of the types of returns that can be simulated by the ESG (e.g. Treasury rates, bond returns of different maturities and credit qualities, equities of different indices, different types of international equities, currencies, inflation rates, etc.).

F. Details on how credit spreads and defaults are implicitly reflected or explicitly simulated in bond fund returns.
G. Description of the methodology for completing the full Treasury yield curve from the simulated interest rates.

H. The level of dependency between different financial variables in the economic scenario generator (ESG). If the ESG is integrated, describe how the correlations are developed and whether they are dynamic (e.g. either exhibiting both positive and negative correlations if appropriate, etc.).

I. Statistics on the range of scenarios produced (e.g. the percentage of scenarios with low interest rates coupled with low equity returns, low interest rates coupled with high equity returns, etc.).

J. An analysis showing how the range of scenarios produced compares to the current Academy VM-20/VM-21 and C3 Phase 1 ESGs, including testing over different historical and/or potential future economic conditions.

K. The frequency of review and consideration of updates for each ESG parameter. Please describe the rationale for the frequency of each parameter update and specify which parameters require judgement to calibrate and those that do not (e.g. parameters updated formulaically).

L. Information on how end-users of the ESG will be able to generate scenarios on-the-fly through a mechanism such as software licensing, an application programming interface (API), and/or available full documentation of the technical workings the ESG.

M. A copy of existing ESG documentation.

N. A copy of existing ESG training materials, and a description of any other support provided.

O. A detailed breakdown of costs for each of the one-time and ongoing deliverables listed in Section II. Bids should also include both first year and ongoing ESG software licensing costs for NAIC staff, regulators, and companies that may wish to license the software for up to five years.

IV. SELECTION PROCESS

The NAIC will be responsible for the selection of the vendor that will be awarded this project to be funded. Input from regulators and other subject-matter experts may also be sought, but the NAIC will make the final decision.

The following factors will be considered in making the vendor selection:

- Completeness of the proposal
- Qualifications of staff dedicated to developing and supporting the ESG
- Professional reputation of the firm
- Ability to deliver the items listed in Section II
- Capability to perform updates to ESG features, parameters, and tools in a timely manner
• Flexibility in being able to work through the NAIC process to customize ESG features, parameters, and tools as needed
• Robustness of economic scenario generator (ESG) and calibration documentation
• Quality of training materials and other means for providing support
• Price, including one-time and ongoing costs

V. CONFLICTS OF INTEREST

The NAIC recognizes that, given the broad scope of this project, any vendor with the experience reasonably necessary to produce the ESG may have certain conflicts of interest based upon past associations with industry participants. These conflicts of interest will not automatically disqualify the vendor, but the vendor must have verifiable policies and procedures in place designed in compliance with established industry standards to address conflicts of interest issues that may arise.

VI. CONDITIONS

The NAIC reserves the right to not award a contract for this ESG. Reasons for not awarding a contract could include, but are not limited to, a lack of acceptable proposals or a finding that insufficient funds are available to proceed. The NAIC also reserves the right to redirect the project as is deemed advisable. The NAIC also reserves the right to cancel this RFP at the direction of its membership.

VII. QUESTIONS

Any questions regarding the Scope of Work should be directed to: Proposals@naic.org. Questions related to any other matter should be directed to Jim Woody, e-mail: JWoody@naic.org
**NAIC CONFLICT OF INTEREST FORM**

**FOR RETENTION OF CONSULTANTS SUBJECT TO BID**

**NAIC RFP 2053**

Any *Entity* that desires to contract with the NAIC must complete this form, including vendors, consultants and purchasers of goods or services. All potential conflicts must be disclosed and approved before the contract execution.

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<tr>
<td><strong>Entity</strong> did not provide gifts, favors, membership points or any other benefits to any employee or representative of the NAIC to affect the bidding and selection process for this contract.</td>
</tr>
<tr>
<td><strong>Entity</strong> will not provide or receive gifts, favors, membership points or any other benefits to any employee or representative of the NAIC in connection with the negotiation or implementation of this contract.</td>
</tr>
<tr>
<td><strong>Entity</strong> owners, principals and employees negotiating or implementing this contract on behalf of <strong>Entity</strong> are not former NAIC employees unless disclosed below.</td>
</tr>
<tr>
<td><strong>Entity</strong> owners, principals and employees negotiating or implementing this contract on behalf of <strong>Entity</strong> are not immediate family members of NAIC employees unless disclosed below.</td>
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The signatory below is a duly authorized representative of **Entity** and hereby certifies to the authenticity and veracity of this disclosure.

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<tr>
<td>Authorized Entity Signature</td>
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Print Name & Company Name

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<th>CLOSURE OF POTENTIAL CONFLICT</th>
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<th>NAIC Executive Approval</th>
<th>Date</th>
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NAIC 12/09
STANDARD TERMS AND CONDITIONS
for
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
PURCHASE ORDERS FOR SERVICES

As used herein, “Seller” means the person, firm, or corporation to whom this Purchase Order is issued; “Buyer” means the National Association of Insurance Commissioners, a nonprofit Delaware corporation.

1. Acceptance of Terms and Conditions. Seller agrees to perform the services (“Services”) described in any purchase order (“Purchase Order”) in accordance with these Terms and Conditions. Upon acceptance of a Purchase Order or upon commencement of Services, Seller shall be bound by these Terms and Conditions and all provisions set forth on the face of any applicable Purchase Order, whether Seller signs or otherwise acknowledges these Terms & Conditions or the Purchase Order, unless Seller objects to such Terms and Conditions in writing prior to commencing Services.

2. Revocable. This writing does not constitute a firm offer and may be revoked at any time prior to acceptance.

3. No modification. No agreement or other understanding in any way altering the terms, prices or conditions of the applicable Purchase Order or these Terms and Conditions shall be binding upon Buyer unless made in writing and signed by Buyer’s duly authorized representative.

4. Termination. Buyer may immediately terminate the Purchase Order upon written notice to Seller if Seller fails to perform or otherwise breaches these Terms and Conditions, files a petition in bankruptcy, becomes insolvent, or dissolves. Buyer may terminate the Purchase Order for any other reason upon thirty (30) days’ written notice to Seller. Upon receipt of notice of termination, Seller shall cease to provide Goods and/or perform Services pursuant to the Purchase Order. In the event of termination, Buyer shall be liable to Seller only for those Services satisfactorily performed before the date of termination, less appropriate offsets. Buyer shall not be subject to any charges or other fees as a result of such cancellation. Seller may terminate this Agreement upon written notice to Buyer if Buyer fails to pay Seller within sixty (60) days after Seller notified Buyer in writing that payment is past due and that it intends to terminate the Purchase Order.

5. Warranty of Services. Seller represents and warrants that all Services shall be completed in a professional, workmanlike manner, with the degree of skill and care that is required by current, good, and sound professional procedures. Further, Seller warrants that the Services shall be completed in accordance with applicable specifications. Seller represents and warrants that the performance of Services hereunder will not conflict with, or be prohibited in any way by any other agreement or statutory restriction to which Seller is bound.

6. Seller’s Indemnification. Seller shall indemnify, hold harmless, and at Buyer’s request, defend Buyer, its officers, directors, agents and employees, against all claims,
liabilities, damages, losses and expenses, including attorneys’ fees and costs of suit arising out of or in any way connected with any claim by a third party against Buyer alleging that the Services infringe a patent, copyright, trademark, trade secret or other proprietary right of third party. Seller shall not settle any such suit or claim without Buyer’s prior written consent. Seller shall also indemnify and hold harmless Buyer from any injury to person or property arising out of or caused by Seller’s performance of the Purchase Order. Seller agrees to pay or reimburse all costs that may be incurred by Buyer in enforcing this indemnity provision, including attorneys’ fees.

7. Compliance with Laws. Seller shall comply with all laws and regulations of federal, state and local governments, including without limitation, laws and regulations dealing with fair labor standards, civil rights, and public contracts. Seller further warrants that all Services performed pursuant to the Purchase Order have been produced or performed in compliance with such laws and regulations and Seller agrees to indemnify Buyer for any liability resulting from such noncompliance by the Seller.

8. Price. The price to be paid by the Buyer shall be the price contained in Seller’s bid and/or the price stated on the face of the Purchase Order whichever is less. Seller represents the price contained in Seller’s bid is no higher than Seller’s current prices on orders by others for similar products or services under similar or like conditions and methods of purchase.

9. Invoices. Seller shall submit invoices on each Purchase Order after each delivery. Buyer shall not be charged sales tax and shall furnish a tax exemption certificate upon request. Discounts will be taken from the date of acceptance of services or date the invoice is received by Buyer whichever is later. Buyer shall retain the right of offset.

10. Force Majeure. Buyer shall not be liable for any failure to perform including failure to: (1) accept performance of Services, or (2) take delivery of the Goods as provided if caused by circumstances beyond Buyer’s control which make such performance commercially impractical including, but not limited to, acts of God, fire, flood, acts of war, government action, accident, labor difficulties or shortage, or the inability to obtain materials, equipment or transportation.

Seller shall not be liable for any failure to perform including failure to: (1) provide Services, or (2) deliver Goods as provided if caused by circumstances beyond Seller’s control which make such performance commercially impractical including, but not limited to, acts of God, fire, flood, acts of war, government action, accident, labor difficulties or shortage, or the inability to obtain materials, equipment or transportation.

11. Insurance. Seller shall be solely responsible for maintaining adequate auto, workers’ compensation, unemployment compensation, disability, liability and other applicable insurance, as is required by law or as is the common practice in Seller’s trade or business, whichever affords greater coverage. Seller shall carry Comprehensive General Liability coverage and Umbrella or Excess Liability coverage with minimum limits of $1,000,000 per occurrence and $2,000,000 in the aggregate for property damage and bodily injury. Upon request, Seller shall provide Buyer with certificates of
insurance evidencing adequate coverage naming the Buyer as additional insured.

12. **Limitation of Liability.** In no event shall Buyer be liable to Seller or Seller’s agents, or any third party for any incidental, indirect, special, or consequential damages arising out of, or in connection with, this Agreement, whether or not Buyer was advised of the possibility of such damage.

13. **Confidentiality.** In the event Seller gains written or oral confidential information of or from the Buyer, Seller agrees not to reveal to anyone or make use of such knowledge and information at any time for any purposes except as necessary in the course and scope of provision of Goods or performance of Services specified hereunder. Upon termination of the Purchase Order, Seller agrees to deliver to Buyer all such confidential information or work product belonging to Buyer.

14. **Assignability.** Seller shall not assign or subcontract this Purchase Order or any of its rights or obligations hereunder without the prior written consent of Buyer. Any assignment or transfer without such written consent shall be null and void.

15. **Publicity.** Seller shall not use Buyer’s name in any form or attribution in connection with any solicitation, publicity, advertising, endorsement or other promotion.

16. **Survivability.** Any obligations and duties, which by their nature extend beyond the expiration or termination of this Purchase Order shall survive the expiration or termination hereof.

17. **Choice of Law.** This Purchase Order shall be construed in accordance with, and disputes shall be governed by, the laws of the State of Missouri.

18. **Severability.** If any provision of this Purchase Order shall be deemed to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

NAIC 8/2012
Do you agree to the NAIC Terms & Conditions?

YES  ________________________________   ______________
      Signature                                                            Date

NO    ________________________________   ______________
      Signature                                                            Date

Please Sign one.

If NO,

Please provide your Terms and Conditions of Sale if you do not agree to the NAIC Terms & Conditions attached.
To: Director Jillian Froment  
Chair, Life Insurance and Annuities (A) Committee  

From: Mike Boerner  
Chair, Life Actuarial (A) Task Force (LATF)  

Date: 3/4/20  

Re: Recommendation to NAIC Staff to Issue a Request for Proposal for an Economic Scenario Generator

The Life Actuarial (A) Task Force has made a recommendation to NAIC staff to issue a Request for Proposal (RFP) for an Economic Scenario Generator (ESG). The purpose of this memorandum is to provide information on this initiative. Funding is not being requested at this time since the cost is unknown.

Background and History

The American Academy of Actuaries (Academy) has developed ESGs over a decade ago which are currently used by the life insurance industry in calculations of life and annuity reserves and capital. An ESG is a complex mathematical model that simulates economic variables such as interest rate and equity returns under a large number of scenarios.

Beginning in early 2017, the Academy notified the Life Actuarial (A) Task Force (LATF) that it did not have the resources to maintain the ESGs, except in their current form until a suitable replacement can be found. Since the NAIC does not currently have the resources or expertise to develop and maintain an ESG, a third-party ESG vendor is needed for these functions. In an open meeting held on 7/16/19, LATF and the Life RBC Working Group (LRBC WG) requested that NAIC staff begin the RFP process. A group consisting of regulators, NAIC staff, Academy and ACLI representatives, and other industry subject matter experts was then formed to draft the Scope of Work section of the RFP.

RFP Deliverables

The RFP will solicit proposals from vendors to provide, maintain, and support an ESG producing real-world interest and equity scenarios to be prescribed for use in calculations of life and annuity Statutory reserves according to the Valuation Manual (e.g. VM-20, VM-21) and capital under the NAIC RBC requirements (e.g. C3 Phase 1, C3 Phase 2).

The chosen vendor will deliver an ESG and supporting tools that meet requirements set by regulators, along with robust documentation and training materials. On an ongoing basis, the vendor will produce the scenarios, support end users of the ESG, research changes considered by LATF and the LRBC WG and implement those that are adopted. Initially, the vendor will need to meet with LATF and the LRBC WG to discuss existing ESG features and parameters, as well as potential modifications desired by regulators. The vendor will customize the ESG with these modifications, and then support a field test (by providing scenarios) to determine potential industry reserve and capital impacts.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
   January 1, 2020, edition of the Valuation Manual with NAIC adoptions through August 6, 2019
   Locations with proposed changes: VM-20 and VM-31

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   The Valuation Manual already requires that if there is additional risk arising from the conversion of term life insurance, whether group or individual, it must be reserved for. The purpose of this APF is to emphasize this requirement and to provide guidance on what must be included in the Life PBR Actuarial Report with respect to conversions.

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

NAIC Staff Comments:

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Notes: VM APF 2019-62 rev 02-10-20; 14-day re-exposure through 2/26/20
VM-20 Section 9.C.4 - Add Section 9.C.4.d

c. The mortality rates from the resulting anticipated experience assumptions must be no lower than the mortality rates that are actually expected to emerge and that the company can justify.

d. In satisfying Section 9.C.4.c, the company must ensure that any excess mortality is appropriately reflected in the anticipated experience mortality rates. This includes but is not limited to excess mortality associated with policies issued via conversion from term policies or from group life contracts.

Exposure of the proposed section 9.C.4.c includes the following changes which have been reviewed and accepted by the Task Force:

VM-31 Section 3.B.3 [Executive Summary – policy overview]

3. Policies – A summary of the base policies within each VM-20 reserving category. Include information necessary to fully describe the company’s distribution of business. For direct business, use PBR Actuarial Report Template A located on the NAIC website (https://www.naic.org/pbr_data.htm?tab_3) to provide descriptions of each base policy product type and underwriting process (including a description of the process, the time period in which it was used, and the level of any additional margin), with a breakdown of policy count and face amount by base policy product type and underwriting process. Also include the target market, primary distribution system, and key product features that affect risk, including conversion privileges.


d. Assumption and Margin Development – The following information for each risk factor: description of the methods used to determine anticipated experience assumptions and margins, including the sources of experience (e.g., company experience, industry experience, or other data); how changes in such experience are monitored; any adjustments made to increase mortality margins above the prescribed margin (such as to reflect increased uncertainty associated with newer underwriting approaches); and any other considerations, such as conversion features, helpful in or necessary to understanding the rationale behind the development of assumptions and margins, even if such considerations are not explicitly mentioned in the Valuation Manual.

VM-31 Section 3.D.3.x (new section) [Life Report – Mortality]

(We suggest placing after Adjustments for Mortality Improvement and before Mortality for Impaired Lives)
Mortality for Converted Policies – Description of the treatment of mortality for
Mortality policies issued under group or term conversion privileges including:

i. A description of the method(s) by which any excess conversion mortality
was taken into account in the development of company experience
mortality rates (e.g., through the use of separate mortality segments for
policies issued upon conversion, through aggregation of claim experience,
or through use of other methods), the rationale for the method(s) used,
and any changes in the method(s) from those used in previous years.

ii. The source(s) of the data used in the method(s) employed.

Mortality for Impaired Lives or Policyholder Behavior – Disclosure of:

i. the percentage of business that is on impaired lives;

ii. whether impaired lives were included or excluded from the mortality study
upon which company experience mortality was based; and

iii. whether any adjustments to mortality assumptions for impaired lives or
policyholder behavior were found to be necessary and, if so, the rationale
for the adjustments that were used.

Item (iii) above is a required disclosure for post-level term mortality assumptions even if
the company uses a 100% shock lapse assumption, since it pertains to the analysis
demonstrating whether there are post-level term profits.

Post-Level Term Testing – For products with a level term period:

i. Summary results of the seriatim comparison of the present value of
postlevel term cash inflows and outflows for the DR as required by VM-20

ii. If this comparison showed that there were post-level term profits, describe
how anti-selection was handled in the post-level term period, including the
prudent estimate premium, mortality and lapse assumptions used.

iii. If the comparison showed that there were post-level term losses, confirm
that the prudent estimate premium, mortality and lapse assumptions for
the post-level period were addressed in Section 3.D.1.a and were used in
the reserve calculation.
l. Term Conversions – Description of how the company reflects the impact of any term conversions privilege contained in the policy when setting reserves.

m. Lapse Rates for Converted Policies – Description of and rationale for lapse rates used for policies issued under any group or term conversion privilege.


a. Agreements – For those reinsurance agreements included in the calculation of the minimum reserve as per VM-20 Section 8.A, a description of each reinsurance agreement, including, but not limited to, the type of agreement, the counterparty, the risks reinsured, any provisions related to converted policies, the portion of business reinsured, identification of both affiliated and non-affiliated, as well as captive and non-captive, or similar relationships, and whether the agreement complies with the requirements of the credit for reinsurance under the terms of the AP&P Manual.
EXPOSURE OF APF 2020-03

Commenters are asked to consider whether having the revised language proposed for VM-20 Section 3.B.3.a might necessitate an additional requirement (possibly 3.B.3.c) to cover calculations utilizing an unearned premium reserve approach.

Please send comments to RMyzycz@naic.org by close of business on March 19, 2020.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
Clarify NPR calculation requirements.

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

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

January 1, 2020 NAIC Valuation Manual

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

See attached.

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

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

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

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

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Notes: APF 2020-03 revised 2/26/20 Exposed 2/27/20
VM-20 Section 3.B.1 – 3.B.3

B. NPR Calculation

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

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

For the purposes of Section 3, the following terms apply:
   a. The “fully funded secondary guarantee” at any time is:
      i. For a shadow account secondary guarantee, the minimum shadow account fund value necessary to fully fund the secondary guarantee for the policy at that time. For any policy for which the secondary guarantee contractually cannot be fully funded in advance, this shall be the present value of the contractually permitted premium stream that would fully fund the guarantee at the earliest possible date (using the valuation interest rate and mortality standard specified in Section 3.C).

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

   b. The “actual secondary guarantee” at any time is:
      a. For a shadow account secondary guarantee, the actual shadow account fund value at that time.

      b. For a cumulative premium secondary guarantee, the actual premiums paid to that point in time, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

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

2. The definition of the NPR in Section 3.B.4, Section 3.B.5 and Section 3.B.6 is intended to result in the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4, Section 3.B.5 and Section 3.B.6, the gross premium referenced should be the gross premium for the policy assuming an annual premium mode.

3. The reported reserve as of any valuation date should reflect the actual premium mode for the policy and the actual valuation date relative to the policy issue date, either directly or through adjusting accounting entries.
   b. Through adjusting accounting entries (such as due and deferred premium asset).

Guidance Note: The definition of the NPR in Section 3.B.4, Section 3.B.5 and Section 3.B.6 is intended to result in a terminal NPR under the assumption of an annual mode gross premium. The gross premium referenced should be the gross premium for the policy assuming an annual premium mode. The reported reserve as of any valuation date should reflect the actual premium mode for the policy and the actual valuation date relative to the policy issue date either directly or through adjusting accounting entries.

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

As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted ASGx+t, as outlined in Section 3.B.2-1.c and the fully funded secondary guarantee, denoted FFSGx+t, as outlined in Section 3.B.1.b.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Staff of Office of Principle-Based Reserving, California Department of Insurance – Address the topic of prescribed templates.

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

Valuation Manual (January 1, 2019 edition), Introduction, Section I, A.1

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

See attached Appendix.

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

See attached Appendix.

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Appendix

ISSUE:

Now that the concept of a prescribed template has been introduced into VM-31, it should be made clear what the rules are surrounding making changes to such templates.

SECTIONS:

Introduction, Section I, Process for Updating the Valuation Manual, Section A.1

REDLINE:

1. Substantive Items

Substantive changes to the Valuation Manual are proposed amendments to the Valuation Manual that would change or alter the meaning, application or interpretation of a provision. All changes to the Valuation Manual – or to templates prescribed for use by the Valuation Manual – will be considered substantive, unless specifically identified as either a nonsubstantive item or an update to a table by simple majority vote of the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force. Any item placed on the Active List as substantive will be exposed by the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force for a public comment period commensurate with the length of the draft and the complexities of the issue, but for no less than 21 days. The comment period will be deemed to have begun when the draft has been placed on the appropriate public NAIC web page. The Life Actuarial (A) Task Force/Health Actuarial (B) Task Force will hold at least one open meeting (in person or via conference call) to consider comments before holding a final vote on any substantive items. Subsequent exposures of substantive items will be for a minimum of seven days. Meeting notices for Life Actuarial (A) Task Force/Health Actuarial (B) Task Force meetings will indicate if a vote is anticipated on any substantive items. Adoption of all changes at the Life Actuarial (A) Task Force/Health Actuarial (B) Task Force will be by simple majority.

REASONING:

Help assure readers that there no back doors through which to create new requirements.
TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

TABLE OF CONTENTS:

Section 1. Authority
Section 2. Purpose and Intent
Section 3. Applicability
Section 4. Exemptions from this Regulation
Section 5. Definitions
Section 6. The Actuarial Method
Section 7. Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation
Section 8. Severability
Section 9. Prohibition against Avoidance
Section 10. Effective Date

Section 1. Authority

This regulation is adopted and promulgated by [title of supervisory authority] pursuant to [insert provision of state law equivalent to section 5B of the Credit for Reinsurance Model Law] of the [name of state] Insurance Code.

Section 2. Purpose and Intent

The purpose and intent of this regulation is to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees; and to ensure that, with respect to each such financing arrangement, funds consisting of Primary Security and Other Security, as defined in Section 5, are held by or on behalf of ceding insurers in the forms and amounts required herein. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer (1) are issued by the ceding insurer or its affiliates; or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any of its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).

Section 3. Applicability

This regulation shall apply to reinsurance treaties that cede liabilities pertaining to Covered Policies, as that term is defined in Section 5B, issued by any life insurance company domiciled in this state. This regulation and [insert provision of state law equivalent to the Credit for Reinsurance Model Regulation] shall both apply to such reinsurance treaties; provided, that in the event of a direct conflict between the provisions of this regulation and [insert provision of state law equivalent to the Credit for Reinsurance Model Regulation], the provisions of this regulation shall apply, but only to the extent of the conflict.

Section 4. Exemptions from this Regulation

This regulation does not apply to the situations described in Subsections A through F.

A. Reinsurance of:

(1) Policies that satisfy the criteria for exemption set forth in [insert provision of state law equivalent to Section 6F of the Valuation of Life Insurance Policies Model Regulation] or [insert provision of state law equivalent to Section 6G of the Valuation of Life Insurance Policies Model Regulation]; and which are issued before the later of:
(a) The effective date of this regulation, and
(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to
establish the ceded policies’ statutory reserves, but in no event later than Jan 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in [insert provision of state law equivalent to Section 6E of the Valuation of Life Insurance Policies Model Regulation] and which
are issued before the later of:
(a) The effective date of this regulation, and
(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to
establish the ceded policies’ statutory reserves, but in no event later than Jan. 1, 2020;

(3) Any universal life policy that meets all of the following requirements:
(a) Secondary guarantee period, if any, is five (5) years or less;
(b) Specified premium for the secondary guarantee period is not less than the net level
reserve premium for the secondary guarantee period based on the Commissioners
Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the
issue year of the policy; and
(c) The initial surrender charge is not less than one hundred percent (100%) of the first year
annualized specified premium for the secondary guarantee period;

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which
varies according to the investment experience of any separate account or accounts; nor

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule
of maximum gross premiums required in order to continue coverage in force for a period in excess
of one year.

B. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provision of
state law equivalent to Section 2D of the Credit for Reinsurance Model Law]; or

C. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provisions of
state law equivalent to Sections 2A, 2B or 2C, of the Credit for Reinsurance Model Law], and that, in
addition:

(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and
Procedures Manual, without any departures from NAIC statutory accounting practices and
procedures pertaining to the admissibility or valuation of assets or liabilities that increase the
assuming insurer’s reported surplus and are material enough that they need to be disclosed in the
financial statement of the assuming insurer pursuant to Statement of Statutory Accounting
Principles No. 1 ("SSAP 1"); and

(2) Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control
Level Event, or Mandatory Control Level Event as those terms are defined in [insert provision of
state law equivalent to the Risk-Based Capital (RBC) for Insurers Model Act] when its RBC is
calculated in accordance with the life risk-based capital report including overview and instructions
for companies, as the same may be amended by the NAIC from time to time, without deviation; or

D. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provisions of
state law equivalent to Sections 2A, 2B or 2C, of the Credit for Reinsurance Model Law], and that, in
addition:
(1) Is not an affiliate, as that term is defined in [insert provision of state law equivalent to Section 1A of the Insurance Holding Company System Regulatory Model Act], of:

(a) The insurer ceding the business to the assuming insurer; or

(b) Any insurer that directly or indirectly ceded the business to that ceding insurer;

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

(3) Is both:

(a) Licensed or accredited in at least 10 states (including its state of domicile), and

(b) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in [insert provision of state law equivalent to the Risk-Based Capital (RBC) for Insurers Model Act] when its Risk-Based Capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer’s reported surplus;

E. Reinsurance ceded to an assuming insurer that meets the requirements of either [insert provision of state law equivalent to Section 5B(4)(a) of the Credit for Reinsurance Model Law, pertaining to certain certified reinsurers] or [insert provision of state law equivalent to Section 5B(4)(b) of the Credit for Reinsurance Model Law, pertaining to reinsurers meeting certain threshold size and licensing requirements]; or

Drafting Note: A state may satisfy the requirements of Section 4E above by either adopting Section 5B(4) of the Credit for Reinsurance Model Law (#785), or it may include the specific provisions of Section 5B(4) of the Credit for Reinsurance Model Law (#785) directly into its adoption of this regulation, Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

E.F. Reinsurance not otherwise exempt under Subsections A through E if the commissioner, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this regulation (as described in Section 2 above);

(2) The risks are included within the scope of this regulation only as a technicality; and

(3) The application of this regulation to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall publicly disclose any decision made pursuant to this Section 4F to exempt a reinsurance treaty from this regulation, as well as the general basis therefor (including a summary description of the treaty).

Drafting Note: The exemption set forth in Section 4F was added to address the possibility of unforeseen or unique transactions. This exemption exists because the NAIC recognizes that foreseeing every conceivable type of reinsurance transaction is impossible; that in rare instances unanticipated transactions might get caught up in this regulation purely as a technicality; and that regulatory relief in those instances may be appropriate. The example that was given at the time this exemption was developed pertained to bulk reinsurance treaties where the ceding insurer was exiting the type of business ceded. The exemption should not be used with respect to so-called “normal course” reinsurance transactions; rather, such transactions should either fit within one of the standard exemptions set forth in Sections 4A, B, C, D, or E or meet the substantive requirements of this regulation.
Section 5. Definitions

A. “Actuarial Method” means the methodology used to determine the Required Level of Primary Security, as described in Section 6.

B. “Covered Policies” means the following: Subject to the exemptions described in Section 4, Covered Policies are those policies, other than Grandfathered Policies, of the following policy types:

(1) Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or,

(2) Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

C. “Grandfathered Policies” means policies of the types described in Subsections B1 and B2 above that were:

(1) Issued prior to January 1, 2015; and

(2) Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in Section 4 had that section then been in effect.

D. “Non-Covered Policies” means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.

E. “Required Level of Primary Security” means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.

F. “Primary Security” means the following forms of security:

(1) Cash meeting the requirements of [insert provision of state law equivalent to Section 3A of the Credit for Reinsurance Model Law];

(2) Securities listed by the Securities Valuation Office meeting the requirements of [insert provision of state law equivalent to Section 3B of the Credit for Reinsurance Model Law], but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

(3) For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

(a) Commercial loans in good standing of CM3 quality and higher;

(b) Policy Loans; and

(c) Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

G. “Other Security” means any security acceptable to the commissioner other than security meeting the definition of Primary Security.

H. “Valuation Manual” means the valuation manual adopted by the NAIC as described in Section 11B(1) of the Standard Valuation Law, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

Drafting Note: Section 5H presumes that each state is permitted under its state laws to directly reference the Valuation Manual adopted by the NAIC. If a state is required by its state laws to reference a state law or regulation, it should modify Section 5H as appropriate to do so.

Drafting Note: Sections 5H and I presume that each state is permitted under its state laws to “adopt” the Valuation Manual in a manner similar to how the Accounting Practices and Procedures Manual becomes effective in many states, without a separate regulatory process such as adoption by regulation. It is desirable that all states adopt the Valuation Manual requirements and that such adoption be achieved without a separate state regulatory process in order to achieve uniformity of reserve standards in all states. However, to the extent that a state may need to adopt the valuation manual through a formal state regulatory process, these sections may be amended to reflect any state’s need to adopt the Valuation Manual through regulation or otherwise.

Section 6. The Actuarial Method

A. Actuarial Method

The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

(1) For Covered Policies described in Section 5B(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in Section 5B(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

(2) For Covered Policies described in Section 5B(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

(3) Except as provided in Paragraph (4) below, the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.

(4) If the reinsurance treaty cedes less than one hundred percent (100%) of the risk with respect to the Covered Policies then the Required Level of Primary Security may be reduced as follows:

(a) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under Subparagraph (c) below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

(b) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(c) If a portion of the Covered Policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be
reduced by the amount resulting by applying the Actuarial Method including the reinsurance section of VM-20 to the portion of the Covered Policy risks ceded in the exempt arrangement, except that for Covered Policies issued prior to Jan 1, 2017, this adjustment is not to exceed \[c_x/ (2 \times \text{number of reinsurance premiums per year})\] where \(c_x\) is calculated using the same mortality table used in calculating the Net Premium Reserve; and

\[(d)\] For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security.

It is possible for any combination of Subparagraphs (a), (b), (c), and (d) above to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than one hundred percent (100%) of the risk.

The Adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

\[(5)\] In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

\[(6)\] If the ceding insurer cedes risks with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this Regulation, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this Regulation;

\[(7)\] If a reinsurance treaty subject to this Regulation cedes risk on both Covered and Non-Covered Policies, credit for the ceded reserves shall be determined as follows:

\[(a)\] The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies, and Section 7 shall be used to determine the reinsurance credit for the Covered Policy reserves; and

\[(b)\] Credit for the Non-Covered Policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of Subparagraph (a), is held by or on behalf of the ceding insurer in accordance with [cite the state’s version of Sections 2 and 3 of the Credit for Reinsurance Model Law]. Any Primary Security used to meet the requirements of this Subparagraph may not be used to satisfy the Required Level of Primary Security for the Covered Policies.

B. Valuation used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

\[(1)\] For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer’s general account and without taking into consideration the effect of any prescribed or permitted practices; and

\[(2)\] For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the
NAIC’s Life Actuarial (A) Task Force no later than the Dec. 31st on or immediately preceding the valuation date for which the Required Level of Primary Security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.

Section 7. Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation

A. Requirements

Subject to the exemptions described in Section 4 and the provisions of Section 7B, credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to Covered Policies pursuant to [insert provisions of state law equivalent to Sections 2 or 3 of the Credit for Reinsurance Model Law] if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

1. The ceding insurer’s statutory policy reserves with respect to the Covered Policies are established in full and in accordance with the applicable requirements of [insert provisions of state law equivalent to the Standard Valuation Law] and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this regulation does not exceed the proportionate share of those reserves ceded under the contract; and

2. The ceding insurer determines the Required Level of Primary Security with respect to each reinsurance treaty subject to this regulation and provides support for its calculation as determined to be acceptable to the commissioner; and

3. Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of [insert provision of state law equivalent to Section 3 of the Credit for Reinsurance Model Law], on a funds withheld, trust, or modified coinsurance basis; and

4. Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (3) above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of [insert provision of state law equivalent to Section 3 of the Credit for Reinsurance Model Law]; and

5. Any trust used to satisfy the requirements of this Section 7 shall comply with all of the conditions and qualifications of [insert provision of state law equivalent to Section 124 of the Credit for Reinsurance Model Regulation], except that:

   a. Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in Section 6B, be valued according to the valuation rules set forth in Section 6B, as applicable; and

   b. There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of Section 7A(3); and

   c. The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by Section 7A(3)) below 102% of the level required by Section 7A(3) at the time of the withdrawal or substitution; and

   d. The determination of reserve credit under [insert provision of state law equivalent to Section 124F of the Credit for Reinsurance Model Regulation] shall be determined according to the valuation rules set forth in Section 6B, as applicable; and
The reinsurance treaty has been approved by the commissioner.

B. Requirements at Inception Date and on an On-going Basis; Remediation

1. The requirements of Section 7A must be satisfied as of the date that risks under Covered Policies are ceded (if such date is on or after the effective date of this regulation) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under Section 7A(3) or 7A(4) with respect to any reinsurance treaty under which Covered Policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

2. Prior to the due date of each Quarterly or Annual Statement, each life insurance company that has ceded reinsurance within the scope of Section 3 shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which Covered Policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of Sections 7A(3) and 7A(4) were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to Section 7A(3), unless either:

   a. The requirements of Section 7A(3) and 7A(4) were fully satisfied as of the valuation date as to such reinsurance treaty; or

   b. Any deficiency has been eliminated before the due date of the Quarterly or Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of Section 7A(3) and 7A(4) to be fully satisfied as of the valuation date.

3. Nothing in Section 7B(2) shall be construed to allow a ceding company to maintain any deficiency under Section 7A(3) or 7A(4) for any period of time longer than is reasonably necessary to eliminate it.

Section 8. Severability

If any provision of this regulation is held invalid, the remainder shall not be affected.

Section 9. Prohibition against Avoidance

No insurer that has Covered Policies as to which this regulation applies (as set forth in Section 3) shall take any action or series of actions, or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of such action, transaction or arrangement or series thereof is to avoid the requirements of this regulation, or to circumvent its purpose and intent, as set forth in Section 2.

Section 10. Effective Date

This regulation shall become effective [insert date] and shall pertain to all Covered Policies in force as of and after that date.
Actuarial Guideline XLVIII
(Applies to 2017 and Subsequent Year Valuations)

ACTUARIAL OPINION AND MEMORANDUM REQUIREMENTS FOR THE REINSURANCE OF POLICIES REQUIRED TO BE VALUED UNDER SECTIONS 6 AND 7 OF THE NAIC VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION (MODEL #830)

Background

The NAIC Principle-Based Reserving Implementation (EX) Task Force (“PBRI Task Force”) serves as the coordinating body for all NAIC technical groups involved with projects related to the Principle-Based Reserves (PBR) initiative for life and health policies. The PBRI Task Force was also charged with further assessing, and making recommendations regarding, the solvency implications of life insurance reserve financing mechanisms addressed in the June 6, 2013 NAIC White Paper of the Captives and Special Purpose Vehicle Use (E) Subgroup of the Financial Condition (E) Committee. Some of these reinsurance arrangements have been referred to as “XXX/AXXX Captive arrangements,” although not all such arrangements actually involve reinsurers organized as captives. In this connotation, XXX denotes the reserves prescribed by Section 6 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model #830) while AXXX denotes the reserves prescribed by Section 7 of Model #830, and by Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38). On June 30, 2014, the PBRI Task Force adopted a framework as found in Exhibits 1 and 2 of the June 4, 2014 report from Rector & Associates, Inc. (the “June 2014 Rector Report”). Exhibit 2 of the report included a charge to the Life Actuarial (A) Task Force (LATF) to develop a level of reserves (the “Required Level of Primary Security”) that must be supported by certain defined assets (“Primary Security”). The level of reserves is to be calculated by a method referred to as the “Actuarial Method.”

Another charge to LATF was to promulgate an actuarial guideline specifying that, in order to comply with the NAIC Actuarial Opinion and Memorandum Regulation, Model 822 (“AOMR”) as it relates to XXX/AXXX reinsurance arrangements, the opining actuary must issue a qualified opinion as to the ceding insurer’s reserves if the ceding insurer or any insurer in its holding company system has engaged in a XXX/AXXX reserve financing arrangement that does not adhere to the Actuarial Method and Primary Security forms adopted by the NAIC. The initial version of Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) was developed in response to that charge, with an effective date of January 1, 2015.

Coordination between this Actuarial Guideline and the NAIC Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787)

Subsequently, on January 8, 2016, the NAIC adopted revisions to the Credit for Reinsurance Model Law (Model #785). Among other things, the revisions to Model #785 provide commissioners with the authority to enact, by regulation, additional requirements for ceding insurers to claim credit for reinsurance with respect to certain XXX/AXXX financing arrangements. On December 13, 2016, the NAIC adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787) as the regulation permitted by Model #785. LATF subsequently received a charge to redraft AG 48 to make it as consistent as possible with the provisions of Model #787. The current version of this actuarial guideline is the result.

The following is an overview of the interrelationship between this actuarial guideline and Model #787, and the regulatory strategy that led to the adoption of each:

1. The initial version of this actuarial guideline immediately established national standards for the use of XXX/AXXX financing arrangements in an attempt to quickly set minimum standards based on the framework adopted by the PBRI Task Force on June 30, 2014. This initial version applied to such reinsurance arrangements entered into on or after 1/1/2015.
2. The revised statute (the NAIC Credit for Reinsurance Model Law (Model #785)) and a new regulation (the NAIC Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787)) were then developed and adopted by the NAIC.

3. Except as noted in #4 below, this actuarial guideline will cease to be effective, on a state by state basis, as individual states enact Model #785 and adopt Model #787 to replace it.

4. Notwithstanding, it is anticipated that in a small number of states, Model #787 will need to be adopted on a “prospective” basis only (that is, it will only apply to ceded policies issued on or after the effective date thereof). In those cases, this actuarial guideline will remain as the authority for ceded policies subject to this actuarial guideline but to which Model #787, as adopted in a given state, does not apply. So although its role might diminish, this actuarial guideline will remain an essential part of the regulatory framework for a small number of states for many years to come.

5. To ensure uniformity of treatment between states, companies, and ceded policies (whether governed by this actuarial guideline or by Model #787) and to avoid confusion, this actuarial guideline is being updated, effective as of January 1, 2017, to make it as substantively identical to Model #787 as possible.

Authority, Avoidance, and Purpose

The requirements in this actuarial guideline derive authority from Section 3 of the AOMR, or, after the Operative Date of the Valuation Manual, from Section 1 of VM-30 of the Valuation Manual. Both Section 3 of the AOMR and Section 1 of VM-30 provide that the commissioner has the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items. As contained in the framework adopted by the PBRI Task Force on June 30, 2014, this actuarial guideline defines new terms, such as Primary Security and Required Level of Primary Security, specifies the Actuarial Method used to calculate the Required Level of Primary Security, and specifies other requirements that must be followed when reinsurance is involved in order for the appointed actuary to render an actuarial opinion that is not qualified.

No statute, regulation or guideline can anticipate every potential XXX/AXXX captive arrangement. Common sense and professional responsibility are needed to assure not only that the text of this actuarial guideline is strictly observed, but also that its purpose and intent are honored scrupulously. To that end, and to provide documentation to the appointed actuary as to the arrangements that are subject to review under this actuarial guideline, the appointed actuary may request from each ceding insurer, and may rely upon, the certification by the Chief Financial Officer or other responsible officer of each ceding insurer filed with the insurer’s domiciliary regulator that the insurer has not engaged in any arrangement or series of arrangements involving XXX or AXXX reserves that are designed to exploit a perceived ambiguity in, or to violate the purpose and intent of, this actuarial guideline.

The purpose and intent of this actuarial guideline is to establish uniform, national standards governing XXX or AXXX reserve financing arrangements on reserve financing arrangements have one or more of the following characteristics: such security/assets (1) are issued by the ceding insurer or its affiliates; and/or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; and/or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any of its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and

1 In general, reserve financing arrangements are those where the security/assets backing part or all of the reserves have one or more of the following characteristics: such security/assets (1) are issued by the ceding insurer or its affiliates; and/or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; and/or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any of its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and
and, in connection with such arrangements, to ensure that Primary Security, in an amount at least equal to the Required Level of Primary Security, is held by or on behalf of the ceding insurer. As described further in Section 4.B., the provisions of this actuarial guideline are not intended to apply to policies that were issued prior to 1/1/2015 if those policies were included in a captive reserve financing arrangement as of 12/31/2014. Further, the requirements of this actuarial guideline should be viewed as minimum standards and are not a substitute for the diligent analysis of reserve financing arrangements by regulators. A regulator should impose requirements in addition to those set out in this actuarial guideline if the facts and circumstances warrant such action.

Text

1. Authority

Pursuant to Section 3 of the AOMR or, after the Operative Date of the Valuation Manual, to Section 1 of VM-30 of the Valuation Manual, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

2. Scope

This actuarial guideline applies to reinsurance contracts that cede liabilities pertaining to Covered Policies as that term is defined in Section 4.

3. Exemptions

This actuarial guideline does not apply to the situations described in Subsections A through F.

A. Reinsurance of:

(1) Policies that satisfy the criteria for exemption set forth in Section 6F or Section 6G of Model #830; and which are issued before the later of:

(a) The effective date of Model #787 in the state of domicile of the ceding insurer, and

(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than January 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in Section 6E of Model #830 and which are issued before the later of:

(a) The effective date of Model #787 in the state of domicile of the ceding insurer, and

used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance arrangement).
(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than January 1, 2020;

(3) Any universal life policy that meets all of the following requirements:

(a) Secondary guarantee period, if any, is five (5) years or less;

(b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables and valuation interest rate applicable to the issue year of the policy; and

(c) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period;

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year; or

B. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Section 2D of Model #785; or

C. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Sections 2A, 2B or 2C, of Model #785, and that, in addition:

(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer’s reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures (“SSAP No. 1”), and

(2) Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in the NAIC Risk-Based Capital (RBC) for Insurers Model Act (Model #312) when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or

D. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Sections 2A, 2B or 2C, of Model #785, and that, in addition:

(1) Is not an affiliate, as that term is defined in Section 1A of the NAIC Insurance Holding Company System Regulatory Model Act (Model #440), of:
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(a) The insurer ceding the business to the assuming insurer; or
(b) Any insurer that directly or indirectly ceded the business to that ceding insurer;

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

(3) Is both:

(a) Licensed or accredited in at least 10 states (including its state of domicile), and
(b) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in Model #312 when its risk-based capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer’s reported surplus; or

E. Reinsurance ceded to an assuming insurer that meets the requirements of either Section 5B(4)(a) of Model #785, pertaining to certain certified reinsurers or Section 5B(4)(b) of Model #785, pertaining to reinsurers meeting certain threshold size and licensing requirements; or

F. Reinsurance not otherwise exempt under Subsections A through E if the commissioner, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this actuarial guideline (as described in the Authority, Avoidance and Purpose section above);

(2) The risks are included within the scope of this actuarial guideline only as a technicality; and

(3) The application of this actuarial guideline to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall publicly disclose any decision made pursuant to this Section 3F to exempt a reinsurance treaty from this actuarial guideline, as well as the general basis therefor (including a summary description of the treaty).

Drafting Note: The exemption set forth in Section 3F was added to address the possibility of unforeseen or unique transactions. This exemption exists because the NAIC recognizes that foreseeing every conceivable type of reinsurance transaction is impossible; that in rare instances unanticipated transactions might get caught up in this actuarial guideline purely as a technicality; and that regulatory
relief in those instances may be appropriate. The example that was given at the time this exemption was
developed pertained to bulk reinsurance treaties where the ceding insurer was exiting the type of business
ceded. The exemption should not be used with respect to so-called “normal course” reinsurance
transactions; rather, such transactions should either fit within one of the standard exemptions set forth in
Sections 3A, B, C, D, or E or meet the substantive requirements of this actuarial guideline.

4. Definitions

A. “Actuarial Method” means the methodology used to determine the Required Level of
Primary Security, as described in Section 5.

B. “Covered Policies” means the following: Subject to the exemptions described in Section
3, Covered Policies are those policies, other than Grandfathered Policies, of the following
policy types:

(1) Life insurance policies with guaranteed nonlevel gross premiums and/or
guaranteed nonlevel benefits, except for flexible premium universal life
insurance policies; or,

(2) Flexible premium universal life insurance policies with provisions resulting in
the ability of a policyholder to keep a policy in force over a secondary guarantee
period.

Note: Although “Covered Policies” is defined to include all the policies described in Subsections
B1 and B2 above, it is noted that whether a given “Covered Policy” is subject to this actuarial
guideline or, instead, to Model #787 should be determined under Section 8 (Sunset).

C. “Grandfathered Policies” means policies of the types described in Subsections B1 and B2
above that were:

(1) Issued prior to January 1, 2015; and

(2) Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not
have met one of the exemptions set forth in Section 3 had that section then been
in effect.

D. “Non-Covered Policies” means any policy that does not meet the definition of Covered
Policies, including Grandfathered Policies.

E. “Required Level of Primary Security” means the dollar amount determined by applying
the Actuarial Method to the risks ceded with respect to Covered Policies, but not more
than the total reserve ceded.

F. “Primary Security” means the following forms of security:

(1) Cash meeting the requirements of Section 3A of Model #785;

(2) Securities listed by the Securities Valuation Office meeting the requirements of
Section 3B of Model #785, but excluding any synthetic letter of credit, contingent
note, credit-linked note or other similar security that operates in a
manner similar to a letter of credit, and excluding any securities issued by the
ceding insurer or any of its affiliates; and
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(3) For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

(a) Commercial loans in good standing of CM3 quality and higher;
(b) Policy Loans; and
(c) Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

G. “Other Security” means any security acceptable to the commissioner other than security meeting the definition of Primary Security.

H. “Valuation Manual” means the valuation manual adopted by the NAIC as described in Section 11B(1) of the Standard Valuation Law, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.


5. The Actuarial Method

A. Description of Actuarial Method

The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this actuarial guideline shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

(1) For Covered Policies described in Section 4B(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in Section 4B(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations. The mortality basis for the NPR shall be the 2017 CSO Mortality Table.

(2) For Covered Policies described in Section 4B(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met. The mortality basis for the NPR shall be the 2017 CSO Mortality Table.
(3) Except as provided in Paragraph (4) below, the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.

(4) If the reinsurance treaty cedes less than one hundred percent (100%) of the risk with respect to the Covered Policies then the Required Level of Primary Security may be reduced as follows:

(a) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under Subparagraph (c) below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

(b) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(c) If a portion of the Covered Policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be reduced by the amount resulting by applying the Actuarial Method including the reinsurance section of VM-20 to the portion of the Covered Policy risks ceded in the exempt arrangement, except that for Covered Policies issued prior to Jan 1, 2017, this adjustment is not to exceed \[\frac{c_i}{2 \times \text{number of reinsurance premiums per year}}\] where \(c_i\) is calculated using the same mortality table used in calculating the Net Premium Reserve; and

(d) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security.

It is possible for any combination of Subparagraphs (a), (b), (c), and (d) above to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than one hundred percent (100%) of the risk.

The Adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.
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(5) In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

(6) If the ceding insurer cedes risks with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this actuarial guideline, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this actuarial guideline.

(7) If a reinsurance treaty subject to this actuarial guideline cedes risk on both Covered and Non-Covered Policies:

(a) The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies; and

(b) Any Primary Security and/or Other Security used to meet any requirements pertaining to the Non-Covered Policies may not be used to satisfy any requirements related to the Required Level of Primary Security and/or Other Security for the Covered Policies.

B. Valuation Used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

(1) For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer’s general account and without taking into consideration the effect of any prescribed or permitted practices; and

(2) For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the NAIC’s Life Actuarial (A) Task Force no later than the December 31 on or immediately preceding the valuation date for which the Required Level of Primary Security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.

6. Required Actuarial Analysis and Actuarial Opinion and Memorandum Requirements

A. Required Actuarial Analysis

Before the due date of each actuarial opinion, as to each reinsurance treaty in which Covered Policies have been ceded, the appointed actuary of each ceding insurer must
perform an analysis on a treaty by treaty basis, of such Covered Policies to determine whether, as of the immediately preceding December 31 (the valuation date):

(1) Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of Section 3 of Model #785, on a funds withheld, trust, or modified coinsurance basis; and

(2) Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (1) above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of Section 3 of Model #785; and

Note: For the sake of clarity, funds consisting of Primary Security pursuant to Paragraphs (1) may exceed the Required Level of Primary Security, and Other Security is only required under Paragraph (2) to the extent that there is any portion of the statutory reserves as to which Primary Security is not so held. For example, if a ceding insurer’s statutory reserves equal $1 Billion, its Required Level of Primary Security is $600 Million, and it holds $1 Billion in Primary Security pursuant to Paragraph (1), no Other Security is required under Paragraph (2).

(3) Any trust used to satisfy the requirements of this Section 6 complies with all of the conditions and qualifications of Section 1244 of the NAIC Credit for Reinsurance Model Regulation (Model #786), except that:

(a) Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in Section 5B, be valued according to the valuation rules set forth in Section 5B, as applicable; and

(b) There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of Section 6A(1); and

(c) The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by Section 6A(1)) below 102% of the level required by Section 6A(1) at the time of the withdrawal or substitution.

B. Qualified Actuarial Opinion; Remediation

(1) The appointed actuary of the ceding insurer performing the analysis required by Section 6A above must issue a qualified actuarial opinion as described in Section 6.D. of the AOMR or Section 3A(10) of VM-30 of the Valuation Manual, as applicable, unless:

(a) The requirements of Section 6A(1) and 6(A)(2) were fully satisfied as of the valuation date as to such reinsurance treaty; or

(b) Any deficiency has been eliminated before the due date of the Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of Section 6A(1) and 6A(2) to be fully satisfied as of the valuation date; or
Appendix C AG XLVIII

(c) The ceding insurer has established a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to Section 6A(1).

(2) In addition to the requirement set forth in Section 6B(1) above, the appointed actuary of the ceding insurer performing the analysis required by Section 6A above must issue a qualified actuarial opinion as described in Section 6.D. of the AOMR or Section 3A(10) of VM-30 of the Valuation Manual, as applicable, if the appointed actuary for any affiliated reinsurer of the ceding insurer issues a qualified actuarial opinion with respect to such affiliated reinsurer where (a) the affiliate reinsures Covered Policies of the ceding insurer and (b) the qualified actuarial opinion pertaining to the affiliated reinsurer results, in whole or in part, from the analysis required by this actuarial guideline.

Note: The remediation option set forth in Section 6B(1)(c) mirrors that set forth in Model #787. Under this option, a ceding company may choose to avoid the consequence (a qualified opinion under this actuarial guideline) by establishing a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held. For example, suppose a ceding insurer has established statutory reserves of $1 Billion and has Primary Security of $550 Million and Other Security of $450 Million. Suppose further that the actuary determines that the insurer’s Required Level of Primary Security is $600 Million. Under Section 6B(1)(c), the insurer may avoid a qualified opinion by establishing a liability equal to $450 Million (the difference between the statutory reserve of $1 Billion and the $550 Million amount of Primary Security actually held).

C. Additional Requirements for the Actuarial Opinion and Memorandum for Companies that have Covered Policies Requiring the Analysis Pursuant to this actuarial guideline

(1) In the statement of actuarial opinion, the appointed actuary of the ceding insurer must state whether (i) he has performed an analysis, as to each reinsurance arrangement under which Covered Policies have been ceded, of the security supporting the Covered Policies and whether funds consisting of Primary Security in an amount at least equal to the Required Level of Primary Security are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis and (ii) funds consisting of Primary Security or Other Security in an amount equal to the statutory reserves are held by or on behalf of the ceding insurer as security under the reinsurance arrangement.

(2) In the actuarial memorandum as described by Section 7 of the AOMR or Section 3B of VM-30 of the Valuation Manual, as applicable, the appointed actuary of the ceding insurer must document the analysis and requirements applied by this actuarial guideline as to each reinsurance arrangement under which Covered Policies are ceded.

(3) In the event that a reinsurance treaty contains both (1) Covered Policies subject to this actuarial guideline rather than to Model #787, and (2) Covered Policies subject to Model #787 rather than to this actuarial guideline, the treaty shall be tested as a whole for purposes of a ceding insurer’s compliance with both (a) the requirements of Section 6A(1) and Section 6A(2) of this actuarial guideline and (b) the requirements of Section 7A(3) and Section 7A(4) of Model #787; provided further, that:
AG XLVIII

Appendix C

(a) If funds consisting of Primary Security are held in amounts less than the Required Level of Primary Security, such funds consisting of Primary Security shall be allocated first to fulfill the Required Level of Primary Security for the Covered Policies subject to this actuarial guideline, with any remainder allocated to those Covered Policies subject to Model #787; and

(b) If funds consisting of Other Security are held in amounts less than the requirements of Section 6A(2), such funds consisting of Other Security shall be allocated first to fulfill the Other Security requirements for the Covered Policies subject to this actuarial guideline, and any remainder shall be allocated to those Covered Policies subject to Model #787.

7. Effective Date

This actuarial guideline shall become effective as of January 1, 2017 with respect to all Covered Policies. This actuarial guideline supersedes and replaces all previous versions thereof with respect to actuarial opinions rendered as to valuation periods ending on or after January 1, 2017.

Note: For the avoidance of doubt, actuarial opinions issued with respect to the year ended December 31, 2016, shall be governed by the version of AG 48 in effect on December 31, 2016, as included in the Accounting Practices and Procedures Manual.

8. Sunset Provision

This actuarial guideline shall cease to apply as to Covered Policies that are both (a) issued by ceding insurers domiciled in a jurisdiction that has in effect, as of December 31st of the calendar year immediately preceding the year in which the actuarial opinion is to be filed, a regulation substantially similar to Model #787 adopted by the NAIC on December 13, 2016; and (b) subject to Model #787 as so adopted by the ceding insurer’s jurisdiction of domicile. This Actuarial Guideline shall continue to apply, without interruption, to any and all Covered Policies not included in both (a) and (b) of the immediate preceding sentence.

Note: It is anticipated that, for most states, this actuarial guideline will sunset pursuant to (a) and (b) of Section 8 and will continue only with respect to the limited number of states in which their version of Model #787 applies prospectively only, i.e., applies only to Covered Policies issued on or after the effective date of their version of Model #787. It is anticipated, however, that most states will be able to adopt a version of Model #787 that, like the Model itself, applies to all Covered Policies (subject to the applicable exemptions and grandfathering provisions) that are “in force” on or after the effective date, even if the policies were originally issued prior to that effective date. The goal of Section 8 is to ensure that all Covered Policies ceded in reinsurance transactions within the scope of this actuarial guideline continue to be subject to this actuarial guideline unless and until they become subject to Model #787.
**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

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<tr>
<td>CONTACT PERSON: Pat Allison</td>
</tr>
<tr>
<td>TELEPHONE:  816-783-8528</td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:pallison@naic.org">pallison@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF: LATF</td>
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<tr>
<td>NAME: Mike Boerner, Chair</td>
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**FOR NAIC USE ONLY**

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**DISPOSITION**

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [ ] Adopted Date ____________________________
- [ ] Rejected Date ____________________________
- [ ] Deferred Date ____________________________
- [ ] Other (Specify) ____________________________

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ X ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ X ] Life, Accident & Health/Fraternal
- [ ] Property/Casualty
- [ ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ X ] Title
- [ ] Other ____________________________

Anticipated Effective Date: Annual 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**

See next page for details of changes to the VM-20 Reserves Supplement.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Changing the reporting units for reserves to attain consistency with other annual statement blanks. Clarifying the instructions to attain consistency in company reporting. Changes are based on findings from the 2018 review of company filings.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________

Other Comments: ____________________________

**This section must be completed on all forms.** Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

VM-20 Reserves Supplement Blank:

- Splitting Part 1 into Part 1A and Part 1B.
- For Part 1A:
  - Changing the description header for Column 3 to be “Due and Deferred Premium Asset” so that it matches the instructions.
  - Adding “XXX” in two places to the indicate that a Due and Deferred Premium Asset does not need to be reported in the lines shown for Total Reserves.
  - Changing the reporting units for all columns to be in dollars rather than in thousands.
  - Expanding all columns to allow room for a number as large as 999,999,999,999.
  - Changing the product labels for clarity.
- For Part 1B:
  - Changing the reporting units for the Reserve columns to be in dollars rather than in thousands.
  - Expanding the Reserve columns to allow room for a number as large as 999,999,999,999.
  - Expanding the Face Amount columns to allow room for a number as large as 9,999,999,999.
  - Changing the product labels for clarity.
- Removing Part 2 and re-numbering the remaining Parts.

VM-20 Reserves Supplement Instructions:

- Adjusting the instructions according to the changes made to the blanks.
- Clarifying instructions and adding examples for Parts 1A and 1B.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

VM-20 RESERVES SUPPLEMENT – PART 1

Life Insurance Reserves Valued According to VM-20 by Product Type

($000 Omitted Except for Number of Policies)

This Supplement provides information on the reserves required to be calculated by Section VM-20 of the Valuation Manual. This includes the Net Premium Reserve and, as applicable, the Deterministic Reserve and the Stochastic Reserve. This Supplement also provides information regarding business where VM-20 of the Valuation Manual is not required to be applied. Only business issued on or after Jan. 1, 2017, valued by the requirements of VM-20 should be reported in Part 1. Part 1 is intended to aid regulators in the analysis of reserves as determined under Section VM-20 of the Valuation Manual for both the prior and current year. Companies that elect the three-year transition for some of their policies should not report those policies in this part.

This Supplement also provides information regarding business where VM-20 of the Valuation Manual is not required to be applied. Companies that elect the three-year transition period for all of their business or are otherwise exempted from the requirements of Section VM-20 are not required to complete Part 1 of this Supplement pursuant to the instructions in Part 2 of this Supplement, but must complete Part 2 or Part 3 as applicable.

VM-20 RESERVES SUPPLEMENT – PART 1A

Life Insurance Reserves Valued According to VM-20 by Product Type

Part 1A of this Supplement breaks out, by product type, the prior year and current year reported reserves on a Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded basis as defined in Section 8.D of Section VM-20 of the Valuation Manual. The Due and Deferred Premium Asset for the current year is also shown. In addition, Part 1 of this Supplement shows, by product type for the current year, the Due and Deferred Premium Asset, the Net Premium Reserve (NPR), the Deterministic Reserve (DR) and the Stochastic Reserve (SR), where the NPR, DR, and SR are as defined in Section VM-20 of the Valuation Manual. This Supplement is intended to aid regulators in the analysis of reserves as determined under Section VM-20 of the Valuation Manual for both the prior and current year.

Section VM-20 of the Valuation Manual requires that the Post-Reinsurance-Ceded Reserve be determined by three product groups: VM-20 Reserving Categories: Term Insurance, Universal Life with Secondary Guarantees (ULSG) and all other. Term Insurance should be reported on line 1.1. ULSG, including Variable Universal Life with a secondary guarantee, Indexed life insurance with a secondary guarantee, regular Universal Life with a secondary guarantee, and ULSG policies with a non-material secondary guarantee as defined in Section VM-01 of the Valuation Manual, should be reported on line 1.2. Each of the other products reported in lines 1.3 – 1.8 should be determined as the sum of the policy reserves using the policy reserves determined following the allocation process of VM-20 Section 2. A similar process should be used for each of the pre-reinsurance-ceded reserves.

Section A: Columns 4 through 8 are to be completed if each of the reserves in Columns 4 through 6 (NPR, DR, SR) is calculated according to the requirements of Section VM-20 of the Valuation Manual.

Section B: Columns 9 through 12 are to be completed only if the reserves in Columns 9 and 10 (NPR, DR) are calculated according to the requirements of Section VM-20 of the Valuation Manual.

Section C: Columns 13 through 15 are to be completed only if the reserve in Column 13 (NPR) is calculated according to the requirements of Section VM-20 of the Valuation Manual.
Provide the reported reserve, in \textit{thousands whole dollars}, for the prior year and current year for each line item. Post-Reinsurance-Ceded is net of reinsurance ceded, and Pre-Reinsurance-Ceded includes reinsurance assumed and excludes any reinsurance ceded should be prior to any reinsurance ceded and include reinsurance assumed. Sections 2 and 8 in the \textit{Valuation Manual} further describe the required reserve and treatment of reinsurance. The reported reserve for the current year should reflect all policies in force as of the end of the current year. The reported reserve for the prior year should reflect all policies in force as of the end of the prior year.

Provide the due and deferred premium asset amount, in \textit{thousands whole dollars}, associated with the current year Reported Reserve from Column 2 and calculated in a manner consistent with lines 15.1 and 15.2 of the Annual Statement Assets page.

\textit{Example 1:}
A company reinsures a ULSG product using YRT reinsurance.
- The ceding company reports their reserve on lines 1.2 and 3.2 for ULSG.
- The assuming company reports their reserve on lines 1.1 and 3.1 for Term.

\textit{Example 2:}
A company reinsures a Term product using YRT reinsurance.
- The ceding company reports their reserve on lines 1.1 and 3.1 for Term.
- The assuming company reports their reserve on lines 1.1 and 3.1 for Term.
VM-20 RESERVES SUPPLEMENT – PART 1B

Life Insurance Reserves Valued According to VM-20 by Product Type

($000 Omitted for Face Amount)

Part 1B of this Supplement provides details underlying the amounts shown in Part 1A.

Section A: Columns 4.1 through 6.3 are to be completed if each of the reserves in Columns 4.1 through 6.3 (NPR, DR, SR) is calculated according to the requirements of Section VM-20 of the Valuation Manual.

Section B: Columns 9.6 through 12.9 are to be completed only if the reserves in Columns 9.6 and 10.7 (NPR, DR) are calculated according to the requirements of Section VM-20 of the Valuation Manual.

Section C: Columns 13.10 through 15.12 are to be completed only if the reserve in Column 13.10 (NPR) is calculated according to the requirements of Section VM-20 of the Valuation Manual.

Column 4.1, 9.6 & 13.10 – Net Premium Reserve (NPR)
Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Net Premium Reserve for each product type, in whole dollars. Report the floored amount. The Net Premium Reserve is defined in Section 3 in VM-20 of the Valuation Manual.

Column 5.2 & 10.7 – Deterministic Reserve
Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Deterministic Reserve for each product type, in thousands. Report the amount whether it is positive or negative; do not floor the amount at zero if it is negative. The Deterministic Reserve calculation is defined in Section 4 in VM-20 of the Valuation Manual.

Column 6.3 – Stochastic Reserve
Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Stochastic Reserve for each product type, in thousands. Report the amount whether it is positive or negative; do not floor the amount at zero if it is negative. The Stochastic Reserve calculation is defined in Section 5 in VM-20 of the Valuation Manual.

Column 7.4, 11.8 & 15.12 – Number of Policies
Report the number of individual life insurance policies by product type and by the required VM-20 methodology used as described in Section A, Section B and Section C above. The number of policies should be prior to any reinsurance ceded and include reinsurance assumed.

Column 8.5, 12.9 & 16.12 – Face Amount
Report the face amount, in thousands, of individual life insurance by product type and by the required VM-20 methodology used as described in Section A, Section B and Section C above. The face amount should be prior to any reinsurance ceded and include reinsurance assumed.

Example:
A company has Term business subject to VM-20, and there is no reinsurance. The Deterministic Exclusion Test was passed. The Deterministic Reserve at year-end was negative:

- The company completes Section B,
- The floored Net Premium Reserve is reported in whole dollars in Column 6,
- The negative Deterministic Reserve is reported in whole dollars in Column 7,
- The Number of Policies is reported in Column 8
- The Face Amount is reported in thousands in Column 9.
VM-20 RESERVES SUPPLEMENT – PART 2

Three Year-Transition Period

($000 Omitted Except for Number of Policies)

This section of the Supplement should be completed when a reporting entity has elected to apply the three-year transition provided in Section II, Sub-section C under Life Insurance Products of the Valuation Manual to some or all of its business. This Part 2 should include the values requested for the business for which the three-year transition has been elected and should not include values for any policies valued based on VM-20. This Part 2 allows the company to establish minimum reserves according to applicable requirements stated in Appendix A (VM-A) and Appendix C (VM-C), in the Valuation Manual, for business otherwise subject to VM-20 requirements and issued during the first three years following the Operative Date of the Valuation Manual. If a company does not elect this three-year transition, but elects to apply VM-20 to a block of business issued on and after the Operative Date, then such company must continue to apply the requirements of VM-20 to this block of business, as well as future new issues of this type of business.

A company that elects to apply the three-year transition for all of its products within the scope of VM-20 does not have to complete Part 1 of the VM-20 Supplement. If a company applies VM-20 to a product or products, then Part 1 of this VM-20 Supplement will need to be completed.

VM-20 RESERVES SUPPLEMENT – PART 3.2

Life PBR Exemption

This section of the Supplement should be completed by a company that has filed and been granted a Life PBR Exemption from its state of domicile.

If a company has been granted a Life PBR Exemption, the company must indicate the source of the Life PBR Exemption, which could be defined in a state statute, a state regulation or in the NAIC-adopted Valuation Manual. If the source of the granted Life PBR Exemption is not the NAIC-adopted Valuation Manual, the company must disclose the criteria of the state’s Life PBR Exemption that the company has met, and the company must disclose the minimum reserve requirements that are required by the state of domicile. If the minimum reserve requirements of the state of domicile are the same as those specified in the NAIC-adopted Valuation Manual, the company may indicate: “Same as NAIC VM”.

Companies whose individual ordinary life business is exempted from the requirements of VM-20 pursuant to a Life PBR Exemption are not required to complete Part 1 of this VM-20 Supplement.

VM-20 RESERVES SUPPLEMENT – PART 4.3

Other Exclusions from Life PBR

Questions 1 and 2 of this section of the Supplement should be completed by a company that has filed and been granted a Single State Exemption from the reserve requirements of VM-20 by its state of domicile pursuant to requirements similar to the optional Section 15 of the NAIC Standard Valuation Law (§ 820). The response to question 2 should be “Yes” if the company has any business assumed that relates to issues outside the state of domicile.

Question 3 of this section of the Supplement should be completed by a company if all its life business is excluded from the requirements of VM-20 pursuant to Section II.B of the Valuation Manual.

Companies responding “Yes” to question 1 are not required to complete Part 1 of this VM-20 Supplement if all of their individual ordinary life business was covered under the Single State Exemption. Companies responding “YES” to question 3 are not required to complete Part 1 of this VM-20 Supplement.
VM-20 RESERVES SUPPLEMENT – PART 1A
Life Insurance Reserves Valued According to VM-20 by Product Type
For The Year Ended December 31, 20__
(To Be Filed by March 1)

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<td>3. Pre-Reinsurance-Ceded Reserve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1. Term Life Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2. Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3. Non-Participating Whole Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4. Participating Whole Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5. Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.6. Variable Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.7. Variable Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.8. Indexed Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Aggregate Write-Ins for Other Products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total Pre-Reinsurance-Ceded Reserve</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>5. Total Reserves Ceded (Line 4 minus Line 2)</td>
<td>XXX</td>
<td></td>
</tr>
</tbody>
</table>

**DETAILS OF WRITE-INS**

<table>
<thead>
<tr>
<th>1.901</th>
<th>1.902</th>
<th>1.903</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.908 Summary of remaining write-ins for Line 1.9 from overflow page</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.909 Totals (Lines 1.901 through 1.903 plus 1.908) (Line 1.9 above)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.901</td>
<td>3.902</td>
<td>3.903</td>
</tr>
<tr>
<td>3.908 Summary of remaining write-ins for Line 3.9 from overflow page</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.909 Totals (Lines 3.901 through 3.903 plus 3.908) (Line 3.9 above)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# VM-20 RESERVES SUPPLEMENT – PART 1B
Life Insurance Reserves Valued According to VM-20 by Product Type
For The Year Ended December 31, 20__
(To Be Filed by March 1)
($500 Certified for Face Amount)

## Current Year

<table>
<thead>
<tr>
<th>SECTION A</th>
<th>SECTION B</th>
<th>SECTION C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Term Life Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4. Participating Whole Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7. Variable Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pre-Reinsurance-Ceded Reserve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5. Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Guaranteed Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Variable Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2. Guaranteed Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Variable Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Aggregate Universal Life Reserves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2. Pre-Reinsurance-Ceded Reserve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Guaranteed Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Variable Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.0. Aggregate Universal Life Reserves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Total (Line 1.9 plus 3.998) (Line 3.9 above)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**VM-20 RESERVES SUPPLEMENT – PART 1B**

**Life Insurance Reserves Valued According to VM-20 by Product Type**

**For The Year Ended December 31, 20__**

(To Be Filed by March 1)

($500 Certified for Face Amount)

<table>
<thead>
<tr>
<th>SECTION A</th>
<th>SECTION B</th>
<th>SECTION C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Term Life Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4. Participating Whole Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7. Variable Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pre-Reinsurance-Ceded Reserve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5. Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Guaranteed Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Variable Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Aggregate Universal Life Reserves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2. Guaranteed Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Variable Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Aggregate Universal Life Reserves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9. Total (Line 1.9 plus 3.998) (Line 3.9 above)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### VM-20 RESERVES SUPPLEMENT – PART 2

Reserves for Policies Not Based on VM-20 as a Result of the Three-Year Transition Period

For The Year Ended December 31, 20__

(To Be Filed by March 1)

($000 Omitted Except for Number of Policies)

<table>
<thead>
<tr>
<th>Three-Year Transition Period</th>
<th>Prior Year</th>
<th>Current Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 Gross Reserve</td>
<td>2 Net Reserve</td>
</tr>
<tr>
<td>1. Life Insurance Reserves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Term Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Non-Participating Whole Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Participating Whole Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6 Variable Universal Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7 Universal Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.8 Indexed Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.9 Variable Life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### DETAILS OF WRITE-INS

- a. If the response to Question 1 is “Yes”, then check the source of the granted “Life PBR Exemption” definition? (Check either 2.1, 2.2 or 2.3)
  - 2.1 NAIC Adopted VM
  - 2.2 State Statute (SVL)
  - 2.3 State Regulation

- b. Complete items “a” and “b”, as appropriate.
  - a. Is the criteria in the State Statute (SVL) different from the NAIC adopted VM? Yes [ ] No [ ]
  - b. If the answer to “a” above is “Yes”, provide the criteria the state has used to grant the Life PBR Exemption (e.g., Group/Legal Entity criteria) and the minimum reserve requirements that are required by the state of domicile (if the minimum reserve requirements are the same as the Adopted VM, write SAME AS NAIC VM):

- a. Is the criteria in the State Regulation different from the NAIC adopted VM? Yes [ ] No [ ]
  - b. If the answer to “a” above is “Yes”, provide the criteria the state has used to grant the Life PBR Exemption (e.g., Group/Legal Entity criteria) and the minimum reserve requirements that are required by the state of domicile (if the minimum reserve requirements are the same as the Adopted VM, write SAME AS NAIC VM):

### VM-20 RESERVES SUPPLEMENT – PART 3.2

Life PBR Exemption

For The Year Ended December 31, 20__

(To Be Filed by March 1)

Life PBR Exemption as defined in the NAIC adopted Valuation Manual (VM)

1. Has the company filed and been granted a Life PBR Exemption from the reserve requirements of VM-20 of the Valuation Manual by their state of domicile? Yes [ ] No [ ]

2. If the response to Question 1 is “Yes”, then check the source of the granted “Life PBR Exemption” definition? (Check either 2.1, 2.2 or 2.3)

2.1 NAIC Adopted VM

2.2 State Statute (SVL)

- a. Complete items “a” and “b”, as appropriate.
  - a. Is the criteria in the State Statute (SVL) different from the NAIC adopted VM? Yes [ ] No [ ]

2.3 State Regulation

- a. Complete items “a” and “b”, as appropriate.
  - a. Is the criteria in the State Regulation different from the NAIC adopted VM? Yes [ ] No [ ]
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the company filed and been granted a Single State Exemption from the reserve requirements of VM-20 of the Valuation Manual by their state of domicile?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the answer to question 1A is “Yes” please discuss any business not covered under the Single State Exemption.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the answer to question 1A is “Yes”, does the company have risks for policies issued outside its state of domicile?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If the answer to question 2A is “Yes” please discuss the risks for policies issued outside the state of domicile, how those risks came to be a responsibility of the company, and why the company would still be considered a Single State Company with such risks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is all of the company’s individual ordinary life insurance business excluded from the requirements of VM-20 pursuant to Section II.B of the Valuation Manual?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
**NAIC BLANKS (E) WORKING GROUP**

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>DATE: XX/XX/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT PERSON: Pat Allison</td>
</tr>
<tr>
<td>TELEPHONE: 816-783-8528</td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:pallison@naic.org">pallison@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF: LATF</td>
</tr>
<tr>
<td>NAME: Mike Boerner, Chair</td>
</tr>
</tbody>
</table>

FOR NAIC USE ONLY

- Agenda Item #
- Year 2020
- Changes to Existing Reporting [ X ]
- New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

- No Impact [ X ]
- Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) ____________

BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS BLANK
- [ ] Life, Accident & Health/Fraternal
- [ ] Property/Casualty
- [ ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ ] Title
- [ ] Other

Anticipated Effective Date: Annual 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Variable Annuities Supplement Blank:
- Changing the header for Column 10
- Changing Lines 1-3 and adding Line 4

Variable Annuities Supplement Instructions:
- Adjusting the instructions to correspond with changes made to the blanks as well as changes in the 2020 Valuation Manual for the new VA Framework.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The new VA Framework is effective for 2020.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:________________________

Other Comments:________________________

**This section must be completed on all forms.** Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

VARIABLE ANNUITIES SUPPLEMENT
PARTS 1 AND 2

This supplement is to be filed on or before April 1.

Complete this supplement for contracts and certificates subject to VM-21. A separate chart shall be prepared for individual contracts and for group contracts with individual certificates.

For variable annuities (VAs) with guaranteed benefits, disclose the type(s) of guaranteed benefit(s), the number of contracts or certificates with those benefits, the amount of the benefit base related to each type of benefit, the net amount at risk for death benefits and the guaranteed annual payout for income and withdrawal benefits, the gross amount of the reserve for the guaranteed benefit(s), the portion of the contract/certificate account value related to contract/certificate funds in the General Account or the Separate Account, and the percent of the guaranteed benefit reinsured.

Column 1 & Column 2 – Type of Guaranteed Benefit

For purposes of this supplement, a Guaranteed Death Benefit is defined in accordance with the term “Guaranteed Minimum Death Benefit” in VM-21, and a Guaranteed Living Benefit (GLB) is defined in accordance with the term “Variable Annuity Guaranteed Living Benefits” in VM-01.

“Type” shall include a summary description of the type of benefit. Examples are provided in the table illustrated below. Descriptions that may apply when identifying “Type” for Column 2 include, “Guaranteed Minimum Accumulation Benefit” (GMAB), “Guaranteed Minimum Income Benefit” (GMIIB), “Hybrid GMIB,” “Traditional GMIB,” “Guaranteed Minimum Withdrawal Benefit” (GMWB), “Lifetime GMWB,” “Non-Lifetime GMWB,” and “Guaranteed Payout Annuity Floor” (GPAF). These terms are defined in VM-01. For those guaranteed benefits that include waiting periods before any benefit can be realized, include the length of the original waiting period in the description.

• A separate line shall be created for each combination of Guaranteed Death Benefit and Guaranteed Living Benefit.
  o See the illustration in the table below for an example.
  o For a category with only one guarantee, show “None” in the other column.
  o For a category with no guaranteed benefit, show “None” in both columns.

• Each contract/certificate shall be included in one and only one line.
  o For a contract with multiple living benefits, determine the most appropriate classification.

A separate chart shall be prepared for individual contracts and for group contracts with individual certificates. In each chart, show the amount of any reinsurance reserve credit being taken separately for treaties with affiliated captive reinsurers and for other reinsurers.

For purposes of this supplement, a Guaranteed Living Benefit (GLB) is defined as a contract, certificate, agreement or rider in which the insurance entity guarantees specified payouts during a defined period, which may include the lifetime of the insured(s). For VAs, these guaranteed payouts are typically made regardless of the performance of the contractual account value that is used to determine cash surrender values and/or withdrawal benefits.

Column 3 – Number of Individual (Part 1) Contracts or Group (Part 2) Certificates
<table>
<thead>
<tr>
<th>Column 4</th>
<th>Benefit Base For Guaranteed Death Benefit (Col 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report the Benefit Base (defined in the contract/certificate) as of the valuation date as the basis for the guaranteed value. If no guarantee exists, enter $0.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 5</th>
<th>Benefit Base For Guaranteed Living Benefit (GLB) (Col 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report the Benefit Base (defined in the contract/certificate) as of the valuation date as the basis for the guaranteed value. If no guarantee exists, enter $0.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 6</th>
<th>Net Amount at Risk For Guaranteed Death Benefit (Col 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Death Benefit Net Amount at Risk (NAR) is defined as the greater of a) zero and b) the difference between the Guaranteed Death Benefit and the Account Value as of the valuation date. Report the sum of the NAR for all contracts/certificates.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 7</th>
<th>Guaranteed Annual Income Amount For Guaranteed Living Benefit (GLB) (Col 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report the total annual income/withdrawal benefits available if the income/withdrawal guarantees were elected on the valuation date. If no GLB/GMWB is available on the valuation date for a particular contract/certificate (e.g. due to a waiting period), use $0. Note, for GLB and GMWB previously elected, show the guaranteed amount based on the prior elections. For GMAB, use $0 since this is not an income benefit. Disclosures for GMAB shall be provided in the AG 43 Memorandum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 8</th>
<th>Account Value – General Account</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Column 9</th>
<th>Account Value – Separate Account</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Column 10</th>
<th>Reserve for Guaranteed Benefits (Total Reserve Less Base Adjusted Reserve) Contract-Level Reserves Less Cash Surrender Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total gross reserve for guarantees as defined in AG-43 or VM-21 as applicable in excess of the base contract reserve. Reserves calculated according to AG-43 and VM-21 are allocated to individual contracts or certificates following the guidance of Appendix 6 of AG-43 or Section 8 of VM-21. Report in column 10 the excess of this per policy reserve over the base contract reserve. For base contract reserve, the company may use CSV or Base Adjusted Reserve (defined in Appendix 3, A.3.2D of AG-43 or Section 5, B.4. of VM-21) for that contract or certificate. For each contract/certificate, calculate the excess amount of the pre-reinsurance ceded contract-level reserve, defined in VM-21, over the contract’s cash surrender value. For each “Type” listed under Columns 1 and 2, report the sum of the excess amounts calculated for the associated contracts/certificates. For the Subtotal, report the sum of the excess amounts calculated for all contracts/certificates. The Subtotal should equal the excess of the aggregate reserve over the aggregate cash surrender value.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 11 &amp; Column 12</th>
<th>Percentage of Guaranteed Benefits Reinsured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Show percentage of the Guaranteed Benefit ceded to all reinsurers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line 1</th>
<th>Aggregate Cash Surrender Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report the sum of the cash surrender values for all contracts/certificates.</td>
</tr>
</tbody>
</table>
**Line 2** – **Pre-Reinsurance Ceded Aggregate Reserve (Subtotal for Column 10 plus Line 1)**

Report the sum of the pre-reinsurance ceded contract-level reserves for all contracts/certificates. This should equal the Subtotal Line for Column 10 plus Line 1.

**Line 3** – **Reserves Ceded (Line 2 minus Line 4)**

**Line 34** – **Total Net of Reinsurance Post-Reinsurance Ceded Aggregate Reserve**

Line 3 Total Net of Reinsurance should equal the Subtotal Line for Column 10 minus the sum of Line 1 Reserve Credit from Affiliated Captive Reinsurance and Line 2 Reserve Credit from Other Reinsurance. Report the sum of the post-reinsurance ceded contract-level reserves for all contracts/certificates.

Illustration:

<table>
<thead>
<tr>
<th>Type</th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Guaranteed Death Benefit</strong></td>
<td><strong>Guaranteed Living Benefit</strong></td>
<td><strong>Number of Individual Contracts/Group Certificates</strong></td>
<td><strong>For Guaranteed Death Benefit (Col 1)</strong></td>
<td><strong>For Guaranteed Living Benefit (GLB) (Col 2)</strong></td>
<td><strong>Net Amount at Risk For Guaranteed Death Benefit (Col 1)</strong></td>
<td><strong>Guaranteed Annual Income Amount For Guaranteed Living Benefit (GLB) (Col 2)</strong></td>
<td><strong>General Account</strong></td>
<td><strong>Separate Account</strong></td>
</tr>
<tr>
<td>Max anniversary value (MAV)</td>
<td>GMAB – 110% of premium</td>
<td>997</td>
<td>$101.4 M</td>
<td>$0</td>
<td>$5.7M</td>
<td>$0</td>
<td>$2.7M</td>
<td>$93.0M</td>
<td>60% 40%</td>
</tr>
<tr>
<td>3% Roll-up</td>
<td>GMIB from account at 3% x 10 yr waiting period</td>
<td>312</td>
<td>$32.6M</td>
<td>$34.6M</td>
<td>$1.4M</td>
<td>$2.4M</td>
<td>$31.2M</td>
<td>100% 100%</td>
<td></td>
</tr>
<tr>
<td>Greater of MAV &amp; 3% Roll-up</td>
<td>GMIB ROP, 10 yrs</td>
<td>482</td>
<td>$40.0M</td>
<td>$35.0M</td>
<td>$3.0M</td>
<td>$0</td>
<td>$37.0M</td>
<td>0% 0%</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>1,751</td>
<td>$174.0M</td>
<td>$69.6M</td>
<td>$10.1M</td>
<td>$2.4M</td>
<td>$2.7M</td>
<td>$161.2M</td>
<td>$4.5M</td>
<td></td>
</tr>
</tbody>
</table>

1. Reserve credit from affiliated captive reinsurance
2. Reserve credit from other reinsurance
3. Aggregate cash surrender value
4. Post-reinsurance ceded aggregate reserve

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### PART I – INDIVIDUAL

<table>
<thead>
<tr>
<th>Type</th>
<th>Guaranteed Death Benefit</th>
<th>Guaranteed Living Benefit</th>
<th>General Account</th>
<th>Separate Account</th>
<th>GLB (Col 2)</th>
<th>Reserves (Subtotal for column 10 plus line 1)</th>
<th>Post-Reinsurance Ceded Aggregate Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

Note: The table continues with additional rows for Type 1, Guaranteed Death Benefit, Guaranteed Living Benefit, General Account, Separate Account, GLB (Col 2), Reserves, and Post-Reinsurance Ceded Aggregate Reserve.
## Variable Annuities Supplement

### Part 2 – Group Contracts with Individual Certificates

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefit Base</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<td>Net Amount at Risk For Guaranteed Death Benefit (Col 1)</td>
<td>Guaranteed Annual Income</td>
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Subtotal: XXX XXX

1. Reserve credit from affiliated captive reinsurance Aggregate Creditor Separate Reserve
2. Reserve credit from other reinsurers Pre-Insurance Ceded Aggregate Reserve (Subtotal for Columns Duplicated Line 7)
3. Total Pre-Insurance Ceded Aggregate Reserve Creditor Line 7 minus Line 8
4. Post Reinsurance Ceded Aggregate Reserve

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© 2020 National Association of Insurance Commissioners
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

2. Identify the document, including the date if the document is “released for comment,” and the location in the
document where the amendment is proposed:
January 1, 2020, edition of the Valuation Manual with NAIC adoptions through August 6, 2019
Locations with proposed changes: VM-20 and VM-31

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
The Valuation Manual already requires that if there is additional risk arising from the conversion of term
life insurance, whether group or individual, it must be reserved for. The purpose of this APF is to
emphasize this requirement and to provide guidance on what must be included in the Life PBR Actuarial
Report with respect to conversions.

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

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Notes: VM APF 2019-62 rev.02-10-20
VM-20 Section 9.C.4

Option 1:

VM-20 Section 9.C.4 - Add Guidance Note related to converted policies at the end of the section.

c. The mortality rates from the resulting anticipated experience assumptions must be no lower than the mortality rates that are actually expected to emerge and that the company can justify.

Guidance Note: Pursuant to Section 9.C.4.c, the company must ensure that excess mortality associated with policies issued via conversion from term policies or from group life contracts is appropriately reflected in the anticipated experience mortality rates.

Option 2:

VM-20 Section 9.C.4 - Add Section 9.C.4.d

c. The mortality rates from the resulting anticipated experience assumptions must be no lower than the mortality rates that are actually expected to emerge and that the company can justify.

d. In satisfying Section 9.C.4.c, the company must ensure that any excess mortality is appropriately reflected in the anticipated experience mortality rates. This includes but is not limited to excess mortality associated with policies issued via conversion from term policies or from group life contracts.

Both Option 1 and Option 2 include all the following changes:

VM-31 Section 3.B.3 [Executive Summary – policy overview]

3. Policies – A summary of the base policies within each VM-20 reserving category. Include information necessary to fully describe the company’s distribution of business. For direct business, use PBR Actuarial Report Template A located on the NAIC website [https://www.naic.org/pbr_data.htm?tab_3] to provide descriptions of each base policy product type and underwriting process (including a description of the process, the time period in which it was used, and the level of any additional margin), with a breakdown of policy count and face amount by base policy product type and underwriting process. Also include the target market, primary distribution system, and key product features that affect risk, including conversion privileges.


d. Assumption and Margin Development – The following information for each risk factor: description of the methods used to determine anticipated experience assumptions and margins, including the sources of experience (e.g., company experience, industry
experience, or other data); how changes in such experience are monitored; any adjustments made to increase mortality margins above the prescribed margin (such as to reflect increased uncertainty with due to newer underwriting approaches; and any other considerations, such as conversion features, helpful in or necessary to understanding the rationale behind the development of assumptions and margins, even if such considerations are not explicitly mentioned in the Valuation Manual.

VM-31 Section 3.D.3.x [new section] [Life Report – Mortality]

(We suggest placing after Adjustments for Mortality Improvement and before Mortality for Impaired Lives)

i. Mortality for Converted Policies – Description of the treatment of mortality for Mortality policies issued under group or term conversion privileges including:

   i. A description of the method(s) by which any excess conversion mortality was taken into account in the development of company experience mortality rates (e.g., through the use of separate mortality segments for policies issued upon conversion, through aggregation of claim experience, or through use of other methods), the rationale for the method(s) used, and any changes in the method(s) from those used in previous years.

   ii. The source(s) of the data used in the method(s) employed.

j. Mortality for Impaired Lives or Policyholder Behavior – Disclosure of:

   i. the percentage of business that is on impaired lives;

   ii. whether impaired lives were included or excluded from the mortality study upon which company experience mortality was based; and

   iii. whether any adjustments to mortality assumptions for impaired lives or policyholder behavior were found to be necessary and, if so, the rationale for the adjustments that were used.

Item (iii) above is a required disclosure for post-level term mortality assumptions even if the company uses a 100% shock lapse assumption, since it pertains to the analysis demonstrating whether there are post-level term profits.
VM-31 Section 3.D.4.xl and ym (new sections) [Life Report – Policyholder Behavior]

k. Post-Level Term Testing – For products with a level term period:

i. Summary results of the seriatiom comparison of the present value of postlevel term cash inflows and outflows for the DR as required by VM-20 Section 9.D.6.

ii. If this comparison showed that there were post-level term profits, describe how anti-selection was handled in the post-level term period, including the prudent estimate premium, mortality and lapse assumptions used.

iii. If the comparison showed that there were post-level term losses, confirm that the prudent estimate premium, mortality and lapse assumptions for the post-level period were addressed in Section 3.D.1.a and were used in the reserve calculation.

l. Term Conversions – Description of how the company reflects the impact of any term conversions privilege contained in the policy when setting reserves.

m. Lapse Rates for Converted Policies – Description of and rationale for lapse rates used for policies issued under any group or term conversion privilege.


a. Agreements – For those reinsurance agreements included in the calculation of the minimum reserve as per VM-20 Section 8.A, a description of each reinsurance agreement, including, but not limited to, the type of agreement, the counterparty, the risks reinsured, any provisions related to converted policies, the portion of business reinsured, identification of both affiliated and non-affiliated, as well as captive and non-captive, or similar relationships, and whether the agreement complies with the requirements of the credit for reinsurance under the terms of the AP&P Manual.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

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

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


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

See attached Appendix.

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

See attached Appendix.

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VM APF 2020-02 (CA APF DP)
Appendix

ISSUE:
Skipping steps in VM-20 should not be allowed on grounds of immateriality or the latitude to use approximations.

SECTION:
VM-20 Section 2.H and new Section 2.I

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

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

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

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

The standard also applies to exclusion tests, as they are an element of the principle-based valuation.

I. Section 2.G and Section 2.H provide companies with a certain amount of latitude when setting assumptions and making approximations, but they should not be misconstrued to be a justification for completely skipping mandated steps.

Guidance Note: Examples of unacceptable omissions of steps would be: not computing an NPR, not computing a DR or SR without having performed and passed the relevant exclusion test(s), leaving out prescribed mortality margins, not building an asset model for the DR, using the alternative investment strategy without having first shown that it produces a higher reserve than the company investment strategy, skipping making a PIMR adjustment to the modeled reserve, and ignoring lapses or expenses or post-level term losses altogether.

REASONING:
Provide clearer guidance on the boundaries of a company’s latitude in following VM-20 steps.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
Eric Pedersen FSA MAAA
Associate Actuary
National Guardian Life
To address the issue of the product types included in the “Preneed Exemption” from PBR as specified in VM-II, B
and as defined in VM-02, Section 3, B.

2. Identify the document, including the date if the document is “released for comment,” and the location in the
document where the amendment is proposed:
  Insurance Products”, B
- NAIC Valuation Manual, adopted August 29, 2016 with changes through 12/31/16. VM-02, Section 3
  “Definitions”
  Insurance Products”, D, footnote 1

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
We are asking that the committee consider the reason Pre-need is excluded from PBR, and consider products
(specifically Final Expense) that are substantially similar to Pre-need in the context of PBR, in the sense they have
the same general chassis – small “whole life” death benefit, generally older insured, little to no underwriting, little to
no investment risk, etc. (I.e. in the modeling world they are handled in exactly the same way.)

My concern is that the VM-02 definition of Pre-need focuses on the qualifying language “…that is issued in
combination with, in support of, with an assignment to, or as a guarantee for a prearrangement agreement for goods
and services…” We sell Final Expense products that are essentially identical to a Pre-need product in every way
except they do not have the “goods and services agreement” as defined in VM-02 and are marketed as “Final
Expense.” The goods and services agreement is important in the context of marketing, administration, product
filings, etc. But we do not think the goods and services agreement is vital in the context of PBR. (I.e. you take a
Pre-need product and strip away the goods and services agreement - that should not make it subject to VM-20.)

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the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

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Notes:
APF 2017-51
B. Minimum reserve requirements for variable and non-variable individual life contracts, excluding preneed life contracts, final expense life contracts, industrial life contracts, credit life contracts, and policies of companies exempt pursuant to the companywide exemption in paragraph D below, are provided by VM-20 except for election of the transition period in paragraph C of this subsection.

Minimum reserve requirements of VM-20 are considered PBR requirements for purposes of the Valuation Manual and VM-31 unless VM-20 or other requirements apply only the net premium reserve method or applicable requirements in VM-A and VM-C.

Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C.


C. Final Expense Whole Life - Any whole life insurance policy that is issued with a generally small face amount and with simplified or guaranteed issue underwriting, is marketed to the senior market to cover funeral services and other final expenses, and bears the words, is marketed as, or is filed as “final expense” or words of similar meaning (such as, but not limited to, “burial insurance policy”, “funeral insurance policy”, or “senior life policy”). The definition of final expense whole life shall be subject to that definition of final expense in a particular state of issue if such definition is different in that state. [Note: To be completed.]  

C.D. Ordinary Life [to be completed].

Premiums are measured as direct plus reinsurance assumed from an unaffiliated company from the Ordinary Life line of business reported in the prior calendar year L & H annual statement, Exhibit 1 Part 1, Column 3, “Ordinary Life Insurance”, excluding premiums for pre-need and final expense life contracts and excluding amounts that represent the transfer of reserves in-force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as Ordinary Life Insurance premium. Pre-need and final expense are as defined in VM-02.
Date: December 12, 2019

Please allow me to submit the following comment on behalf of Virginia regarding the following exposure:

**APF 2019-33 (Clarify definition of individually underwritten life insurance and applicability of PBR for group insurance)**

**Comment:**

Subsection 1.B under Section II. “Reserve Requirements” of the VM addresses minimum reserve requirements for “individual life contracts”. Since individual life and group life are two distinct and non-overlapping categories of contracts, the new proposed Subsection 1.B.1 which address certain group life contracts should not be placed under Subsection 1.B, but should be pulled out from under Subsection 1.B and made its own Subsection 1.C. Subsections 1.B.2 and 1.B.3 should also be pulled out from under Subsection 1.B and renumbered.

**Suggested Edits to APF 2019-33:**

**Subsection 1: Life Insurance Products**

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

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

**C.** Minimum reserve requirements for group life contracts in which the individual certificate holders were subjected to an individual risk selection process as described in VM-20 Section 1.B to obtain the insurance coverage are provided by VM-20, except for election of the transition period in paragraph F below.

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

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

1. Business described in paragraph C above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.
2. Business not described in paragraph C otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

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

**G.D. Life PBR Exemption**

1. A company meeting the condition in G.D.2 below may file a statement of exemption for ordinary life insurance policies and group life contracts individually underwritten life insurance policies, except for policies in G.D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. Such a statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that condition G.D.2 was met based on premiums from the prior calendar year annual statement. The statement of exemption must also be included with the NAIC filing for the second quarter of that year.

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

2. Condition for Exemption:
   a. The company has less than $300 million of ordinary life premiums, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums of less than $600 million.

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

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

Footnote change

- Premiums are measured as direct plus reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance”. For exemptions after 1/1/2024, premiums should also include the premiums from
group life insurance certificates that were subject to an individual risk selection process as defined in VM-20 Section 1.B and included in the group life certificates subject to an individual risk selection process line of business reported in the prior calendar year life/health annual financial statement, VM-20 Reserves Supplement, Part 3.

Premiums should exclude premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed and guaranteed issue life insurance policy are as defined in VM-01.

Thank you for providing me the opportunity to submit this comment.

Craig Chupp, FSA, MAAA
Life and Health Insurance Actuary
Virginia Bureau of Insurance
 craig.chupp@sec.virginia.gov
Phone: (804) 371-9131
The APF mentions a revision to VM-51 to incorporate these contracts. However, no modifications to the VM-51 layout are offered.

APF 2019-56 addresses a series of important changes to the VM-51 layout, which will make it a multi-table system. I have previously commented that the table structure of the system needs to be carefully designed.

Adding group contracts will also require careful design considerations. For example, it is possible that fields should be added for

(a) Certificate Number (applicable to each covered individual in the group contract); and

(b) An indicator, “I” for individual”, and “G” for group, to tell whether a particular contract is individual or group.

I suggest that these considerations be included in the work currently being done for APF 2019-56.

Thank you.

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

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

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
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   Locations with proposed changes: VM-20 and VM-31

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   See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   The Valuation Manual already requires that if there is additional risk arising from the conversion of term life insurance, whether group or individual, it must be reserved for. The purpose of this APF is to emphasize this requirement and to provide guidance on what must be included in the Life PBR Actuarial Report with respect to conversions.

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Notes: VM APF 2019-62
VM-20 Section 9.C.4

Add Guidance Note related to converted policies at the end of the section.

Guidance Note: The company must ensure that excess mortality associated with policies issued via conversion from term policies or from group life contracts is appropriately reflected in the anticipated experience mortality rates. This can be accomplished through the use of a separate segment for converted policies, through inclusion of conversion experience with the experience of a group of similar directly issued policies, by adjustment of anticipated experience rates for such group of similar directly issued policies, or through other methods.

Commented [A1]: Since the intent is to determine the range of company practices, it may be better not to give examples.

VM-31 Section 3.B.3 [Executive Summary – policy overview]

3. Policies – A summary of the base policies within each VM-20 reserving category. Include information necessary to fully describe the company’s distribution of business. For direct business, use PBR Actuarial Report Template A located on the NAIC website (https://www.naic.org/pbr_data.htm?tab_3) to provide descriptions of each base policy product type and underwriting process (including a description of the process, the time period in which it was used, and the level of any additional margin), with a breakdown of policy count and face amount by base policy product type and underwriting process. Also include the target market, primary distribution system, and key product features that affect risk, including conversion privileges.


d. Assumption and Margin Development – The following information for each risk factor: description of the methods used to determine anticipated experience assumptions and margins, including the sources of experience (e.g., company experience, industry experience, or other data); how changes in such experience are monitored; any adjustments made to increase mortality margins above the prescribed margin (such as to reflect increased uncertainty due to newer underwriting approaches; and any other considerations, such as conversion features, helpful in or necessary to understanding the rationale behind the development of assumptions and margins, even if such considerations are not explicitly mentioned in the Valuation Manual.

Commented [A2]: The conversion features have been moved away from the margins sentence because conversions should inform anticipated experience and the general requirement for uncertainty margins covers conversions. Not sure if we should just delete this.

VM-31 Section 3.D.3.x (new section) [Life Report – Mortality]
We suggest placing after Adjustments for Mortality Improvement and before Mortality for Impaired Lives

\[\text{Mortality for Converted Policies} – \text{Description of the treatment of mortality for policies issued under group or term conversion privileges including:}\]

\begin{itemize}
\item[i.] A description of the method(s) by which any excess conversion mortality was taken into account in the development of company experience mortality rates (e.g., through the use of separate mortality segments for policies issued upon conversion, through aggregation of claim experience, or through use of other methods), the rationale for the method(s) used, and any changes in the method(s) from those used in previous years.
\item[ii.] The source(s) of the data used in the method(s) employed.
\end{itemize}

VM-31 Section 3.D.4.x and y (new sections) [Life Report – Policyholder Behavior]

\begin{itemize}
\item Term Conversions – Description of how the company reflects the impact of any term conversion privilege contained in the policy when setting reserves.
\item Lapse Rates for Converted Policies – Description of and rationale for lapse rates used for policies issued under any group or term conversion privilege.
\end{itemize}


\begin{itemize}
\item[a.] Agreements – For those reinsurance agreements included in the calculation of the minimum reserve as per VM-20 Section 8.A, a description of each reinsurance agreement, including, but not limited to, the type of agreement, the counterparty, the risks reinsured, any provisions related to converted policies, the portion of business reinsured, identification of both affiliated and non-affiliated, as well as captive and non-captive, or similar relationships, and whether the agreement complies with the requirements of the credit for reinsurance under the terms of the AP&P Manual.
\end{itemize}
January 31, 2020

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force (LATF)

Re: Amendment Proposal Forms (APFs) Exposed During NAIC Fall Meeting

Dear Mike:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to submit the following comments regarding the following APFs exposed during the NAIC 2019 Fall Meeting:

**APF 2019-33: Individually underwritten group life insurance**

ACLI has significant concerns with this amendment in its current form. We have two main areas of concern: the scope implied by the definition of “individual risk selection process” and practical implementation concerns.

Regarding scope, we believe that the wording may inadvertently loop in business not intended to be in scope. For example, something as simple as smoking status could be construed as “individual underwriting”, greatly expanding the business that would be impacted by this proposal. The use of underwriting as the criteria to define what is in scope for PBR is a simplification that could scope in traditional group life policies that are priced based on the unique claim costs of an employer group. We do not believe that is the intent of this APF. The definition of what is in scope for the APF requires additional contemplation.

Our second concern is around the practical implementation of the amendment. If individually underwritten group business becomes subject to PBR, it would have to follow the prescribed NPR requirements. However, the expected mortality and lapse rates for individually underwritten group business may be different than the prescribed mortality and lapse assumptions in VM-20. Compounding the problem, we are unaware of any experience studies that have been done on this type of business and deriving appropriate assumptions for other underwriting types, such as guaranteed issue and simplified issue, have proven difficult. Without potential adjustments to mortality and lapse rates for individually underwritten group business, companies may see excessive or nonsensical results for the NPR.

At this time, ACLI is unaware of a wide-spread issue associated with individually underwritten group business; we suspect this is more of a hypothetical problem. As such, we don’t see a pressing need for

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\(^1\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.
this APF. We suggest that LATF continue to monitor this issue, and if changes are deemed necessary, LATF should request that the Academy make significant revisions to avoid excessive scope and unintended consequences.

**APF 2019-62: Considerations for term conversion reserves**
ACLI agrees with the American Academy of Actuaries’ Life Reserves Work Group on the need to understand what mortality adjustments are being made for term conversions. We support this APF’s improved disclosures associated with conversions.

**APF 2019-60: Allowance for additional credibility methods**
ACLI supports this amendment. This APF provides important flexibility around credibility methods for companies with simplified underwriting business.

**APF 2019-61: Clarification around secondary guarantee riders**
ACLI believes this APF is a straight-forward clarification around what constitutes a secondary guarantee, and supports this amendment.

We look forward to a discussion of these issues. Thank you.

Sincerely,

[Signature]

cc Reggie Mazyck, NAIC
Date: December 12, 2019

Please allow me to submit the following comment on behalf of Virginia regarding the following exposure:

**APF 2019-62 (Term Conversions additional risk)**

**Comment:**

The proposed Guidance Note to be added to Section 9.C.4 of VM-20 uses the word “must” as follows: “The company must ensure that excess mortality associated with policies issued via conversion from term policies or from group life contracts is appropriately reflected in the anticipated experience mortality rates.” Since the word “must” is used, which is mandatory, the added language in the Guidance Note should not be in a Guidance Note but rather should be made a separate subparagraph 9.C.4.d.

Thank you for providing me the opportunity to submit this comment.

Craig Chupp, FSA, MAAA  
Life and Health Insurance Actuary  
Virginia Bureau of Insurance  
craig.chupp@scc.virginia.gov  
Phone: (804) 371-9131
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
The Life PBR Exemption restriction is intended to apply to ULSG with material secondary guarantees regardless of whether the secondary guarantee is an embedded guarantee or is a separate rider.

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

VM Section II, Subsection 1.D.3
January 1, 2020 NAIC Valuation Manual

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

See attached.

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

ULSG policies with material secondary guarantees are intended to be excluded from the Life PBR Exemption, regardless of whether the secondary guarantee is embedded in the base policy or is a separate rider. The VM does say that non-ULSG base policies with secondary guarantee riders follow the reserving requirements for ULSG policies in Section II, Subsection 6.C: “ULSG and other secondary guarantee riders shall be valued with the base policy and follow the reserve requirements for ULSG policies under VM-20, VM-A and/or VM-C, as applicable.” It should be made clear that following the reserve requirements for ULSG includes exclusion from the Life PBR Exemption, when the secondary guarantee is material.

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

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Notes: APF 2019-61
VM Section II, Subsection 1.D.3

3. Policies Excluded from the Life PBR Exemption:
a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee, or policies – other than
ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee that does not meet the
VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

   **Identification:**
   Rachel Hemphill, Texas Department of Insurance
   Mary Bahna-Nolan, Pacific Life

   **Title of the Issue:**
   VM-20 restriction on using different credibility methods for significantly different blocks of business

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

   VM-20 Sections 9.C.5.a and 9.C.7.b.ii
   January 1, 2020 NAIC Valuation Manual

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

   See attached.

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

   Currently, a company must select a single credibility methodology, Limited Fluctuation or Bühlmann, for all business that company has that is subject to VM-20 and requires credibility percentages. The Bühlmann methodology is technically allowed for Simplified Issue business within the Valuation Manual; however, at present, it is not practically possible since there are no industry factors available for Simplified Issue. Therefore, only the Limited Fluctuation method can currently be used for determining credibility for Simplified Issue business. The factors in VM-20 for the Bühlmann were developed to only be used in conjunction with the 2015 VBT. Thus, currently, a company with any Simplified Issue business subject to VM-20 that requires credibility calculations must use the Limited Fluctuation method for all of their business subject to VM-20 that requires credibility calculations, including the fully underwritten business. We do not see this as a reasonable restriction. VM-20 already requires that companies not change their credibility method once selected unless they receive commissioner approval for the change, and we believe that that constraint is sufficient to avoid any significant gaming of the credibility method selection.

---

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</table>

**Notes:** APF 2019-60
**VM-20 Section 9.C.5.a**

5. Credibility of Company Experience

a. For valuations in which the industry basic mortality table is the 2008 VBT, determine an aggregate level of credibility over the entire exposure period using a methodology to determine the level of credibility that follows common actuarial practice as published in actuarial literature (for example, but not limited to, the Limited Fluctuation Method or Bühlmann Empirical Bayesian Method).

For valuations in which the industry basic mortality table is the 2015 VBT, determine an aggregate level of credibility following either the Limited Fluctuation Method by amount, such that the minimum probability is at least 95% with an error margin of no more than 5% or Bühlmann Empirical Bayesian Method by amount. Once chosen, the credibility method must be applied to all business subject to VM20 and requiring credibility percentages.

Not all blocks of a company’s business subject to VM-20 necessarily need to use the same credibility method. However, a company seeking to change the credibility methods for a given block of business must request and subsequently receive the approval of the insurance commissioner. The request must include the justification for the change and a demonstration of the rationale supporting the change.

**VM-20 Section 9.C.7.b.ii**

7. Process to Determine Prudent Estimate Assumptions

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

b. If the company uses company experience mortality rates as the anticipated experience assumptions, the following process shall be used to develop prudent estimate assumptions:

i. Determine the values of A, B and C from the Grading Table below, based on the level of credibility of the data as provided in Section 9.C.5.

<table>
<thead>
<tr>
<th>Credibility of company data (as defined in Section 9.C.5 above) rounded to nearest %</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% - 30%</td>
<td>10</td>
<td>2</td>
<td>8</td>
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<tr>
<td>31%–32%</td>
<td>11</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>33%–34%</td>
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<tr>
<td>35%–36%</td>
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<td>9</td>
</tr>
<tr>
<td>37%–38%</td>
<td>14</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>39%–40%</td>
<td>15</td>
<td>3</td>
<td>10</td>
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<tr>
<td>41%–42%</td>
<td>16</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>43%–44%</td>
<td>17</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Percentage</td>
<td>Claims</td>
<td>Mortality</td>
<td>Value</td>
</tr>
<tr>
<td>------------</td>
<td>--------</td>
<td>-----------</td>
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</tr>
<tr>
<td>45%–46%</td>
<td>18</td>
<td>3</td>
<td>11</td>
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<td>47%–48%</td>
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<tr>
<td>94%–100%</td>
<td>50</td>
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<td>25</td>
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ii. Determine the value of D, which represents the last policy duration that has a substantial volume of claims, using the chosen data source(s) as specified in Section 9.C.2.b. D is defined as the last policy duration at which there are 50 or more claims (not the first policy duration in which there are fewer than 50 claims), not counting riders. This may be determined at either the mortality segment level or at a more aggregate level if the mortality for the individual mortality segments was determined using an aggregate level of mortality experience pursuant to Section 9.C.2.d.
**Guidance Note:** The same level of aggregation is used in Section 9.C.2.d for determining company experience mortality rates, Section 9.C.5.b for determining credibility, and Section 9.C.7.b.ii for determining the value of D. Thus, when determining the value of D, all claims being aggregated will have used the same credibility method in Section 9.C.5.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Pat Allison, NAIC
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
Add guidance notes to refer the reader to Excel examples available for mortality aggregation and for assumption reporting.

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

VM-20 Section 9.C.2.d.vi and VM-31 Section 3.D.1.a
January 1, 2020 NAIC Valuation Manual

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

See attached.

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

During the exposure of the presentation and Excel examples that were developed for mortality aggregation, we received feedback that it would be helpful for companies if we included a link to the examples in a guidance note in the Valuation Manual. We agree that this would be helpful for the users of the Valuation Manual.

Similarly, an example in Excel was developed for the listing of assumptions required by VM-31 Section 3.D.1.a and we propose that a reference be added to the guidance note in VM-31 Section 3.D.1.a to point the reader to this additional reference material.

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Notes: VM APF 2020-01
VM-20 Section 9.C.2.d.vi

vi. If the company uses the aggregate company experience for a group of mortality segments when determining the company experience mortality rates for each of the individual mortality segments in the group, the company shall either:

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

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

In doing so, the company must ensure that when the mortality segments are weighted together, the total amount of expected claims is not less than the aggregate company experience data for the group.

Guidance Note: There are several examples of the two mortality aggregation methods outlined in VM-20 Section 9.C.2.d.vi.a and VM-20 Section 9.C.2.d.vi.b in a Mortality Aggregation Excel Spreadsheet, along with a Mortality Aggregation Presentation from the 2019 Summer Meeting, located on the NAIC website (https://www.naic.org/pbr_data.htm?tab_3). These may be useful reference documents when using aggregate company experience for a group of mortality segments in determining the company experience mortality rates.

VM-31 Section 3.D.1.a

1. Assumptions and Margins – Details on the valuation assumptions and margins, including:

   a. Tables – For each material risk, the anticipated experience assumptions, margins, and prudent estimate assumptions used in the model, provided in Excel format. A complete table of reinsurance premiums is not required. If applicable, provide upon request a sample calculation demonstrating the methodology used to determine future reinsurance premiums reflecting non-guaranteed reinsurance features, including margins and details of any simplifications and approximations used.

Guidance Note: See VM-20 Section 9.B.1 for a discussion on material risks.

There is a Sample Assumptions Summary for PBR Actuarial Report located on the NAIC website (https://www.naic.org/pbr_data.htm?tab_3), which may be a useful reference document when developing reporting in accordance with Section 3.D.1.a. For valuation dates prior to Dec. 31, 2022, the company’s domiciliary commissioner may permit less than full compliance with the above Section 3.D.1.a, provided that the commissioner determines that the company has made a good faith attempt to comply.
Executive summary

Oliver Wyman was requested by the American Council of Life Insurers, the American Academy of Actuaries and the National Association of Insurance Commissioners to support an industry field test being conducted to aid the NAIC Life Actuarial (A) Task Force in the selection of a long-term solution for the treatment of non-guaranteed reinsurance under PBR.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

This report does not represent investment advice or provide an opinion regarding the fairness of any transaction to any and all parties. The report does not profess to be authoritative, and merely the product of expert opinion. The views, conclusions and recommendations expressed herein are those of Oliver Wyman and are provided as information for the purpose of general interest and discussion of the topics addressed. The information contained herein is based on Oliver Wyman’s best knowledge and belief at the date of the report, and should not be considered as a warranty or guarantee of the future or success of any program, project or transaction.

Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of such information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

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1 Executive summary 3
2 Background 6
3 Analysis design 15
4 Initial analysis and insights 20
5 Next steps 27

Appendix A: Supplementary results
Appendix B: Model design and assumptions
Appendix C: Analysis and validation tools
Appendix D: Project team and governance
Executive summary
Long-term solution for modeling non-guaranteed reinsurance

BACKGROUND
A wide range of practice was observed from early adopters of FRPS in regards to the modeling of non-guaranteed reinsurance and a formulaic solution was adopted on an interim basis for the 2020 Valuation Manual.

OLIVER WYMAN SUPPORT
Oliver Wyman was selected to support and supplement the industry field test. The scope of our support is summarized below and further outlined in the remaining slides in this section of the presentation.

1 - Analysis and insights
Using generic industry models, Oliver Wyman will perform analysis that will be provided in advance of field test results and will provide additional insights beyond those provided by field test participants, informed by a survey of broader industry practice. As needed, analysis outside the scope of the field test may be performed.

2 - Field test support
Oliver Wyman will work closely with field test participants and assist in the preparation and interpretation of results. Additionally, analysis will be performed to better understand the range of variation in participant results (e.g., company and reinsurance structure, field test interpretations, modeling simplifications and/or limitations).

The purpose of today’s presentation is to share details on the design of the analysis models as well as initial insights.

Deliverables
Deliverables for the stages of work shown on the prior slide are described below

Stage Deliverables
Analysis and insights
- AXIS models, documentation and software which will be made available to the NAIC
- Initial analysis and associated model design, with capabilities to analyze the impact field tested proposals across a range of products types, insurance structure and reinsurance structure
- ‘Range of interpretation’ survey intended to further understand the range of interpretations for field tested proposals in a much larger participant base than the actual field test
- Reports summarizing results from industry field test, with additional analysis to further understanding of these results
- Conference calls with field test participants to ensure consistent understanding of field testing instructions and provide advice as to the use of model simplifications or limitations (insurer-specific calls with participants will be used as needed)

Field test support
- Conference calls with field test participants to ensure consistent understanding of field testing instructions and provide advice as to the use of model simplifications or limitations
- ‘Range of interpretation’ survey and beyond the scope of the field test (of each AXIS to be shared with the NAIC)

Timeline
Oliver Wyman will support the stages of the field test depicted below

Deliverables for the stages of work are described on the next slide

Field test support
- The industry field test will commence; initially the focus will be on model preparation, testing of simple solutions and point-in-time reserve assessments with a goal of defining model challenges and testing the integrity and range of variability of the results of Oliver Wyman’s analysis
- The range of results for each model proposal will be communicated to LATF as part of the March 2020 meeting (March 2020)
- Field test participants will produce projected reserves for the various solutions, while Oliver Wyman assists with the interpretation and collection of results. The results of this test will give regulators additional comfort in conclusion that was shared in the field analysis by extending the range of results for understanding variation and any previously unaccounted for

Analysis and insights
- Field test participants will prepare their models for the field test while Oliver Wyman performs deep analysis across a range of products and reinsurance structures to provide insights with implementable potential solutions inputs on an supplement to the standard basis

Initial analysis and insights
Assumptions and modeling methodology underlying the results shown today are summarized below

Component Description
Model
- Governmental (GOV A/X)
- 30-year prepayment horizon (30/15 Terms)
Best estimate assumptions
- Mortality is improved in each valuation date to reflect historic mortality improvement
- Initial forecasted duration period equal to 10 years and increased by one year at each future valuation date, subject to maximum years of future data allowed under VM-20 for the level of credibility
- Prudent margin intended for entire industry averages with a separate set of mortality margins to resemble a small/mid-sized and large insurer (or reinsurer)
Reserve assumptions
- The IRPS uses the 2017 CSO and a reservation interest rate of 6% for calculations subject to VM-20 Sections 3.4, 3.5 and 3.6
- The valuation scenario for the IRPS follows the 12/31/2018 scenario at each valuation date
- Interpolation of credits at each valuation date and the formula of the approach
- The 12 (and fewer) S0 in common annually for 15 years and every 5 years thereafter. Reserve balances are interpreted using a unique method for each insurance company and are measured to account for “reserve reserve” coverage by the reinsurance triggering (frequency and severity-related)

Analysis is intended to align with industry field test instructions and the products and assumptions are intended to be broadly representative of the industry
Background

This section explores the relationship between mortality margin and the impact that reinsurance has on reserves under PBR.

1. Mortality and PBR prescribed margins
2. Impact of mortality margins
3. Projected reinsurance credit
4. Formulaic reserve credit

Results are presented for two sets of boundary reinsurer reactions under PBR mortality margins, and an analytical benchmark (10% mortality margin).

Mortality and PBR prescribed margin

Level of margin by VM-20 mortality assumption component is illustrated below.

- The mortality assumption under VM-20 contains both direct sources of margin and an indirect source of margin (lack of future mortality improvement).

Impact of mortality margins (1/2)

The impact of a 50% first dollar YRT reinsurance agreement with the current scale of rates equal to best estimate mortality is shown below.

The impact of reinsurance depends largely on the modeled reinsurer reaction.
Impact of mortality margins (2/2)
The impact of the 50% reinsurance agreement is re-evaluated below after updating the PBR mortality assumption to use a level 10% margin.

The impact of reinsurance depends largely on the modeled reinsurer reaction.

Projected reinsurance credit
The reinsurance reserve credit (difference between pre- and post-reinsurance reserve) under the two sets of margins is shown below.

Key takeaways

<table>
<thead>
<tr>
<th>Takeaway</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reinsurer reaction scenarios can produce reserve credits in excess of 1/2 Cs.</td>
</tr>
<tr>
<td></td>
<td>• 1/2 Cs represents the cost of reinsurance that corresponds to the period for which the reinsurance premium has been paid, but not yet earned by the reinsurer, with no provision for reinsurance beyond the paid to date.</td>
</tr>
<tr>
<td></td>
<td>• Full reinsurer reaction scenario tested above for:</td>
</tr>
<tr>
<td></td>
<td>o Reinsurer reaction that reflects differences between evolution of mortality margin and reinsurance premium payment dates.</td>
</tr>
<tr>
<td></td>
<td>o Contractual provisions around the return of future unearned reinsurance premiums on death and lapse.</td>
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<td></td>
<td>o Other mechanical differences due to VM-20 requirements (e.g. differences in starting assets and the resulting earned rate).</td>
</tr>
<tr>
<td>2</td>
<td>It is important to look at long-term projections of reserves when evaluating the impact of reinsurance modeling approaches.</td>
</tr>
<tr>
<td></td>
<td>• The level of margin in mortality as compared to best estimate changes at future valuation dates due to unlocking of mortality improvement and extending the sufficient data period.</td>
</tr>
<tr>
<td></td>
<td>• As the business ages, higher mortality and shorter projection horizons will change the impact of reinsurance on reserves at future valuation dates.</td>
</tr>
</tbody>
</table>
Proposed granularity for the analysis and modeling is outlined below

<table>
<thead>
<tr>
<th>Reinsurance reaction</th>
<th>Grading</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>High</td>
<td>High-level granularity on the amount of reinsurance and relationship between rates and best mortality is required to provide coverage of treaty terms, provisions, and the range of company usage of YRT reinsurance.</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium</td>
<td>Medium-level granularity is needed to provide projected long-term impacts in support of a long-term solution.</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
<td>Low-level granularity is acceptable for field test participants.</td>
</tr>
</tbody>
</table>

This section contains the results of sensitivities performed to confirm this level of granularity. See Appendix B for further details on the analysis design.

Reinsurance reaction scenarios
Proposed coverage is shown below. As needed, these results will be produced for the methodology analysis dimensions (e.g., product, company size, reinsurance attributes)

Impact analysis | High granularity
The following summarizes the impact reinsurance on PBR reserves for the sensitivities on model components with high granularity

Impact on Deterministic Reserve
Impact on PBR reserve (price of DR and NPR)

Mortality
- Reduced mortality and probability of death by 5 years
- Reduced probability of death by 10 years
- Reduced probability of death by 15 years

Mortality sensitivity
- Reduced mortality and probability of death by 5 years
- Reduced probability of death by 10 years
- Reduced probability of death by 15 years

Mortality sensitivity
- Reduced mortality and probability of death by 5 years
- Reduced probability of death by 10 years
- Reduced probability of death by 15 years

Reinsurance reserve credit
- Reduced mortality and probability of death by 5 years
- Reduced probability of death by 10 years
- Reduced probability of death by 15 years

Both the properties of reinsurance and mortality have a significant impact on the reinsurance reserve credit

Impact analysis | Low-medium granularity
The following summarizes the impact reinsurance on PBR reserves for the sensitivities on model components with low-medium granularity

Impact on Deterministic Reserve
Impact on PBR reserve (price of DR and NPR)

Mortality
- Reduced mortality and probability of death by 5 years
- Reduced probability of death by 10 years
- Reduced probability of death by 15 years

Product sensitivity
- Reduced mortality and probability of death by 5 years
- Reduced probability of death by 10 years
- Reduced probability of death by 15 years

Yield curve sensitivity
- Reduced mortality and probability of death by 5 years
- Reduced probability of death by 10 years
- Reduced probability of death by 15 years

The product and yield curve sensitivities have a lower impact on the reinsurance reserve credit

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Initial insights and analysis

The scope of the industry field test is focused on the “field test modified” APFs discussed on the September 12th LATF call and summarized below.

<table>
<thead>
<tr>
<th>APF</th>
<th>Description</th>
<th>Field testing variations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-40</td>
<td>Actuarial judgement with clarified modeling principles/guidance</td>
<td>- Prudent estimate of all uncertain event assumptions. - Prudent estimate of rate changes only after reaching 115% reinsurer loss ratio. - Model prudent estimate of rate changes only after reaching 5 consecutive years of reinsurer losses.</td>
</tr>
<tr>
<td>2019-41</td>
<td>Reinsurance margin such that the difference between best estimate mortality and the current scale of YRT rates is maintained</td>
<td>- Best estimate mortality for the purpose of calculating reinsurance margin contains future mortality improvement for 15 years at a rate of 0%, 3%, and 1% per year.</td>
</tr>
<tr>
<td>2019-42</td>
<td>Future mortality improvement included in best estimate mortality used for the purpose of calculating reinsurance margin for 5, 10, 15 and 20 years.</td>
<td></td>
</tr>
</tbody>
</table>

The field test submission calls for two baselines; the interim solution (½ Cx) and a scenario where no change from the current scale of YRT rates is assumed.

Impact analysis | Baseline
½ Cx and no change to current scale of YRT rates

The purpose of these results is to foster dialogue among these APFs, the format results are presented in, and any desired follow-up analysis.

There is no margin on reinsurance premiums under the baseline results because the first is formulaic and the second assumes that YRT rates are unchanged.

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Impact analysis | APFs 2019-40

YRT rates are increased by 105% of the difference between the current scale and PBR mortality, until recapture in 2044

- Mortality and reinsurance margins
- 40-year-old male, preferred non-tobacco, 2019 valuation
- Impact analysis | APF 2019-40
- YRT rate increase followed by recapture
- Reserve credit – PBR reserve
- Gross and net reserves
- APFs 2019-41, 2019-42 | Progressive rate increases starting in 2024
- Projected reserves
- Duration (Years)
- Reserve ($MM) Reserve credit ($MM)
- 0% 20% 40% 60% 80% 100%
- 100 150 200 250 300 350
- 100 150 200 250 300 350

The reinsurance reaction (5% over mortality margin) produces a reserve credit in excess of ½ Cx (See Background section for explanation) until recapture in 2044

Impact analysis | APF 2019-40

No change in YRT rates until 2024 followed by progressive increases to break even in 2044 and later

- Mortality and reinsurance margins
- 40-year-old male, preferred non-tobacco, 2019 valuation
- Impact analysis | APF 2019-40
- YRT rate increase followed by recapture
- Reserve credit – PBR reserve
- Gross and net reserves
- APFs 2019-41, 2019-42 | Progressive rate increases starting in 2024
- Projected reserves
- Duration (Years)
- Reserve ($MM) Reserve credit ($MM)
- 0% 20% 40% 60% 80% 100%
- 100 150 200 250 300 350
- 100 150 200 250 300 350

The reserve credit is higher than the prior slide because of a slower reinsurer action. The reserve credit persists beyond 2044 because recapture is not modeled.

Impact analysis | APFs 2019-41, 2019-42

Future mortality improvement included in the best estimate component of reinsurance margin for 15 years at a rate of .75% per year

- Mortality and reinsurance margins
- 40-year-old male, preferred non-tobacco, 2019 valuation
- Impact analysis | APFs 2019-41, 2019-42
- YRT rate increase followed by recapture
- Reserve credit – PBR reserve
- Gross and net reserves
- APFs 2019-41, 2019-42 | 15 years of improvement
- Projected reserves
- Duration (Years)
- Reserve ($MM) Reserve credit ($MM)
- 0% 20% 40% 60% 80% 100%
- 100 150 200 250 300 350
- 100 150 200 250 300 350

The impact of APFs 2019-41 and 2019-42 are equal due to the selection of mortality improvement parameters and the method used to calculate the reinsurance margin

Next steps
Listed below are next steps for the analysis and field test:

<table>
<thead>
<tr>
<th>Next Step</th>
<th>Target Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Point in time reserves</td>
<td>February 2020</td>
<td>Oliver Wyman to confirm and share results of industry field test for point-in-time reserves as well as additional consultant analysis at a LATF call in February.</td>
</tr>
<tr>
<td>2. APF results</td>
<td>March 2020</td>
<td>Oliver Wyman to share APF specific results informed by industry range of practice survey at the March LATF meeting.</td>
</tr>
<tr>
<td>3. Projected reserves</td>
<td>April 2020</td>
<td>Oliver Wyman to work alongside companies to develop projected reserves and share results with LATF at an April call.</td>
</tr>
<tr>
<td>4. Draft amendment</td>
<td>May - June 2020</td>
<td>Academy working group will work with LATF to draft an amendment and expose for comment. Oliver Wyman will perform additional analysis as needed.</td>
</tr>
</tbody>
</table>

Impact analysis | gross reserves (1 of 2)
Pre-reinsurance reserves are shown below for the sensitivities on model components with high granularity:

Impact analysis | gross reserves (2 of 2)
Pre-reinsurance reserves are shown below for the sensitivities on model components with low-medium granularity.
Impact analysis | net reserves (1 of 2)
Post-reinsurance reserves are shown below for the sensitivities on model components with high granularity.

Baseline: Results from Section 1

Reinsurance sensitivity
Reduce portion of business reinsured

Mortality sensitivity
Reduce credibility and years of sufficient data

Impact analysis | net reserves (2 of 2)
Post-reinsurance reserves are shown below for the sensitivities on model components with low-medium granularity.

Baseline: Results from Section 1

Assets sensitivity
100bps increase to outer loop yield curve

Product sensitivity
5% increase in premium loads (and retail premiums)

Methodology analysis dimensions
The proposed coverage for the analysis is summarized below:

<table>
<thead>
<tr>
<th>Component</th>
<th>Granularity</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinsurance</td>
<td>Very high</td>
<td>• Amount of reinsurance (Note: 10% and 50%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Attachment point (First-dollar and excess of retention)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Relationship between the current scale of VST rates and best estimate mortality (i.e., equal to, less than and greater than)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Default/company mortality and various reinsurance reaction scenarios</td>
</tr>
<tr>
<td>Mortality</td>
<td>High</td>
<td>• Different best-estimate mortality improvement rates (0%, .5%, .75%, 1% per year) and levels of credibility &amp; years of sufficient data</td>
</tr>
<tr>
<td>Reserves</td>
<td>Medium</td>
<td>• Projected reserves will be calculated based on the 2020 Valuation Manual and set to the Max(NPR, DR) with the SR enabled for select runs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reserves will be re-valued annually</td>
</tr>
<tr>
<td>Products and population</td>
<td>Medium</td>
<td>• Mix of business by issue age, risk class, gender and band for Terms (7Y and 20Y), ULSG, 55-year account, lifetime guarantee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CAUL (5-year specified premium guarantee, general account only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reserves for the 2020 Valuation Manual will be calculated based on the 2020 Valuation Manual and set to the Max(NPR, DR) with the SR enabled for select runs</td>
</tr>
<tr>
<td>Assets</td>
<td>Low</td>
<td>• Reinvestments only (level yield curve)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• #Solid line of in-force assets with 15-year duration in both inner and outer loop (Note: Credit spread and returns will vary by inner and outer loop)</td>
</tr>
</tbody>
</table>

Appendix B | Model design and assumptions
Liability assumptions (ULSG)
The assumptions used in the analysis are below, including assumed PBR margins

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Anticipated experience assumption</th>
<th>Prudent estimate assumption (e.g. margin)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2015 VBT gender distinct, smoker distinct ANB</td>
<td>• Prescribed margins applied to company mortality</td>
<td></td>
</tr>
<tr>
<td>• Relative risk varies by risk class</td>
<td>• Industry rate 2015 VBT with prescribed margins and mortality improvement scale</td>
<td></td>
</tr>
<tr>
<td>• A/E factors vary by high/low band</td>
<td>• Grading and margins assumes 100% LF credibility</td>
<td></td>
</tr>
<tr>
<td>• .75% annual future mortality improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed margins applied to company mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Industry rate 2015 VBT with prescribed margins and mortality improvement scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grading and margins assumes 100% LF credibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lapse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 3% annual lapse rate</td>
<td>• 2% annual lapse rate</td>
<td></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $50 per policy (annual)</td>
<td>• 105% margin on expenses</td>
<td></td>
</tr>
<tr>
<td>• 2.5% premium tax</td>
<td>• 2% inflation</td>
<td></td>
</tr>
<tr>
<td>• 2% inflation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Appendix C | Analysis and validation tools

#### Suite of modeling tools

**Overview (1 of 2)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AXIS Dataset</strong></td>
<td>• AXIS platform business model equipped with ALM and PBR functionality, representative policies from generic product type and flexible to run various reinsurance and PBR revaluation scenarios</td>
</tr>
<tr>
<td></td>
<td>• DataLink functionality allowing for automated updates to product features and assumptions</td>
</tr>
<tr>
<td><strong>Model documentation</strong></td>
<td>• Self-contained documentation of model requirements, design, and testing</td>
</tr>
<tr>
<td><strong>Detailed user guide</strong></td>
<td>• Comprehensive guide showing the model setup for product features, assumptions and limitations</td>
</tr>
<tr>
<td></td>
<td>• Instructions on how to use the Testware and perform updates to the model</td>
</tr>
</tbody>
</table>

**Overview (2 of 2)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Testware</strong></td>
<td>• Comprehensive testing workbook which validates all calculations (asset information, investment gain/loss, hedge, and interpolated reserves, etc.)</td>
</tr>
<tr>
<td><strong>Analysis tool</strong></td>
<td>• Summarizes, confirms, and provides meaningful metrics for the model office results</td>
</tr>
<tr>
<td></td>
<td>• Graphs of reserve balances, distributable earnings, and the earned rate on general account assets</td>
</tr>
<tr>
<td></td>
<td>• Provides high-level checks on outer and inner loop decrements and other implied values</td>
</tr>
<tr>
<td><strong>Input builders</strong></td>
<td>• User-friendly Excel tools in which assumptions and other required model values are translated from user-friendly “source information” into AXIS formatted tables</td>
</tr>
<tr>
<td></td>
<td>• These tools are embedded in the Dataset in order to enhance controls and governance</td>
</tr>
</tbody>
</table>
Documentation
Details the requirements, design, documentation, and testing of the model in a modular and expandable structure.

User guide
Supplements the model documentation and provides additional detail on the AXIS model structure.

Testware
Replicates model calculations while supporting version management, increasing transparency, and augmenting documentation.

Analysis tool
Aggregates results under pre-PBR and PBR setups and provides financial metrics and implied rate analysis.
Input builders
Document and generate assumptions and product features in Excel with a process to import into AXIS

Appendix D  Project team and governance

The consultant analysis will be overseen by NAIC Staff, the Academy, and the ACLI, as depicted in the following chart

Oliver Wyman team

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Whitney, FSA, MAAA</td>
<td>Engagement manager</td>
</tr>
<tr>
<td>Dylan Strother, FSA, MAAA</td>
<td>Technical lead</td>
</tr>
<tr>
<td>Katie van Ryn, FSA, MAAA</td>
<td>AXIS model development</td>
</tr>
</tbody>
</table>

The report and the findings herein are subject to the reliance and limitations outlined at the beginning of this report. This report is considered a statement of actuarial opinion under the guidelines promulgated by the American Academy of Actuaries. Chris Whitney, Dylan Strother and Katie van Ryn of Oliver Wyman developed this report and meet the qualification requirements of the American Academy of Actuaries to render the opinion contained herein.
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Oliver Wyman was requested by the American Council of Life Insurers, the American Academy of Actuaries, and the National Association of Insurance Commissioners to support an industry field test being conducted to aid the NAIC Life Actuarial (A) Task Force in the selection of a long-term solution for the treatment of non-guaranteed reinsurance under PBR.

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BACKGROUND
This presentation is intended to supplement the materials entitled “YRT & PBR – Overview and Initial Analysis (Fall 2019 NAIC meeting)” that were presented to LATF at the Fall NAIC Meeting in December 2019.

This supplement expands the background information and analysis to an assuming reinsurers perspective. Additionally, it provides key take-aways from the analysis provided in the Background section of the initial materials.

CONTENTS
1 | Assuming reinsurer’s perspective 3
2 | Key take-aways 8
Appendix: Supplementary results (from Section 1) 10
Conceptual example (1 of 2)
As illustrated below, applying the PBR methodology under the same assumptions can produce differences in reserves between the cedant and assuming reinsurer.

Even with the exact same assumptions, the mechanics of the PBR calculation can result in a difference in ceded reserves and assumed reserves.

Supplementary projections (1 of 2)
The graphs show projected ceded and assumed reserves, where YRT rates are modeled as the current scale plus 105% of the increase in mortality under PBR.

Conceptual example (2 of 2)
Aggregation and mix of business can also lead to differences in ceded and assumed reserves.

Total reserves ceded by the direct writers is 7.0 while the reserve assumed is 6.3.

Supplementary projections (2 of 2)
Projected ceded and assumed reserves where YRT rates are modeled as the current scale plus 105% of the increase in mortality under PBR.

Using an adjustment to YRT reinsurance premiums reflective of a reinsurer’s perspective reduces the differences between reserve credit and assumed reserves.
Key takeaways

1. Reinsurer reaction scenarios can produce reserve credits in excess of \( \frac{1}{2} C_x \).
   - \( \frac{1}{2} C_x \) represents the cost of reinsurance that corresponds to the period for which the reinsurance premium has been paid, but not yet earned by the reinsurer, with no provision for reinsurance beyond the paid to date.
   - Full reinsurer reaction scenario tested allow for:
     - Reinsurer reaction that reflects differences between evolution of mortality margin and reinsurance premium payment dates.
     - Contractual provisions around the return of future unearned reinsurance premiums on death and lapse.
     - Other mechanical differences due to VM-20 requirements (e.g., differences in starting assets and the resulting earned rate).

2. It is important to look at long-term projections of reserves when evaluating the impact of reinsurance modeling approaches.
   - The level of margin in mortality as compared to best estimate changes at future valuation dates, due to unlocking of mortality improvement and extending the sufficient data period.
   - As the business ages, higher mortality and shorter projection horizons will change the impact of reinsurance on reserves at future valuation dates.

3. Differences in reserve credits and assumed reserves under PBR are likely to occur for multiple reasons.
   - Reserves between direct writers and reinsurers will not be mirrored, primarily due to differences in valuation assumptions (including changes to non-guaranteed YRT premiums).
   - Other drivers include the mechanics of computing final PBR reserves, and reinsurers aggregating results across multiple treaties and multiple cedants.
   - Differences between ceded and assumed reserves are reduced when adjustments to YRT premiums are based on the level of mortality margin specific to each party.

---

Appendix A

Supplementary results

The below tables provide the gross vs. net values driving the reinsurance credit vs the assumed reserve.

### Table 1 - Calculation of PBR reinsurance credit

<table>
<thead>
<tr>
<th>Y</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
<th>2060</th>
<th>2070</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR (1)</td>
<td>490</td>
<td>1046</td>
<td>1101</td>
<td>828</td>
<td>522</td>
<td>265</td>
</tr>
<tr>
<td>Net DR (2)</td>
<td>278</td>
<td>852</td>
<td>934</td>
<td>705</td>
<td>452</td>
<td>235</td>
</tr>
<tr>
<td>NPR (3)</td>
<td>108</td>
<td>871</td>
<td>1022</td>
<td>784</td>
<td>508</td>
<td>275</td>
</tr>
<tr>
<td>Net NPR (4)</td>
<td>105</td>
<td>863</td>
<td>1007</td>
<td>771</td>
<td>499</td>
<td>269</td>
</tr>
<tr>
<td>PBR reinsurance credit</td>
<td>-212</td>
<td>-183</td>
<td>-94</td>
<td>-56</td>
<td>-22</td>
<td>-6</td>
</tr>
</tbody>
</table>

### Table 2 - Calculation of PBR reinsurance credit

<table>
<thead>
<tr>
<th>Y</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
<th>2060</th>
<th>2070</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR (1)</td>
<td>490</td>
<td>1046</td>
<td>1101</td>
<td>828</td>
<td>522</td>
<td>265</td>
</tr>
<tr>
<td>Net DR (2)</td>
<td>490</td>
<td>1033</td>
<td>1077</td>
<td>807</td>
<td>510</td>
<td>261</td>
</tr>
<tr>
<td>NPR (3)</td>
<td>108</td>
<td>871</td>
<td>1022</td>
<td>784</td>
<td>508</td>
<td>275</td>
</tr>
<tr>
<td>Net NPR (4)</td>
<td>105</td>
<td>863</td>
<td>1007</td>
<td>771</td>
<td>499</td>
<td>269</td>
</tr>
<tr>
<td>PBR reinsurance credit</td>
<td>0</td>
<td>-13</td>
<td>-24</td>
<td>-21</td>
<td>-11</td>
<td>-6</td>
</tr>
</tbody>
</table>

### Table 3 - Calculation of PBR assumed reserve

<table>
<thead>
<tr>
<th>Y</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
<th>2060</th>
<th>2070</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR (1)</td>
<td>451</td>
<td>1018</td>
<td>1084</td>
<td>817</td>
<td>516</td>
<td>264</td>
</tr>
<tr>
<td>Net DR (2)</td>
<td>275</td>
<td>857</td>
<td>943</td>
<td>796</td>
<td>505</td>
<td>260</td>
</tr>
<tr>
<td>NPR (3)</td>
<td>108</td>
<td>871</td>
<td>1022</td>
<td>784</td>
<td>508</td>
<td>275</td>
</tr>
<tr>
<td>Net NPR (4)</td>
<td>105</td>
<td>863</td>
<td>1007</td>
<td>771</td>
<td>499</td>
<td>269</td>
</tr>
<tr>
<td>PBR reserve</td>
<td>176</td>
<td>155</td>
<td>77</td>
<td>46</td>
<td>17</td>
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### Table 4 - Calculation of PBR assumed reserve

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<td>1046</td>
<td>1101</td>
<td>828</td>
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<td>265</td>
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<tr>
<td>Net DR (2)</td>
<td>275</td>
<td>852</td>
<td>934</td>
<td>705</td>
<td>452</td>
<td>235</td>
</tr>
<tr>
<td>NPR (3)</td>
<td>108</td>
<td>871</td>
<td>1022</td>
<td>784</td>
<td>508</td>
<td>275</td>
</tr>
<tr>
<td>Net NPR (4)</td>
<td>105</td>
<td>863</td>
<td>1007</td>
<td>771</td>
<td>499</td>
<td>269</td>
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<tr>
<td>PBR reserve</td>
<td>24</td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
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</table>

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QUALIFICATIONS, ASSUMPTIONS AND LIMITING CONDITIONS

Oliver Wyman was requested by the American Council of Life Insurers, the American Academy of Actuaries and the National Association of Insurance Commissioners to support an industry field test being conducted to aid the NAIC Life Actuarial (A) Task Force in the selection of a long-term solution for the treatment of non-guaranteed reinsurance under PBR.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

This report does not represent investment advice or provide an opinion regarding the fairness of any transaction to any and all parties. The report contains opinion, data, analysis, and advice, and must be considered in relation to the context, circumstances, and guidance of the report. This report is for the sole and exclusive benefit of the American Council of Life Insurers, the American Academy of Actuaries, and the National Association of Insurance Commissioners. This report may not be reproduced, transmitted, or made available to any third party in whole or in part, in any form, without the express written permission of Oliver Wyman.

The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof.

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The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met via conference call Feb. 26, 2020. The following Subgroup members participated: Bruce Sartain, Chair and Vincent Tsang (IL); Jim Jakielo (CT); William Leung (MO); Bill Carmello (NY); Tomasz Serbinowski (UT); and Craig Chupp (VA). Also participating was: Elaine Lam (CA).

1. Discussed the Potential Revisions to VM-22

Mr. Sartain discussed the Subgroup priorities for revising VM-22, Maximum Valuation Interest Rates for Income Annuities to incorporate principle-based reserving (PBR). He acknowledged monitoring the American Academy of Actuaries (Academy) Annuity Reserves Work Group conference calls, during which they worked on the details of PBR for non-variable annuities. He said the target date for implementation of the Work Group’s PBR version of VM-22 is Jan. 1, 2023.

Mr. Sartain said there are six items on which the Work Group needs state insurance regulator feedback. He anticipates that the Subgroup will provide that feedback via making recommendations to the Life Actuarial (A) Task Force. He said current thinking is that all non-variable annuities will be subject to an exclusion test. Deferred annuity contracts passing the exclusion test will be valued according to the requirements of Actuarial Guideline XXXIII—Determining CARVM Reserves for Annuity Contracts with Elective Benefits (AG 33). The requirements for determining valuation interest rates for an immediate annuity that passes the exclusion test will default to the current version of VM-22.

Mr. Chupp questioned whether it is necessary to have a PBR approach for immediate annuities that fail the exclusion test.

Mr. Sartain said that one aspect of a PBR approach would be a robust approach for handling reinvestment risk.

Ben Slutsker (Academy Annuity Reserves Work Group) said the exclusion tests can be calibrated to consider the characteristics of the various annuity designs, including the duration, longevity risk and reinvestment risk.

Ms. Lam said the Subgroup should consider that scoping immediate annuities out of the PBR approach would preclude them from being subject to VM-G, Appendix G – Corporate Governance Guidance for Principle-Based Reserves. She said having immediate annuities opt out by passing an exclusion test does not offer the same opportunity.

Mr. Leung asked if VM-22, which currently considers only valuation rates, should be expanded to include the valuation methods.

Mr. Sartain said that the Subgroup charges include the potential for changes to valuation methodology, but it has not been determined whether a methodology change would reside in VM-22 or be placed elsewhere in the Valuation Manual.

Mr. Serbinowski said having separate regimes for different subclasses of annuities encourages companies to search for regulatory arbitrage opportunities.

Mr. Slutsker said the ARWG’s preference is to have all non-variable annuity requirements contained in a single Valuation Manual chapter.

Mr. Sartain stated it was his intent to vote on these issues during the Subgroup’s next conference call.

Mr. Sartain said about three years ago, the Academy Standard Valuation Law (SVL) Interest Rate Modernization Work Group was asked by the Life Actuarial (A) Task Force to consider whether a new methodology for determining interest rates for the Commissioners Annuity Reserve Valuation Method (CARVM) would make sense. He said, given the move toward a PBR methodology for non-variable annuities, including the use of exclusion tests, it is questionable whether the Work Group’s work should continue.
Chris Conrad (Academy) said that because single premium immediate annuities (SPIAs) have little policyholder optionality, valuation of SPIAs will not require the same level of modeling sophistication required for non-SPIAs. He recommended pausing the Academy SVL Interest Rate Modernization Work Group’s work on SPIAs until the work on exclusion tests and other aspects of non-variable annuities valuation are farther along.

Mr. Sartain said the group could quickly resume its work when the time arises.

Mr. Leung made a motion, seconded by Mr. Chupp, to request the Academy SVL Interest Rate Modernization Work Group to delay work until further notice on modernizing the process for determining valuation rates for non-SPIA non-variable annuities, as referenced in Mike Boerner’s letter of Jan. 25, 2017. The motion passed unanimously.

Having no further business, the VM-22 (A) Subgroup adjourned.
Update on Life Insurance Mortality Experience Reporting

Pat Allison, MAAA, FSA
5/7/2020

Planned Communication with Companies Selected for Experience Reporting

<table>
<thead>
<tr>
<th>Month</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2020</td>
<td>Reminder of available training materials and VM-51 file layout</td>
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<tr>
<td>June 2020</td>
<td>Answers to frequently asked questions</td>
</tr>
<tr>
<td>July 2020</td>
<td>VM-51 data dictionary</td>
</tr>
<tr>
<td>August 2020</td>
<td>Details on all RDC form and format validations</td>
</tr>
<tr>
<td>September 2020</td>
<td>Control Totals template*</td>
</tr>
<tr>
<td>October 2020</td>
<td>Reconciliation template**</td>
</tr>
<tr>
<td>TBD</td>
<td>Process for reporting business administered by a reinsurer or third-party administrator</td>
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</table>

* VM-50 Section 4.B.2 requires control totals for each data submission

** VM-50 Section 4.B.3 requires a reconciliation between submitted data and the company’s statistical and financial data

5/7/2020
To: Life Actuarial (A) Task Force  
From: NAIC Support Staff  
Date: April 15, 2020  
Re: Recommendation to Delay 2020 Collection of Company Mortality Experience Data

Background

VM-50 Section 2.B.2 designates the NAIC as the Experience Reporting Agent for the Statistical Plan for Mortality beginning Jan. 1, 2020. At a June 25, 2019 LATF meeting, NAIC life actuarial support staff presented information on the selection of companies required to submit mortality experience data in 2020. A total of 176 companies were selected, representing 31 states of domicile. Since then, all selected companies were notified, and the data call was planned to begin during Q2, 2020.

Recommendation to Delay 2020 Data Collection

Due to the disruption being experienced by life insurance companies from the COVID-19 pandemic and the significant resources required to provide mortality experience data, the American Council of Life Insurers (ACLI) has requested a delay in the 2020 data collection. NAIC support staff recommends a one-year delay. This means that mortality data for the 2018 observation year would not be collected in 2020. Instead, data for both the 2018 and 2019 observation years would be collected in 2021. The 2021 data call would occur during the second quarter of 2021, and would require data for both the 2018 and 2019 observation years. Data submissions for both observation years would be due by Sept. 30, 2021. Corrections of data submissions for both observation years would be required by Dec. 31, 2021.

VM-51 Section 2.D states that data shall be submitted on an annual basis, and defines the reporting year (the calendar year the company submits experience data) and observation year (two years prior to the reporting calendar year). This language is not in sync with a 2021 reporting year for two observation years (2018 and 2019). However, VM-50 Section 5.A.3 states that the Experience Reporting Agent may modify or enlarge the requirements of the Valuation Manual, through recommendation to the Life Actuarial (A) Task Force and in accordance with the Valuation Manual governance process for information to accommodate changing needs and environments. Therefore, NAIC staff recommends the collection of mortality experience data for the 2018 and 2019 observation years in 2021 under the timeline noted above.

The collection of company mortality experience data under the Valuation Manual remains a high priority regulatory issue for the NAIC, and the proposed one-year delay in the collection of this data should not be interpreted as diminishing the importance of this issue to the NAIC. This accommodation does not reflect on diminishment of the role of experience reporting as the foundation for principle-based reserving. Because successful life experience reporting traditionally has relied on year-to-year continuity of processes and staff, it is expected that life insurers taking advantage of this accommodation will take care to ensure this continuity takes place and future experience reporting submissions will be of high quality, even with the one-year delay and potential temporary disruption of continuity. Lack of quality data submissions could create uncertainty which could lead to additional margins in reserve assumptions being required.
April 30, 2020

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force

Re: ACLI Comments on Proposed Delay of PBR Experience Reporting

Dear Mike:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to comment on the proposed delay of PBR Experience Reporting.

ACLI is supportive of the temporary deferral of the mortality experience reporting requirement. We are appreciative of the NAIC responsiveness to the pandemic and current economic environment.

We look forward to a discussion of this issue. Thank you.

Sincerely,

cc Reggie Mazyck, NAIC

\(^1\) The American Council of Life Insurers (ACLI) advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States. Learn more at www.acli.com.
Update on the Request for Proposal for the Economic Scenario Generator (ESG)

Pat Allison, MAAA, FSA

5/7/2020

RFP for a New ESG

- An RFP has been issued to select a vendor to provide a new ESG to be prescribed for life and annuity reserves and capital (e.g., VM-20, VM-21, C-3 Phase I, and C-3 Phase II)

- RFP Timeline:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>Wed 03/04</td>
<td>Release of RFP</td>
</tr>
<tr>
<td>Fri 03/13</td>
<td>Notification of intent to bid</td>
</tr>
<tr>
<td>Wed 03/25</td>
<td>Submission of questions</td>
</tr>
<tr>
<td>Wed 04/08</td>
<td>Responses to questions provided via email and the NAIC website</td>
</tr>
<tr>
<td>Fri 05/01</td>
<td>Proposal due to NAIC</td>
</tr>
<tr>
<td>May 2020</td>
<td>Vendor Selection and Award of RFP</td>
</tr>
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- The new ESG is expected to be implemented no earlier than 2022
Cessation of the London Interbank Offered Rate (LIBOR)

Pat Allison, MAAA, FSA
5/7/2020

Agenda

- Background
- Actions Needed
  - Company Preparation
  - Valuation Manual Amendment

Background

- The UK’s Financial Conduct Authority is responsible for regulating LIBOR and has indicated that publication of LIBOR is not guaranteed beyond 2021
- The Alternative Reference Rates Committee (AARC) was formed in 2014 by the Federal Reserve Board and the NY Fed
- In 2017, the AARC identified the Secured Overnight Financing Rate (SOFR) as the rate that represents best practice for use in certain new USD derivatives and other financial contracts
- The AARC has 10 working groups to help ensure a successful transition from USD LIBOR to SOFR, e.g.:
  - Outreach/Communications Working Group
  - Regulatory Issues Working Group
  - Accounting/Tax Working Group

Actions Needed

- Insurance companies will need to take inventory of existing products and processes that use LIBOR, which may include:
  - Investments (e.g., floating rate debt, where the interest rate is reset periodically based on LIBOR; derivatives linked to LIBOR)
  - Contracts with policyholders (e.g., annuities with credited rate equal to LIBOR plus a margin)
  - Reinsurance treaties
  - IT feeds
- Take action where required to move toward SOFR or another rate (e.g. for annuity contracts with policyholders, file for approval with the IIPRC and notify owner)
Actions Needed

  Interest rate swap spreads over Treasuries shall be prescribed by the NAIC for use throughout the cash-flow model whenever appropriate for transactions and operations including, but not limited to, purchase, sale, settlement, cash flows of derivative positions and reset of floating rate investments. A current and long-term swap spread curve shall be prescribed for year one and years four and after, respectively, with yearly grading in between. The three-month and six-month points on the swap spread curves represent the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries.

- VM-20 Spreads Drafting Group was formed to consider the changes needed to this language

Questions?
Background

- Current spreads are market-observable values, and not assumptions.
- The NAIC is currently receiving current spread data from Bank of America and JP Morgan daily.
- Data published by the NAIC has not consistently been tracking market-observable values in the derivatives market. These differences are most notable at the 3-month and 6-month tenors.
- Absolute differences between the NAIC Table J Spread and market-observable spreads have been as large as 10bps.

Issue Raised by Industry

- Charts showing differences in recent spreads:

  ![Chart 1](image1)
  ![Chart 2](image2)

  *Market observed swap spreads source is Bloomberg data*
Issues Raised by Industry

- Review current calculated rates and verify data sources
- Address elimination of LIBOR: includes both direct replacement for LIBOR as well as potential LIBOR fallback rates
- Request increased clarity in VM-20/VM-21 as company observed spreads will differ from published spreads:
  - Swap contract specifics – Plain Vanilla Swap terms are not uniformly defined. For example, which LIBOR rate, 3-month or 6-month? Other terms such as rate reset frequency and payment dates should also be disclosed. Also, assume these are exchange cleared contracts.
  - How the swap rates are determined (short, intermediate, and long end).
- How the Treasury rates are determined/source.
- Importance of other uses of swap spreads
  - Market value determination (e.g., buying/selling of assets impact)
  - Hedging

Actions to Address this concern

- LATF formed an informal VM-20 Spreads Drafting Group to review industry concerns.
- The Drafting Group and industry/ACLI had a call on 2/3/2020 to discuss the identified issue and possible path forward.
- Industry favors finding a solution as soon as possible. We would seek an APF for the 2021 Valuation Manual, and if possible, data source modification for 2020 reporting.
- ACLI will work on a proposal to LATF to modify the Valuation Manual so that the any guidance around Swap Spreads allows for a data source that:
  - (1) aligns with use in the actuarial models and reflects the market economics appropriately;
  - (2) is accessible for Industry to use independent of NAIC;
  - (3) is flexible to address the expected end of LIBOR in 2021.

Questions?
1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   
   Brian Bayerle, ACLI – Interest Rate Swap Spread Determination
   
2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
   
   
3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)
   
   See attached.
   
4. State the reason for the proposed amendment? (You may do this through an attachment.)
   
   Interest Rate Swap Spreads are currently being calculated by the NAIC under methodology outlined in the Valuation Manual. With the forthcoming termination of LIBOR, the requirements of the Valuation Manual will need to change. This APF provides broad guidance allowing for one or more currently unnamed rate to replace LIBOR in these calculations. Additionally, it allows the company to calculate its own current rates only using market observable values. The spread requirements are currently included in VM-20, with VM-21 referencing the applicable sections. With the potential of VM-22 likely having similar references, LATF may want to consider moving these and other asset requirements to their own section.

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

NAIC Staff Comments:

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Notes: VM APF 2020-06
VM-20 Section 9.F.8.d
Interest rate swap spreads over Treasuries shall be prescribed calculated by the NAIC for use throughout the cash-flow model wherever appropriate for transactions and operations including, but not limited to, purchase, sale, settlement, cash flows of derivative positions and reset of floating rate investments. A current and long-term swap spread curve shall be prescribed for year one and years four and after, respectively, with yearly grading in between. The three-month and six-month points on the swap spread curves represent the corresponding London Interbank Offered Rate (LIBOR) spreads over Treasuries.

The company may elect to produce their own current swap spread curves based on current observable rates. The company will document the data source(s) of the observable rates in the VM-31 report.

**Guidance Note:** The swap curves should be determined by the NAIC using appropriate market-observable rate or rates. The London Interbank Offered Rate (LIBOR) spreads over Treasuries was the defined spread curves up to and including the 2020 NAIC Valuation Manual, however with the expectation that this rate will be terminated, the rate or rates used in the calculations should be replaced with the most appropriate rate or rates that replace LIBOR for the specified purpose.

VM-31 Section 3.D.6.v (additional bullet):

v. Current Swap Spreads Data Source: If the company used something other than the NAIC produced current swap spreads as permitted by VM-20 Section 9.F.8.d, documentation of the data source(s) used in the determination of the swap spreads.

VM-31 Section 3.F.4.h (additional bullet):

v. Current Swap Spreads Data Source: If the company used something other than the NAIC produced current swap spreads as permitted by VM-20 Section 9.F.8.d, documentation of the data source(s) used in the determination of the swap spreads.
STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES
ACLI DRAFT EDIT APRIL 30, 2020

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Section 11. Proration of Values; Additional Benefits
Section 12. Rules
Section 13. Effective Date

Section 1. Title

This Act shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

Section 2. Applicability

A. This Act shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

B. Sections 3 through 8 shall not apply to contingent deferred annuities.

C. Notwithstanding Subsection B, the commissioner shall have the authority to prescribe, by regulation, nonforfeiture benefits for contingent deferred annuities that are, in the opinion of the commissioner, equitable to the policyholder, appropriate given the risks insured, and to the extent possible, consistent with general intent of this law.

Drafting Note: It is expected that any regulation prescribing specific nonforfeiture requirements for the CDAs and promulgated by the commissioner under Subsection C above would apply only to the CDA contracts issued subsequent to the effective date of such regulation.

Section 3. Nonforfeiture Requirements

A. In the case of contracts issued on or after the operative date of this Act as defined in Section 13, no contract of annuity, except as stated in Section 2, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Sections 5, 6, 7, 8 and 10;

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is
specified in Sections 5, 6, 8 and 10. The company may reserve the right to defer the payment of
the cash surrender benefit for a period not to exceed six (6) months after demand therefor with
surrender of the contract after making written request and receiving written approval of the
commissioner. The request shall address the necessity and equitability to all policyholders of the
deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-
up annuity, cash surrender or death benefits that are guaranteed under the contract, together with
sufficient information to determine the amounts of the benefits; and

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under
the contract are not less than the minimum benefits required by any statute of the state in which
the contract is delivered and an explanation of the manner in which the benefits are altered by the
existence of any additional amounts credited by the company to the contract, any indebtedness to
the company on the contract or any prior withdrawals from or partial surrenders of the contract.

B. Notwithstanding the requirements of this section, a deferred annuity contract may provide that if no
considerations have been received under a contract for a period of two (2) full years and the portion of the
paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations
paid would be less than $20 monthly, the company may at its option terminate the contract by payment in
cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the
mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit,
and by this payment shall be relieved of any further obligation under the contract.

Section 4. Minimum Values

The minimum values as specified in Sections 5, 6, 7, 8 and 10 of any paid-up annuity, cash surrender or death benefits
available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

A. (1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity
payments shall be equal to an accumulation up to such time at rates of interest as indicated in
Subsection B of the net considerations (as hereinafter defined) paid prior to such time, decreased
by the sum of Paragraphs (a) through (d) below:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of
interest as indicated in Subsection B;

(b) An annual contract charge of $50, accumulated at rates of interest as indicated in
Subsection B;

(c) Any premium tax paid by the company for the contract, accumulated at rates of interest
as indicated in Subsection B; and

(d) The amount of any indebtedness to the company on the contract, including interest due
and accrued.

(2) The net considerations for a given contract year used to define the minimum nonforfeiture amount
shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations
credited to the contract during that contract year.

B. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest
determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the
contract if the interest rate will be reset:
The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20th of one percent, specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under Section 4B(4);

Reduced by 125 basis points;

Where the resulting interest rate is not less than one zero percent (10%); and

The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Subsection B(2) above by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

The commissioner may adopt rules to implement the provisions of Section 4C and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

Section 5. Computation of Present Value

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Section 6. Calculation of Cash Surrender Value

For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at surrender arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Section 7. Calculation of Paid-up Annuity Benefits

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.
Section 8. Maturity Date

For the purpose of determining the benefits calculated under Sections 6 and 7, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant’s seventieth birthday or the tenth anniversary of the contract, whichever is later.

Section 9. Disclosure of Limited Death Benefits

A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

Section 10. Inclusion of Lapse of Time Considerations

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

Section 11. Proration of Values; Additional Benefits

For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Sections 5, 6, 7, 8 and 10, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Act. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Section 12. Rules

The commissioner may adopt rules to implement the provisions of this Act.

Section 13. Effective Date

After the effective date of this Act, a company may elect to apply its provisions to annuity contracts on a contract form-by-contract form basis before the second anniversary of the effective date of this Act. In all other instances, this Act shall become operative with respect to annuity contracts issued by the company after the second anniversary of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2017 3rd Quarter (amended).
LONG-TERM SOLUTION
(YRT & VM-20)
Results and analysis for field test and interpretation survey

June 2020
OVERVIEW
This report contains results and additional analysis for the industry field test and interpretation survey which will aid the NAC Life Actuarial (A) Task Force ("LATF") in the selection of a longer-term solution for the treatment of non-guaranteed reinsurance under PBR.

Following the delivery of this report, Oliver Wyman and NAIC staff are available to answer questions and perform additional analysis requested by LATF members to assist in decisions for the long-term treatment of non-guaranteed reinsurance under PBR.

KEY TAKEAWAYS
Key takeaways from analysis of field test and interpretation survey results are highlighted below in addition to those previously established.

1. Multiple mortality improvement scenarios were included with APF 2019-41 and 42
2. It is important to look at long-term projections of reserves when evaluating the impact of reinsurance modeling approaches.
3. Differences in reserve credits and assumed reserves under PBR are likely to occur for multiple reasons.
4. Differences in modeled reserves are primarily driven by the relationship between the current scale of NY premiums and PBR mortality (anticipated experience and the level of margin).
5. Differences in reserve credits and assumed reserves are minimized when a mechanical perspective using the representative PBR model) from both a direct writer and assuming reinsurers as well as the potential for asymmetry in reserves due to differences in interpretation and application of the PBRs.
6. Potential for asymmetry between actual and potential reserves due to differences in interpretation and application of the PBRs.

Additional details for each key takeaway can be found in this report in the sections listed.

REPORT OBJECTIVES

Executive summary

COMPARISON OF PROPOSED SOLUTIONS
This comparison is informed by results and analysis contained in this report.

<table>
<thead>
<tr>
<th>Section</th>
<th>Contents and objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Review of proposed solutions</td>
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<tr>
<td>03</td>
<td>Field test results and analysis</td>
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<td>04</td>
<td>Interpretation survey results and additional analysis</td>
</tr>
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</table>

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<thead>
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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Level of prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model complexity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survival in results</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential for asymmetry between assumed and potential reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Software level of risk sharing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential PBR revisions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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02 REVIEW OF PROPOSED SOLUTIONS

APF 2019-40

Representative language

• Model YRT premiums using anticipated experience with margins based on clarified modeling principles/guidance and actuarial judgment

The company shall base its company and counterparty action assumptions relating to YRT reinsurance consistent with the moderately adverse environment as applicable to the valuation of all other policyholders (APF 2019-40, Section 8.5)

The assuming company shall not be assumed to incur indefinite losses if treaty terms allow adjustment of the underlying economics (APF 2019-40, Section 8.7)

The company shall base its company and counterparty action assumptions relating to YRT reinsurance treaty changes reflecting that, in general, there is no relevant company or industry experience currently available upon which to base the anticipated experience assumption (APF 2019-40, Section 8.6)

Companies are responsible for developing their own margin used in the projection of future non-guaranteed reinsurance premiums

APF 2019-41

VRT premiums and claims

• Premiums determined using current YRT premium scale with projected adjustments based on what the company actually expects will occur
  • Claims determined using the company's anticipated experience mortality assumptions including mortality improvement

Reinsurance premium margin development

The formula for the prescribed margin (additive to current rates) from APF 2019-42 is summarized below:

\[ m = \frac{\Omega - \Omega_0}{\Omega} \times \text{current YRT rate} \]

where:
- \( m \) = prescribed experience mortality calculated using a minimum of 80% credibility and a 4% [future data period of at least 10 years]
- \( \Omega \) = company experience mortality reflecting industry mortality improvement beyond the valuation date

Non-guaranteed reinsurance premiums are developed based on prescribed inputs, with some flexibility to make adjustments to reflect contract provisions

APF 2019-42

VRT premiums

• Use current VRT premium rates, plus a prescribed margin for non-guaranteed rates based on the difference between "baseline credibility" prudent estimate mortality and company experience mortality

• Baseline credibility assumes a minimum level of credibility and sufficient data period to avoid bias against small companies

Non-guaranteed reinsurance premiums are modeled as the current scale plus a margin, which is developed based on prescribed inputs, with some flexibility to make adjustments to reflect contract provisions
REFINEMENTS TO REPRESENTATIVE PBR MODEL

Field test results and analysis

Observation:

- Turn off mortality assumption unlocking

Model refinements:

- Model refinements: in their reserve projections did not reflect unlocking of mortality up to future valuation dates

- Utilize two credibility scenarios in representative PBR model, Model YRT scales based on relationships to anticipated experience assumptions and underlying levels of credibility

- Normalize reinsurance reserve credits per 1,000 of ceded reinsurance parameters; in particular the portion of business reinsured and the relationship between the current scale of rates and anticipated mortality

Further details on refinements made to methodology analysis dimensions in the representative PBR model are shown

FIELD TEST RESULTS AND ANALYSIS

OVERVIEW

Field test scenarios

- Two baseline runs and each proposed solution with modification per testing scenarios (see below)

- Produce modeled results and detailed disclosures for Term and/or ULSG products, using the 2020 Valuation Manual with modifications to the treatment of non-guaranteed reinsurance

- Compute point-in-time and projected reserves for submissions reflecting the range in levels of credibility observed in field test submissions

- Examined based on information provided in (Unlocking)

Reserves (Credibility)

- Reserves

Mortality

Reinsurance

Properties of reinsurance

Submission requirements Participation

- Source: 2018 individual life insurance sales

- One Term submission and one ULSG submission did not include projected reserves

<table>
<thead>
<tr>
<th>Participation</th>
<th>Baseline</th>
<th>2019-40</th>
<th>2019-42</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entities invited to participate</td>
<td>187</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Participating companies</td>
<td>89</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>

- Action A – No change in YRT rates and counterparty actions

- Action B – Prudent estimate YRT rates and counterparty actions

- Action D – Prudent estimate YRT rates after consecutive years of Loss Trigger

- Action F – Prudent estimate YRT rates and counterparty actions

- Anticipated experience mortality includes future mortality improvement for a specified number of years:
  - 0%, 0.5% and 1.0%

- Relationships between the current scale of YRT rates and anticipated mortality experience were developed:
  - Higher YRT scale: 
  - Lower YRT scale: 
  - Baseline YRT scale:

- Relationships between the current scale of YRT rates and anticipated mortality experience including FMI:
  - Baseline YRT scale:
  - Higher YRT scale: 
  - Lower YRT scale:

- Relationships between the current scale of YRT rates and anticipated mortality experience excluding FMI:
  - Baseline YRT scale:
  - Higher YRT scale: 
  - Lower YRT scale:

- Relationships between the current scale of YRT rates and anticipated mortality experience including FMI and anticipated mortality experience without FMI:
  - Baseline YRT scale:
  - Higher YRT scale: 
  - Lower YRT scale:

- 1–5 6–20

- 0%, 0.5% and 1.0%

- 5, 10, 15 and 20 years

- “Baseline YRT scale” (i.e. utilizes declining durational multiples applied to mortality assumption unlocking (sufficient data period, 12 for further details)

<table>
<thead>
<tr>
<th>Assumption unlocking (Percent)</th>
<th>0%</th>
<th>0.5%</th>
<th>1.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future mortality improvement at rates of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0%, 0.5% and 1.0%</td>
<td>Not included</td>
<td>Not included</td>
<td>Not included</td>
</tr>
<tr>
<td>5, 10, 15 and 20 years</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>
3.5 Field test results and analysis

**BASELINE | ULSG RESULTS**

The representative PBR model explains the variance in impacts of reinsurance on modeled reserves observed in field test submissions.

- The representative PBR model includes a margin to reinsurance premiums equal to the difference between best estimate mortality and valuation mortality.
- Various approaches in field test submissions to incorporate margins to YRT premiums were observed, resulting in higher DR "reserve credits" compared to the representative PBR model.
- Approaches included grading to an increased premium over time, increasing premiums after a certain duration, and increasing premiums after a loss ratio is triggered.

Derivations of the unitized reduction to DR can be found in Appendix A.

3.1 Field test results and analysis

The representative PBR model explains the variance in impacts of reinsurance on modeled reserves observed in field test submissions.

- The representative PBR model includes a margin to reinsurance premiums equal to the difference between best estimate mortality and valuation mortality.
- Various approaches in field test submissions to incorporate margins to YRT premiums were observed, resulting in higher DR "reserve credits" compared to the representative PBR model.
- Approaches included grading to an increased premium over time, increasing premiums after a certain duration, and increasing premiums after a loss ratio is triggered.

Commentary

- Action A produces only a slight shift in the impact of reinsurance on modeled reserves relative to the baseline, as it is limited to the inclusion of anticipated counterparty actions such as default, recapture and other terminations.
- Action B reflects the impact of a "loss ratio" trigger, which is lower in the projection for "Lower YRT scale" (lower bound) compared to "Baseline YRT scale" and "Higher YRT scale" (upper bound).
- Action C is to model a prudent estimate of all counterparty actions (which includes changes to YRT rates), apply the PBR with no additional restrictions or guidance.
- In the representative PBR model, margins were applied based on the difference between best estimate mortality (including future mortality improvements) and valuation mortality.
- Various approaches in field test submissions to incorporate margins to YRT premiums were observed, resulting in higher DR "reserve credits" compared to the representative PBR model. Approaches included grading to an increased premium over time, increasing premiums after a certain duration, and increasing premiums after a loss ratio is triggered.

Deviations from GDR are shown primarily for observed gain and loss results.

APF 2019-40 (ACTION B) | ULSG RESULTS

The impact of reinsurance on modeled reserves is dependent on the range of participant prudent estimates used in modeling counterparty actions.

Commentary

- Action A is to model a prudent estimate of all counterparty actions (which includes changes to YRT rates), apply the PBR with no additional restrictions or guidance.
- The representative PBR model includes a margin to reinsurance premiums equal to the difference between best estimate mortality (including future mortality improvements) and valuation mortality.
- Various approaches in field test submissions to incorporate margins to YRT premiums were observed, resulting in higher DR "reserve credits" compared to the representative PBR model. Approaches included grading to an increased premium over time, increasing premiums after a certain duration, and increasing premiums after a loss ratio is triggered.
3.14 APF 2019-42 | ULSG RESULTS

Applying a “consecutive losses” approach to determine the timing of reinsurer reaction reduces variability in the impact that reinsurance has on modeled reserves relative to the baseline, albeit to a lesser extent than the application of a "loss ratio" trigger.

APF 2019-40 (ACTION D) | ULSG RESULTS

Field test results and analysis

3.9 • Prudent estimate margins are not applied ubiquitously, therefore the results are less dependent on the relationship of current YRT rates and valuation mortality compared to other solutions.

Similar to Action C, application of prudent estimates are driven by the relationship between YRT rates and valuation mortality during the projection.

3.11 APF 2019-41 | ULSG RESULTS

Introducing future mortality improvement to the projected claims reduces reinsurance gains, given the current scale of reinsurance premiums is held constant.

Field test results and analysis

3.12 Additional key takeaways from analysis of field test results are highlighted below in addition to those previously established.

Field test results and analysis

APF 2019-42 | ULSG RESULTS

Similar to APF 2019-42, increasing the level of future mortality improvement decreases reserve credits.

Field test results and analysis

APF 2019-41 and APF 2019-42 produce similar results, with more moderate effects driven by the application of mortality improvement (magnitude and length).

A 5-year incremental mortality improvement reduces the DR "reserve credit" by roughly 50% (relative to DR "reserve credit") with no future mortality improvement.

When a margin is defined as the relationship between anticipated experience and best estimate mortality, “Higher YRT rate scales” lead to negative reserve credits.

When reinsurance premium margins are based on the level of mortality margin, the application of mortality improvement (magnitude and length) improves the degree of variability in impacts of reinsurance on modeled reserves across companies.

Field test results and analysis

KEY TAKEAWAYS

Additional key takeaways from analysis of field test results are highlighted below in addition to those previously established.

1. Automatic reinsurance reaction can produce reserve reserve reaction relative to loss of life.

2. In all cases, it is important to look at long-term bias of reserve reaction after considering the impact of actuarial reserving assumptions.

3. Differences in reserve credits and assumed reserves under PBR are unlikely to exceed the sample reserves.

4. Differences in modelled reserves are generally driven by the level of future mortality improvement or the period for which the reinsurance premium has been paid, plus net premium following the reinsurance, with assumptions for mortality beyond the paid date.

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Attachment Nine

Life Actuarial (A) Task Force
8/3-6/20
04 INTERPRETATION SURVEY RESULTS AND ADDITIONAL ANALYSIS

SUMMARY OF OPTIONS

<table>
<thead>
<tr>
<th>Survey option</th>
<th>Reinsurer reaction</th>
<th>Assumption for projected YRT premium rate increases</th>
<th>Parameters requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None</td>
<td>Maintain current scale throughout the projection</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>Reactive</td>
<td>Increase by percent of prescribed mortality margin after a specified period of time and every X years thereafter, with and without future mortality improvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>through specified mortality margin (e.g., PBR mortality) for current and projected periods, and utilizing a prudent estimate rate over a period of time, as follows:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No change to YRT premiums</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increasing by a specified percent of the prescribed mortality margin after a specified period of time and every X years thereafter, with and without future mortality improvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increasing by the difference between current scale and prudent estimate (i.e., PBR) mortality, with specified parameters</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Break-even</td>
<td>Increase by percent of difference between PBR mortality and current scale of YRT rates</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
<td>Modeling approach not adequately captured by other choices</td>
<td></td>
</tr>
</tbody>
</table>

SURVEY COMMENTARY

Range of responses

- APF with largest variance across survey options
- Largest percentage selecting "Other"
- Examples: recapture at certain periods, utilize a loss trigger to determine when rates are raised, grading into a prudent estimate rate over a period of time

Complexity

- Responses ranged from straightforward (reactive or break-even) to complex
- Complex responses were often associated with None and Other and related to reflect modeling solutions used for other applications or adjustments to cash flows other than YRT premiums
**APF 2019-40 | ULSG**

A fully reactive reinsurance margin produces the largest post-reinsurance DR relative to other options.

**APF 2019-40 | TERM**

No change in rates scenario produces the highest modeled “reserve credit” for Term but is smaller than ½ cx for most valuation dates due to a higher baseline YRT scale than ULSG.

**APF 2019-41 | SURVEY RESULTS**

Reinsurer reaction

- None: 55%
- Reactive: 17%
- Break-even: 18%
- Other: 10%

**SURVEY COMMENTARY**

- Range of responses: Most respondents were either none or break even. These responses generally included a comment regarding intent to adjust claims in lieu of premiums.
- Complexity: Many respondents indicated the need for multiple models or scenarios to reflect the shift in reflected mortality and reinsurance cash flows and to address ½ cx mortality for all other cash flows. Some respondents expressed concerns with consistency between using one projection using prudent estimate assumptions and a separate one using best estimate assumptions.

**APF 2019-41 | ULSG**

The relationship between YRT rates and anticipated mortality minimizes the impact of interpretation differences. This is because Option 1 uses anticipated experience assumptions, and reinsurance premiums are closely aligned with benefits (nearly break-even) and reinsurance is break-even under Option 5.
Pre-reinsurance DR (projected reserve amount)

High credibility

Post-reinsurance DR (projected reserve amount)

"Baseline YRT scale" and high credibility

Pre-reinsurance DR – Post-reinsurance DR (projected reserve amount)

"Baseline YRT scale" and high credibility

Reserve ($MM)

Year

Pre-reinsurance DR

NPR (gross and net)

No change in rates (option 1)

Break even after 1 year (option 5)

1/2 Cx

APF 2019-41 | TERM

Similar to ULSG, the no change in rate scenario produces the largest "reserve credit", but it is considerably smaller than for ULSG and ½ Cx

Interpretation survey results and additional analysis

APF 2019-42 | SURVEY RESULTS

Reinsurer reaction

None 1%

Reactive 64%

Break-even 29%

Other 6%

Modeling approaches illustrated

Increase YRT premiums by

• 100% of the difference between current YRT premium and prescribed mortality immediately and each year thereafter

• 100% of prescribed mortality margin after 1 year and every year thereafter

• Including 10 years of future mortality improvement in implicit margin

Range of responses

• Most responses were reactive and incorporate 100% of the prescribed margin

• Variation in reactive responses was the number of years of mortality improvement included in the margin

Complexity

• Some responses pointed out that the prescribed solution will require a company to develop multiple sets of mortality assumptions to determine the prescribed margin

• Given that over 35% of responses were something other than a reactive margin, the prescribed margin formula may be difficult to interpret and understand

Attachment Nine

Life Actuarial (A) Task Force

8/3-6/20
**KEY TAKEAWAYS**

Additional key takeaways from analysis of range of interpretation survey results are highlighted below in addition to those previously established.

<table>
<thead>
<tr>
<th>Takeaway</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Differences in assumptions on preliiminary reserve and valuations of the assumed reserves are the primary driver of differences in modeled reserves and assumed reserves.</td>
</tr>
<tr>
<td>2</td>
<td>如何看待未调整的预估准备金和估值差异是导致差异的主要原因。</td>
</tr>
<tr>
<td>3</td>
<td>Differences in modeled reserves across field test participants are driven by differences in reinsurance assumptions and how reinsurance is modeled.</td>
</tr>
<tr>
<td>4</td>
<td>Differences in modeled reserves are also driven by differences in modeled reserves for multiple lines of business.</td>
</tr>
<tr>
<td>5</td>
<td>Differences in modeled reserves for multiple lines of business are also driven by differences in modeled reserves for multiple business lines.</td>
</tr>
</tbody>
</table>

**EVALUATION OF TOTAL IMPACT ON DR (CEDED AND ASSUMED)**

Most common responses and responses resulting in the largest reduction in aggregate DR from reinsurers and direct writers are compared, removing impact of any differences between reserve credits and assumed reserves shown by assumptions for modeled reserves and PBR methodology.

**Observation:** Differences in assumptions between ceded and aggregate perspective for modeled reserves are the primary driver of differences between reserve credits and assumed reserves.

**Analytical adjustment:** The consistent assumption for both perspectives to isolate the impact of interpretation in regards to the treatment of non-guaranteed reinsurance.

Assumed reserves in the following slides are developed using the ceded pre- and post-reinsurance DR, an approach which captures reinsurance cash flows in determining the assumed reserve with some simplification (i.e., excludes reinsurers expenses and uses ceding company asset assumptions).
Interpretation survey results and additional analysis

### APF 2019-40 | Ceded and Assumed

Combined impact to DR from both ceding and assuming companies for the most common surveyed reactions is positive; combinations of other surveyed reactions could lead to a reduction in total DR.

- **Differences in calculation methodology and assumptions**
- **Interpretation survey results and additional analysis**

#### Reinsurer reaction – Ceding company

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Break-even</th>
<th>None</th>
<th>Reactive</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break-even</td>
<td>60%</td>
<td>50%</td>
<td>15%</td>
<td>5%</td>
</tr>
</tbody>
</table>

#### Reinsurer reaction – Assuming company

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Break-even</th>
<th>None</th>
<th>Reactive</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break-even</td>
<td>60%</td>
<td>50%</td>
<td>15%</td>
<td>5%</td>
</tr>
</tbody>
</table>

#### Commentary

- Differences in modeling approach result in differences between ceded credit and assumed reserve.
- Some assuming companies noted that they may raise their rates in response to these differences.
- Ceding companies noted that the life modeling approach and assumptions typically reconcile to those previously established.
- Differences in methodology and assumptions can lead to changes in future mortality improvement included in the margin, versus fully driving the difference between current YRT premiums and mortality and can be thought of as mechanisms around return of unearned reinsurance premium and other mechanical differences due to VM-20 requirements.

**APF 2019-41 | Ceded and Assumed**

Impact of reinsurance on combined DR based on most common responses is smaller than APF 2019-40.

- **None** reaction refers to no adjustments to premium, mortality, or other assumptions.
- Reinsurers had similar comments as direct companies regarding the need to make reinsurance risk assumptions separate to properly reflect the guidance in the APF.
- Reinsurers noted that APF 2019-40 issue responses did not reflect "no adjustment.

---

**KEY TAKEWAYS**

**Additional key takeaway:** From evaluation of total impact on DR (ceded and assumed) are highlighted below in addition to those previously established.

1. **Reinsurer reaction**
   - **Impact to total projected deterministic reserves (ULSG)**
   - **None**
   - Reacting to reinsurance is used by both parties.

2. **Impact of reinsurance on DR combined (assumed – credit)**
   - **None**
   - Most common responses (     ceded credit,     assumed reserve)

3. **Largest reduction to DR**
   - **None**
   - Impact to total projected deterministic reserves (ULSG)

---

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FIELD TEST SOLUTIONS
Dimensions for comparison were established over the course of the project.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description and comments</th>
<th>Key supporting analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of prescription</td>
<td>• Judgement allowed by the potential solution</td>
<td>• Prescribed solutions</td>
</tr>
<tr>
<td></td>
<td>• Prescribed solutions provide more uniformity but may not fully account for the unique risk set provisions, relationship between underlying agreements</td>
<td>• Proposed solutions</td>
</tr>
<tr>
<td>Modeling complexity</td>
<td>• Simplicity of implementing solution in valuation system and process</td>
<td>• Field test, interpretation survey and representative analysis</td>
</tr>
<tr>
<td>Variability in results</td>
<td>• Potential for variability in results, given interpretation of requirements</td>
<td>• Field test, interpretation survey and representative analysis</td>
</tr>
<tr>
<td>Potential for asymmetry</td>
<td>• Propensity for variance between reserve credits and assumed reserves</td>
<td>• Interpretation survey and representative analysis</td>
</tr>
<tr>
<td>Defined level of risk sharing</td>
<td>Well defined amount of excess mortality experience that is shared with the assuming reinsurer (e.g., prescribed reserve/credit, mortality improvement, “loss ratio” trigger, etc.)</td>
<td>• Interpretation survey and representative analysis</td>
</tr>
<tr>
<td>Potential APF revisions</td>
<td>• Amount of revisions required to current proposal language before LATF exposure</td>
<td>• “Field tested” APFs</td>
</tr>
</tbody>
</table>

Some dimensions have clear ideal outcomes (e.g., modeling complexity) while other dimensions will need to be weighed.
FIELD TEST RESULTS
Compiled and documented by the American Academy of Actuaries

INTERPRETATION SURVEY RESULTS
Compiled and documented by the American Academy of Actuaries

PRIOR REPORTS

APPENDIX A.2
PRIOR REPORTS

2019 NAIC FALL MEETING LATF PRESENTATION (DECEMBER 2019)
Initial presentation focused on education of modeling reinsurance under PBR, initial representative PBR model design and analysis of the APRs
### APPENDIX B

**Model design and assumptions**

### LIABILITY ASSUMPTIONS (ULSG)

The assumptions used in the analysis are below, including assumed PBR margins.

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Anticipated Experience Assumption</th>
<th>Prudent Estimate Assumption (e.g. margin)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td>2015 VBT gender distinct, smoker distinct ANB</td>
<td>Prescribed margins applied to company mortality</td>
</tr>
<tr>
<td></td>
<td>Relative risk varies by risk class</td>
<td>Industry table: 2015 VBT with prescribed margins and mortality improvement scale</td>
</tr>
<tr>
<td></td>
<td>A/E factors vary by high/low band</td>
<td>Grading and margins assumes 100% Limited Fluctuation Method credibility</td>
</tr>
<tr>
<td></td>
<td>Future mortality improvement of .50%</td>
<td></td>
</tr>
<tr>
<td><strong>Lapse</strong></td>
<td>3% annual lapse rate</td>
<td>2% annual lapse rate</td>
</tr>
<tr>
<td></td>
<td>0% lapse rate when the secondary guarantee is in-the-money (i.e. CSV &lt; 0)</td>
<td></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td>$100 per policy (annual)</td>
<td>100% margin on expenses</td>
</tr>
</tbody>
</table>

---

### LIABILITY ASSUMPTIONS (TERM)

The assumptions used in the analysis are below, including assumed PBR margins.

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Anticipated Experience Assumption</th>
<th>Prudent Estimate Assumption (e.g. margin)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td>2015 VBT gender distinct, smoker distinct ANB</td>
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<tr>
<td></td>
<td>A/E factors vary by high/low band</td>
<td>Grading and margins assumes 100% Limited Fluctuation Method credibility</td>
</tr>
<tr>
<td></td>
<td>Future mortality improvement of .50%</td>
<td></td>
</tr>
<tr>
<td><strong>Lapse</strong></td>
<td>6.5% during level term period</td>
<td>5% margin on lapses</td>
</tr>
<tr>
<td></td>
<td>100% shock lapse after level term period</td>
<td></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td>$85 per policy (annual)</td>
<td>100% margin on expenses</td>
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<tr>
<td></td>
<td>Additional $200 per policy and $0.40 per $1000 face</td>
<td>2.5% inflation</td>
</tr>
</tbody>
</table>

---
APPENDIX C
Supplemental results

FIELD TEST RESULTS AND ANALYSIS

APPENDIX C.1

C.1 – Gross DR – Net DR (per 1000 of projected ceded NAAR)

No change to YRT rates

C.2 – Gross DR – Net DR (per 1000 of projected ceded NAAR)

1/2 Cx

(6) (4) (2) -2 4 6 8 10

Lower bound = 1/2 Cx

Upper bound = 1/24 Cx

Field test results and analysis

BASELINE | TERM RESULTS

Similar to LiLG, the representative PBR model explains the variance in impacts of reinsurance on modeled reserves observed in field test submissions.

C.3 – Gross DR – Net DR (per 1000 of projected ceded NAAR)

Action A

C.4 – Gross DR – Net DR (per 1000 of projected ceded NAAR)

Action B

APF 2019–40 | TERM RESULTS

Application of prudent estimate margins in Action B lowers the impact to DR and including additional parameters to determine the application of margins (Action C and Action D) reduces the variation in field test results.

C.5 – Gross DR – Net DR (per 1000 of projected ceded NAAR)

Action C

C.6 – Gross DR – Net DR (per 1000 of projected ceded NAAR)

Action D

Analysis coverage range (OW)

Neutral YRT rate scale (OW)

Coverage range (Representative PBR model)

"Baseline YRT scale" with high credibility
Similar to ULSG, introducing future mortality improvement to the projected claims reduces reinsurance gains, given the current scale of reinsurance premiums is held constant.

Field test results and analysis
APF 2019-41 | TERM RESULTS

Similar to ULSG, increasing the level of future mortality improvement has a similar impact on both APF 2019-41 and 2019-42.

Notes
- Impact to DR is unitized as per 1000 of Ceded NAAR.
- Unitized impact to DR for no changes to YRT policy = \frac{(a) - (b)}{(c)} * 1000

BASELINE | ULSG RESULTS
Development of unitized impact to DR for baseline YRT Rate scale and high credibility

Impact to DR is unitized as per 1000 of Ceded NAAR.
- Unitized impact to DR for no changes to YRT rates = \frac{(a) - (b)}{(c)} * 1000

APF 2019-40 | ULSG RESULTS
Development of unitized impact to DR for baseline YRT Rate scale and high credibility

Impact to DR is unitized as per 1000 of Ceded NAAR.
- Unitized impact to DR for no changes to YRT rates = \frac{(a) - (b)}{(c)} * 1000
## Development of unitized impact to DR for baseline YRT Rate scale and high credibility

### APF 2019-41 | ULSG RESULTS

**BASELINE | TERM RESULTS**

Development of unitized impact to DR for baseline YRT Rate scale and high credibility

<table>
<thead>
<tr>
<th>Category</th>
<th>1.0% FMI</th>
<th>0.0% FMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-reinsurance (a)</td>
<td>1,978</td>
<td>2,368</td>
</tr>
<tr>
<td>Pre-reinsurance (b)</td>
<td>1,978</td>
<td>2,368</td>
</tr>
<tr>
<td>Post-reinsurance (b)</td>
<td>1,984</td>
<td>2,341</td>
</tr>
<tr>
<td>Ceded NAAR (c)</td>
<td>2,161</td>
<td>2,530</td>
</tr>
<tr>
<td>Post-reinsurance adjustment (d)</td>
<td>0.79</td>
<td>0.45</td>
</tr>
</tbody>
</table>

### APF 2019-42 | ULSG RESULTS

**BASELINE | TERM RESULTS**

Development of unitized impact to DR for baseline YRT Rate scale and high credibility

<table>
<thead>
<tr>
<th>Category</th>
<th>1.0% FMI</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Post-reinsurance adjustment (d)</td>
<td>0.79</td>
<td>0.45</td>
</tr>
</tbody>
</table>

### Unitized impact to DR

- Impact to DR is unitized as per 1000 of Ceded NAAR
- Impact to DR is unitized as per 1000 of Ceded NAAR

- Unitized impact to DR = \[(a) – (b)\] / (c) * 1000
- Unitized impact to DR = \[(a) – (b)\] / (c) * 1000

### Notes

- Impact to DR is unitized as per 1000 of Ceded NAAR
- Impact to DR is unitized as per 1000 of Ceded NAAR

### Baseline Results

<table>
<thead>
<tr>
<th>Category</th>
<th>1.0% FMI</th>
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</thead>
<tbody>
<tr>
<td>Pre-reinsurance (a)</td>
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### Table

<table>
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<th>Category</th>
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<tbody>
<tr>
<td>Pre-reinsurance (a)</td>
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<td>2,530</td>
</tr>
<tr>
<td>Post-reinsurance adjustment (d)</td>
<td>0.79</td>
<td>0.45</td>
</tr>
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</table>
APPENDIX C.2

INTERPRETATION SURVEY RESULTS AND ADDITIONAL ANALYSIS
APF 2019-40 | TERM RESULTS
Development of Net DR for illustrated interpretation scenarios

C.40 - No change in rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-reinsurance DR (a)</th>
<th>Post-reinsurance DR (b)</th>
<th>Impact to DR (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-9</td>
<td>-39</td>
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<tr>
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</table>

C.41 - Break even after 1 year

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-reinsurance DR (a)</th>
<th>Post-reinsurance DR (b)</th>
<th>Impact to DR (c)</th>
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<tbody>
<tr>
<td>0</td>
<td>-9</td>
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<tr>
<td>35</td>
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<td>18</td>
<td>17</td>
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</tbody>
</table>

C.42 - Fully reactive after 1 years

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-reinsurance DR (a)</th>
<th>Post-reinsurance DR (b)</th>
<th>Impact to DR (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-9</td>
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<td>225</td>
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<tr>
<td>35</td>
<td>35</td>
<td>18</td>
<td></td>
</tr>
</tbody>
</table>

Notes
• Impact to DR is (a) – (b)

APF 2019-41 | ULSG RESULTS
Development of Net DR for illustrated interpretation scenarios

C.43 - No change in rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-reinsurance DR (a)</th>
<th>Post-reinsurance DR (b)</th>
<th>Impact to DR (c)</th>
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<tbody>
<tr>
<td>0</td>
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</tr>
<tr>
<td>35</td>
<td>35</td>
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</table>

C.44 - Break even after 1 year

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-reinsurance DR (a)</th>
<th>Post-reinsurance DR (b)</th>
<th>Impact to DR (c)</th>
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<tbody>
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<td>0</td>
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<td>10</td>
<td>-1</td>
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</tr>
<tr>
<td>35</td>
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<td>18</td>
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</table>

C.45 - Break even in 1 year

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-reinsurance DR (a)</th>
<th>Post-reinsurance DR (b)</th>
<th>Impact to DR (c)</th>
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<tbody>
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<tr>
<td>35</td>
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</tr>
</tbody>
</table>

Notes
• Impact to DR is (a) – (b)

APF 2019-42 | ULSG RESULTS
Development of Net DR for illustrated interpretation scenarios

C.46 - Fully reactive after 1 year

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-reinsurance DR (a)</th>
<th>Post-reinsurance DR (b)</th>
<th>Impact to DR (c)</th>
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<tbody>
<tr>
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<td>35</td>
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</table>

C.47 - Fully reactive after 1 year, including 10 year MI

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-reinsurance DR (a)</th>
<th>Post-reinsurance DR (b)</th>
<th>Impact to DR (c)</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>-9</td>
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<tr>
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</tr>
</tbody>
</table>

Notes
• Impact to DR is (a) – (b)
APPENDIX D

Project team

PROJECT TEAM AND GOVERNANCE
The consultant analysis will be overseen by NAIC Staff, the Academy, and the ACLI, as depicted in the following chart.

OLIVER WYMAN TEAM

<table>
<thead>
<tr>
<th>Contact information</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Whitney, FSA, MAAA</td>
<td>Engagement manager</td>
</tr>
<tr>
<td>Dylan Strother, FSA, MAAA</td>
<td>Technical lead</td>
</tr>
<tr>
<td>Katie van Ryn, FSA, MAAA</td>
<td>AXIS model development</td>
</tr>
<tr>
<td>Sara Flores</td>
<td>Support</td>
</tr>
</tbody>
</table>

The report and the findings herein are subject to the reliances and limitations outlined at the beginning of this report. This report is considered a statement of actuarial opinion under the guidelines promulgated by the American Academy of Actuaries. Chris Whitney, Dylan Strother and Katie van Ryn of Oliver Wyman developed this report and meet the qualification requirements of the American Academy of Actuaries to render the opinion contained herein.
QUALIFICATIONS, ASSUMPTIONS, AND LIMITING CONDITIONS

Oliver Wyman was engaged by the American Council of Life Insurers, the American Academy of Actuaries and the National Association of Insurance Commissioners to support an industry field test being conducted to aid the NAIC Life Actuarial (A) Task Force in the selection of a long-term solution for the treatment of non-guaranteed reinsurance under PBR.

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STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

ACLI DRAFT EDIT APRIL 30, 2020

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Section 4. Minimum Values
Section 5. Computation of Present Value
Section 6. Calculation of Cash Surrender Values
Section 7. Calculation of Paid-Up Annuity Benefits
Section 8. Maturity Date
Section 9. Disclosure of Limited Death Benefits
Section 10. Inclusion of Lapse of Time Considerations
Section 11. Proration of Values; Additional Benefits
Section 12. Rules
Section 13. Effective Date

Section 1. Title

This Act shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

Section 2. Applicability

A. This Act shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

B. Sections 3 through 8 shall not apply to contingent deferred annuities.

C. Notwithstanding Subsection B, the commissioner shall have the authority to prescribe, by regulation, nonforfeiture benefits for contingent deferred annuities that are, in the opinion of the commissioner, equitable to the policyholder, appropriate given the risks insured, and to the extent possible, consistent with general intent of this law.

Drafting Note: It is expected that any regulation prescribing specific nonforfeiture requirements for the CDAs and promulgated by the commissioner under Subsection C above would apply only to the CDA contracts issued subsequent to the effective date of such regulation.

Section 3. Nonforfeiture Requirements

A. In the case of contracts issued on or after the operative date of this Act as defined in Section 13, no contract of annuity, except as stated in Section 2, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Sections 5, 6, 7, 8 and 10;

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is
specified in Sections 5, 6, 8 and 10. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

(4) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

B. Notwithstanding the requirements of this section, a deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than $20 monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

Section 4. Minimum Values

The minimum values as specified in Sections 5, 6, 7, 8 and 10 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

A. (1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in Subsection B of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of Paragraphs (a) through (d) below:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection B;

(b) An annual contract charge of $50, accumulated at rates of interest as indicated in Subsection B;

(c) Any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection B; and

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(2) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

B. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:
The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest 1/20th of one percent, specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under Section 4B(4);

Reduced by 125 basis points;

Where the resulting interest rate is not less than one zero percent (10%); and

The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

C. During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in Subsection B(2) above by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

D. The commissioner may adopt rules to implement the provisions of Section 4C and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines adjustments are justified.

Section 5. Computation of Present Value

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Section 6. Calculation of Cash Surrender Value

For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at the time arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Section 7. Calculation of Paid-up Annuity Benefits

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.
Section 8. Maturity Date

For the purpose of determining the benefits calculated under Sections 6 and 7, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant’s seventieth birthday or the tenth anniversary of the contract, whichever is later.

Section 9. Disclosure of Limited Death Benefits

A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

Section 10. Inclusion of Lapse of Time Considerations

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

Section 11. Proration of Values; Additional Benefits

For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Sections 5, 6, 7, 8 and 10, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this Act. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Section 12. Rules

The commissioner may adopt rules to implement the provisions of this Act.

Section 13. Effective Date

After the effective date of this Act, a company may elect to apply its provisions to annuity contracts on a contract form-by-contract form basis before the second anniversary of the effective date of this Act. In all other instances, this Act shall become operative with respect to annuity contracts issued by the company after the second anniversary of this Act.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2017 3rd Quarter (amended).
Brian Bayerle  
Senior Actuary  
July 20, 2020

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)

Re: ACLI Comments on Opening of NAIC Model #805

Dear Mr. Boerner:

The American Council of Life Insurers (ACLI) appreciates the opportunity to provide comments on the opening of NAIC Model #805 on Standard Nontopertual Law for Individual Deferred Annuities. We appreciate the leadership of LATF and the Life Insurance and Annuities (A) Committee to address this critical issue for consumers.

ACLI believes regulators should make quick, tactical revisions to Model #805 in light of the current economic environment. Specifically, we believe the appropriate course of action is to reduce the minimum nontopertual interest rate in Section 4 (B) (3) from 1% to 0%.

The current interest rate environment creates unique challenges on crediting rates. As of June 30th, the yields for the US 5-year and 10-year Treasurys were 0.29% and 0.66%, respectively. It is difficult to support the current 1.00% minimum guaranteed rate given these historically low interest rates. An annuity contract is a long-term commitment and requires that insurers maintain a long time horizon with respect to managing contract liabilities. Many companies are contemplating or have begun to limit their product offerings in response to the current situation and would appreciate greater flexibility to address the current environment. Greater flexibility will help promote expanded product availability to consumers.

We note that the 0% is a floor only; and the current formula will continue to be used to determine the minimum rates companies are permitted to guarantee on newly-issued contracts. The 0% floor will only be triggered in low interest rate environments, such as the one we are currently experiencing. Companies will continue to use non-guaranteed crediting rates, bonuses, and other features in order to maintain market competitiveness and product differentiation. If, and when, market conditions improve, competitive pressures will necessitate that insurers increase both their current and guaranteed crediting rates regardless of the regulatory floor.

We look forward to a discussion on this important issue.
Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
May 29, 2020

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force (LATF)

Mr. Reggie Mazyck
Life Actuary, NAIC

Re: Model 805 Exposure, Standard Nonforfeiture Law for Individual Deferred Annuities

Dear Mr. Boerner and Mr. Mazyck:

On behalf of our members, the Insured Retirement Institute (“IRI”)\(^1\) appreciates the opportunity to comment on the proposed change to Model 805 Exposure. For the reasons set forth below, we support the proposal and respectfully urge the NAIC to move expeditiously to adopt the proposal.

The current financial environment is challenging institutional and individual investors and product offerings. The proposed change from 1% to 0% will give companies more flexibility to provide the value and benefits wanted and needed by consumers. If companies are required to offer 1% crediting rates, and interest rates remain low or decrease further, certain products will no longer be feasible to offer. The products most at risk are often those in greatest demand by consumers. For example, products with short surrender charge periods may not be able to find investments that have a high enough yield to support a 1% rate. At the same time, many consumers will be understandably hesitant to purchase long term products in a low yield environment. Additional guarantees in contracts such as a return of premium benefit may become unaffordable if the asset yield available is exhausted by the 1% guarantee.

IRI is committed to responding to the country’s economic condition with policy recommendations that support individual investment. Companies must have a diverse product portfolio to respond to the

\(^1\) IRI is the leading association for the entire supply chain of insured retirement strategies, including life insurers, asset managers, and distributors such as broker-dealers, banks and marketing organizations. IRI members account for more than 95 percent of annuity assets in the U.S., include the top 10 distributors of annuities ranked by assets under management, and are represented by financial professionals serving millions of Americans. IRI champions retirement security for all through leadership in advocacy, awareness, research, and the advancement of digital solutions within a collaborative industry community.
May 29, 2020

changing economic and individual situation. IRI supports the responsive approach of Model 805 and encourages the Life Actuarial Task Force to adopt as proposed.

Thank you again for the opportunity to share our views on this important subject. Please contact the undersigned if you have questions about anything in this letter, or if we can be of any further assistance in connection with this important regulatory effort.

Sincerely,

Jason Berkowitz
Chief Legal & Regulatory Affairs Officer
Insured Retirement Institute

Liz Pujolas
Director, State Affairs
Insured Retirement Institute
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met via conference call July 15, 2020. The following Subgroup members participated: Bruce Sartain, Chair (IL); Jim Jakielo (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Bill Carmello (NY); Tomasz Serbinowski (UT); and Craig Chupp (VA). Also participating was: Russell Toal (NM); and Rachel Hemphill (TX).

1. Discussed the Revisions to VM-22

Mr. Sartain said the aggregation discussion will be deferred until the American Academy of Actuaries (Academy) Annuity Reserve Work Group (ARWG) finalizes its development of aggregation principles. He presented a list of Subgroup decisions that could be presented to the Life Actuarial (A) Task Force for its consideration. The first item on the list was the inclusion of payout annuities in the principle-based reserving (PBR) framework. He noted that the decision on the location of the PBR requirements for payout annuities will be decided later. The second item was the decision to continue development of an exclusion test for less risky annuities. The third item was the deferral of discussions on whether the PBR requirements for payout annuities are to be applied retroactively. He said that the decision on retroactivity will be tabled until the Subgroup gets closer to a final product. Mr. Carmello said the New York Department of Financial Services (NYDFS) prefers retaining Actuarial Guideline XXXIII, Determining CARVM Reserves for Annuity Contracts with Elective Benefits (AG 33) and Actuarial Guideline XXXV, The Application of the Commissioners Annuity Reserve Method to Equity Indexed Annuities (AG 35). He said those requirements are sufficient and the PBR payout annuities project is not necessary. The Subgroup agreed to forward the three decisions to the Task Force for its review. Mr. Carmello did not agree with moving the decisions forward. Although not a member of the Subgroup, Commissioner Toal also voiced opposition sending the items to the Task Force.

Mr. Sartain said two issues related to the standard projection amount (SPA) are whether to develop an SPA and, if an SPA is developed, whether it should be a reserve floor or a disclosure item. He said the benefits of having an SPA in the PBR payout annuity framework that would be analogous to the SPA in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, have been discussed. He said there is a thought that having consistency between VM-21 and the PBR payout annuities framework would be a positive step to keep companies from cherry picking requirements for products that straddle the line of variable and fixed identification. He said there is also thinking that supports waiting until field testing has been completed to decide whether the SPA would be a floor or disclosure item. He noted that the Task Force has been charged with reviewing the VM-21 SPA by the end of 2023. He said it may make sense to have the floor/disclosure decision coincide with the VM-21 SPA review. He asked subgroup members if there were any objections to proceeding with the development SPA. Ms. Ahrens said that during the VM-21 deliberations, the Nebraska Department of Insurance spoke against using the SPA as a floor. She said her current stance on the PBR payout annuity framework SPA is that it should be a disclosure item, but she is willing to await completion of the ARWG work before making a final decision. Ms. Ahrens suggested that there could be a set of multiple standard scenarios. Mr. Sartain asked if VM-21 assumptions for the CTE with Prescribed Assumptions (CTEPA) will be periodically revisited. Ms. Hemphill said the intent was to revisit the prescribed assumptions, but no set period for revisiting was determined. She said she finds the VM-21 SPA helpful when doing company reviews and at minimum would like to have the PBR payout annuity SPA as a disclosure item. Ms. Ahrens said her preference would be to only have the PBR stochastic calculations with the cash value as the floor. She said she is not opposed to continuing the work on the SPA but is concerned that there is a presupposition that the SPA will be used as a floor. Ben Slutsker (Academy ARWG) said the Academy does not support using the SPA a floor. He said they would rather have the SPA as a disclosure item. Mr. Sartain asked if subgroup members would like to add the discussion of the SPA to the list of items for Task Force consideration or to continue SPA discussions within the subgroup. The Subgroup voted, 5-4, to keep the SPA discussions at the subgroup level.

Having no further business, the VM-22 (A) Subgroup adjourned.

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The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met via conference call July 1, 2020. The following Subgroup members participated: Bruce Sartain, Chair and Vincent Tsang (IL); Jim Jakielo (CT); William Leung (MO); Bill Carmello (NY); Tomasz Serbinowski (UT); and Craig Chupp (VA). Also participating were: Pete Weber (OH); John Robinson (MN); and Rachel Hemphill and Karen Jiang (TX).

1. Discussed the Revisions to VM-22

Mr. Sartain said his thought is to move forward with developing a standard projection amount (SPA) for VM-22, Statutory Maximum Valuation Interest Rate for Income Annuities, and wait to decide whether it should be a floor amount or a disclosure item until the SPA development process is nearly complete. He said another decision is whether the VM-22 SPA will use the CTE with Prescribed Assumptions (CTEPA) method or the Company-Specific Market Path (CSMP) method, the two VM-21, Requirements for Principle-Based Reserves for Variable Annuities, methods for determining the SPA. Mr. Sartain said using the SPA would be consistent with the decision to use VM-21 as a model for VM-22, making changes wherever necessary. He noted that a field test, using an initial set of prescribed assumptions which will allow for comparisons of the stochastic reserve, SPA, cash surrender value, and the CARVM reserve, will be conducted in 2021. He said it is premature to make decisions on the SPA before completion of the field test. He said the Life Actuarial (A) Task Force has received a charge requiring review of the VM-21 SPA by the end of 2023. He said the VM-22 SPA could also be reviewed at that time. Also, an SPA floor would be stochastically based, and if it were decided to be a disclosure item that would also be helpful in regulatory reviews. John Robinson asked if a different SPA would be considered for deferred annuities (DAs) and single premium immediate annuities (SPIAs). Mr. Sartain said prescribed assumptions would be developed by product line and modeled according to the aggregation rules.

Ms. Jiang asked whether the prescribed assumptions would be best estimates or margins added to industry averages. Mr. Sartain said his simplistic view is to use best estimate assumptions with a margin. Ben Slutsker (American Academy of Actuaries Annuity Reserves Work Group—ARWG) said the ARWG approach has been to focus on the principle-based reserve (PBR). He said a floor reserve may impede the PBR objective. He said the prescribed assumptions should align with the objectives of the adopted approach. Mr. Sartain asked if VM-21 used a best estimate or a best estimate plus a margin. Ms. Hemphill said VM-21 does not use an explicit margin but adds conservatism when encountering uncertainty. She questioned whether there is double buffering if prescribed assumptions have explicit margins. Mr. Weber said, Oliver-Wyman stated that, while it does not have an explicit margin, the VM-21 reserve requirements are sufficiently conservative. Mr. Sartain said VM-22 should use the VM-21 margin approach. Ms. Hemphill suggested considering ways to quantify the size of the margin. She said having the margin quantified is helpful when conducting reviews. Cindy Barnard (Pacific Life) said developing assumptions for areas in which there are no experience will be challenging.

Mr. Robinson asked for the reasons why the SPA is being considered for VM-22. Mr. Sartain said it is reasonable to consider the SPA as a floor reserve. He said even if it is not used as a floor, disclosing the SPA provides valuable information. Mr. Weber said having a floor for VM-21 and no floor for VM-22 would require clear differentiation of the variable and non-variable annuity products. Mr. Sartain said discussion of the issue will continue on the next subgroup call.

Mr. Sartain said the concept of aggregation is discussed in section 5A of VM-20, Requirements for Principle-Based Reserves for Life Products. Mr. Slutsker said aggregation refers to the grouping of policies with off-setting risks. He said aggregation interacts with lots of elements within the PBR framework, primarily appearing in the CTE-70 calculation, the comparing of reserve components and in exclusion testing. He detailed the uses of aggregation within VM-20 and VM-21. He said the ARWG believes an approach which outlines principles will be best for VM-22. He suggested one principle might be aggregating in a manner consistent with the company’s risk management process. Mr. Slutsker noted that exclusion testing may require prescribed prudent requirements that may utilize knockout criteria, such as not excluding future hedging strategies supporting guaranteed living benefits. He said the ARWG is drafting principles for aggregation for elements other than exclusion testing.

Having no further business, the VM-22 (A) Subgroup adjourned.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met via conference call June 11, 2020. The following Subgroup members participated: Bruce Sartain, Chair and Vincent Tsang (IL); Jim Jakielo (CT); Nicole Boyd (KS); William Leung (MO); Rhonda Ahrens (NE); Bill Carmello (NY); Tomasz Serbinowski (UT) and Craig Chupp (VA). Also participating were: John Robinson (MN); Pete Weber (OH); and Rachel Hemphill (TX).

1. Discussed the Potential Revisions to VM-22

Mr. Sartain said the American Academy of Actuaries (Academy) Annuity Reserve Work Group (ARWG) has been working on principle-based reserve (PBR) developments for non-variable annuities, including possibly using the VM-20, Requirements for Principle-Based Reserves for Life Products, exclusion test concept. John Miller (ARWG) said the ARWG has long thought that an exclusion test was needed for annuities that do not have material risk. He reiterated that the current ARWG thinking is to use the VM-20 concept. Products that pass the exclusion test will use Actuarial Guideline XXXIII, Determining CARFM Reserves for Annuity Contracts with Elective Benefits (AG 33).

Ben Slutsker (ARWG) provided an overview of the three options for the VM-20 exclusion test. He said the first option, the stochastic ratio test, compares the greatest scenario reserve resulting from the 16 prescribed scenarios from the Academy test scenario generator to the baseline scenario reserve to determine if the ratio meets the criteria to pass the test. He said the second option is to compare the PBR results to the reserve amount that would otherwise be held, to determine if the pre-PBR reserve is sufficient. He said the third option for an exclusion test is the certification option. Rachel Hemphill said consideration should be given to having absolute dollar amount criteria in addition to applying the VM-20 stochastic ratio test thresholds for non-variable annuities. She expressed concern about whether contracts with different risk profiles should be aggregated for the stochastic ratio test. Mr. Slutsker said the concerns will be considered as discussions progress. No subgroup members voiced objection to the overall direction of the ARWG VM-22 development efforts.

Mr. Weber provided an overview of the standard projection amount (SPA) used in VM-21, Requirements for Principle-Based Reserves for Variable Annuities. He said the Variable Annuity Issues (E) Working Group considered whether VM-21 needed a floor reserve. He said working group members thought it unwise to remove the guardrail provided by the SPA. He said the working group charged the Life Actuarial (A) Task Force with revisiting the SPA issue within five years to determine whether the hard floor could be replaced by a disclosure requirement.

Mr. Weber said there are two methods for determining the SPA, the company-specific market path (CSMP) and the CTE with prescribed assumptions (CTEPA). He said, once a company chooses a method, domestic commissioner approval is required to change. Mr. Jakielo asked if the VM-21 prescribed assumptions would be a good starting point for development of prescribed assumptions for non-variable annuities. Mr. Weber responded that, while VM-21 might provide a good starting point, the characteristics of variable annuity buyers and non-variable annuity buyer are different. He said the prescribed assumptions must be changed to reflect the differences. Mr. Robinson asked if development of an SPA for VM-22 is within the scope of the ARWG work. Mr. Slutsker said the ARWG is focused on developing the modeled reserve and would prefer the SPA be a disclosure item. Mr. Sartain said it has not been determined if the ARWG would be tasked with development of the SPA. Mr. Carmello said he would like to retain the AG 33 as the floor for non-variable annuities. He said AG 33 works well for products with guaranteed living benefits.

Having no further business, the VM-22 (A) Subgroup adjourned.
The VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met via conference call May 20, 2020. The following Subgroup members participated: Bruce Sartain, Chair and Vincent Tsang (IL); Jim Jakielo (CT); Mike Yanacheak (IA); Nicole Boyd (KS); Rhonda Ahrens (NE); Bill Carmello (NY); and Tomasz Serbinowski (UT).

1. Discussed the Potential Revisions to VM-22

Mr. Sartain said the Subgroup has two options to consider: 1) to go farther out on the principle-based reserve (PBR) curve by eliminating guardrails present in VM-20, Requirements for Principle-Based Reserves for Life Insurance and VM-21, Requirements for Principle-Based Reserves for Variable Annuities; or 2) to keep the guardrails currently in VM-20 and VM-21 for the moment, followed by a measured approach using a determined timeline to open and revise the guidance. He said an example of the first option would be to allow companies to use more of their own asset experience than they can use in VM-20 and VM-21. Ms. Ahrens said there are some areas in which there should be less prescription and more application of principles. She suggested that policyholder behavior experience is an area where using company specific experience might be feasible. She said she would be less comfortable with allowing a company to use its own asset experience. Mr. Carmello asked if contracts that fail the exclusion test will be subject to a formulaic floor. Mr. Sartain said that is yet to be determined. Mr. Carmello said that in absence of a formulaic floor he favors option 1.

Ben Slutsker (American Academy of Actuaries Annuity Reserves Work Group—ARWG) gave a presentation on the work of the ARWG. He said the ARWG is working to develop a PBR framework for fixed annuities, with a focus on the stochastic reserve. He expects that once the framework is completed a full presentation will be provided to the Subgroup. The presentation will include assumptions for assets and liabilities, as well as exclusion tests. Mr. Slutsker said the framework design will follow VM-21 and will result in a revised VM-22, Statutory Maximum Valuation Interest Rate for Income Annuities. He said the target effective date for the revised VM-22 is Jan. 2023. He said because products are becoming increasingly similar, the plan is to apply the PBR methodology to fixed deferred annuities, fixed indexed annuities and fixed payout annuities. He said initially the scope will not include guaranteed investment contracts (GICs), funding agreements and stable value contracts, which tend to have more specific windows for optionality, have less longevity risks and are subject to different regulations. Mr. Sartain asked if any Subgroup members are against applying PBR to payout annuities. Mr. Carmello said he supports applying PBR to payout annuities if the current reserve is retained as a floor. Ms. Ahrens said the PBR methodology is designed to prepare for product innovation without requiring regulatory changes. She said, with the increasing demand for longevity risk products possibly leading to greater longevity product innovations, she prefers keeping payout annuities in scope. She said a PBR reserving standard for pension risk transfer business should be considered. Mr. Sartain said pension risk transfer business is expected to be in scope. Mr. Jakielo asked whether the PBR requirements for fixed annuities will reside in VM-22. Mr. Sartain said he envisions the requirements residing in VM-22, but the geography issue is still a matter for discussion.

Ms. Ahrens commented that there should be separate chapters for deferred annuities and payout annuities. Mr. Sartain said the major issue seems to be aggregation. He suggested that the products could reside in the same chapter if there are clear guidelines on how to aggregate the contracts.

Mr. Sartain said the question of whether the PBR requirements for fixed annuities will be retrospective is to be resolved by the Life Actuarial (A) Task Force.

Having no further business, the VM-22 (A) Subgroup adjourned.
Preliminary Framework Elements for Fixed Annuity PBR

American Academy of Actuaries Annuity Reserves Work Group (ARWG)

Ben Slutsker, MAAA, FSA
Chairperson, Annuity Reserves Work Group
John R. Vohs, MAAA, FSA
Vice Chairperson, Annuity Reserves Work Group
Chris Conrad, MAAA, FSA
Vice Chairperson, Annuity Reserves Work Group

ARWG Pillars of Objective

1) Appropriate Reflection of Risk — All else equal, greater risk in moderately adverse conditions requires greater statutory reserves, and vice-versa.

2) Comprehensive — The statutory reserve accounts for all material risks covered in the Valuation Manual and inherent in product features and potential management actions associated with the policies or contracts being valued.

3) Consistency Across Products — Statutory reserves between two contracts with similar features and risks are consistent given the same anticipated experience, regardless of product type.

4) Practicality and Applicability — Balance principles above with an approach that is practical, auditable, and able to be implemented.

ARWG Objective

Objective: Propose a new statutory reserve methodology for fixed annuities that uses an actuarial framework to determine reserves based on the level and type of risk inherent in the contract.

Notes:

1. These objectives are specific to the ARWG and intentionally condensed; Refer to VM-21, Section 1.B for a formal list of PBR principles.

ARWG Vision and Need

Vision: Provide Academy framework on principle-based reserve (PBR) methodology for fixed annuity products and promote consistency with existing PBR frameworks.

How ARWG Plans to Accomplish Vision:

a) Propose a PBR Approach — ARWG plans to propose a CTE70 stochastic reserve calculation.

b) Develop a Framework Deck — Develop a set of slides laying out various elements of methodology.

c) Recommend Consistency With VM-21 Where Appropriate — Start with VM-21 methodology.

Why Fixed Annuity PBR now?

Flexible Methodology — As new products emerge introducing greater optionality and reinvestment risk, there is greater need for a reserve methodology that appropriately captures the risks in these products.

Extend Existing PBR Framework — Seek consistency between fixed annuities and life/variable annuities (VM-20/VM-21).

Preliminary Timeline

- Fall 2019–Spring 2020
  - Develop proposed fixed annuity PBR framework deck
  - Initial modeling sensitivities for generic FIA/guarantee

- Summer 2020
  - ARWG to present framework deck proposal to LATF

- Fall 2020
  - Seek LATF endorsement of PBR framework deck (with feedback addressed)
  - Valuation Manual language drafting efforts

- Spring 2021
  - Begin industry field testing using draft (specifics TBD)

- Spring 2022
  - Target adoption of fixed annuity PBR (potentially VM-22)
  - Target 1/1/2023 effective date (monitor as progress develops)

(i) The ARWG only proposes a PBR modeling framework and we not include any formulaic or prescriptive floors in its proposal.
ARWG Key Topics

1. Preliminary Steps
   - Question: Apply PBR to both deferred annuity and payout annuity contracts?
   - ARWG Perspective: Recommend applying the PBR framework to both deferred and payout contracts. Not applying to immediate annuities allows companies to avoid principle-based reserves and creates possible advantages for some products over others, even if they share the same risks. That said, the recommendation is to hold off applying to Guaranteed Investment Contracts (GICs), funding agreements, and stable value contracts for the first round of fixed annuity PBR and revisit these at a later point in time.

2. Exclusion Test Methodology
   - Question: Allow for exclusion test on new business that follows a similar framework to the VM-20?
   - ARWG Perspective: Recommend following an exclusion test similar to the framework outlined in VM-20, which includes following a stochastic exclusion ratio test or certification method test. Products that pass the exclusion test are deemed to have lower levels of market risk and policyholder optionality risk and, therefore, may elect to use the pre-PBR Commissioners’ Annuity Reserve Valuation Method (CARVM) reserve standards (i.e., AG33, current VM-22, AG35, etc.).

3. Asset Reinvestment Assumptions
   - Question: Use fixed-income reinvestment limits of 50% A / 50% AA and prescribed defaults and reinvestment spreads for fixed-income general account assets.
   - ARWG Perspective: A general account investment risk has a proportionately larger impact on fixed annuity modeled reserves relative to other risks, whereas this may not necessarily be the case to the same extent for variable annuities and life insurance (mortality dependent).
   - ARWG Perspective: If requiring prescribed default/reinvestment spread assumptions, then give the emphasis on general account spreads for fixed annuity products, we suggest revisiting the reinvestment 50% AA / 50% A fixed-income guardrail, which does not reflect industry experience.
   - ARWG Perspective: Eventually consider updating VM-20 uses an exclusion test and VM-21 uses an Alternative Methodology.
   - ARWG Perspective: VM-20/VM-21 Treatment: VM-20 permits aggregation across contracts; VM-20 permits aggregation within terms vs. USAA, or other buckets.
   - ARWG Perspective: VM-20/VM-22 Treatment: VM-21 permits aggregation across contracts; VM-20 permits aggregation within terms vs. USAA, or other buckets.
   - ARWG Perspective: Aggregate across fixed annuity contracts, whether payouts or deferred, based on a set of outlined principles (including whether policies are part of the same integrated risk management system, managed/administered together, same or similar asset portfolios, etc.), but with no pre-defined buckets restricting aggregation.

4. Aggregation
   - Question: What assumptions should be used for reinvestment strategy?
   - ARWG Perspective: VM-20/VM-22 Treatment: Use fixed-income reinvestment limits of 50% A / 50% AA and prescribed defaults and reinvestment spreads for fixed-income general account assets.
   - ARWG Perspective: VM-20/VM-21 Treatment: Use fixed-income reinvestment limits of 50% A / 50% AA and prescribed defaults and reinvestment spreads for fixed-income general account assets.
   - ARWG Perspective: VM-20/VM-21 Treatment: Use fixed-income reinvestment limits of 50% A / 50% AA and prescribed defaults and reinvestment spreads for fixed-income general account assets.

5. Inforce Application
   - Question: What assumptions should be used for reinvestment strategy?
   - ARWG Perspective: VM-20/VM-22 Treatment: Use fixed-income reinvestment limits of 50% A / 50% AA and prescribed defaults and reinvestment spreads for fixed-income general account assets.
   - ARWG Perspective: VM-20/VM-21 Treatment: Use fixed-income reinvestment limits of 50% A / 50% AA and prescribed defaults and reinvestment spreads for fixed-income general account assets.
   - ARWG Perspective: VM-20/VM-21 Treatment: Use fixed-income reinvestment limits of 50% A / 50% AA and prescribed defaults and reinvestment spreads for fixed-income general account assets.

Questions?

- Questions or comments may be directed to:
- Ian Trepanier
- Life Policy Analyst
- American Academy of Actuaries
- Trepanier@actuary.org
The IUL Illustration (A) Subgroup of the Life Actuarial (A) Task Force met via conference call June 2, 2020. The following Subgroup members participated: Fred Andersen, Chair (MN); Ted Chang (CA); Andrew Greenhalgh (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Rhonda Ahrens (NE); Bill Carmello (NY); Peter Weber (OH); Mike Boerner and John Carter (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Technical Edits to the ACLI AG 49 Proposal

Mr. Andersen discussed the redline version of AG 49-A, the proposed revisions to *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49) (Attachment Eighteen-A). He said the revisions include technical edits to replace the term “annual percentage rate” with “annual rate” because the former term is commonly used in places other than AG 49. Birny Birnbaum (Center for Economic Justice—CEJ) recommended revising the proposed definition of “annual rate of index credits” because the definition seemed circular.

Brian Bayerle (American Council of Life Insurers—ACLI) discussed the remaining revisions. Upon Mr. Andersen’s request, Mr. Bayerle agreed to provide an updated version of AG 49-A for submission to the Life Actuarial (A) Task Force. Mr. Andersen said the Task Force will address the question of retroactivity.

Graham Summerlee (Lincoln Financial Group) said the IUL Coalition comment letter (Attachment Eighteen-B) is seeking to add a sentence to Section 5A to ensure that the assumed earned rate from the hedge will not exceed the amount of index credits being illustrated. Mr. Bayerle said the suggested sentence has already been incorporated into the AG 49-A revision.

Mr. Chupp said his comment letter (Attachment Eighteen-C) recommends several changes, including a change to correct the language in Section 5A to be consistent with the examples that the ACLI provided. He agreed to work with Mr. Bayerle to correct the issues in advance of the Task Force conference call.

Having no further business, the IUL Illustration (A) Subgroup adjourned.
THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST SOLD AFTER [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption]

Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for inforce illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective for all new business and in force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption].

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

i. The policy is subject to Model #582.
ii. The policy offers Indexed Credits.

3. Definitions

A. Alternate Scale: A scale of non-guaranteed elements currently being illustrated such that:

   i. The total annual percentage rate \[Annual Rate\] of Indexed Credits for each Index Account does not exceed the lesser of the maximum total percentage rate \[Annual Rate\] of Indexed Credits for the illustrated scale less 100 basis points and the credited rate for the Fixed Account. If the insurer does not offer a Fixed Account with the illustrated policy, the total annual percentage rate \[Annual Rate\] of Indexed Credits for each Index Account shall not exceed the average of the maximum total percentage rate \[Annual Rate\] of Indexed Credits for the illustrated scale and the guaranteed total percentage rate \[Annual Rate\] of Indexed

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Credits for that account. However, the total annual percentage rate Annual Rate of Indexed Credits for each Index Account shall never be less than the guaranteed total percentage rate Annual Rate of Indexed Credits for that account.

ii. If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.

iii. All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding hedges for Indexed Credits), less provisions for investment expenses and default cost, allocated to support the policy. Charges of any kind are not included in, cannot be used to increase the Annual Net Investment Earnings Rate.

C. Annual Rate of Indexed Credits: The annualized total Indexed Credits divided by the account value used to determine index credits according to the policy features.

C.D. Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. The hedge budget Hedge Budget used to determine the cap in 3 (C) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind are not included in, cannot be used to increase the applicable annual cap rate.

vii. There are no additional amounts credited that are linked to an index or indices in excess of the interest calculation provided by the annual cap, including but not limited to experience refunds, multipliers, and bonuses.

viii. There are no limitations on the portion of account value allocated to the account.

ix. A single Benchmark Index Account will be determined for each policy. This can be either an Index Account offered with the illustrated policy or determined according to Section 4(A)(ii) for purposes of complying with this regulation. A policy shall have no more than one Benchmark Index Account.

D.F. Fixed Account: An account where the amounts credited are not tied to an index or indices Indexed Credits.

E.F. Index Account: An account where some or all of the amounts credited are tied to an index or indices Indexed Credits.

F.G. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Credits Amounts credited to the policy resulting from a floor greater than zero on an Index Account are included.

G.H. Hedge Budget: For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This total annualized amount should be consistent with the hedging program of the company.
H.I. **Loan Balance**: Any outstanding policy loan and loan interest, as defined in the policy.

I.J. **Policy Loan Interest Rate**: The current annual interest rate as defined in the policy that is charged on any Loan Balance. This does not include any other policy charges.

J.K. **Policy Loan Interest Credited Rate**: The annual interest rate credited that applies to the portion of the account value backing the Loan Balance, as defined in the policy.

i. For the portion of the account value in the Fixed Account that is backing the Loan Balance that is in a Fixed Account, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate, as defined in the policy.

OPTION FOR CONSIDERATION: Please see commentary on these approaches in the ACLI Comment Letter; language for Option 1 and Option 2 may need to be tightened up:

Option 1: ii. For any portion of the account value in an Index Account that is backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage rate Annual Rate of Indexed Credits, net of any applicable Supplemental Hedge Budget, for that account, as defined in the policy.

Option 2: ii. For any portion of the account value in an Index Account that is backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage rate of the Annual Rate of Indexed Credits and all illustrated bonuses, charge reductions or other enhancements that impact the portion of the account value backing the Loan Balance, as defined in the policy, net of any applicable Supplemental Hedge Budget for that account, as defined in the policy.

K.L. **Supplemental Hedge Budget**: For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that determines the Benchmark Index Account. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

4. **Illustrated Scale**

The total annual percentage rate Annual Rate of Indexed Credits for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for the Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

i. If the insurer offers a Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the Benchmark Index Account in 4 (A).

ii. If the insurer does not offer a Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of the Benchmark Index Account, and shall use that cap in 4 (A).

B. For the Benchmark Index Account the total Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account shall not exceed the minimum of (i) and (ii):

i. the arithmetic mean of the geometric average annual credited rates calculated in 4 (A).

ii. 145% of the Annual Net Investment Earnings Rate.
C. For any other Index Account that is not the Benchmark Index Account in 3 (C), the total Annual Rate of Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii):

i. The maximum Annual Rate of Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the Index Account.

ii. The total Annual Rate of Indexed Credits that should reflect the fundamental characteristics of the Index Account and the appropriate relationship to the expected risk and return of the Benchmark Index Account. The illustration actuary shall use actuarial judgment to determine this value using lookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.

D. For purposes of compliance with Section 6 (C) of Model #582, the Supplemental Hedge Budget may cause the illustrated rate before comparing to exceed the earned interest rate underlying the Disciplined Current Scale. As it is supported by policy charges and not the earned interest rate.

At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale
The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for Indexed Credits, the assumed earned interest rate underlying the disciplined current scale for the policy, inclusive of all general account assets, both hedge and non-hedge assets, that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed:

i. the Annual Net Investment Earnings Rate, plus

ii. 45% of the lesser of (1) and (2):

1. Hedge Budget minus any annual floor.

2. The minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that determines the Benchmark Index Account.

These amounts should be adjusted for timing differences to ensure that fixed interest is not earned on the hedge cost. The assumed returns on hedges shall only be used in the disciplined current scale testing to support the illustrated Index Credits in the policy.

Guidance Note: The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate under the disciplined current scale.

For a product with multiple Index Accounts with different Hedge Budgets that are less than or equal to the NIER, a maximum rate in 5.A. should be calculated for each set of accounts with different Hedge Budgets.

B. If an insurer does not engage in a hedging program for Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the Annual Net Investment Earnings Rate.

C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy’s account value.

6. Policy Loans
If the illustration includes a loan, the illustrated Policy Loan Interest Credited Rate shall not exceed the illustrated Policy Loan Interest Rate by more than 100 basis points. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 5%.

7. Additional Standards

The basic illustration shall also include the following:

A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical Indexed Credits using current index parameters for the most recent 20-year period.
April 30, 2020

Fred Andersen
Deputy Commissioner of Insurance
Minnesota Department of Commerce
Chair, NAIC IUL Illustration (A) Subgroup

Re: ACLI Proposed Draft of Actuarial Guideline 49-A and clarity on earned rate in the DCS and the percentage rate of Indexed Credits

Fred:

This letter is submitted on behalf of John Hancock, Lincoln Financial Group, Pacific Life Insurance Company and Sammons Financial Group. The purpose of this letter is to ask regulators to consider clarifying language on the relationship between the earned rate underlying the DCS in Section 5 and the percentage rate of Indexed Credits in Section 4 of the ACLI draft. The above noted companies have also submitted a separate letter that supports the direction of the ACLI’s proposed AG49-A including prospective-only application and Option #1 regarding the treatment of policy loans. This letter is meant to supplement that letter.

We believe that having clarity regarding the DCS and the rate of Indexed Credits is a minor but necessary change for the industry to have a common understanding of how to apply AG49-A. Different interpretations for this relationship were identified during discussions among carriers regarding potential changes to AG49.

**Interpretation 1:** The earned rate underlying the DCS in Section 5A is not restricted by the percentage rate of Indexed Credits in an illustration.

**Interpretation 2:** The earned rate underlying the DCS in Section 5A should be restricted by the percentage rate of the Indexed Credits in an illustration.

The ACLI examples represent the first interpretation. Example 1 on the tab with the hedge budget equal to the net investment earnings rate shows Indexed Credits at a level of 6.20%, while the Section 5A rate is calculated at 6.53%. In the illustration testing calculations for this example, Interpretation 1 could allow the earned rate underlying the DCS to be 0.33% more than the illustrated rate of Indexed Credits.

However, in a typical IUL design, the contract will state that the index-linked credits will equal the increase in the underlying index and if a carrier has perfectly hedged the amount of index credits, these amounts would be the same and there would be no additional return on the hedge. The hedge return would match the amount credited to the policy values.
Therefore, we believe that the correct interpretation is number 2, that the earned rate underlying the DCS should be limited by the illustrated Indexed Credits. Otherwise, the illustration tests could include margins that are not contractually realizable. For this reason, the IUL Coalition proposal dated February 21 contained the following in Section 5A:

*The assumed return on hedges shall only be used in the disciplined current scale testing to support the illustrated Index Credits in the policy.*

If regulators are comfortable with Interpretation 1, that the earned rate underlying the DCS need not be restricted by the level of Indexed Credits, it would be valuable to have AG49-A directly state this or include a drafting note that clearly allows an illustration actuary to use this interpretation. This will ensure there is consistent interpretation on this issue and clarity for actuaries certifying illustrations for these products.

Thank you for consideration of our comments and we are happy to answer any questions or concerns you may have.

Respectfully Submitted,

Scott R. Harrison
High Point Strategies, LLC
scott@highpointstrategies.llc

cc: Reggie Mazyck, NAIC
Date: April 20, 2020

Please allow me to submit the following comments on behalf of Virginia regarding the following exposure:

ACLI Comments and Draft of AG 49 Dated 4-14-20

1. **Benchmark Index Account.** Section 3(C)(vi). “The hedge budget used to determine the cap” is confusing. Since the floor is zero and we are not allowing multipliers or bonuses, would not all the hedge budget be used for the cap? Why not just say “The Supplemental Hedge Budget shall be zero”?

2. **Policy Loan Interest Rate.** Section 3(I). Other policy charges are not included in the loan charges. I would just like to point out that on the 10/17/19 LATF call, asset-based charges were included with loan charges in the 100 bps limit. It would seem that not including asset-based charges is more restrictive and therefore may be acceptable?

3. **Interest Credits.** Section 3(F). The second sentence of the definition is not consistent with the first sentence. The first sentence requires the interest credit to be linked to an index. The second sentence seems to include any credit whether or not it is linked to an index. If the intention is to include guaranteed interest credited due to a floor, then would not any guaranteed interest credits fall under this definition, including guaranteed interest credits on a non-indexed UL policy? This would potentially bring non-indexed UL policies into the scope of AG 49. Also, by including guaranteed interest credits in the definition of Interest Credits, they also get included in the definition of Hedge Budget, which does not seem right, since these amounts are not used for hedging.

4. **Supplemental Hedge Budget.** Section 3(K). Should not “hedge budget” be capitalized? “The hedge budget that determines the Benchmark Index Account” is somewhat confusing. Would it be clearer to say “The Hedge Budget that is used in the determination of the Benchmark Index Account”? This also applies to Section 5(A)(ii)(2).

5. **Illustrated Scale.** Section 4(A)(ii). This subsection states that it is possible for an insurer to “not offer a Benchmark Index Account with the illustrated policy.” However, Section 3(C)(ix) states a “Benchmark Index Account will be determined for each policy.” Does this mean that an insurer is required to determine a single Benchmark Index Account for each policy for purposes of Section 4(B) but does not have to offer this Benchmark Index Account as an option to the policyholder? If so, this should be made more clear in Section 4(A)(ii) or elsewhere in AG 49. If this is not the case, then language in Sections 3(K) and 4(C)(i) which assumes that each policy will have a Benchmark Index Account will need to be changed.

6. **Disciplined Current Scale.** Section 5(A). In the last sentence of Section 5(A), “NIER” is not defined. Also, the language is not clear. Does it mean one maximum rate that applies for all Index Accounts or a separate maximum rate for each Index Account? Also, there may be other situations where a maximum rate in 5(A) should be calculated for each set of Index Accounts. What if there is an Index Account with a floor and a Hedge Budget greater than the Annual Net Investment Earnings Rate (see Examples 8 and 9 in the mechanics worksheet)? What if the
Hedge Budget is the same for two different Index Accounts which have different floors? Also, the formula in the worksheet examples does not match the language. Should not the Earned Rate in Examples 8 and 9 be 6.12% and 6.20%, respectively? For Example 8: .045 + .45*min(.0461 -.01, .045) = 6.12%.

Thank you for providing me the opportunity to submit this comment.

Craig Chupp, FSA, MAAA
Life and Health Insurance Actuary
Virginia Bureau of Insurance
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Phone: (804) 371-9131
The IUL Illustration (A) Subgroup of the Life Actuarial (A) Task Force met via conference call May 26, 2020. The following Subgroup members participated: Fred Andersen, Chair (MN); Ted Chang (CA); Andrew Greenhalgh (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Rhonda Ahrens (NE); Bill Carmello (NY); Peter Weber (OH); Mike Boerner and John Carter (TX); Tomasz Serbinowski (UT); and Craig Chupp (VA).

1. Discussed Technical Edits to the ACLI AG 49 Proposal

Brian Bayerle (American Council of Life Insurers—ACLI) discussed the changes made to the ACLI proposal for edits to Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49) (Attachment Nineteen-A) resulting from comments provided on the May 21 Life Actuarial (A) Task Force conference call. The Subgroup agreed with the revisions being proposed, except for a few minor edits. Mr. Bayerle said he would create a redline version by applying the agreed upon edits to the current version of AG 49. He noted that the Task Force will be called upon to decide on the desired approach for determining the crediting rate for policy loans.

Having no further business, the IUL Illustration (A) Subgroup adjourned.
THE APPLICATION OF THE LIFE ILLUSTRATIONS MODEL REGULATION TO POLICIES WITH INDEX-BASED INTEREST SOLD AFTER [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption]

Background

The Life Insurance Illustrations Model Regulation (#582) was adopted by the NAIC in 1995. Since that time there has been continued evolution in product design, including the introduction of benefits that are tied to an index or indices. Although these policies are subject to Model #582, not all of their features are explicitly referenced in the model, resulting in a lack of uniform practice in its implementation. In the absence of uniform guidance, two illustrations that use the same index and crediting method often illustrated different credited rates. The lack of uniformity can be confusing to potential buyers and can cause uncertainty among illustration actuaries when certifying compliance with Model #582.

In 2019, the NAIC decided that illustrations of products with multipliers, cap buy-ups, and other enhancements should not illustrate better than products without such features. This new requirement is intended to apply to illustrations on policies sold on or after the effective date of this guideline while the existing requirements continue to apply for in-force illustrations on policies sold before the effective date of this guideline.

This guideline provides uniform guidance for policies with index-based interest. In particular, this guideline:

1. Provides guidance in determining the maximum crediting rate for the illustrated scale and the earned interest rate for the disciplined current scale.
2. Limits the policy loan leverage shown in an illustration.
3. Requires additional consumer information (side-by-side illustration and additional disclosures) that will aid in consumer understanding.

Text

1. Effective Date

This Actuarial Guideline shall be effective for all new business and in force illustrations on policies sold on or after [greater of 5 months after LATF adoption and 3 months after EX/Plenary Adoption].

   i. Sections 4 and 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after September 1, 2015.
   ii. Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in-force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold.
   iii. Sections 6 and 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

2. Scope

This Actuarial Guideline shall apply to any life insurance illustration that meets both (i) and (ii), below:

   i. The policy is subject to Model #582.
Definitions

Annual Net Investment Earnings Rate: The annual net investment earnings rate for each Index Account does not exceed the lesser of the maximum annual net investment earnings rate for each Index Account shall not exceed the average of the maximum annual net investment earnings rate of Indexed Credits for that account. However, the annual net investment earnings rate of Indexed Credits for each Index Account shall never be less than the guaranteed annual percentage rate of Indexed Credits for that account.

If the illustration includes a loan, the illustrated rate credited to the loan balance does not exceed the illustrated loan charge.

Policy Loan Interest Rate. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 4%.

All other non-guaranteed elements are equal to the non-guaranteed elements for the illustrated scale.

B. Annual Net Investment Earnings Rate: Gross portfolio annual earnings rate of the general account assets (excluding policy. Charges of any kind are not included in the Annual Net Investment Earnings Rate.

Benchmark Index Account: An Index Account with the following features:

i. The interest calculation is based on the percent change in the S&P 500® Index value only, over a one-year period using only the beginning and ending index values. (S&P 500® Index ticker: SPX)

ii. An annual cap is used in the interest calculation.

iii. The annual floor used in the interest calculation shall be 0%.

iv. The participation rate used in the interest calculation shall be 100%.

v. Interest is credited once per year.

vi. Account charges do not exceed the account charges for any corresponding Index Accounts within the policy in any policy year. If Index Accounts with different levels of account charges are offered with the illustrated policy, more than one Benchmark Index Account may be used in determining the annual net investment earnings rate for the policy's Index Accounts, subject to the requirements of 5.D.

vi. Additional amounts credited The Hedge Budget used to determine the cap in 3 (C) (ii) does not exceed the Annual Net Investment Earnings Rate. Charges of any kind are not included when determining the applicable cap rate.
vii. There are not less than these additional amounts credited for any corresponding Index Accounts within the policy in any policy year. Any rate calculated in (B) shall not apply for an Index Account if the additional amounts credited for the applicable Benchmark Index Account that are less than the additional amounts credited for that Index Account in any policy year. Additional amounts include all credits that increase policy values linked to an index or indices in excess of the interest calculation, including but not limited to experience refunds, multipliers and bonuses.

viii. There are no limitations on the portion of account value allocated to the account.

ix. A single Benchmark Index Account will be determined for each policy. A policy shall have no more than one Benchmark Index Account.

C.D. Fixed Account: An account where the amounts credited rate are not tied to an external index or indices.

D.E. Index Account: An account where the amounts credited rate are tied to an external index or indices.

F. Indexed Credits: Any interest credit, multiplier, factor, bonus, charge reduction, or other enhancement to policy values that is linked to an index or indices. Credits to the policy resulting from a floor are included.

G. Hedge Budget: For each Index Account, the total annualized amount assumed to be used to generate the Indexed Credits of the account, expressed as a percent of the account value in the Index Account. This amount should be consistent with the hedging program of the company.

H. Loan Balance: Any outstanding policy loan and loan interest, as defined in the policy.

Commented [A10]: Academy #4: We are unclear on how to do the “in excess of the interest calculation” that is specified in the definition and suggest examples or more wording to provide clarity.

Commented [A11R10]: ACLI suggest “in excess of the interest provided by the cap”

Commented [A12]: Academy #6: Suggests “an account where no amount credited is linked to an index or indices”

Commented [A13R12]: ACLI: Make Consistent with Index Account: “an account where there are no Indexed Credits”

Commented [A14]: Academy #7: Suggests: ”We suggest modifying the definition of Index Account to be ‘an account that includes a guaranteed interest credited due to a floor, then would not any guaranteed interest credits fall under this definition, including guaranteed interest credits on a non-indexed UL order? This would potentially bring non-indexed UL policies into the scope of AC #6. Also, by including guaranteed interest credits at the definition of Indexed Credits, they are not included in the definition of Hedge Budget, which does not seem right, since these amounts are not used for hedging.”

Academy #8: It is unclear in the definition of Indexed Credits how a company addresses the floor, for example, is this an annuity floor or a cumulative floor? Also, is there a difference between interest credit vs. credit to the policy? To be consistent with previous language in the draft, using “Amounts credited to the policy” rather than “Credits to the policy...” when including the floor may be clearer.

Commented [A14R15]: ACLI: Agree need to clarify 2+ statement. Suggest: “Amounts credited to the policy resulting from a floor on an Index Account are included.”

Commented [A17]: Academy #5: Agrees with Academy #3 that non-indexed amounts should be...
I. Policy Loan Interest Rate: The annual interest rate that is charged on any Loan Balance. This does not include any other policy charges.

J. Policy Loan Interest Credited Rate: The annual interest rate credited that applies to the portion of the account value backing the Loan Balance, as defined in the policy.

i. For the portion of the account value backing the Loan Balance that is in a Fixed Account, the Policy Loan Interest Credited Rate is the applicable annual interest crediting rate, as defined in the policy.

OPTION FOR CONSIDERATION: Please see commentary on these approaches in the ACLI Comment Letter; language for Option 1 and Option 2 may need to be tightened up:

Option 1: ii. For any portion of the account value backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage rate of Indexed Credits, net of any applicable Supplemental Hedge Budget for that account, as defined in the policy.

Option 2: ii. For any portion of the account value backing the Loan Balance that is in an Index Account, the Policy Loan Interest Credited Rate is the total percentage rate of Indexed Credits and all illustrated bonuses, charge reductions or other enhancements that impact the portion of the account value backing the Loan Balance, net of any applicable Supplemental Hedge Budget for that account, as defined in the policy.
K. **Supplemental Hedge Budget.** For each Index Account, the Hedge Budget minus the minimum of the Annual Net Investment Earnings Rate and the Hedge Budget that determines the Benchmark Index Account. The Supplemental Hedge Budget will never be less than zero. This amount should be consistent with the hedging program of the company.

4. **Illustrated Scale**

The **annual percentage rate of Indexed Credits** for the illustrated scale for each Index Account shall be limited as follows:

A. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.

i. If the insurer offers an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use the current annual cap for the applicable Benchmark Index Account in 4 (A).

ii. If the insurer does not offer an applicable Benchmark Index Account with the illustrated policy, the illustration actuary shall use actuarial judgment to determine a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of applicable Benchmark Index Account, and shall use that cap in 4 (A).

B. For each applicable Benchmark Index Account, the total Indexed Credits illustrated as a percentage of the account value in the Index Account shall not exceed the minimum of (i) and (ii):

i. The arithmetic mean of the geometric average annual credited rates calculated in 4 (A) shall be the maximum credited rate(s) for the illustrated scale.

ii. 145% of the Annual Net Investment Earnings Rate.

C. For any other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgment to determine the maximum credited rate Account that is not the Benchmark Index Account in 3 (C), the total Indexed Credits illustrated as a percentage of the account value in the Index Account prior to the deduction of any charges used to fund a Supplemental Hedge Budget shall not exceed the minimum of (i) and (ii):

i. The maximum Indexed Credits for the Benchmark Index Account calculated in 4 (B) plus the Supplemental Hedge Budget for the illustrated scale. The determination shall Index Account.

ii. The total Indexed Credits that reflect the fundamental characteristics of the Index Account and the parameters shall have the appropriate relationship to the expected risk and return of the applicable Benchmark Index Account. The determination shall use actuarial judgment to determine this value using lookback methodology consistent with 4 (A) and 4 (B) (i) where appropriate.

D. For purposes of compliance with Section 6 (C) of Model #582, the credited rate for Supplemental Hedge Budget may cause the illustrated scale rate to exceed the earned interest rate underlying the Disciplined Current Scale, applicable rate calculated in 4 (B).
At the beginning of each calendar year, the insurer shall be allowed up to three (3) months to update the credited rate for each Index Account in accordance with 4 (B) and 4 (C).

5. Disciplined Current Scale
The earned interest rate for the disciplined current scale shall be limited as follows:

A. If an insurer engages in a hedging program for index-based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed 145% for the policy, inclusive of the annual net investment earnings rate (gross portfolio earnings less provisions for investment expenses and default costs) of all general account assets (excluding hedges for index-based credits) allocated to support the policy and hedge assets that support the policy, net of default costs and investment expenses (including the amount spent to generate the Indexed Credits of the policy) shall not exceed:
   i. the Annual Net Investment Earnings Rate, plus
   ii. 45% of the lesser of (1) and (2):
       1. Hedge Budget minus any annual floor.
       2. the Annual Net Investment Earnings Rate and the Hedge Budget that determines the Benchmark Index Account.

   These amounts should be adjusted for timing differences to ensure that fixed interest is not earned on the hedge cost.

The above approach does not stipulate any required methodology as long as it produces a consistent limit on the assumed earned interest rate.

For a product with multiple Index Accounts with different Hedge Budgets that are less than or equal to the Annual Net Investment Earnings Rate a maximum rate in 5.A. should be calculated for each set of accounts with different Hedge Budgets.

B. If an insurer does not engage in a hedging program for index-based interest Indexed Credits, the assumed earned interest rate underlying the disciplined current scale shall not exceed the annual net investment earnings rate of the general account assets allocated to support the policy.

C. These experience limitations shall be included when testing for self-support and lapse-support under Model #582, accounting for all illustrated benefits including any illustrated benefits and bonuses that impact the policy’s account value.

E. If more than one Benchmark Index Account is used for an illustrated policy, each set of Index Accounts that correspond to each Benchmark Index Account must independently pass the self-support and lapse-support tests under Model #582, subject to the limitations in 5.A., 5.B., and 5.C. All experience assumptions that do not directly relate to the Index Accounts or to expenses, mortality, investment earnings rate of the general account assets, lapses, and election of any Fixed Account shall equal the assumptions used in the testing for the entire policy.

2.6. Policy Loans
If the illustration includes a loan, the illustrated rate credited to the loan balance Policy Loan Interest Credited Rate shall not exceed the illustrated loan charge Policy Loan Interest Rate by more than 100 basis points. For example, if the illustrated Policy Loan Interest Rate is 4%, the Policy Loan Interest Credited Rate shall not exceed 5%.

7. Additional Standards
The basic illustration shall also include the following:
A. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

B. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

C. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical Indexed Credits using current index parameters for the most recent 20-year period.
January 31, 2020

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force (LATF)

Re: Amendment Proposal Forms (APFs) Exposed During NAIC Fall Meeting

Dear Mike:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to submit the following comments regarding the following APFs exposed during the NAIC 2019 Fall Meeting:

**APF 2019-33: Individually underwritten group life insurance**

ACLI has significant concerns with this amendment in its current form. We have two main areas of concern: the scope implied by the definition of “individual risk selection process” and practical implementation concerns.

Regarding scope, we believe that the wording may inadvertently loop in business not intended to be in scope. For example, something as simple as smoking status could be construed as “individual underwriting”, greatly expanding the business that would be impacted by this proposal. The use of underwriting as the criteria to define what is in scope for PBR is a simplification that could scope in traditional group life policies that are priced based on the unique claim costs of an employer group. We do not believe that is the intent of this APF. The definition of what is in scope for the APF requires additional contemplation.

Our second concern is around the practical implementation of the amendment. If individually underwritten group business becomes subject to PBR, it would have to follow the prescribed NPR requirements. However, the expected mortality and lapse rates for individually underwritten group business may be different than the prescribed mortality and lapse assumptions in VM-20. Compounding the problem, we are unaware of any experience studies that have been done on this type of business and deriving appropriate assumptions for other underwriting types, such as guaranteed issue and simplified issue, have proven difficult. Without potential adjustments to mortality and lapse rates for individually underwritten group business, companies may see excessive or nonsensical results for the NPR.

At this time, ACLI is unaware of a wide-spread issue associated with individually underwritten group business; we suspect this is more of a hypothetical problem. As such, we don’t see a pressing need for

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\(^1\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.
this APF. We suggest that LATF continue to monitor this issue, and if changes are deemed necessary, LATF should request that the Academy make significant revisions to avoid excessive scope and unintended consequences.

APF 2019-62: Considerations for term conversion reserves
ACLJ agrees with the American Academy of Actuaries’ Life Reserves Work Group on the need to understand what mortality adjustments are being made for term conversions. We support this APF’s improved disclosures associated with conversions.

APF 2019-60: Allowance for additional credibility methods
ACLJ supports this amendment. This APF provides important flexibility around credibility methods for companies with simplified underwriting business.

APF 2019-61: Clarification around secondary guarantee riders
ACLJ believes this APF is a straight-forward clarification around what constitutes a secondary guarantee, and supports this amendment.

We look forward to a discussion of these issues. Thank you.

Sincerely,

[Signature]

cc Reggie Mazyck, NAIC
Date: December 12, 2019

Please allow me to submit the following comment on behalf of Virginia regarding the following exposure:

APF 2019-33 (Clarify definition of individually underwritten life insurance and applicability of PBR for group insurance)

Comment:

Subsection 1.B under Section II. “Reserve Requirements” of the VM addresses minimum reserve requirements for “individual life contracts”. Since individual life and group life are two distinct and non-overlapping categories of contracts, the new proposed Subsection 1.B.1 which address certain group life contracts should not be placed under Subsection 1.B, but should be pulled out from under Subsection 1.B and made its own Subsection 1.C. Subsections 1.B.2 and 1.B.3 should also be pulled out from under Subsection 1.B and renumbered.

Suggested Edits to APF 2019-33:

Subsection 1: Life Insurance Products

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

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

C. Minimum reserve requirements for group life contracts in which the individual certificate holders were subjected to an individual risk selection process as described in VM-20 Section 1.B to obtain the insurance coverage are provided by VM-20, except for election of the transition period in paragraph F below.

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

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

1. Business described in paragraph C above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.
2. Business not described in paragraph C otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

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

Life PBR Exemption

1. A company meeting the condition in GD.2 below may file a statement of exemption for ordinary life insurance policies and group life contracts individually underwritten life insurance policies, except for policies in GD.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. Such a statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that condition GD.2 was met based on premiums from the prior calendar year annual statement. The statement of exemption must also be included with the NAIC filing for the second quarter of that year.

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

2. Condition for Exemption:
   a. The company has less than $300 million of ordinary life premiums1, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums1 of less than $600 million.

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

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

Footnote change

1-Premiums are measured as direct plus reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance”. For exemptions after 1/1/2024, premiums should also include the premiums from...
group life insurance certificates that were subject to an individual risk selection process as defined in VM-20 Section 1.B and included in the group life certificates subject to an individual risk selection process line of business reported in the prior calendar year life/health annual financial statement, VM-20 Reserves Supplement, Part 3. Premiums should exclude premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed and guaranteed issue life insurance policy are as defined in VM-01.

Thank you for providing me the opportunity to submit this comment.

Craig Chupp, FSA, MAAA
Life and Health Insurance Actuary
Virginia Bureau of Insurance
craig.chupp@scc.virginia.gov
Phone: (804) 371-9131

Commented [A1]: This will need to be added to the PBR Supplement by the NAIC Blanks (E) Working Group.
APF 2019-33 – Individually Solicited Group Contracts

Comments by John Robinson, Minnesota

January 7, 2020

The APF mentions a revision to VM-51 to incorporate these contracts. However, no modifications to the VM-51 layout are offered.

APF 2019-56 addresses a series of important changes to the VM-51 layout, which will make it a multi-table system. I have previously commented that the table structure of the system needs to be carefully designed.

Adding group contracts will also require careful design considerations. For example, it is possible that fields should be added for

(a) Certificate Number (applicable to each covered individual in the group contract); and

(b) An indicator, “I” for individual”, and “G” for group, to tell whether a particular contract is individual or group.

A suggest that these considerations be included in the work currently being done for APF 2019-56.

Thank you.

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

American Academy of Actuaries, Life Reserves Work Group

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

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

January 1, 2020 version of the Valuation Manual used.

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

See Appendix

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

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

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

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate and do not require continued membership in the group in order to maintain coverage. The certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing and risk classification, and are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Eight changes are recommended:

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

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

3) Within the Reserve Requirements section (Section II), add language to Subsection 1.D and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes;

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

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

6) Modify VM-51 Section 2.B to no longer exempt individually solicited group life which meet the requirements and definitions under items (1) and (2) above; and

7) Modify VM-51, Appendix 4, Item 17 to no longer exempt individually solicited group life contracts which meet the requirements under items (1) and (2) above.

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

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

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

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

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

Subsection 1: Life Insurance Products

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

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

C. Minimum reserve requirements for group life contracts with individual certificates which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F below.

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

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

F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for...
1. Business described in subsection 1.C above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

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

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

Life PBR Exemption

1. A company meeting the condition in subsection DG.2 below may file a statement of exemption for ordinary life insurance policies including group life insurance certificates subject to an individual risk selection process and meeting all the conditions in VM-20 Section 1.B, except for policies in subsection DG.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. Such a statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that condition subsection DG.2 was met based on premiums from the prior calendar year annual statement. The statement of exemption must also be included with the NAIC filing for the second quarter of that year.

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

2. Condition for Exemption:
   a. The company has less than $300 million of ordinary life premiums, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums of less than $600 million.

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

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

Footnote change

Premiums are measured as direct plus reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance”. Premiums should include the premiums from group life insurance certificates that were subject to an individual risk selection process and meet all the conditions as defined in VM-20 Section 1.B. For a statement of exemptions filed for calendar year 2022 and beyond, the premiums for these group life certificates were reported in the prior calendar year life/health annual financial statement, VM-20 Reserves Supplement Part 2, if applicable. Premiums should exclude premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force at the effective date of a reinsurance transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed and guaranteed issue life insurance policies are as defined in VM-01.
VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

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

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.

B. If all of the following requirements are met, individual life certificates under a group contract are included in the requirements of VM-20.

(i) An individual risk selection process, defined below, is used to obtain group life insurance coverage;

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

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

(iv) The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification as individual ordinary life insurance contracts;

(v) The group master contract and individual certificates are issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #820.

An individual risk selection process is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), on-line health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.
Guidance Note: The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.
VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

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

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

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
Section 1: Introduction

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

Section 2: Statistical Plan for Mortality

A. Type of Experience Collected Under This Statistical Plan

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

B. Scope of Business Collected Under This Statistical Plan

The data for this statistical plan is the individual ordinary life line of business. Such business is to include direct written business issued in the U.S., and all values should be prior to any reinsurance ceded. Therefore, reinsurance assumed from a ceding company shall be excluded from data collection to avoid double-counting of experience submitted by an issuer and by its reinsurers; however, assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life that does not meet all the requirements as defined in VM-20 Section 1.B, direct response, final expense, preneed, home service, credit life and COLI BOLI/charity-owned life insurance (CHOLI).

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

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

Additional exemptions may be granted by the Experience Reporting Agent where appropriate, following consultation with the domestic insurance regulator, based on achieving a target level of approximately 85% of industry experience for the type of experience data being collected under this statistical plan.
### VM Change 7 – VM-51: Experience Reporting Formats, Appendix 4: Mortality Data Elements and Format

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1–5</td>
<td>5</td>
<td>NAIC Company Code</td>
<td>Your NAIC Company Code</td>
</tr>
<tr>
<td>2</td>
<td>6–9</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
</tr>
<tr>
<td>3</td>
<td>10–29</td>
<td>20</td>
<td>Policy or Certificate Number</td>
<td>Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.</td>
</tr>
<tr>
<td>4</td>
<td>30</td>
<td>1</td>
<td>Individual Contract or Group Certificate</td>
<td>Enter I if for an Individual Contract or G for Group Contract, even if issued using an individual risk selection process and meets all the requirements as defined in VM-20 Section 1.B.</td>
</tr>
</tbody>
</table>
| 45   | 30–32  | 31–33 | Segment Number | If only one policy segment exists, enter segment number ‘1.’ For a single life policy, the base policy is to be put in the record with segment number ‘1.’ Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. For joint life policies, the base policy of the first life is to be put in a record with segment number ‘1,’ and the base policy of the second life is to be put in a separate record with segment number ‘2.’ Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. Policy segments with the same policy number are to be submitted for:
   a) Single life policies;
   b) Joint life policies;
   c) Term/paid up riders; or
   d) Additional amounts of insurance including purchase through dividend options. |
| 6    | 33–34  | 34–35 | State of Issue | Use standard, two-letter state abbreviation codes (e.g., NY for New York) |
| 67   | 36     | 1 | Gender | 0 = Unknown or unable to subdivide
1 = Male
2 = Female
3 = Unisex – Unknown or unable to identify
4 = Unisex – Male
5 = Unisex – Female |
| 28   | 37–43  | 38–44 | Date of Birth | Enter the numeric date of birth in YYYYMMDD format |
| 89   | 45     | 1 | Age Basis | 0 = Age Nearest Birthday
1 = Age Last Birthday
2 = Age Next birthday |

**Drafting Note:** Professional actuarial organization will need to develop either age next birthday mortality tables.
or procedure to adapt existing mortality tables to age next birthday basis.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>910</td>
<td>44-46</td>
<td>3</td>
<td>Issue Age</td>
<td>Enter the insurance Issue Age</td>
</tr>
<tr>
<td>1011</td>
<td>48-50</td>
<td>8</td>
<td>Issue Date</td>
<td>Enter the numeric calendar year in YYYYMMDD format.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>L</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td>1112</td>
<td>54-56</td>
<td>1</td>
<td>Smoker Status (at issue)</td>
<td>Smoker status should be submitted where reliable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0 = Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = No tobacco usage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Nonsmoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Cigarette smoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 = Tobacco user</td>
</tr>
<tr>
<td>1113</td>
<td>57-58</td>
<td>1</td>
<td>Preferred Class Structure Indicator</td>
<td>0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: If Preferred Class Structure Indicator is 0, or if preferred information is unknown, leave next four items blank.</td>
</tr>
<tr>
<td>1114</td>
<td>59-60</td>
<td>1</td>
<td>Number of Classes in Nonsmoker Preferred Class Structure</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue.</td>
</tr>
<tr>
<td>1115</td>
<td>61-62</td>
<td>1</td>
<td>Nonsmoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = Best preferred class</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Next Best preferred class after 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Next Best preferred class after 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 = Next Best preferred class after 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 = Next Best preferred class after 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 = Next Best preferred class after 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7 = Next Best preferred class after 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8 = Next Best preferred class after 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9 = Next Best preferred class after 8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: The policy segment with the highest nonsmoker Preferred Class number should have that number equal to the Number of Classes in Nonsmoker Preferred Class Structure.</td>
</tr>
<tr>
<td>ITEM</td>
<td>COLUMN</td>
<td>D</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>S16</td>
<td>4461</td>
<td>1</td>
<td>Number of Classes in Smoker Preferred Class Structure</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.</td>
</tr>
<tr>
<td></td>
<td>4462</td>
<td>1</td>
<td>Smoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker policy segments that could have been issued as one of multiple preferred and standard classes: 1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8 Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure.</td>
</tr>
<tr>
<td></td>
<td>4463</td>
<td>2</td>
<td>Type of Underwriting Requirements</td>
<td>If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life that does not meet all the requirements as defined in VM-20 Section 1.B, direct response, final expense, pre-need, home service and COLI/BOLI/CHOLI 01 = Underwritten, but unknown whether fluid was collected 02 = Underwritten with no fluid collection 03 = Underwritten with fluid collected 06 = Term Conversion 07 = Group Conversion 09 = Not Underwritten 99 = For issues where underwriting requirement unknown or unable to subdivide</td>
</tr>
<tr>
<td>ITEM</td>
<td>COLUMN</td>
<td>L</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
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<td>-------------</td>
</tr>
<tr>
<td>1819</td>
<td>1</td>
<td>Substandard Indicator</td>
<td>0 = Policy segment is not substandard 1 = Policy segment is substandard 2 = Policy segment is uninsurable</td>
<td></td>
</tr>
</tbody>
</table>
| 1820 | 65–6766-68 | Plan Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below: 000 = If unable to distinguish among plan types listed below 100 = Joint life plan unable to distinguish among joint life plan types listed below Permanent Plans: 010 = Traditional fixed premium fixed benefit permanent plan 011 = Permanent life (traditional) with term 012 = Single premium whole life 013 = Econolife (permanent life with lower premiums in the early durations) 014 = Excess interest whole life 015 = First to die whole life plan (submit separate records for each life) 016 = Second to die whole life plan (submit separate records for each life) 017 = Joint whole life plan – unknown whether 015 or 016 (submit separate records for each life) 018 = Permanent products with non-level death benefits 019 = Permanent plans 010, 011, 012, 013, 014, 015, 016, 017, 018 combined (i.e. unable to separate) Term Insurance Plans: 020 = Term (traditional level benefit and attained age premium) 021 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for five years) 211 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 10 years) 212 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 15 years) 213 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 20 years)
<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>214</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>215</td>
<td>Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>022</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)</td>
</tr>
<tr>
<td>221</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)</td>
</tr>
<tr>
<td>222</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>223</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)</td>
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<tr>
<td>224</td>
<td>Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)</td>
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<tr>
<td>023</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)</td>
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<tr>
<td>231</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)</td>
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<tr>
<td>232</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>233</td>
<td>Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>024</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)</td>
</tr>
<tr>
<td>241</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>242</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 years)</td>
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<tr>
<td>025</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>251</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>026</td>
<td>Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>027</td>
<td>Term (level death benefit with guaranteed level premium period equal to anticipated level term period where the period is other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>271</td>
<td>Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than five, 10, 15, 20, 25 or 30 years)</td>
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<tr>
<td>028</td>
<td>Term (decreasing benefit)</td>
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<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>040</td>
<td>Select ultimate term (premium depends on issue age and duration)</td>
</tr>
<tr>
<td>041</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 15 years)</td>
</tr>
<tr>
<td>042</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 20 years)</td>
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<tr>
<td>043</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 25 years)</td>
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<tr>
<td>044</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 30 years)</td>
</tr>
<tr>
<td>045</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)</td>
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<tr>
<td>046</td>
<td>Economatic term</td>
</tr>
<tr>
<td>059</td>
<td>Term plan, unable to classify</td>
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<tr>
<td>101</td>
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<tr>
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<td>Second to die term plan (submit separate records for each life)</td>
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<tr>
<td>103</td>
<td>Joint term plan – unknown whether 101 or 102 (submit separate records for each life)</td>
</tr>
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<td>Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:</td>
</tr>
<tr>
<td>061</td>
<td>Single premium universal life</td>
</tr>
<tr>
<td>062</td>
<td>Universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>063</td>
<td>Universal life (level risk amount)</td>
</tr>
<tr>
<td>064</td>
<td>Universal life – unknown whether code 062 or 063</td>
</tr>
<tr>
<td>065</td>
<td>First to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>066</td>
<td>Second to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>067</td>
<td>Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)</td>
</tr>
<tr>
<td>068</td>
<td>Indexed universal life</td>
</tr>
<tr>
<td></td>
<td>Universal Life Plans (Other than Variable) with Secondary Guarantees:</td>
</tr>
<tr>
<td>071</td>
<td>Single premium universal life with secondary guarantees</td>
</tr>
<tr>
<td>072</td>
<td>Universal life with secondary guarantees (decreasing risk amount)</td>
</tr>
<tr>
<td>073</td>
<td>Universal life with secondary guarantees (level risk amount)</td>
</tr>
<tr>
<td>074</td>
<td>Universal life with secondary guarantees – unknown whether code 072 or 073</td>
</tr>
<tr>
<td>075</td>
<td>First to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>076</td>
<td>Second to die universal life plan with secondary guarantees (submit separate records for each life)</td>
</tr>
<tr>
<td>077</td>
<td>Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)</td>
</tr>
<tr>
<td>078</td>
<td>Indexed universal life with secondary guarantees</td>
</tr>
<tr>
<td></td>
<td>Variable Life Plans issued without a Secondary Guarantee:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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080 = Variable life
081 = Variable universal life (decreasing risk amount)
082 = Variable universal life (level risk amount)
083 = Variable universal life – unknown whether code 081 or 082
084 = First to die variable universal life plan (submit separate records for each life)
085 = Second to die variable universal life plan (submit separate records for each life)
086 = Joint life variable universal life plan – unknown whether 084 or 085 (submit separate records for each life)

Variable Life Plans with Secondary Guarantees:
090 = Variable life with secondary guarantees
091 = Variable universal life with secondary guarantees (decreasing risk amount)
092 = Variable universal life with secondary guarantees (level risk amount)
093 = Variable universal life with secondary guarantees – unknown whether code 091 or 092
094 = First to die variable universal life plan with secondary guarantees (submit separate records for each life)
095 = Second to die variable universal life plan with secondary guarantees (submit separate records for each life)
096 = Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)

Nonforfeiture:
098 = Extended term
099 = Reduced paid-up
198 = Extended term for joint life (submit separate records for each life)
199 = Reduced paid-up for joint life (submit separate records for each life)
VM Change 8 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for the group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other Group Insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.
Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
Clarify NPR calculation requirements.

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

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

January 1, 2020 NAIC Valuation Manual

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

See attached.

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

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

24. Since terminal reserves are computed as of the end of a policy year and not the reporting date, the terminal reserve as of policy anniversaries immediately prior and subsequent to the reporting date are adjusted to reflect that portion of the net premium that is unearned at the reporting date. This is generally accomplished using either the mean reserve method or the mid-terminal method as discussed in paragraphs 25-28. Other appropriate methods, including an exact reserve valuation, may also be used.
For re-exposure, to address both the question posed in the initial exposure of clearly reflecting both mean and mid-terminal adjustments, as well as to address comments received, I recommend language consistent with SSAP 51R, paragraph 24. SSAP 51R paragraphs 25-28 are referenced by paragraph 24. They are provided below for completeness, and specific references for policies subject to the Valuation Manual are highlighted.

**Mean Reserve Method**

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

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

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

**Mid-Terminal Method**

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

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

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

**NAIC Staff Comments:**

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**Notes:** APF 2020-03 revised 2/26/20 Exposed 2/27/20, Revised 3/31/20
VM-20 Section 3.B.1 – 3.B.3

B. NPR Calculation

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

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

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

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

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

2. The definition of the NPR in Section 3.B.4, Section 3.B.5 and Section 3.B.6 is intended to result in the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4, Section 3.B.5 and Section 3.B.6, the gross premium referenced should be the gross premium for the policy assuming an annual premium mode.

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

Guidance Note: The definition of the NPR in Section 3.B.4, Section 3.B.5 and Section 3.B.6 is intended to result in a terminal NPR under the assumption of an annual mode gross premium. The gross premium referenced should be the gross premium for the policy assuming an annual premium mode. The reported reserve as of any valuation date should reflect the actual premium mode for the policy and the actual valuation date relative to the policy issue date either directly or through adjusting accounting entries.

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

As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted $ASG_{x+t}$, as outlined in Section 3.B.2-1.c and the fully funded secondary guarantee, denoted $FFSG_{x+t}$, as outlined in Section 3.B.1.b.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

John Robinson, Director PBR – Valuation Actuary, MN

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


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

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

The purposes of this APF are to
(a) Affirm that if a block of business is subject to SVL before being reinsured on a modco basis, it remains subject to SVL when reinsured on a modco basis.
(b) Clarify the responsibilities of the appointed actuaries of both the ceding and assuming companies, relative to both the SAO and asset adequacy analysis.
(c) Make a minor modification to the table headings in VM-30, Section 3.A.5.

The proposed text is in the Appendix below.

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

NAIC Staff Comments:

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<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Notes: VM Maintenance Agenda 2019-34
APPENDIX

1. It is proposed to add the following text as VM-30, Section 4:

Section 4: Modified Coinsurance Reserves

1. A block of business that would be subject to Model #820 were it not reinsured under
   a modified coinsurance agreement remains subject to Model #820 if it is reinsured under
   a modified coinsurance agreement.

2. Reserves for a block of business that is subject to Model #820 and is reinsured under
   a modified coinsurance agreement, are subject to
   a. the statement of actuarial opinion of the ceding company’s appointed actuary
      (Section 3.A); and
   b. asset adequacy analysis (Section 3.B).

Guidance Note: The asset adequacy analysis may be performed by either the
ceding or assuming company. The result of the asset adequacy analysis must be
reported in the ceding company’s actuarial memorandum.

In accordance with Section 3.A.6, the ceding company’s appointed actuary may
rely on the assuming company for data, assumptions and more, but may not
simply rely on their actuarial opinion. Similarly, in accordance with Section 3.B.2,
ceding company’s appointed actuary may rely on the assuming company’s
actuarial memorandum, but may not simply rely on their actuarial opinion.

3. In the event that the assuming company is required, either by law or under the
   reinsurance agreement, to ensure the adequacy of such reserves, the assuming
   company shall perform an asset adequacy analysis (Section 3.B).

2. Revision to Section 3.A.5, Table Headings:

| Asset Adequacy Tested And Not Tested Amounts—Reserves and Related Actuarial Items |
|-----------------------------------------------|------------------------------|----------------|----------------|----------------|----------------|
| Statement Item | Formula Reserves (1) | Principle-Based Reserves (2) | Additional Reserves (3) | Analysis Method (4) | Other Amount Not Tested (5) | Total Amount = (1)+(2)+(3)+(4) |

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2021 GRET Recommendation

2021 GRET Recommendation

LEON LANGLITZ, CHAIR SOA COMMITTEE ON LIFE INSURANCE COMPANY EXPENSES
R. DALE HALL, MANAGING DIRECTOR OF RESEARCH, SOCIETY OF ACTUARIES

NAIC LATF – August 4, 2020

Presentation Disclaimer

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GRET Agenda

• Methodology
• Recommendation
• Comparison to Prior Years
• Information on Companies in Study

Methodology

• Select data points provided by NAIC from company Annual Statement submissions
• SOA surveyed companies to determine Distribution Channels
• SOA analyzed data to derive unit expense factors by those Distribution Channels
Additional Comments on Methodology

- Allocated expenses to acquisition and maintenance categories using the same seeds as has been previously used
  - Acquisition/Policy: $200.00
  - Acquisition/Face Amount: $1.10
  - Acquisition/Premium: 50%
  - Maintenance/Policy: $60.00

Recommendation

Proposed 2021 Factors Based on Average of 2018/2019 Data

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<th>2021</th>
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<th>Percentage</th>
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<th>Percentage</th>
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Current 2020 Factors Based on Average of 2017/2018 Data

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Comparison to Prior Years

Acquisition Per Policy

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Acquisition Per Unit

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Comparison to Prior Years

Acquisition Per Premium

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<th>2019</th>
<th>Percentage</th>
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<td>42%</td>
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</tr>
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<td>0%</td>
<td>54%</td>
<td>-7%</td>
<td>58%</td>
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<tr>
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<td>-9%</td>
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<tr>
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Maintenance Per Policy

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<td>-10%</td>
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<td>2%</td>
<td>$41.00</td>
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Information on Companies in Study

- The following percentages of companies responded that GRET factors are used for individual life sales illustration purposes:
  - 2020 Survey: 29%
  - 2019 Survey: 26%
  - 2018 Survey: 28%
  - 2017 Survey: 30%
  - 2016 Survey: 26%

- We believe variation is a result of the mix of respondents and the limited number of responses.

Information on Companies in Study

- Included 292 companies in this year’s study
  - Decrease of 34 companies from last year’s study.
  - This is due to companies that are new outliers or have large premiums which fall outside the preset range.
  - There were a total of 776 companies originally in the data received from the NAIC in this year’s data extraction versus 722 in last year.
  - However, total ordinary policies issued for these 776 companies remained essentially flat (14,000 more policies out of a total of 9.9M) over the prior year.
  - Face amount issued increased by 6.1% over the prior year.

Questions?
TO: Reggie Mazyck, NAIC  
FROM: Dale Hall, Managing Director of Research, Society of Actuaries (SOA)  
Leon Langlitz, Chair, SOA Committee on Life Insurance Company Expenses  
DATE: July 23, 2020  
RE: 2021 Generally Recognized Expense Table (GRET) – SOA Analysis

Dear Mr. Mazyck:

As in previous years, the Society of Actuaries expresses its thanks to NAIC staff for their assistance and responsiveness in providing Annual Statement expense and unit data for the 2021 GRET analysis for use with individual life insurance sales illustrations. The analysis is based on expense and expense-related information reported on companies’ 2018 and 2019 Annual Statements. This project has been completed to assist the Life Actuarial Task Force (LATF) in its consideration of potential revisions to the GRET that could become effective for calendar year 2021. This memo describes the analysis and resultant findings.

NAIC staff provided Annual Statement data for life insurance companies for calendar years 2018 and 2019. This included data from 722 companies in 2018 and 776 companies in 2019. This increase breaks the trend of small decreases over the previous few years. Of the total companies, 292 were in both years and passed the outlier exclusion tests and were included as a base for the GRET factors (326 companies passed similar tests last year).

APPROACH USED

The methodology for calculating the recommended GRET factors based on this data is similar to that followed the last several years. The methodology was last altered in 2015. The changes made at that time can be found in the recommendation letter sent to LATF on July 30, 2015.

To calculate updated GRET factors, the average of the factors from the two most recent years (2018 and 2019 for those companies with data available for both years) of Annual Statement data was used. For each company an actual-to-expected ratio was calculated. Companies with ratios that fell outside predetermined parameters were excluded. This process was completed three times to stabilize the average rates. The boundaries of the exclusions have been modified from time to time; however, there were no adjustments made this year. Unit expense seed factors (the seeds for all distribution channel categories are the same), as shown in Appendix B, were used to compute total expected expenses. Thus, these seed factors were used to implicitly allocate expenses between acquisition and maintenance expenses, as well as among the three acquisition expense factors (on a direct of ceded reinsurance basis).

Companies were categorized by their reported distribution channel (four categories were used as described in Appendix A included below). There remain a significant number of companies for which no distribution channel was provided, as no responses to the annual surveys have been received from those companies. The characteristics of these companies vary significantly, including companies not currently writing new business or whose major line of business is not individual life insurance. Any advice or assistance from LATF

1 https://www.soa.org/Files/Research/Projects/research-2016-gret-recommendation.pdf
in future years to increase the response rate to the surveys of companies that submit Annual Statements in order to reduce the number of companies in the “Other” category would be most welcomed. The intention is to continue surveying the companies in future years to enable enhancement of this multiple distribution channel information.

Companies were excluded from the analysis if (1) their actual to expected ratios were considered outliers, often due to low business volume, (2) the average first year and single premium per policy were more than $40,000, (3) they are known reinsurance companies or (4) their data were not included in both years of the data supplied by the NAIC. To derive the overall GRET factors, the unweighted average of the remaining companies’ actual-to-expected ratios for each respective category was calculated. The resulting factors were rounded, as shown in Table 1.

THE RECOMMENDATION

The above methodology results in the proposed 2021 GRET values shown in Table 1. To facilitate comparisons, the current 2020 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount ($000s) per policy issued.

To facilitate comparisons, the current 2020 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount ($000s) per policy issued.

**TABLE 1**
PROPOSED 2021 GRET FACTORS, BASED ON AVERAGE OF 2018/2019 DATA

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$166</td>
<td>$0.90</td>
<td>42%</td>
<td>$50</td>
<td>121</td>
<td>2,916</td>
<td>194</td>
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<tr>
<td>Career</td>
<td>214</td>
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<td>54%</td>
<td>64</td>
<td>63</td>
<td>2,517</td>
<td>195</td>
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<tr>
<td>Direct Marketing</td>
<td>195</td>
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<td>67</td>
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* Includes companies that did not respond to this or prior year surveys

**TABLE 2**
CURRENT 2020 GRET FACTORS, BASED ON AVERAGE OF 2017/2018 DATA

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<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
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<td>140</td>
<td>0.80</td>
<td>35%</td>
<td>42</td>
<td>104</td>
<td>876</td>
<td>34</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys

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In previous recommendations, an effort was made to reduce volatility in the GRET factors from year-to-year by limiting the change in GRET factors between years to about ten percent of the prior value. The changes from the 2020 GRET were reviewed to ensure that a significant change was not made in this year’s GRET recommendation. The Direct Marketing and Other distribution channel categories experienced a change greater than ten percent so the factors for this line were capped at the ten percent level (the Acquisition per unit factor changed somewhat more than 10% because of rounding) from the corresponding 2020 GRET values. The volatility occurred due to the change in the composition of the companies in this category where a small number of companies were included.

USAGE OF THE GRET
This year’s survey, responded to by companies’ Annual Statement correspondent, included a question regarding whether the 2020 GRET table was used in its illustrations by the company. Last year, 26% of the responders indicated their company used the GRET for sales illustration purposes, with similar percentage results by size of company; this contrasted with about 28% in 2018. This year, 29% of responding companies indicated that they used the GRET in 2019 for sales illustration purposes. The range was from 22% for Direct Marketing to 48% for career carriers. Based on the information received over the last several years, the variation in GRET usage appears to be in large part due to the relatively small sample size and different responders to the surveys.

We hope LATF finds this information helpful and sufficient for consideration of a potential update to the GRET. If you require further analysis or have questions, please contact Dale Hall at 847-273-8835.

Kindest personal regards,

Dale Hall, FSA, MAAA, CERA, CFA  
Managing Director of Research  
Society of Actuaries

Leon Langlitz, FSA, MAAA  
Chair, SOA Committee on  
Life Insurance Company Expenses
APPENDIX A -- DISTRIBUTION CHANNELS

The following is a description of distribution channels used in the development of recommended 2021 GRET values:

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

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

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

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

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

The expense seeds used in the 2014 and prior GRETs were differentiated between branch office and all other categories, due to the results of a relatively old study that had indicated that branch office acquisition cost expressed on a per Face Amount basis was about double that of other distribution channels. Due to the elimination of the branch office category in the 2015 GRET, non-differentiated unit expense seeds have been used in the current and immediately prior studies.

The unit expense seeds used in the 2021 GRET and the 2020 GRET recommendations were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2019 Annual Statement submission this information will become more readily available.

2006-2010 (AVERAGE) CLICE STUDIES:

<table>
<thead>
<tr>
<th>Term</th>
<th>Acquisition/Premium</th>
<th>Maintenance/Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Average</td>
<td>$149 (000)</td>
<td>$0.62</td>
</tr>
<tr>
<td>Unweighted Average</td>
<td>$237</td>
<td>$0.80</td>
</tr>
<tr>
<td>Median</td>
<td>$196</td>
<td>$0.59</td>
</tr>
<tr>
<td>Weighted Average</td>
<td>$167</td>
<td>$1.43</td>
</tr>
<tr>
<td>Unweighted Average</td>
<td>$303</td>
<td>$1.57</td>
</tr>
<tr>
<td>Median</td>
<td>$158</td>
<td>$1.30</td>
</tr>
</tbody>
</table>

CURRENT UNIT EXPENSE SEEDS:

<table>
<thead>
<tr>
<th></th>
<th>Acquisition/Premium</th>
<th>Acquisition/Premium</th>
<th>Maintenance/Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>All distribution channels</td>
<td>$200  (000)</td>
<td>$1.10</td>
<td>50%</td>
</tr>
</tbody>
</table>
Society of Actuaries Research Update

DALE HALL, FSA, MAAA
Managing Director of Research
August, 2020

Presentation Disclaimer
The material and information contained in this presentation is for general information only. It does not replace independent professional judgment and should not be used as the basis for making any business, legal or other decisions. The Society of Actuaries assumes no responsibility for the content, accuracy or completeness of the information presented.

SOA COVID-19 Research
https://www.soa.org/programs/covid-19/research
- COVID-19 Key Statistics Update
- 2021 Health Care Cost Model
- Defined Benefit Plans and COVID-19
- Tabulation tool for John Hopkins University Data
- COVID-19 Research Briefs
- COVID-19 Pulse Surveys
- Impact of COVID-19 on Aging & Retirement – Essays
- Podcasts
- and more

COVID-19 Impact on Group Life Insurance
- Group Life COVID-19 Survey
  - Requested monthly mortality claims & exposure, starting with 5/2020
  - Use 2018-2019 as baseline for comparing 2020 emerging experience
  - Optional segment information also requested: state, industry, age/gender, cause of death
- Results
  - Monthly reports to contributors
  - Industry report and updates to public
COVID-19 Impact on Individual Life Insurance

- Individual Life COVID-19 Study
  - Designing a data request for periodic (monthly?) submission mortality claims & exposure
  - Use 2018-2019 as baseline for comparing 2020 emerging experience
  - Include age/gender, duration, product type, cause of death (if available)

- Results
  - Summary reports to contributors
  - Industry report and updates to public

SOA Experience Studies

<table>
<thead>
<tr>
<th>Study Title</th>
<th>Description</th>
<th>Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 Impact on Business Interruption Insurance</td>
<td>Examines the impact of COVID-19 on business interruption insurance</td>
<td>2021</td>
</tr>
<tr>
<td>COVID-19 Impact on Property-Casualty Insurance</td>
<td>Analyzes the impact of COVID-19 on property-casualty insurance</td>
<td>2021</td>
</tr>
<tr>
<td>COVID-19 Impact on Group Life Insurance</td>
<td>Investigates the impact of COVID-19 on group life insurance</td>
<td>2021</td>
</tr>
</tbody>
</table>

SOA Practice Research & DDIR

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Description</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 Mortality Impact Study</td>
<td>Evaluates the impact of COVID-19 on mortality trends</td>
<td>2020</td>
</tr>
<tr>
<td>COVID-19 Incidence Impact Study</td>
<td>Investigates the impact of COVID-19 on incidence trends</td>
<td>2020</td>
</tr>
<tr>
<td>COVID-19 Severity Impact Study</td>
<td>Analyzes the impact of COVID-19 on severity trends</td>
<td>2020</td>
</tr>
<tr>
<td>COVID-19 Site Impact Study</td>
<td>Examines the impact of COVID-19 on site-specific trends</td>
<td>2020</td>
</tr>
</tbody>
</table>

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Agenda for Discussion

1. Objective for the annual mortality improvement (MI) scale updates
3. Considerations for 2020
4. LMISG 2020 recommendation
5. Future issues

Objective of Annual MI Scale Updates
Addresses VM20 Incorporation of MI: Section 9C3g

Objective of Annual MI Scale Updates
Level of Event Covered – Reserve vs Capital: VM Introduction
Objective for Annual MI Scale Updates

Our annual update exercise seeks to apply judgment to historical mortality improvement (or deterioration) data to arrive at a set of mortality rates that can be used to calculate reserves for future events.


<table>
<thead>
<tr>
<th>Historical Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most relevant relevant historical MI data (10-year moving average)</td>
</tr>
<tr>
<td><strong>Age- and gender-based</strong></td>
</tr>
<tr>
<td>Use of a long-term consistent source of population data, Social Security Administration (SSA)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Forecasted Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent forecast of future improvements over future period (20 years)</td>
</tr>
<tr>
<td><strong>Age- and gender-based data</strong></td>
</tr>
<tr>
<td>Consistent with historical data and projections (Alt. II) available from SSA Trustees’ Annual Report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unsmoothed MI Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted average of historical data and forecasted expectations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Smoothed MI Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsmoothed MI scale with smoothing process applied</td>
</tr>
</tbody>
</table>

Considerations for 2020 & beyond

- **Date** - we don’t have sufficient data to fully understand the impact of the COVID-19-related mortality shock on the insured population (anecdotal reports from companies indicate they are seeing a smaller shock).
- **MI scale update** - reflecting a shock in 2020 does not seem in line with the goals for the MI scale updates
  - Are shock events more appropriately reflected in capital planning rather than reserves?
  - An effective vaccine may make COVID-19’s impact on MI much shorter than the long-term impact arising from the opioid epidemic.
  - However, COVID-19 may have potential longer-term impacts that may arise from survivor impaired health, health impacts from delays in health care, and/or testing for early detection of dread diseases, etc.
  - Conversely, some experts and models indicate the 2020/2021 COVID-19 shock is mainly a moving forward of deaths that would have occurred due to other causes and/or combinations. Might that improve future mortality improvement?
- **Precedent for other excess mortality events**
  - First group to consider the impact of a short-term shock event – setting a precedent for other future MI scale work.
  - The current methodology uses a moving average to “smooth out” the impact of any one year or event.
  - 2008/2009 influenza season and the effect of the opioid epidemic – the methodology was not adjusted for those events.
**LMISG 2020 Recommendation**

Apply the historical methodology for 2020 consistent with the past scale updates (2013–2019).

Implications:
- There will be no specific impact included for the 2020 scale for the pandemic shock effect.
- The 10-year historical average in the 2022 scale update will include a "smoothed" impact of the shock as part of the usual methodology.

**Future Issues**

- Insured vs. general population impacts
  + Some evidence that impact on insured population will be less
  + SOA “Socioeconomic decile” study will provide some guidance here
  + Consideration of consistent framework and changes to the current methodology (i.e., averaging periods)

- Will COVID-19 have a long-term impact on mortality improvement rates, and what will the impact be?
  + Lower due to survivor impaired health as well as the redirect effect arising from the virus delaying the early condition diagnosis of dread diseases and preventive treatments?
  + Higher due to greater application of good hygiene habits (e.g., social distancing and washing hands) and/or higher utilization of other vaccines (such as the annual flu shot)?
  + Need to understand the impact in terms of potential effects on future slope and size of MI
  + Impact in light of a COVID-19 vaccine availability and effectiveness
General Population:
Pattern of excess deaths vs general mortality

- Actual deaths = COVID-19
- Expected deaths = 2015
- Unismoke, ANB 2015 VBT rates, weighted by 7/2019 estimated U.S. population
- Slope of VBT matches COVID-19 female rates better than male rates
- Small ratios >>> only 1 cause of death (COD) in numerator, all CODs in denominator

2013-2019 MI Scale Update Reports

- 2016 Scale: https://www.soa.org/resources/experience-studies/2016/research-mortality-improvement-2016/
- 2013 Scale: https://www.soa.org/resources/experience-studies/2013/research-2013-mortality-improvement-rates
Principle-Based Reserves (PBR) Resources From the Life Practice Council of the American Academy of Actuaries

Donna Claire, MAAA, FSA, CERA
Chairperson, PBR Governance Work Group

PBR Page on Academy Website

- Go to actuary.org and click on Principle-based Reserving (navigation bar on right or bottom)
- www.actuary.org/content/pbr-practice
- Page includes a PBR Toolkit

Academy PBR Toolkit

- PBR Overview: Resources that provide the mechanics of PBR, as well as industry practices and guidance in performing a principle-based valuation.
  - PBR Checklist
  - The Details Behind PBR Implementation
  - Model Governance Checklist
  - Model Governance Practice Note

- Implementation Tools: Resources that provide tools and frameworks to assist actuaries in implementing principle-based valuations.
  - Principle-Based Approach Projections Practice Note
  - VM-20 Practice Note
  - ASOP No. 52: Principle-Based Reserves for Life Products
  - Economic Scenario Generators
  - Life PBR Assumptions Resource Manual

NAIC Resources

- Valuation Manual 2019-2020 Comparison
- Valuation Manual, published January 2020
- Valuation Manual Versions and Amendments
- SVL Model Law
- VM-20 / VM-22 Tables
- NAIC Impact Study of VM-20 on PBR for Life Insurance
- Life Actuarial (A) Task Force of the NAIC
- 2018 PBR Review Report
- 2017 PBR Review Report
ACADEMY COMMENTS ON PBR
- Life Insurance Issues (VM-20)
- Variable Annuity Issues (VM-21)
- Fixed Annuity Issues (VM-22)
- Long Term Care Issues (VM-25)
- RBC Requirements Under PBR
- Read reports from Life Practice Council groups to the NAIC on the principle-based project.

ACADEMY PUBLICATIONS ON PBR
- SVL Legislation in Brief
- Life Perspectives

ACADEMY PUBLICATIONS ON PBR (cont.)
- ASOP No. 52, Principle-Based Reserves for Life Products under the NAIC Valuation Manual

More ASOPs

PBR QUALIFICATION STANDARDS

Qualification Standards Response on PBR
What are the minimum requirements an actuary should consider to be qualified to render opinions related to PBR under the U.S. Qualification Standards? This question and answer came from the Academy's Committee on Qualifications, which developed a list of frequently asked questions for actuaries.

PBR QUALIFICATION STANDARDS (cont.)

PBR RELEVANT ASOPS
- ASOP No. 52, Principle-Based Reserves for Life Products under the NAIC Valuation Manual

PBR Boot Camp Seminar
- Academy is having a 4-day (5½ hours a day) seminar virtually September 14–17
  - Life Topics: September 14 & 15
  - Variable Annuity Topics: September 16
  - Preparing Reports and for Audits, Regulatory Updates: September 17
- For more info, please visit: https://www.actuary.org/pbr2020
- Registration will open soon!
PBR Analysis Template

- Academy group under Pat Allison is developing ways to display PBR (and other) data:
  - Such as: waterfalls, trend analysis graphs
  - Advantages: one picture is worth a 1,000 words
- Goal is to have this done in 2020

Questions/Suggestions

- Anything else the Academy can do to assist you with PBR implementation and/or education?

Contact

- Donna Claire, MAAA, FSA, CERA
  Chairperson, PBR Governance Work Group
  American Academy of Actuaries
- Ian Trepanier
  Life Policy Analyst
  American Academy of Actuaries
  Trepanier@actuary.org
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Aug. 11, 2020, Minutes................................................................. 7-2
Health Insurance and Managed Care (B) Committee April 28, 2020, Minutes (Attachment One) .................................. 7-6
Health Insurance and Managed Care (B) Committee Feb. 26, 2020, Minutes (Attachment Two) .................................. 7-10
Consumer Information (B) Subgroup July 9, 2020, Minutes (Attachment Three) ......................................................... 7-11
Consumer Information (B) Subgroup Jan. 21, 2020, Minutes (Attachment Four) ............................................................ 7-12
Using Your Health Plan, Jan. 21, 2020, Draft (Attachment Four-A) .......................................................... 7-13
Consumer Information (B) Subgroup Jan. 7, 2020, Minutes (Attachment Five) ............................................................... 7-37
Health Innovations (B) Working Group July 30, 2020, Minutes (Attachment Six) ........................................................... 7-38
Health Innovations (B) Working Group June 23, 2020, Minutes (Attachment Six-A) ....................................................... 7-40
The Health Insurance and Managed Care (B) Committee met via conference call Aug. 11, 2020. The following Committee members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Vicki Schmidt (KS); Kathleen A. Birrane (MD); Steve Kelley represented by Grace Arnold and Peter Brickwedde (MN); Mike Chaney (MS); Jon Godfread (ND); Linda A. Lacewell represented by John Powell (NY); Glenn Mulready (OK); Andrew R. Stolfi and TK Keen (OR); Hodgen Mainda (TN); Todd E. Kiser (UT); and Mike Kreidler (WA). Also participating were: David Altmaier (FL); Dean L. Cameron (ID); Sharon P. Clark (KY); Eric A. Cioppa (ME); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Bruce R. Ramge (NE); Marlene Caride (NJ); Russell Toal (NM); and Marie Ganim (RI).

1. Adopted its April 28, Feb. 26, and 2019 Fall National Meeting Minutes

The Committee met April 28, Feb. 26, and Dec. 8, 2019. During its April 28 and Feb. 26 meetings, the Committee took the following action: 1) received a report from the Health Actuarial (B) Task Force on its work to develop an outline and eventual 2021 rate pricing resource and guidance document for the states to consider when reviewing initial 2021 rates in light of the COVID-19 pandemic; 2) discussed and heard comments from stakeholders on areas, such as telehealth requirements and form filing requirements, in which state insurance regulators can provide regulatory flexibility due to the COVID-19 pandemic; and 3) adopted the Regulatory Framework (B) Task Force’s revised 2020 charges, which added a charge for the newly appointed MHPAEA (B) Working Group.

Commissioner Godfread made a motion, seconded by Commissioner Conway, to adopt the Committee’s April 28 (Attachment One), Feb. 26 (Attachment Two) and Dec. 8, 2019, (see NAIC Proceedings – Fall 2019, Health Insurance and Managed Care (B) Committee) minutes. The motion passed unanimously.

2. Adopted its Subgroup, Working Group and Task Force Reports

Commissioner Schmidt made a motion, seconded by Ms. Arnold, to adopt the following reports: the Consumer Information (B) Subgroup, including its July 9 (Attachment Three), Jan. 21 (Attachment Four) and Jan. 7 (Attachment Five) minutes; the Health Innovations (B) Working Group (Attachment Six); the Health Actuarial (B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

3. Heard a Presentation on Health Equity and Disparities in Health Care and Coverage

Samantha Artiga (Kaiser Family Foundation—KFF) provided an overview of disparities in health and health care. She defined health and health care disparities as: 1) differences in health and health care between populations; 2) arising from a complex and interrelated set of individual, provider, health system, societal and economic factors; and 4) occurring across a broad range of dimensions—race/ethnicity, socioeconomic status, gender, age, disability, sexual orientation or gender identity, geographic location and more. She discussed the implications of such disparities for black and Hispanic populations, including higher infant mortality rates, higher mortality rates due to certain diseases, and a disproportionate share of COVID-19 cases. She described health disparities as a symptom of social and economic inequities.

Ms. Artiga said uninsured rates have declined since the implementation of the federal Affordable Care Act (ACA); but despite that, disparities in health care persist for some populations, such as African Americans and other people of color. She discussed some of the reasons for this occurrence, such as coverage gaps and geography. African Americans make up a larger share of the population in the South, where many states have not expanded Medicaid.

Ms. Artiga ended her presentation with five key takeaways for the Committee to consider: 1) health and health care disparities are a longstanding and persistent issue; 2) the COVID-19 pandemic has highlighted and exacerbated underlying disparities; 3) health disparities are a symptom of broader social and economic inequities rooted in structural and systemic barriers that disadvantage people of color, including racism and discrimination; 4) increased awareness and recognition of disparities provides an opportunity to advance equity; and 5) progress will require long-term efforts across sectors to prioritize equity and address systemic and structural barriers, including racism and discrimination.
Professor Meuse said Pennsylvania expanded Medicaid under the ACA as an approach to alleviate the disparities in health and health care. She asked Ms. Artiga if such actions actually make a difference. Ms. Artiga said research has shown that states that have opted to expand Medicaid eligibility under the ACA have improved disparities in health and health care. However, she noted that coverage is one piece of the puzzle because improving access to coverage does not necessarily improve other factors that lead to these disparities, such as access to certain types of foods and reliable transportation to get to health care providers. Director Wing-Heier asked for additional information about disparities in health and health care for Alaska Natives. Ms. Artiga said there is limited data on this population because of the way states report it. She said states report aggregate data on Alaska Natives that includes other populations, such as American Indians. She said this is an ongoing issue, that affects the ability of researchers to understand what is happening, specifically to these populations.

Commissioner Mainda asked Ms. Artiga what types of stakeholders she believed could come together to address disparities in health care and coverage. Ms. Artiga said she envisions the states coordinating across multiple agencies and sectors to address not only health and health care disparities, but other issues that underlie them, such as housing and transportation. She said this also includes more data collection to better understand the problems and setting certain outcomes. Commissioner Birrane asked Ms. Artiga whether expanded access to telehealth services has had an impact on health and health care disparities. Ms. Artiga said the KFF has data on telehealth services and its use, but it has not analyzed it specifically with respect to health and health care disparities. However, she said anecdotally, given the unequal access to telehealth service coverage and attitudes on using such services, in addition to probable issues with having access to compatible equipment and broadband for certain populations, in the short-term, telehealth most likely has not improved health and health care disparities.


4. Heard a Presentation on COVID-19 and Employer-Sponsored Insurance

Daniel Meuse (State Health and Value Strategies (SHVS), Princeton School of Public and International Affairs) discussed COVID-19 and the resulting recession’s effect on employer-sponsored insurance (ESI) coverage. He raised the following questions for the Committee’s consideration: 1) what do we know about how the COVID-19 recession is affecting ESI; 2) where do people go if they lose ESI, and what does that mean for consumers and providers; and 3) what are the larger policy considerations for state insurance regulators. He walked the Committee through these issues, describing the differences in ESI coverage pre-COVID-19 and post-COVID-19 because of the COVID-19 driven recession. He discussed federal and state policymakers’ responses to the recession, such as enacting the federal Paycheck Protection Program (PPP) and new special enrollment periods (SEPs) established by state health insurance exchanges. He also highlighted what policymakers do not know with respect to ESI coverage, such as who is actually losing ESI coverage, where consumers go to get coverage, and whether the loss of ESI coverage disproportionately affects people of color or patients at risk for increased morbidity.

Mr. Meuse touched on the options consumers have after losing ESI coverage, such as Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Medicaid/Children’s Health Insurance Plan (CHIP), non-compliant plans like short-term, limited-duration (STLD) plans, or becoming uninsured. He also discussed what consumers consider in choosing what option to take after losing ESI coverage, including premium costs, deductibles and provider networks. He discussed the policy opportunities and lessons to be learned. He said because this is the first widespread coverage loss since full ACA implementation, it provides an opportunity for policymakers to consider existing and new options to address it. Those options include: 1) Medicaid expansion; 2) reconsidering the timing of enrollment and outreach; and 3) alternative payment models.

Commissioner Altman asked Mr. Meuse for any best practices he would suggest to assist people in moving from ESI coverage to other coverage, particularly with assisting consumers in obtaining sufficient information to make informed decisions. Mr. Meuse said the states should partner with community-based organizations that may already have a relationship with certain populations to assist in providing outreach and distributing information. Commissioner Conway asked Mr. Meuse if he has any recommendations on what state insurance regulators could use to assist consumers in transitioning to other coverage in addition to SEPs. Mr. Meuse suggested additional marketing campaigns particularly targeted at individuals transitioning on and off Medicaid coverage. Health Insurance Commissioner Ganim asked Mr. Meuse if any states that have an individual mandate are considering changes to that mandate, considering the COVID-19 driven recession resulting in consumers losing ESI coverage. Mr. Meuse said he is not aware of any such activity, but he anticipates that the states would relax their hardship exemption documentation requirements in order for consumers to meet the requirements of a state’s hardship exemption from having to have health insurance coverage.

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5. **Heard a Presentation on COVID-19 Testing and Costs**

Matt Eyles (America’s Health Insurance Plans—AHIP) discussed expanding access to COVID-19 testing and the need for additional federal funding for such testing. He discussed the purposes of COVID-19 testing—guiding care and treatment, public health surveillance, and occupational health—and its essential components. He explained that with respect to COVID-19 testing, federal agencies have a critical responsibility to ensure quality, support appropriate use, and prioritize affordable solutions. He also outlined the role that insurers, governmental and public health agencies, and employers play in the COVID-19 testing framework.

Mr. Eyles said AHIP and 48 other organizations believe that COVID-19 testing is one of the most important tools the U.S. has to combat the pandemic, both for identifying the virus and for preventing its spread. He said it is vital that the federal government designate the resources to support expanded access to testing. He discussed AHIP’s recommendations related to COVID-19 testing: 1) ensure all Americans have access to testing regardless of coverage status; 2) ensure federal funding accounts for the magnitude of tests required to get the economy back on track and reduces the risk of transmission in different settings and the progression of the disease; 3) solidify comprehensive strategies that incorporate testing to achieve occupational and public health goals; 4) ensure that testing does not lead to premium spikes in 2021; and 5) protect against fraud.

6. **Heard an Update on ACA Federal Court Cases**

Katie Keith (Out2Enroll) gave an update on ACA federal court cases. She discussed U.S. Supreme Court (Court) decisions from its 2019 session, including the Court’s 8-1 decision in favor of insurers in *Maine Community Health Options v. United States*, which challenged the legality of the federal government withholding full risk corridor payment amounts to participants. She also discussed cases scheduled for oral arguments during the Court’s upcoming 2020 session, including the *California v. Texas* case, which challenges the constitutionality of the ACA’s individual mandate and its potential impact on other key ACA provisions, as well as the *Rutledge v. PCMA* case, which challenges the state regulation of pharmacy benefit managers (PBMs).

Ms. Keith also discussed other pending ACA cases in the federal circuit courts, including a case pending in the D.C. Circuit Court of Appeals, *Association of Community Affiliated Plans, et al. v. U.S. Department of Treasury, et al.*, which upheld the legality of the federal STLD plan regulation, and a case pending in the U.S. Court of Appeals for the Second Circuit, *UnitedHealthcare of New York, v. Lacewell*, which ruled that New York’s risk adjustment rule is preempted by the ACA.

7. **Received an Update on the Work of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup**

Mr. Keen updated the Committee on the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s work to complete its charge to develop a new NAIC model establishing a registration or licensing process for PBMs. He said after the Subgroup was appointed in late 2018, the Subgroup decided during its first meetings in early 2019 that it wanted to obtain more information on the issues before beginning its work to draft the new model regulating PBMs and potentially including additional provisions related to PBM prescription drug pricing and cost transparency. The Subgroup held a series of conference calls throughout the summer and early fall of 2019 to hear from various stakeholders on the issues the Subgroup wanted to hear more about, such as rebating, discounts, prescription drug pricing, and how PBMs are currently regulated.

Mr. Keen said during these meetings, the Subgroup heard presentations from consumers, economists, the PBM industry, insurers, and the states on these issues and suggestions on how the Subgroup might address them. He said after finishing these information-gathering sessions, the Subgroup decided that it had obtained sufficient information to move forward with its charge. In November 2019, the Subgroup established an ad hoc technical drafting group to develop an initial draft for the full Subgroup’s review.

Mr. Keen said after a series of meetings late last year and early this year, the ad hoc group developed a draft for the Subgroup’s review. He said the ad hoc group based its draft on the National Council of Insurance Legislators (NCOIL) model and made changes based on the Subgroup’s charge to the ad hoc group.

Mr. Keen said the Subgroup met July 16 via conference call to discuss the ad hoc group’s draft. He said there was robust discussion among the Subgroup members about the draft, particularly about a proposed provision that lists potential provisions, such as PBM network adequacy requirements and rebates, that states could include in any regulations adopted to implement the proposed model’s provisions. At the end of the discussion, the Subgroup agreed that the draft was just the beginning of the drafting process, not the end of the process, and it exposed the draft for a public comment period ending Sept. 1. Mr. Keen said after the public comment period ends, the Subgroup will begin meeting via conference call to discuss and consider changes to the draft based on the comments received.
8. **Heard a Federal Legislative Update**

Brian Webb (NAIC) provided a federal legislative update on Congressional activity of interest to the Committee. He discussed the current status of surprise billing legislation, saying that the NAIC sent yet another letter to Congressional leaders urging them to pass federal surprise bill legislation and extend protections to air ambulances. He explained that the COVID-19 health emergency has stymied a lot of action in Congress on this issue despite bi-partisan support and support from the Trump Administration to address the issue. NAIC staff will continue to monitor this issue.

Mr. Webb said the U.S. House of Representatives (House) Committee on Appropriations passed its package of fiscal year 2021 appropriations bills, which included additional funding in the U.S. Department of Labor (DOL)/U.S. Department of Health and Human Services (HHS) bill in the amount of $2.9 million for state health insurance assistance programs (SHIPs), bringing the total appropriation to $55 million. He said the U.S. Senate (Senate) Committee on Appropriations has not acted yet.

Mr. Webb said with respect to the administrative action, the NAIC has requested additional guidance on a number of issues, such as COVID-19 testing and the insurer payment responsibilities. He said the federal Centers for Medicare & Medicaid Services (CMS) did issue guidance on the issue, but state insurance regulators still have questions. NAIC staff are working with CMS representatives to seek answers to those questions. Mr. Webb said the NAIC also requested guidance on premium holidays, particularly with respect to the individual market and its potential impact on advance premium tax credit (APTC) payments. The CMS released additional guidance on that issue last week, as announced during the Regulatory Framework (B) Task Force’s meeting on Aug. 4. Mr. Webb said the guidance did not answer all the questions, and NAIC staff will be working with CMS staff to receive answers on the outstanding issues.

Mr. Webb said one issue still awaiting additional guidance concerns the risk corridor payments owed to insurers as a result of the 8-1 Court decision of the *Maine Community Health Options v. United States* case that Ms. Keith mentioned during her presentation. However, he said he recently learned that one state’s insurer has received its payment after completing the Court of Federal Claims process and receiving a final certification of payment from the Judgement Fund. Therefore, payments are being made, but the CMS has not provided guidance on how it will be accounted for for the purposes of medical loss ratio (MLR) refunds.

Mr. Webb said the NAIC sent a comment letter, like many other states, on the Internal Revenue Services’ (IRS’) proposed regulations on health reimbursement arrangements (HRAs) that would permit an individual to use an HRA to fund health care sharing ministry (HCSM) payments. He said the letter expressed concern with adverse selection and other potential issues that could affect the stability of the individual market. He said NAIC staff will be closely tracking what happens with this proposed regulation.

Mr. Webb said NAIC staff continues to work closely with the CMS and DOL on mental health parity implementation. He said NAIC staff also has been working with the CMS and its federal Center for Program Integrity (CPI) on improper marketing concerns. NAIC staff have also had numerous discussions with the CMS on its new requirement that the states annually submit a report to the CMS on state mandates. The states still have many questions on this new requirement.

Mr. Webb said a new issue has arisen concerning telehealth and the ability for the states and insurers to continue to provide access to this expanded coverage after the COVID-19 health emergency declaration ends because of Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy concerns. NAIC staff are working with the CMS and the federal Office of Civil Rights (OCR) to find a solution to address this concern. NAIC staff are also working with the CMS and state insurance regulators on issues related to outreach with the upcoming open enrollment for plan year 2021 during the COVID-19 health emergency and discussing alternatives to what the states have traditionally done to educate and inform consumers about open enrollment in lieu of face-to-face meetings and forums.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
The Health Insurance and Managed Care (B) Committee met via conference call April 28, 2020. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); John F. King represented by Teresa Winer (GA); Vicki Schmidt (KS); Al Redmer Jr. (MD); Steve Kelley represented by Grace Arnold and Sherri Mortensen Brown (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); Linda A. Lacewell represented by John Powell and Frank Horn (NY); Glen Mulready (OK); Andrew R. Stolfi represented by TK Keen (OR); Hodgen Mainda (TN); Todd E. Kiser represented by Jaakob Sundberg (UT); and Mike Kreidler represented by Molly Nollette and Jane Beyer (WA). Also participating were: David Altmaier (FL); Chlora Lindley-Myers (MO); Russell Toal (NM); Barbara D. Richardson (NV); and Marie Ganim (RI).

1. Received a Report from the Health Actuarial (B) Task Force

Mr. Sundberg provided a brief overview of the Health Actuarial (B) Task Force’s April 23 meeting. He said the Task Force heard presentations from the American Academy of Actuaries (Academy), America’s Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association (BCBSA) and the Society of Actuaries (SOA) on COVID-19’s potential effects on health care spending and the health insurance system, particularly with respect to the federal Affordable Care Act (ACA) 2021 premium rate assumptions. He said each presenter emphasized the uncertainty in 2021 pricing assumptions due to COVID-19 because of several factors, including 1) the rate of COVID-19 testing; 2) treatment rate, including treatment setting and treatment services provided; 3) treatment cost; 4) rate of services deferred from 2020; and 5) cost of services deferred from 2020. Mr. Sundberg said some presenters also suggested that the states assess their current rate filing deadlines and delay them if possible. Specifically, they recommended that the states target July 22 to give issuers time to incorporate the most recent data on the impact of COVID-19 when finalizing 2021 rates and strongly encouraged the states to allow issuers to revise their rate filings using the latest information available prior to states finalizing rates. He said presenters also stressed the importance of state insurance regulators working collaboratively with the industry to address these issues.

Mr. Sundberg said that among its next steps, the Task Force is meeting May 1 via conference call in regulator-to-regulator session to begin development of an outline and eventual 2021 rate pricing resource and guidance document for the states to consider when reviewing initial 2021 rates. He said the Task Force also will be discussing potential impact on risk corridors, particularly in light of the recent U.S. Supreme Court decision in Maine Community Health Options v. United States, which ruled that, in accordance with the ACA, the federal government illegally withheld full risk corridor payment amounts to insurers for significant losses to their health plans incurred during the first three years of the ACA’s health marketplaces and that the insurers could sue for nonpayment of approximately $12 billion in the U.S. Court of Federal Claims.

Commissioner Altman asked Mr. Sundberg about the Task Force’s timeline for completing the resource and guidance document. Mr. Sundberg said he anticipates the Task Force completing this work and sending out a draft of the document within the next few weeks for comment given that some states have initial filing deadlines in May.

2. Discussed and Heard Comments from Stakeholders on Regulatory Flexibility Requests Due to COVID-19

Brian R. Webb (NAIC) said the NAIC has received letters from various stakeholders requesting state insurance regulatory relief due to COVID-19 in a brief overview of the Health Actuarial (B) Task Force’s April 23 meeting. He said the Task Force heard presentations from the American Academy of Actuaries (Academy), America’s Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association (BCBSA) and the Society of Actuaries (SOA) on COVID-19’s potential effects on health care spending and the health insurance system, particularly with respect to the federal Affordable Care Act (ACA) 2021 premium rate assumptions. He said each presenter emphasized the uncertainty in 2021 pricing assumptions due to COVID-19 because of several factors, including 1) the rate of COVID-19 testing; 2) treatment rate, including treatment setting and treatment services provided; 3) treatment cost; 4) rate of services deferred from 2020; and 5) cost of services deferred from 2020. Mr. Sundberg said some presenters also suggested that the states assess their current rate filing deadlines and delay them if possible. Specifically, they recommended that the states target July 22 to give issuers time to incorporate the most recent data on the impact of COVID-19 when finalizing 2021 rates and strongly encouraged the states to allow issuers to revise their rate filings using the latest information available prior to states finalizing rates. He said presenters also stressed the importance of state insurance regulators working collaboratively with the industry to address these issues.

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Commissioner Altman asked Mr. Sundberg about the Task Force’s timeline for completing the resource and guidance document. Mr. Sundberg said he anticipates the Task Force completing this work and sending out a draft of the document within the next few weeks for comment given that some states have initial filing deadlines in May.

Mr. Webb noted that AHIP and the BCBSA recently submitted a letter to the Committee recommending that the states assess their current rate filing deadlines and delay them if possible to July 22 to give carriers time to incorporate the most recent data on the impact of COVID-19 when finalizing 2021 rates. Specifically, AHIP and the BCBSA are encouraging the states to allow issuers to revise their rate filings using the latest information available prior to states finalizing rates in the Health Insurance and Oversight System (HIOS).
Mr. Webb said another outstanding issue some stakeholders have raised is the creation of a new special enrollment period (SEP) for individuals who obtained their health insurance coverage through the individual market, but lose income and become eligible for subsidized individual market coverage through the health insurance marketplaces. He said there is no existing SEP that addresses this situation. Mr. Webb said the federal Center for Consumer Information and Insurance Oversight (CCIIO) is relying on its existing SEPs to address loss of health insurance coverage issues due to COVID-19.

Commissioner Altman said NAIC staff prepared a summary compilation chart of the stakeholder letters submitted to the NAIC, which she went through section-by-section to provide each stakeholder the opportunity to provide any additional comments.

Allison Ivie (Eating Disorders Coalition for Research, Policy & Action—EDC), on behalf of the Mental Health Liaison Group (MHLG), said that, as stated in its letter to the NAIC, the MHLG’s most pressing concern is ensuring the continuity of care for its stakeholders via telehealth due to COVID-19. She said it is important that the states provide access to this benefit, regardless of the type of insurance and ensure that consumers can receive this benefit from out-of-network providers, including providers across state lines, if the consumer’s health benefit plan does not have an in-network specialty provider to treat the covered person.

Kate Gilliard (American Physical Therapy Association—APTA) said the APTA realizes that most states have already expanded telehealth to provide physical therapy-related services. She said, however, that this benefit has been provided with respect to established patients, not for new patients requiring an initial evaluation. She said that unless this issue is addressed, it could be problematic moving forward.

Emily Carroll (American Medical Association—AMA) said that as state insurance regulators continue to debate how best and responsibly to address the myriad of health insurance issues that have arisen due to COVID-19, the AMA urges the states to examine current policies that establish or fail to remove roadblocks between patients and their physicians that could threaten continuity of care or access to care, such as policies involving prior authorization and step therapy. She suggested that the states consider suspending such policies during the COVID-19 emergency because physicians are: 1) caring for COVID-19 patients; and 2) physician support staff are not in the office to process these requirements.

Kim Horvath (AMA) stressed the need for plan flexibility for telehealth benefits, particularly for consumers with chronic health conditions. She noted the new requirements the U.S. Department of Health and Human Services (HHS) issued expanding telehealth services for Medicare enrollees. She said the AMA encourages all states to adopt telehealth policies that reflect those now being required under Medicare.

Justine Handelman (BCBSA) stressed the importance of extending the final rate filing deadline for plan 2021 rates, at least until August, because of the uncertainty insurers have in determining rates due to COVID-19. She urged state insurance regulators to use their influence with the CCIIO to move the date.

Kristin Hathaway (AHIP) discussed the work the health insurance industry has done to date related to COVID-19, such as COVID-19 testing and fast-tracking providing credentialing and audits. She said AHIP appreciates the NAIC’s and state insurance regulators’ work providing flexibility in financial filing requirements and collaboration among the states in data requests.

Jessica Adams (American Society for Radiation Oncology—ASTRO) said the ASTRO has similar issues and concerns as those discussed by the AMA, particularly with respect to prior authorization requirements. She urged state insurance regulators to direct insurers to suspend prior authorization requirements for radiation therapy services for the duration of the COVID-19 health emergency because non-treating provider staff members, who would be processing these requests, are working remotely and treating provider staff members are being diverted to COVID-19 response activities, reducing staff manpower to process prior authorization requests.

Molly Collins Offner (American Hospital Association—AHA) said the AHA’s comments are similar to those already expressed. She said the AHA is working with its members to discuss additional operational challenges and areas where state insurance regulatory flexibility would be helpful.

Robert Still (Radiology Business Management Association—RBMA) said the RBMA’s comments are similar to the ASTRO’s, the AMA’s and the AHA’s comments.
Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said that as state insurance regulators encounter challenges in their states and continue to advocate for policy changes to federal law due to the COVID-19 emergency, the NAIC consumer representatives urge state insurance regulators to: 1) maximize access to comprehensive health coverage so people can access the care they need. More limited coverage or coverage that triggers only if a person becomes ill will be less successful at achieving the goals of getting people to proactively seek testing and treatment; 2) find ways to ease financial strain and support people’s ability to comply with social distancing measures, such as ensuring easier access to prescription drug refills, telehealth services and mental health services—especially as the crisis continues; 3) ensure coverage of important health benefits, as well as cost protections, related to treatment and detection of the virus, including protection from surprise medical bills; and 4) continue to protect consumers from fraud and scams.

Katie Morgan (National Infusion Center Association—NICA) said the NICA supports patients’ access to non-hospital non-oncology infusion centers, where they can receive provider-administered medical benefit drugs for the treatment of autoimmune diseases, immunodeficiency disorders, rare and genetic disorders, and other chronic, complex conditions. She said these patient populations are at high risk of severe COVID-19 disease should they be exposed. She said the NICA urges state insurance regulators to provide needed insurance flexibility and consider policy options that proactively facilitate continuity of care for these patients, such as: 1) allowing patients to use an out-of-network site of care at the in-network benefit level in the event they are unable to get treatment in their usual care setting due to a drug shortage or closure related to COVID-19; 2) waiving prior authorization requirements for established patients currently on therapy that are switching site of care; and 3) waiving step therapy policies and formulary restrictions in the event of drug shortages.

Rodney Peele (American Optometric Association—AOA) said the AOA urges state insurance regulators to provide the same regulatory flexibility for vision plans that is being provided for health benefit plans. He said the AOA suggestions for regulatory flexibility include: 1) extending contract renewal deadlines; 2) delaying claims audits and recoupments; 3) extending deadlines for filing claims and appeals; and 4) expanding access to telehealth services. He said state insurance regulators also should promote and respect the role of optometrists in the COVID-19 health emergency, including acknowledging that optometrists: 1) may order or perform COVID-19 testing; 2) provide essential eye health and vision care; and 3) have the autonomy to follow the advice of local, state and public health authorities, and best meet the needs of patients.

Mr. Peele said optometrists take a leading role in patient care with respect to eye health and vision care, as well as general health and well-being. As primary health care providers, optometrists have extensive, ongoing training to examine, diagnose, treat and manage ocular disorders, diseases and injuries, and many of these treatments are essential. He said studies show that the same groups burdened by COVID-19 complications, such as those with hypertension and respiratory conditions, also suffer more vision problems. He said ensuring patient access to urgent and emergency eye care provided by optometrists is critical to ensuring that patients, particularly from at-risk populations, do not needlessly end up in an emergency room and potentially exposed to COVID-19 during this current public health emergency.

Commissioner Altman requested comments from Committee members.

Director Lindley-Myers said she could support the NAIC requesting the federal Centers for Medicare & Medicaid Services (CMS) to push the final 2021 rate filing back to sometime in September to provide additional time for insurers to factor in any changes related to COVID-19.

Superintendent Toal expressed support for Director Lindley-Myers’ comments.

The Committee members discussed whether to make such a request to the CMS. Some Committee members explained that they are maintaining their initial rate filing deadlines, but typically they permit carriers to revise their rate assumptions many times during the rate review process before the rates are final.

After additional discussion, Commissioner Altman said the next step is for this issue to be discussed by the Government Relations (EX) Leadership Council. The Committee agreed.

Commissioner Godfread said the states have addressed on an individual basis the issues stakeholders raised in their letters to the NAIC. He said he thinks the next issue the state insurance regulators will have to address concerns payment for COVID-19 antibody testing. He said it would be nice if there could be some uniformity on how this issue is addressed across the states.
Commissioner Mulready said he also is concerned and has contacted Oklahoma’s U.S. Senate delegation to obtain guidance on this issue and others.

Commissioner Conway said it would be helpful to receive clarification from the CMS on the issue.

Mr. Webb said the CMS anticipates providing additional guidance on the issue, but it has not set a time frame on when such guidance will be released.

3. **Heard an Update from the CCIIO**

Randy Pate (CCIIO) updated the Committee on the CCIIO’s recent activities, particularly its activities related to the COVID-19 health emergency. He said the CCIIO recently released guidance related to the expansion of telehealth services in response to COVID-19. He said that as part of the Trump administration’s efforts to combat the COVID-19, the CMS has postponed the 2019 benefit year HHS Risk Adjustment Data Validation (HHS-RADV) process in order for issuers and providers to focus on the health and safety threats currently faced by enrollees, participants and other impacted individuals due to the COVID-19 pandemic.

Mr. Pate said the CCIIO is working on establishing a new SEP for consumers enrolled in individual health insurance plans off the health insurance marketplace, but due to reduction of income because of job loss or some other event become eligible for subsidized individual health insurance coverage on the health insurance marketplace. He said the CCIIO is working quickly to operationalize this new SEP, but, currently, it does not have a specific date when it will be operational.

Mr. Pate said the CCIIO also is considering providing additional time for submission of final 2021 rates consistent with the Committee’s discussion. The CCIIO is helping to disseminate information to individuals and employees to assist them in taking advantage of SEPs they might be eligible for due to COVID-19 through the HealthCare.gov website.

Mr. Pate said the HHS, through the Health Resources and Services Administration (HRSA), has launched a new COVID-19 Uninsured Program Portal, allowing health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after Feb. 4 to submit claims for reimbursement. Providers can access the portal at https://COVIDUninsuredClaim.HRSA.gov.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
Health Insurance and Managed Care (B) Committee
E-Vote
February 26, 2020

The Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Feb. 26, 2020. The following Committee members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); John F. King (GA); Vicki Schmidt (KS); Steve Kelley represented by Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); Jon Godfread (ND); Glen Mulready (OK); Andrew R. Stolfi (OR); Hodgen Mainda represented by Rachel Jrade-Rice (TN); and Mike Kreidler represented by Molly Nollette (WA).

1. **Adopted the Regulatory Framework (B) Task Force’s 2020 Revised Charges**

The Committee conducted an e-vote to consider adoption of the Regulatory Framework (B) Task Force’s 2020 revised charges, which add 2020 charges for the newly appointed MHPAEA (B) Working Group (see NAIC Proceedings – Summer 2020, Regulatory Framework (B) Task Force, Attachment One-A). A majority of the Committee members voted in favor of adopting the Task Force’s 2020 revised charges. The motion passed unanimously.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call July 9, 2020. The following Subgroup members participated: Mary Kwei, Chair, (MD); Debra Judy, Vice Chair (CO); Alex Peck, Jenifer Groth and Claire Szpara (IN); LeAnn Crow (KS); Judith Watters (ME); Carrie Couch, Marjorie Thompson, Camille Anderson-Weddel and Amy Hoyt (MO); Laura Arp and Barbara Peterson (NE); Cuc Nguyen (OK); Katie Dzurec and Elizabeth Hart (PA); Gretchen Brodkorb and Jill Kruger (SD); Jennifer Ramcharan (TN); Tanji Northrup, Heidi Clausen, Shelley Wiseman and Jaakob Sundberg (UT); Jennifer Stegall, Julie Walsh, Mary Kay Rodriguez and Christina Keeley (WI). Also participating were: Chelsey Maller (AK); William Rodgers (AL); Vanessa Darrah (AZ); Stephen Kim (CA); Howard Liebers (DC); Pamela White (FL); Teresa Winer (GA); Arlene Ige (HI); Cynthia Banks-Radke and Angela Boston (IA); Kathy McGill and Kristen Finau (ID); Jill Mitchell and Daniel McIlwain (KY); Emily DeLaGarza (MI); Candace Gergen (MN); Kathy Hall (MS); Robert Kurzydlowski and Jennifer Grady (NC); Chanell McDevitt (NJ); Jessica Baker (NM); Tynesia Dorsey (OH); Teresa Luna, Valerie Brown and Scott Helmcamp (TX); Jackie Myers (VA); Barbara Hudson and Joylynn Fix (WV); and Mavis Earnshaw, Denise Burke and Tara Howard (WY).

1. **Discussed its 2020 Work Plan**

Ms. Judy outlined a few potential work products the Subgroup could take up next. She mentioned the consumer guide regarding the claims process, which had been planned by the Subgroup since 2019; materials related to the COVID-19 pandemic; and the “Frequently Asked Questions about Health Care Reform” (FAQ document), which the Subgroup has worked on in each of the past several years and should be updated for plan year 2021.

Some Subgroup members supported consumer-facing documents related to COVID-19, but they were unsure exactly what form they should take. Others suggested a consumer guide related to short-term plans and coverage that is not comprehensive health insurance, such as health care sharing ministries (HCSMs).

Harry Ting (Consumer Advocate Volunteer, Chester County Department of Aging Services – Apprise Program) also suggested a guide focused on short-term plans.

Bonnie Burns (California Health Advocates—CHA) said any guides developed by the Subgroup should reference Medicare.

Kris Hathaway (America’s Health Insurance Plans—AHIP) said enrollment materials, such as the FAQ document, should be updated with COVID-19 in mind.

Chris Petersen (Arbor Strategies) said any materials from the Subgroup related to short-term plans should be aligned with the minimum standards for such plans being developed in other NAIC groups.

Ms. Kwei said the Subgroup plans to work on the FAQ document closer to the beginning of open enrollment. She encouraged Subgroup members and interested parties to submit any feedback via email.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Jan. 21, 2020. The following Subgroup members participated: Angela Nelson, Chair, Camille Anderson-Weddele, Carrie Couch and Jessica Schrimpf (MO); Anthony L. Williams (AL); Weston Trexler (ID); Michelle Baldock, Ryan Gillespie and Eryn Krueger (IL); LeAnn Crow (KS); Mary Kwei and Joy Hatchette (MD); Kathy Shortt (NC); Cuc Nguyen and Rebecca Ross (OK); Elizabeth Hart (PA); Gretchen Brodkorb and Jill Kruger (SD); Vickie Trice and Jennifer Ramcharan (TN); and Jennifer Stegall, Julie Walsh and Shannon McNally (WI). Also participating were: Chelsey Maller (AK); Julia Yee (CA); Adam Bogess (CO); Matthew Smith and Justine Sorrentino (DC); Matthew Guy and Bryan Peters (FL); Cynthia Banks Radke and Sonya Sellmeyer (IA); Shawn Boggs (KY); Sherri Montana Brown (MN); Bob Williams (MS); Jeannie Keller (MT); Jason Dexter (NH); Jana Jarrett (OH); Scott Helmcamp and Valarie Brown (TX); Yolanda Tennyson (VA); and Dena Wildman, Joylynn Fix and Ellen Potter (WV).

1. **Adopted the Consumer Guide, Using Your Health Plan**

Ms. Nelson noted that the current version of the consumer guide under review is in good shape, and she expressed her hope that after a final walk-through during today’s conference call, the document could be finalized.

The Subgroup then proceeded to review the draft consumer guide, page by page, and discussed any comments received prior to the call or that participants wanted to raise.

In the section titled, “Choose a Primary Care Provider in Your Network,” Ms. Shortt asked whether OB-GYN practitioners should be listed as primary care providers. NAIC staff noted that other providers (e.g., pediatricians) could also be added.

The Subgroup decided that listing types of providers could be too confusing, and no such references were added. It was also noted that the last paragraph of the page did not seem to belong, so it was deleted.

Additional minor edits were made to the document to make it clearer and more readable.

The Subgroup then adopted the amended consumer guide, *Using Your Health Plan* (Attachment Four-A). The consumer guide will be posted to the Subgroup’s page on the NAIC website.

Ms. Nelson said that the next module the Subgroup will be working on is “claims process.” She asked call participants to send to the Subgroup any existing documents on internal/external review that they think would be helpful. She said the Subgroup plans to meet again in mid-February via conference call.

Having no further business, the Consumer Information (B) Subgroup adjourned.
Using Your Health Plan

Adopted by the Consumer Information (B) Subgroup, Jan. 21, 2020
Important Information

You have a health plan. Great news – now you’re insured! But what’s next? You’ll use your plan to access health care.

How much your plan will pay or what services it will cover depends on the plan’s details. This tool will help you know what the details of your health plan mean. It will help you to better understand your plan. With this information, you can make better decisions about your health care.

The examples in this tool are general. They aren’t specific to your health plan.

There are different types of health plans. This tool doesn’t include details about how to use Medicaid [States can customize to identify state Medicaid plan by name], Medicare, or other types of health plans like supplemental policies. See the Health Plan Resources Section to get information and help with Medicaid, Medicare, and other types of health plans.

See the Glossary for definitions for some of the terms used in this tool.

A special thanks to the Maine Health Access Foundation (www.mehaf.org) for information and graphics derived from its original brochure, I Have Health Insurance! Now What?
Using Your Health Plan

Here are a few important things you need to remember:

✔ Always carry your insurance card with you. It has basic information about your health plan. It tells your doctor and other health care providers who the plan covers. Show it when you check in at your doctor’s office or go to the pharmacy.
   → Your Insurance Card

✔ Understand how your health plan works. The best way to avoid surprise health care bills is to understand your plan and what your costs will be ahead of time.
   → Get to Know Your Health Plan
   → Summary of Benefits and Coverage (SBC)
   → Schedule of Benefits/Outline of Coverage
   → Get the Most Out of Your Health Plan

✔ Manage your care and out-of-pocket costs. Pick a Primary Care Provider in your plan’s network. This can be a doctor, nurse, or physician assistant.
   → Cost-Sharing: How You and Your Health Plan Share Costs

✔ Manage your prescription drugs.
   → Your Prescription Medicines

✔ Know what to do in an urgent or emergency medical situation.
   → What to Do in an Emergency

✔ Plan ahead. Know what you need to do if you have a planned health procedure or a surgery. Check to make sure the facility (for example, a hospital or lab) and all health care providers are in your plan’s network. If they aren’t, you’ll have to pay more of the costs yourself. If you’re going to have a major health care service, like a surgery or procedure, you should call your insurer to ask if you need their approval before you use the health care service.
   → Choose a Primary Care Provider in Your Network
   → Avoid Balance Billing
   → Referrals and Prior Authorizations

✔ Understand the key points of your health plan, your health, and your health care.
   → Different Kinds of Health Plans
   → Job-Based Health Plans
   → If You Have More Than One Health Plan:
      → Coordination of Benefits
   → How to File a Claim
   → Health Plan Resources
   → Glossary of Terms

✔ Update your plan if something in your life changes. Life is unpredictable. If you get married, divorced, or have a baby or adopt a child, your health plan needs to change. If you’re turning 65, find out when you need to sign up for Medicare and when you need to cancel your health plan. Call your insurer and let them know if something in your life changes.
   → Life Changes – Your Health Plan Should Too
Get to Know Your Health Plan

Not every health plan is the same. Maybe you can’t remember the details about your plan – what it covers, what it doesn’t, or what your out-of-pocket costs may be.

Don’t worry. You can get that information when you need it. Here is where you can find information about your plan and get help to understand your benefits.

**Check your insurance card.** Your insurance card has some of the most important information you need about your health plan. It tells providers basic information about your plan and who’s covered. Most insurance cards list toll-free phone numbers and website information where you can access the most current information for your plan. Be sure you check the back of the card for important information.

You also may find other important telephone numbers on your insurance card. For example, there may be a number you can call if your plan offers advice from a nurse or telehealth services.

**Check your health plan’s website.** Most health insurers have websites you can use to access the most up-to-date information about your plan. You can learn what your plan covers, what doctors and facilities (for example, hospitals and labs) are in your plan’s network, what prescription drugs the plan covers, what claims the plan has paid, and how much of your deductible you still need to meet. You usually need to register or create an account to log in to get information specific to your health plan.

**Check the SBC.** Ask your insurance company or employer for a Summary of Benefits and Coverage (called an “SBC”). This is a short list of your benefits and deductibles, co-pays, and coinsurance amounts (called cost-sharing).

**Check the policy or certificate.** Be sure you have a copy of your policy and review it for more information about your benefits. If you get your health insurance through work, look for your plan certificate.

Your plan information should include a document called a “Schedule of Benefits” or an “Outline of Coverage.” Both have more information about your costs and benefits. They’ll also tell you what services the plan doesn’t cover (called “exclusions”).

**Call the insurer.** If after looking at your plan documents you still have questions about your plan, call your health insurer.

**Other Resources.** If you bought your plan outside of work, ask your health insurance agent for help. If your health plan is through work, ask your HR Department to explain things.

The next few pages will help you find more information about your health plan.
Your Insurance Card

Some of the most important information you need to use your health plan is on your insurance card. You'll need the information on your card if you talk on the phone about your plan or look for information on your insurer's website.

Your insurance card tells health providers basic information about your plan and who it covers. You'll need to show your insurance card any time you receive a health care service or talk to a health care provider (a doctor, for example) in person. If you're covered under more than one health plan (you have coverage through work, but you're also covered under your spouse's health plan), you need to bring both insurance cards with you.

When you get your insurance card, check the information on the front of the card. Does the information match what you bought? Is the plan type correct? Is the network name what you expected? Are the cost-sharing amounts correct? If there is a Primary Care Provider (PCP) listed on your insurance card, is it correct?

If any of this information is wrong, call your health insurer right away.

Make sure you also check the information on the back of the card. This is where you will find other helpful information – like phone numbers to call your insurer if you have questions.

Health plans usually give you one or two insurance cards. If you don't get a card, call your insurer. You also may be able to print a paper copy of your card from your health insurer's website.

Keep the card with you at all times. Protect your insurance card like you would other sensitive personal and financial information.

Sample Insurance Card

---

**Front**

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Member Name: Jane Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Type: Titanium PPO Plan</td>
<td>Member Number: XXX-XX-XXX</td>
</tr>
<tr>
<td>Effective Date: 01/01/2020</td>
<td>Group Number: XXXXX-XX</td>
</tr>
<tr>
<td>Prescription Group # XXXX</td>
<td>PCP Co-Pay $15.00</td>
</tr>
<tr>
<td>Prescription Co-Pay</td>
<td>Specialist Co-Pay $25.00</td>
</tr>
<tr>
<td>$15.00 Generic</td>
<td>Emergency Room Co-Pay $75.00</td>
</tr>
<tr>
<td>$20.00 Name Brand</td>
<td>Member Service: 800-XXX-XXXX</td>
</tr>
</tbody>
</table>

---

**Back**

| www.myplan.com | Member Service: 800-XXX-XXXX |
| Nurse Advice Line 24/7: 866-XXX-XXXX | |
| Telehealth Services: 888-XXX-XXXX | |
| Send claims to: | |
| My Plan, Inc | |
| P.O. Box XXXX | |
| City, State XXXX | |
Information on your insurance card about your plan and your cost-sharing can help you figure out what your out-of-pocket costs will be. You also can find more information to help you on the Summary of Benefits & Coverage or SBC. For example, you'll find information about deductibles on the SBC. The SBC also tells you the types of services your health plan covers and what co-pays or coinsurance you'll pay. Below is what the front page of an SBC looks like.

A Summary of Benefits & Coverage is usually available when you shop for a health plan on your own or through work, or when you renew or change your plan. If you can't find an SBC for your plan, ask the insurer, your agent, or your employer for one. Just remember, short-term health plans aren't required to give you an SBC. (A short-term plan is one that only covers you for 12 months or less and doesn't have to follow the rules in the Affordable Care Act.)


Below is a picture of the first page of an SBC to give you an idea of what an SBC looks like and the kind of information it gives. If you have questions about what the underlined words mean, remember to check the Glossary at the end of this tool.

---

**Summary of Benefits and Coverage (SBC)**

**Insurance Company 1: Plan Option 1**

**Coverage Period:** 01/01/2013 – 12/31/2013

** Coverage for:** Individual + Spouse | Plan Type: PPO

---

**Important Questions**

**Answers**

**Why this Matters:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why it Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500 person / $1,000 family</td>
<td>You must pay all the costs up to the deductible amount before the plan begins to pay for covered services you use. Check your policy or plan document to see where the deductible starts (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, $300 for prescription drug coverage. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before the plan begins to pay for these services.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For participating providers $2,500 person / $5,000 family. For non-participating providers $4,000 person / $8,000 family</td>
<td>The out-of-pocket limit is the most you can pay for your share of the costs of covered services. Even though you pay these expenses, they don't count toward the plan's annual limit.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn't cover.</td>
<td>The chart starting on page 2 describes any services not covered, such as office visits.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes the plan's annual limit, the most the plan can pay for covered services you use.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.%5Binsert%5D.com">www.[insert].com</a> or call 1-800-[insert] for a list of participating providers.</td>
<td>If you use an in-network doctor or other health care provider, you may pay less than if you go out of network.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes. You don't need a referral to see a specialist.</td>
<td>You can see the specialist you choose with this plan.</td>
</tr>
<tr>
<td>Are these services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover, such as a specialists, are not covered.</td>
</tr>
<tr>
<td>What is the overall deductible?</td>
<td>$500 person / $1,000 family</td>
<td>Doesn't apply to preventive care.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. Yes, $300 for prescription drug coverage. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before the plan begins to pay for these services.</td>
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<td>Yes.</td>
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</tr>
</tbody>
</table>
Schedule of Benefits/Outline of Coverage

You can get a list of the services your health plan covers, along with which costs you’ll have to pay. You’ll find this list in the Schedule of Benefits (if your plan is through work) or in the Outline of Coverage (if you bought your plan outside of work). Both list the various services a health plan covers, along with what costs you’ll have to pay. This document also shows which services the plan covers and doesn’t cover.

Many health insurers send a printed copy of your Schedule of Benefits (Schedule) or Outline of Coverage (Outline) when you first enroll in a plan. It’s usually with your insurance policy or certificate. You also may have access to an electronic copy in your member portal on the plan’s website. This list will help you get an idea of how much you’ll pay for services. Keep this document with your insurance papers.

“Benefits” is the term health plans use for health care services the plan covers. The Schedule (or Outline) lists the various categories of benefits your plan covers, such as preventive, hospital, medical, surgical, diagnostic, therapeutic, urgent care, and prescription drug services. For example, under preventive services, the schedule may list "Adult physical examination (1 exam per calendar year)."

A Schedule or Outline is usually broken into several sections:

The **heading** gives the basic information about your health plan. It explains what type of health plan you have (HMO, POS, EPO, PPO, or FFS/Indemnity), who the plan is through, the benefit year, and your plan’s start date. If you get your health plan through work, this start date will be for the company, not just you. You can learn more about the different plan types on page 12.

The **responsibilities** section tells you the deductible, co-payments, and coinsurance and what the annual out-of-pocket maximums are. You can learn more about the different types of cost-sharing on page 9.

The **health benefits** section lists the specific covered benefits. This section also often has information about your cost-sharing.

The **pharmacy benefits** section identifies the prescription drug benefits in your health plan and the co-payment. You can learn more about how to use your pharmacy benefits on page 13.

The **network(s)** section tells you the provider network(s) your health plan has contracts with. When you use providers in the network (sometimes called preferred providers), your costs will be lower than if you use providers outside the network.

The **dependent benefits** section lists which dependents your plan covers and for how long.
Cost-Sharing: How You and Your Health Plan Share Costs

Jot down information about your health plan and cost-sharing below. Use your insurance policy or certificate, your insurance card, your Schedule of Benefits/Outline of Coverage, and/or your SBC to find the information. Then read the next few pages to understand what the different terms mean and how your costs are calculated.

**Deductible:** The amount of money you must spend each year on your health care before your plan starts to pay. If family members are covered under your health plan, there will be two deductibles. Once you’ve met the family deductible, you’ve also met the individual deductible. Your plan may pay for some preventive services, like an annual physical, even if you haven’t met your deductible. You may have a separate deductible for prescription drugs.

- Your Deductible (Individual): __________
- Your Deductible (Family): __________
- Prescription Drug (Rx) Deductible:
  - [ ] included in the deductible above
  - [ ] Not included in the deductible above
- Your Rx Deductible (Individual): ________
- Rx Deductible (Family): __________

**Co-Pay:** A fixed fee you pay directly to the provider when you get health care (for example, $40 for every primary care visit).

- Your Co-Pays:
  - In-network Primary Care: __________
  - Out-of-network Primary Care: __________
  - In-network Specialist: __________
  - Out-of-network Specialist: __________
  - In-network Emergency Department: __________
  - Out-of-network Emergency Department: __________
  - In-network Urgent Care: __________
  - Out-of-network Urgent Care: __________
- Prescription: __________

**Coinsurance:** A percentage you pay for most health care even after you meet your deductible. For example, if your coinsurance is 20%, then the insurance company pays 80% of the covered amount and you pay 20% until you reach your out-of-pocket maximum.

- Your Coinsurance:
  - In-network: __________
  - Out-of-network: __________

**Out-of-Pocket Maximum:** The most you pay during a plan period before your health plan pays all of the costs for covered services. This maximum doesn’t include your monthly premium.

- My Out-of-Pocket Maximum: __________
- Family Out-of-Pocket Maximum: __________

**Monthly Premium:** A fixed amount that you pay each month or with each paycheck for your health plan. If you miss payments or pay late, the insurer could cancel your plan.

- Your Monthly Premium: __________
How You and Your Health Plan Share Costs—Example

Jane’s Plan Deductible: $1,500 | Co-Pay: $0 | Coinsurance: 20% | Out-of-Pocket Maximum: $5,000

Jan. 1st
Beginning of Coverage Period

Patient Pays 100%
Plan Pays 0%

Jane hasn’t reached her $1,500 deductible yet.
Her plan doesn’t pay any of the costs.
Office Visit Costs: $125
Jane Pays: $125
Her Plan Pays: $0

Note: All plans pay 100% of included preventive services from the start.

Jane has reached her $1,500 deductible, coinsurance begins.
Jane has seen a doctor several times. Her plan pays some of the costs.
Office Visit Costs: $75
Jane Pays: 20% of $75 = $15
Her Plan Pays: 80% of $75 = $60

Note: Some plans require the patient to pay a “co-pay,” a fixed amount per visit or per prescription filled.

Jane reaches her $5,000 out-of-pocket limit.
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office Visit Costs: $200
Jane Pays: $0
Her Plan Pays: $200
Choose a Primary Care Provider in Your Network

Your insurance company may assign you to a Primary Care Provider. Usually you can change providers if you don’t like the one the plan assigns you. Contact your insurance company to find out how.

For most people, it makes sense to pick a Primary Care Provider from your health plan’s network. You’ll pay the least money out-of-pocket if you use providers in your plan’s network. That’s because the plan has negotiated contracts with the providers.

If you use a provider outside of your health plan’s network when it’s not an emergency, you’ll pay more. And, some plans don’t pay anything for care from non-network providers unless you see them in an emergency.

Your Primary Care Provider is your first stop for health care. It’s where you call or visit each time you need care. They help you get services from any specialists or other health professionals that you need.
How to Choose a Provider in Your Network

To find the names of providers near you who are in your health plan’s network, first you need to know the name of the network. You’ll find the name in your insurance policy or certificate or on your insurance card. Then, go on your insurer’s website and look for the directory of network providers. Or, you can call your insurer. The phone number is on your insurance card. If your health plan is through work, your employer may have a provider directory.

After you find a provider you want to use, call their office and ask:

1. Are you in my plan’s network?
2. Are you accepting new patients?

If you need help, call your insurance company. The number is on your insurance card.

If you need specialized health care, check whether your local hospitals or specialists are part of your plan’s network.

Avoid Balance Billing

Balance bills happen when a provider who isn’t in your health plan’s network charges more than your plan pays, and the provider bills you for the difference. In-network providers have agreed to accept the plan’s payment as full payment and will not send you a balance bill. So, you can avoid the extra cost of balance bills if you choose providers in your health plan’s network.

Sometimes you may not be able to choose a provider who is in your plan’s network. You may need emergency treatment, or you may see an out-of-network provider at an in-network hospital. Or, you may need care from a specialist and there aren’t any in your network. In these cases, your state may have laws to protect you from balance billing. Contact your state insurance department to find out more.
Different Kinds of Health Plans

My plan is: a PPO □ an HMO □ an EPO □ a FFS □ a POS □ I don't know □

**PPO**
Preferred Provider Organization
You can see any provider who will accept the insurance.
You may have higher out-of-pocket costs for out-of-network care.
Monthly premiums are generally higher as you have more choice of providers.
You aren’t required to get a referral from your Primary Care Provider to see specialists.

**HMO**
Health Maintenance Organization
You must choose an in-network Primary Care Provider when you enroll.
You must see in-network providers, except in an emergency.
Premiums and cost-sharing may be lower as you have less choice.
You must get referral from your Primary Care Provider to see any specialist.

**EPO**
Exclusive Provider Organization
You must see in-network providers, except in an emergency.
Premiums are generally lower than PPOs due to network restrictions.
A Primary Care Physician referral is not required to see specialists.

**FFS**
Fee For Service (Indemnity)
You can see any provider.
Once you meet a deductible the plan pays a fixed amount (usually a percentage) of the usual and reasonable cost of the service.
Monthly premiums are higher because you can see any provider.

**POS**
Point of Service
You must choose an in-network Primary Care Provider.
Your cost are lower if you use in-network providers but you have the freedom to seek care outside the network.
You are required to get a referral from your Primary Care Provider to see out-of-network specialists.

See page 11 to learn more about in-network and out-of-network providers.
Job-Based Health Plans

Your health plan may be through your job or a family member’s job. If the employer pays the costs of the health care services these plans cover, the plan is called self-funded health plans. Many large employers, unions, government agencies, and school districts have self-funded health plans.

Self-funded health plans usually use a third-party administrator (TPA) to review and pay claims for the plan. Sometimes, that TPA shares a brand name with a health insurance company. But the employer still is responsible to provide the money to pay claims – not the insurance company. If a unit of government is the employer, then the government is responsible to provide the money to pay claims.

The U.S. Department of Labor’s Employee Benefits Security Administration (DOL-EBSA) regulates self-funded health plans. State insurance laws generally don’t apply to self-funded plans.

Some employer-based plans are fully insured. Unlike self-funded plans, in a fully-insured plan, an insurance company is responsible for covered health care costs. The insurer charges your employer a premium to take on that financial responsibility.

State insurance departments regulate fully-insured health plans. These plans must follow state insurance laws. State insurance departments can help consumers who have fully-insured plans.
Your Prescription Medicines

Health plans help pay the cost of covered prescription medicines. Insurers use a “formulary” that determines how much of the cost you’ll pay. You can find a link to your plan’s formulary in the Summary of Benefits Coverage in the “Common Medical Events” section in the row labeled “if you need drugs to treat your illness or condition.” A formulary usually has different tiers. Prescription medicines listed in one tier may cost you more than those in another tier.

Always show your pharmacy your health insurance card. Prescriptions that you pay for will count toward your annual out-of-pocket maximum.

To find out which prescriptions your plan covers:

- Visit your insurance company website to find your online health plan formulary.
- Check your insurance policy or certificate to learn more about your formulary.
- If you need help, call your insurance company directly to find out what’s covered.

Example: Categories of prescription drugs in a tiered formulary:

$ Tier 1—Generic drugs. These are lower-cost drugs.

$$ Tier 2—Preferred, brand-name drugs. These drugs cost more because they’re unique, and just one drug company makes them.

$$ Tier 3—Non-preferred, brand-name drugs. These are also brand-name drugs. But they may cost you more than other brand name drugs that treat the same condition.

$$ Tier 4—Some plans use this tier for specialty drugs. Other plans have a separate “specialty” tier. These are high-cost drugs that treat rare or complex diseases.

It’s a good idea to talk with your providers about the best affordable medications for you, based on your plan.

If the pharmacy says that your plan doesn’t cover a prescription drug you’ve been taking, some insurance companies may let you refill the prescription once. That will give you time to talk with your provider about other options.

You also can ask your provider to ask your health plan for an exception. With an exception, you can get a prescription medicine that your plan doesn’t normally cover. Your health insurer might agree because:

- All other drugs the plan covers haven’t worked or won’t work as well as the drug the provider prescribed, or
- All other drugs the plan covers have caused or could cause harmful side effects.
Get the Most Out of Your Health Plan

You can use your health plan to get preventive care to stay healthy. Schedule needed appointments for you and your family. Avoid emergency department visits when you can – it’ll save you money. And, your plan may cover other services that can help you stay healthy. Some services that can help you get the most from your health plan include:

- Care for new mothers and babies
- Annual physicals
- Well-baby visits
- Scheduled preventive screenings such as mammograms, colonoscopies, and others
- Other preventive and wellness services
- Counseling and services for substance use disorders
- Prescription medicines
- Laboratory services
- Help to manage diseases like diabetes or high blood pressure
- Services for kids (for example, vision checks)
- Vaccinations

Your plan may pay all of the costs for some of these services even before you meet your deductible. You don’t have to pay anything for some preventive services. Check with your provider and your plan to make sure your service is considered preventive.

Your plan likely covers the Essential Health Benefits.¹ All Qualified Health Plans that you buy through the Health Insurance Marketplace [State Marketplace Brand] cover these benefits. Some grandfathered plans or employer-based plans that you buy outside the Marketplace may not.

---

¹ Essential Health Benefits include these categories:
1. Ambulatory patient services (outpatient services)
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care
What to Do in an Emergency

Use an emergency department (or ER) only if you have a real emergency, such as any severe pain, like chest or stomach pain, bleeding you can’t stop, or sudden weakness.

You can use urgent care facilities, sometimes called Quick Care, Express Care, or First Care, when you need to see a provider more quickly than you can see your primary provider. They almost always cost less than if you go to the emergency department. If your plan has co-pays, your co-pay for urgent care may not be much more than your co-pay for a doctor visit. Some urgent care facilities take appointments so you may not have to wait long to see a provider.

Contact your insurance company to ask which urgent care facilities near you are in-network.

If you have an emergency or life-threatening situation, call 9-1-1 or go to the nearest emergency department. In an emergency, you should go to the closest hospital. Your health plan can’t require prior authorization before you go to the emergency department or charge you more because the hospital isn’t in your plan’s network. You may still have to pay some of the costs of emergency services, depending on your plan. For instance, you may have to pay a co-pay or part of the costs if you haven’t met your deductible. And, your share of the costs may be more if the hospital wasn’t in your health plan’s network.

If you’re not sure where to go, don’t be afraid to call your Primary Care Provider.
Referrals and Prior Authorizations

Some health plans, mainly Health Maintenance Organizations (HMOs), require a referral before you get care from some providers. A referral is an order from your Primary Care Provider for you to see a specialist or get certain medical services. If you don’t get a referral first, the plan may not pay any of the costs of the services.

Other types of health plans, not just HMOs, may require prior authorization for some services. If you need a special treatment, service, or medical equipment, you may need to get approval first from your health plan. This is called prior authorization. A health plan gives prior authorization when a service is medically necessary. Without it, your health plan may not pay any of the costs. You can ask your provider if you need prior authorization. Some providers will ask the health plan for prior authorization.
If You Have More Than One Health Plan: Coordination of Benefits

If you have more than one health plan, all of your plans work together to pay their shares of your health care costs.

You need to tell your providers if you have more than one health plan. Coordination of benefits rules determine which plan is primary (pays first) and which is secondary (pays second). Talk to both health insurers. Learn what’s expected of you and how the plans will coordinate.

The primary health plan processes your insurance claim first. If there’s still a balance, then the secondary plan processes the claim for the balance. The plans won’t pay more than the total claim amount. You won’t get double the benefits if you have two health plans. And, you have to meet the deductibles and pay your share of the costs in each plan.

Even if you have more than one plan, that doesn’t mean that the plan covers every health care service. A plan only pays for covered benefits. So, for example, if you have cosmetic surgery to improve your looks, neither health plan will pay any of the costs if neither covers cosmetic surgery.

Here’s an example of how coordination of benefits works: Let's say you visit your doctor, and the bill comes to $100. The primary plan pays the amount it covers. Let's say that's $50. If the secondary plan covers the doctor's visit, it might pay up to $50 – if you’ve met your deductible and don’t have any other cost-sharing responsibilities.

A few examples of ways people may have more than one health plan are:

- You’re enrolled in your employer’s health plan, and your spouse has added you to his or her plan.
- A child is covered by both parents’ separate health plans.
- A child has her own health plan (from school or work) and stays on her parent's plan until age 26.
- A child is married and on his spouse's plan and stays on his parent's plan until age 26.
- A person is enrolled in Medicare and also has a private health plan.
- A person is enrolled in Medicaid and also has a private health plan.
- A service member or veteran has TRICARE or coverage through the Veterans Administration (VA) as well as another health plan.

When you use health care services, check that they are in-network for both health plans if you’ll use both health plans.
Life Changes – Your Health Plan Should Too

When life changes — for example, a move, a marriage, a job change — you may need to make changes in your health plan. But often there are special rules about changing your health plan.

Usually you can enroll in health plans only once a year during a set period of time called the annual open enrollment period. Many life changes qualify you to enroll in or change your plan when the change happens. You don’t have to wait for the next open enrollment period. These life changes are called qualifying events. Qualifying events apply to both employer plans and ones you buy on your own.

Changes in Your Family

A family health plan covers more than one family member. When your family changes, due to marriage, divorce, or a child’s birth or adoption, it’s time to review your health plan. You may need to add or remove family members.

You also might need to change your plan when an adult child reaches age 26 and isn’t eligible to stay on your plan. You might need to change from an individual to a family plan – or from a family to an individual plan. You can call your health insurer or visit its website to learn how to add or remove family members. If your health plan is through work, check with Human Resources.

As soon as possible, tell your insurance company when any of these happen:

- Change of address
- Marriage
- Divorce or separation
- Birth or adoption of a child
- Death of covered family member
- A child on your health plan reaches age 26
- An adult on your health plan reaches age 65

Leaving a Group Plan

If you change your job, you might need to change your health plan. If your plan was through work at your old job, you probably have to sign up for a new health plan.

If you lose your job, you may be able to keep the health plan you had through the job. But you’ll have to pay the full premium – your share and the employer’s share. Ask your employer about COBRA continuation coverage. And, if you’re 65 or older when you lose your job and haven’t yet signed up for Medicare, you should do that now to avoid premium penalties or delays in coverage. Contact your State Senior Health Insurance Assistance Program [State SHIP brand] if you have questions.

If you leave a group plan because you can no longer work due to a disability, you can apply for Social Security disability benefits. Once you’ve received these benefits for two years, you’ll be eligible for Medicare.
Check for Affordable Health Plan Options

If your individual or family income changes, it might change your eligibility for help with health plan costs. You can apply at the Marketplace [State Marketplace Brand] to find out if you’re eligible for financial help to buy a Marketplace plan. You also might be eligible for a low- or no-cost health plan through Medicaid or the Children’s Health Insurance Program (CHIP) [State Program Names].

There’s an annual open enrollment period for Marketplace plans. In this period, anyone can enroll in or change their plan. But you might be eligible to enroll or change plans through the Marketplace at other times if one of these happens:

- You lose your health plan, but you paid the premiums
- You lose coverage through Medicare, Medicaid, or Children’s Health Insurance Program
- You can’t stay on the health plan you have now because you’re no longer a dependent
- You move
- You get married
- You divorce or separate from your spouse
- You give birth to or adopt a child
- A covered family member dies

These events qualify you for a special enrollment period – a chance to enroll in or change your health plan without waiting for the next open enrollment period. But you must contact the Marketplace within 60 days of the event. If you missed the special enrollment period, you’d have to wait for the next open enrollment period. You can find out more about special enrollment periods (SEPs) at https://bit.ly/2Df4Wv7.

Medicare

If you’re turning 65 years old soon, find out when you should sign up for Medicare. You should sign up for Medicare Parts A and B if your employer has fewer than 20 employees because Medicare will be primary (pay claims first). If your employer has 20 or more employees and you do not have a Health Savings Account (HSA), then you should sign up for Medicare Part A if you qualify for free coverage. Contact your State Senior Health Insurance Assistance Program [State SHIP brand] if you have questions.

Once you stop working or lose your health plan at work, after you turn 65, you have eight months to sign up for Medicare Part B. If you miss that window, your Medicare premiums will be higher.
How to File a Claim

Most providers file insurance claims for you. That’s why they need your insurance card when you see them. The providers send a bill to your health plan with information about your condition and how they treated you. Your health plan compares your benefits with the services billed and pays your provider. This payment won’t include any amounts that are your responsibility— for example, the deductible, co-payments, or coinsurance. If the plan doesn’t cover any part of your claim or doesn’t cover the health care service, your health care provider can ask you to pay the balance. If you’ll owe coinsurance, many providers estimate the amount and ask you to pay that when you see them.

Some health care providers won’t submit claims for you. You can ask your providers if they will. If you have to submit your own claim, ask your provider to help you so you have the right dates, procedures, and codes on the claim form. Keep in mind that when you submit your own claim, most providers require you to pay the full amount upfront. Then, your health plan will reimburse you after it processes the claim.

When Your Health Plan Pays Your Claims

If your provider submits your claim, don’t pay a bill for a covered service until your health plan has reviewed the claim.

How do you know if the plan has reviewed the claim? Your health plan will send you an “Explanation of Benefits” (EOB) after you receive services. The EOB tells what services the plan paid or didn’t pay, and why.

Your health plan must explain in writing within a set amount of time why it didn’t pay for a service. If you think the plan should have paid for the service, you can appeal the decision.

Your health plan must tell you how you can appeal their decisions. If taking the time to appeal would put your life or ability to fully function at risk, you can file an “expedited” appeal to get a quicker decision.

If you need help to file an appeal, you can contact [State Insurance Agency] Consumer Assistance Program:

[(800) xxx-xxxx ]

[TTY: (xxx) xxx-xxxx | State Website]

You also can contact the [State Insurance Agency] to file a complaint and start an investigation against an insurance company. The [State Insurance Agency] encourages you to call about any problems you have when a health plan denies a claim or service that you believe should have been covered.
Health Plan Resources

The Health Insurance Marketplace [State Marketplace brand] is a resource where individuals, families, and small businesses can learn about their health plan options. You also can compare health plans based on costs, benefits, and other important features; choose a plan; and enroll in a plan.

1 (800) 318-2596 | TTY: 1 (855) 889-4325 | HealthCare.gov

Your state department of insurance regulates the insurance industry. It examines and licenses insurance companies and those who sell insurance, reviews rates and coverage forms, conducts audits, and sponsors programs that increase awareness of State laws.

Consumer Assistance Hotline:
1 (800) | website | other phone number

For seniors and others enrolled in Medicare, each state operates a State Health Insurance Assistance Program (SHIP) [State Brand]. This is a free health benefits counseling service for Medicare beneficiaries and their families or caregivers. Find your state’s SHIP at the number below or at https://www.shiptacenter.org/

State SHIP Program

Medicare beneficiaries also can contact Medicare directly at the following number:

Medicare 800-MEDICARE
Glossary of Terms

**Balance Billing:** When a provider, who isn’t in your plan’s network, charges more than your plan pays and bills you for the difference in addition to cost-sharing.

**Benefits:** The health care services a health plan covers. The plan’s documents define the benefits that it does and doesn’t cover.

**Claim:** A request for your health plan to pay for health care services. You or your health care provider submits to the claim.

**Coinsurance:** The percentage of the cost of a covered health care service you pay (20%, for example) after you've met your deductible.

- If you've met your deductible: You pay 20% of $100 or $20. The insurance company pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, $100.

**Coordination of Benefits:** A way to figure out which plan pays first when two or more health plans are responsible to pay the same claim.

**Co-payments:** A fixed amount ($20, for example) you pay for a covered health care service after you've met your deductible.

- If you've met your deductible: You pay $20, usually at the time of the visit.
- If you haven't met your deductible: You pay $100, the full allowed amount for the visit.

Co-payments (sometimes called "co-pays") can vary within the same plan for different services, like drugs, lab tests, and visits to specialists.

**Cost-Sharing:** The share of costs for covered services that you pay yourself. This term generally includes deductibles, coinsurance, and co-payments. It doesn't include premiums, balance billing amounts for providers not in the network, or the cost of health care services the plan doesn’t cover.

**Deductible:** The amount you pay for covered health care services before your health plan starts to pay. If you have a $2,000 deductible, for example, you pay the first $2,000 of covered services in a plan year. After you've paid $2,000 of your own money for covered services, you usually pay only a co-payment or coinsurance for covered services for the rest of the plan year. Your plan pays the rest.

**Exclusions:** Health care services your health plan doesn’t cover. If you receive these services, you pay all of the costs.

**Network:** The facilities, providers, and suppliers your health plan has a contract with to provide health care services.

**Open Enrollment Period:** A time (once a year) when anyone can enroll in or change their health plan.

**Out-of-Pocket Costs:** Expenses for health care your health plan doesn’t pay. Out-of-pocket costs include deductibles, coinsurance, and co-payments for covered services plus all costs for services your health plan doesn’t cover.

**Out-of-Pocket Maximum/Limit:** The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, co-payments, and coinsurance, your health plan pays all of the costs of covered services.

The out-of-pocket limit doesn't include your monthly premium. It also doesn't include anything you pay for services your plan doesn't cover.
Primary Care: Health services that include a range of prevention and wellness as well as treatments for common illnesses.

Primary Care Providers (PCP): Health care professionals (including doctors, nurses, nurse practitioners, and physician assistants) who manage your care. A PCP often maintains long-term relationships with you. She advises and treats you for a range of health-related issues. A PCP also may coordinate your care with specialists.

Prior Authorization: Approval from a health plan to get a service or fill a prescription. If your plan requires prior authorization and you don’t get it, the plan may not pay any of the costs.

Qualifying Event: A life change (for example, a marriage or a job change) that lets you enroll in or change your health plan before the next open enrollment period.

Referral: An order from your Primary Care Provider to see a specialist or get certain medical services. Many Health Maintenance Organizations (HMOs) require you to have a referral before they pay for health care from anyone other than your Primary Care Provider.

Self-Funded Health Plan: A type of plan where the employer itself collects premiums from enrollees and pays medical claims. Used by many large employers, the employers can contract with a third-party administrator to manage enrollment, process claims, and manage provider networks. Or, the employer can manage the plan itself.

Special Enrollment Period: A time when you can enroll in or change your health plan because of a qualifying event.

Third-Party Administrator: A company that reviews and pays claims for an employer’s self-funded health plan. May share a brand name with a health insurance company.

Urgent Care: Care for an illness, injury, or condition so serious that a reasonable person would seek care right away, but not so serious as to require emergency department care.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Jan. 7, 2020. The following Subgroup members participated: Angela Nelson, Chair (MO); Anthony L. Williams (AL); Weston Trexler (ID); Michelle Baldock and Eryn Krueger (IL); LeAnn Crow (KS); Judith Watters (ME); Mary Kwei (MD); Laura Arp and Martin Swanson (NE); Cuc Nguyen and Rebecca Ross (OK); Elizabeth Hart (PA); Gretchen Brodkorb and Jill Kruger (SD); Jennifer Ramcharan (TN); Tanji Northrup, Shelley Wiseman, Heidi Clausen and Jaakob Sundberg (UT); and Jennifer Stegall (WI). Also participating were: Chelsy Maller and Jacob Lauten (AK); Debra Judy (CO); Matthew Guy, Bryan Peters and Carolyn Diggs (FL); Cynthia Banks-Radke and Sonya Sellmeyer (IA); Sherri Mortensen-Brown (MN); Bob Williams (MS); Pam Koenig (MT); Tynesia Dorsey (OH); John Garrett (RI); Scott Helmcamp and Doug Danzeiser (TX); Michelle McNamee (VA); Todd Dixon (WA); and Dena Wildman and Joylynn Fix (WV).

1. Discussed the Consumer Guide, *Using Your Health Plan*

Ms. Nelson reviewed the plan of the Subgroup to produce a series of modules for consumer assistance. The one currently under development is to help consumer understand their health plans; the next would be to help consumers use their plans, including claims and appeals. She said she hopes to release the guide titled *Using Your Health Plan* as early as possible in the year. She asked Subgroup members to focus on the edits suggested by consumer representatives who had reviewed the latest draft.

The Subgroup discussed the section on different network types. It considered whether to list network types so that the more commonly used types are listed first.

Ms. Watters observed that the most common types in one state may not be the same in other states.

Ms. Nelson suggested that preferred provider organizations (PPOs), exclusive provider organizations (EPOs) and health maintenance organizations (HMOs) be listed first. Others agreed.

The Subgroup discussed the section on prescription drugs.

Kris Hathaway (America’s Health Insurance Plans—AHIP) suggested that the section reference the Summary of Benefits and Coverage (SBC), because that document describes whether a plan has a formulary. She also said the section should be clear that four formulary tiers is an example; plans could have more or fewer tiers.

The Subgroup discussed the section on coordination of benefits. Members discussed how commonly plans impose a surcharge when covering an enrollee’s spouse who could be covered by his or her own employer insurance plan.

Mr. Trexler pointed out that the presence or absence of a surcharge does not relate to coordination of benefits between two plans on enrollee is enrolled it. He suggested removing the reference to the surcharge and others agreed.

The Subgroup discussed the section on leaving a group health plan.

Ms. Watters said the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) should not be the only option mentioned; individual market coverage should also be presented as an option for those leaving a group plan.

Mr. Swanson said it would also be worth mentioning the different continuation options available depending on the size of the employer. The Subgroup agreed that a few options should be referenced.

The Subgroup discussed circulating a revised version of the guide and considering it for adoption on its next call.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met via conference call July 30, 2020. The following Working Group members participated: Marie Ganim, Chair (RI); Andrew R. Stolfi, Vice Chair, TK Keen, Dorothy Bean, Rick Barry and Tashia Sizemore (OR); Martin Swanson, Vice Chair, Bruce R. Ramge, Michael Muldoon, Tracy Burns, and Laura Arp (NE); Sarah Bailey, Jacob Lauten and Mayumi Gabor (AK); Anthony L. Williams, Yada Horace and Steve Ostlund (AL); Howard Liebers and Cheryl Wade (DC); Cynthia Banks Radke, Angela Burke Boston, Johanna Nagel and Sonya Sellmeyer (IA); Alex Peck and Claire Szpara (IN); Barbara Torkelson, Shannon Lloyd, Craig Van Aalst and Tate Flott (KS); Robert Wake, Marti Hooper and Keith Fougere (ME); Jessica Schrimpff, Teresa Kroll, Amy Hoyt, Cynthia Amann, Camille Anderson-Weddle and Christie Kincannon (MO); John Arnold, Ross Hartley, Chyrstal Bartuska and Johnny Palsgraaf (ND); Sarah Cahn and Maureen Belanger (NH); Philip Gennace and Chanell McDevitt (NJ); Paige Duhamel and Viara Janakieva (NM); Mark Garratt, Jeremy Christensen, David Cassetty and Jeremy Goldstone (NV); Lars Thorne, Karen M. Feather, Sandra Y. Ykema, Michael Humphreys, Richard L. Hendrickson, Shannen Logue and Katie Dzurec (PA); Raja Malkani, Luke Bellsnyder, R. Michael Markham, Carol Lo, David Bolduc, Kenisha Schuster, Leah Gillum and Chris Herrick (TX); Tanji Northrup, Heidi Clausen and Jaakob Sundberg (UT); Molly Nollette, Kimberly Tocco, Ali Butler, Mandy Weeks-Green, Pam Brannan, Jane Beyer, Candice Myrum and Sue Hedrick (WA); Julie Walsh, Diane Dambach, Barbara Belling, Nathaniel Houdek, Rebecca Rebolholz and Darcy Paskey (WI); and Joylynn Fix, Tonya Gillespie and Erin K. Hunter (WV). Also participating were: Taryn Lewis, Alan McClain and Melissa Vance (AR); Liane Kidoo (AZ); Lydia Wang, Bob Darnell, Annette Fortman, Lan Brown and David Noronha (CA); Debra Judy and Eric Unger (CO); Paul Lombardo, Jared Kosky and Aza Mosley (CT); Leslie Ledogar (DE); Ray Wegner, Bryan Peters, Matt Guy, Chris Struk, Toma Wilkerson and David Jones (FL); Teresa Winer (GA); Ian Robertson, Jason Asaeda, Arlene Ige and Mavis Ohikari (HI); Kathy McGill, Weston Trexler, Michele Mackenzie and Kristen Finau (ID); Michelle Baldock, Andi VanderKolk, Mike Teer, Kate Morthland, Ryan Gillespie, KC Stralka, Robert Plantholm and Lauren Peters (IL); Heather Quinn, Patrick Smith, Jill Mitchell, Sharon P. Clark and DJ Wasson (KY); Frank Opelka, Gayle Raby, Rachael Lundy-Davis and Richard Piazza (LA); Jackie Horigan (MA); Dytonia Reed, James Williams, Gia Wilkerson, Brad Boban, Adam Zimmerman, Ted Sines and Todd Switzer (MD); Parker Fisher, Chad Arnold, Kevin Dyke, Renee Campbell, Joseph Stoddard and Karen Dennis (MI); Grace Arnold, Sherri Mortensen-Brown, Galen Benshooft, Annelisa Steeber, Cam Jenkins, Adam Goldhammer and Peter Brickwedde (MN); Judy Newton (MS); Jeannie Keller (MT); Robert Croom and Kathy Shorrt (NC); Sylvia Lawson, Alison Gold and Patricia Swolak (NY); Kyla Dembowski, Dan Bradford, Meredith Craig, Laura Miller and Carrie Haughawout (OH); Cuc Nguyen, Lydia Shirley and Ron Kreiter (OK); Katrina Rodon, Joe Cregan, Katie Geer, Shari Miles and Michael Wise (SC); Jill Kruger, Gretchen Brodkorb and Candy Holbrook (SD); Brian Hoffmeister, Bill Huddleston and Rachel Jade-Rice (TN); Bob Grissom, Jackie Myers, Rebecca Nichols, Trish Todd and James Young (VA); Suzette Richards (VI); Jill Rickard, Christine Menard-O'Neil, Emily Brown, Anna Van Fleet, Marcia Violeta and Isabelle Turpin Keiser (VT); and Mavis Earnshaw, Denise Burke and Tana Howard (WY).

1. **Adopted its June 23 Minutes**

Ms. Northrup made a motion, seconded by Ms. Bailey, to adopt the Working Group’s June 23 minutes (Attachment Six-A). The motion passed unanimously.

2. **Heard a Presentation on Federal and State Regulation of Telehealth Coverage**

Randi Seigel (Manatt Health) gave a presentation on privacy requirements for telehealth communications under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). She reviewed which HIPAA standards are required versus addressable, the flexibility established under the COVID-19 pandemic, and other considerations for covered entities in complying with privacy requirements.

3. **Heard Presentations on Telehealth Policies from Stakeholders**

Andrew Sperling (National Alliance on Mental Illness—NAMI) shared poll results and concerns from patients and mental health providers. Kate Berry (America’s Health Insurance Plans—AHIP) reviewed the growth in telehealth services, ongoing
challenges, and what the states can do to further promote telehealth. Stephanie Quinn (American Academy of Family Physicians—AAFP) discussed changes to provider workflows, regulatory flexibilities, and ongoing challenges, including lack of alignment across payers.

Ms. Duhamel asked about paid online talk therapy portals and whether insurance should be required to cover their services. Mr. Sperling said such portals can be helpful, but NAMI has quality concerns and would like to see insurance coverage to promote affordability as well as greater quality. Ms. Dzurec asked what cost saving levers are available by using telehealth. Ms. Berry said there are advantages for consumers from avoided travel and to the health care system from avoided in-person procedures that may not be necessary with timely remote care. Ms. Quinn said over time, staffing models could change based on telehealth and generate savings.

4. **Heard a Presentation on Cost Control, Payment Reform and the Pandemic**

Christopher F. Koller (Milbank Memorial Fund) presented on health care system strategies for cost control, and he suggested five areas in which state insurance regulators can incentivize and encourage greater health care system affordability. He highlighted multi-agency efforts in Colorado and Oregon to promote system affordability.

Health Insurance Commissioner Ganim described opportunities to address cost issues even as state insurance regulators work to put out the fires of the pandemic. Mr. Koller said state insurance regulators should have a long-term notion of where they are headed, which will likely include an environment of more consolidated providers. State insurance regulators may get pulled in to respond to these market changes and higher prices. Ms. Quinn agreed, and she noted that providers continue to feel pressure to join consolidated systems.

Having no further business, the Health Innovations (B) Working Group adjourned.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met via conference call June 23, 2020. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew R. Stolfi, Vice Chair (OR); Sarah Bailey and Jacob Lauten (AK); Anthony L. Williams (AL); Howard Liebers (DC); Cynthia Banks Radke and Sonya Sellmeyer (IA); Julie Holmes and Tate Flott (KS); Carrie Couch, Jessica Schrimpfl, Michelle Vickers, Chlora Lindley-Myers, Amy Hoyt and Cynthia Amann (MO); John Arnold, Sara Gerving and Chrystl Bartuska (ND); Tyler Brannen and Maureen Belanger (NH); Philip Gennace and Chanell McDevitt (NJ); Brittany ODell, Paige Duhamel and Viara Ianakieva (NM); Jeremy Christensen and Jack Childress (NV); Sandra L. Ykema, Jessica K. Altman and Katie Dzurec (PA); Doug Danzeiser, Rachel Bowden and Kenisha Schuster (TX); Molly Nollette (WA); Jennifer Stegall, Diane Dambach, Barbara Belling, Mary Kay Rodriguez, Nathan Houdek, Jody Ullman, and Darcy Paskey (WI); and Joylynn Fix and Vanessa George (WV). Also participating were: Erin Klug and Mary Boatright (AZ); Debra Judy (CO); Chris Struk and Carolyn Diggs (FL); Ian Robertson, Arlene Ige and Mavis Okihara (HI); Kristen Finau (ID); Ryan Gillespie (IL); Claire Szpara and Alex Peck (IN); David Cooney (MD); Grace Arnold (MN); Jeannie Keller (MT); Rosemary Gillespie (NC); Marjorie Ellis (OH); Andrew Dvorine (SC); Jill Kruger, Gretchen Brodkorb and Candy Holbrook (SD); Shelley Wiseman (UT); Julie Blauvelt (VA); and Denise Burke and Tana Howard (WY).

1. Discussed the Regulation of Coverage for Telehealth Services

Health Insurance Commissioner Ganim introduced Joel Ario (Manatt Health) and Jared Augenstein (Manatt Health). Mr. Augenstein presented on state and federal law and regulatory actions related to telehealth. He showed the growth in states with telehealth private payor laws prior to the COVID-19 pandemic. He reviewed federal and state actions taken to expand access to telehealth during the pandemic.

Commissioner Stolfi described Oregon’s recent actions on telehealth and he observed that payment parity can be limited by state authority and disparate access to telecommunications technology is an issue. Mr. Swanson said Nebraska had not issued emergency orders, but the issuers stepped up themselves. He said some fraud issues were emerging. Ms. Arp added that provider groups are asking for extensions of relaxed telehealth policies and for reimbursement parity to be required for at least 12 months. She said stakeholders should be clear that states cannot relax requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Mr. Augenstein shared statistics on the utilization of telehealth during the pandemic. He described equity issues raised by telehealth and several other policy considerations for the states. He also outlined an array of policy levers that states and other policymakers could use to regulate telehealth, including coverage, originating and distant sites, eligible services and providers, eligible communications modes, utilization management, and networks.

Ms. Arnold said some insurance carriers have preferential contracts with telehealth providers that are distinct from the carrier’s contracts with other providers, which can make it difficult for traditional providers to engage in telehealth. She said Minnesota changed state law so that payment parity requirements are agnostic to the existence of a preferential contract between carriers and telehealth providers. She said carriers have not resisted this change.

Ms. Judy said preferential networks may also exist for dental care or preventive services. She questioned how network adequacy should be determined with prevalent telehealth, and she said Colorado’s law specifies that telehealth providers do not modify an issuer’s obligation to meet in-person network requirements. She also mentioned concerns about inequities in access.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) asked whether issuers offer help for people with disabilities who cannot utilize telehealth services without assistance. Mr. Augenstein said North Carolina allows providers to bill for telehealth, and it provides an evaluation and management code for assistive services in the patient’s home.
2. **Discussed Potential Topics for the Summer National Meeting**

Health Insurance Commissioner Ganim asked the Working Group which topics it should address at the Summer National Meeting. Because time was short, she encouraged Working Group members to submit ideas via e-mail.

Having no further business, the Health Innovations (B) Working Group adjourned.
**HEALTH ACTUARIAL (B) TASK FORCE**

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The Health Actuarial (B) Task Force met virtually Aug. 4, 2020. The following Task Force members participated: Todd E. Kiser, Chair, represented by Jaakob Sundberg (UT); Eric A. Cioppa, Vice Chair, represented by Marti Hooper (ME); Jim L. Ridling represented by Steve Ostlund (AL); Lori K. Wing-Heier represented by Jacob Lauten (AK); Elizabeth Perri (AS); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Eric Anderson (IL); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt represented by Nicole Boyd (KS); Chlora Lindley-Meyers represented by William Leung (MO); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Mike Causey represented by Kevin Conley (NC); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Tracie Gray (PA); Kent Sullivan represented by Mike Boerner (TX); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. **Adopted its May 27, April 23 and Feb. 14 Minutes**


During its April 23 meeting, the Task Force discussed issues related to the impact of COVID-19 on the pricing and regulatory review of 2021 (ACA-compliant health insurance policies.

During its Feb. 14 meeting, the Task Force took the following action: 1) adopted its 2019 Fall National Meeting minutes; and 2) adopted changes to the annual financial statement Long-Term Care Insurance Experience Reporting Forms as forwarded by the Long-Term Care Actuarial (B) Working Group.

Mr. Lombardo made a motion, seconded by Ms. Miller, to adopt the Task Force’s May 27 (Attachment One), April 23 (Attachment Two) and Feb. 14 (Attachment Three) minutes. The motion passed unanimously.

2. **Heard an Update from the SOA on Health Insurance Research**

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Four) on recent SOA health insurance research.

3. **Adopted the Report of the Long-Term Care Actuarial (B) Working Group**

Mr. Kupferman said the Long-Term Care Actuarial (B) Working Group met Aug. 4 and took the following action: 1) adopted the reports of the Long-Term Care Pricing (B) Subgroup and the Long-Term Care Valuation (B) Subgroup; 2) heard an update from the American Academy of Actuaries (Academy) regarding its Long-Term Care Valuation Work Group’s development of mortality and lapse valuation tables for long-term care insurance (LTCI); and 3) heard an update from the SOA on recent work on the SOA’s Long-Term Care Experience Study.

Mr. Kupferman said revisions to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions for the revised Forms have been adopted by the Blanks (E) Working Group, and will be effective for the 2020 reporting year annual financial statement. He said he is confident the revised Forms will help state insurance regulators better answer LTCI questions from policyholders and media.

Mr. Kupferman made a motion, seconded by Mr. Ostlund, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment Five). The motion passed unanimously.
4. Received the Report of the Health Care Reform Actuarial (B) Working Group

Mr. Shea said the Health Care Reform Actuarial (B) Working Group has not met since the 2019 Fall National Meeting.

Brent Plemons (federal Center for Consumer Information and Insurance Oversight—CCIIO) gave an update on ACA rate filings for the 2021 plan year. He asked state insurance regulators to make sure their insurers are not filing rates using retired Health Insurance Oversight System (HIOS) plan IDs for rate submissions. He said an issuer should not retire a plan and then present a new plan, even if it is the same metal level as the retired plan, using the HIOS ID associated with the retired plan. He said a new HIOS ID should always be used.

Mr. Plemons said the CCIIO has observed occurrences of unintentional market withdrawals. He said each issuer should have renewing plans in the system, and an issuer that does not will be classified as withdrawing from the market. He said guidance on this topic can be found on page 11 of the Uniform Rate Review Template (URRT) instructions.

Ms. Hooper said the CCIIO recently issued guidance on premium holidays and that the Working Group may discuss this guidance during a future conference call.

5. Heard an Update from the Academy Council on Professionalism

Shawna Ackerman (California Earthquake Authority—CEA), Kathleen Riley (Actuarial Standards Board—ASB), and Godfrey Perrott (Actuarial Board for Counseling and Discipline—ABCD) gave a presentation (Attachment Six) on recent ASB and ABCD activities.

6. Heard an Update from the Academy Health Practice Council

Barb Klever (Blue Cross and Blue Shield Association—BCBSA) gave an update (Attachment Seven) on recent Academy Health Practice Council activities and publications.

Having no further business, the Health Actuarial (B) Task Force adjourned.

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The Health Actuarial (B) Task Force met via conference call May 27, 2020. The following Task Force members participated: Todd E. Kiser, Chair, represented by Jaakob Sundberg (UT); Eric A. Cioppa, Vice Chair, represented by Marti Hooper (ME); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Eric Anderson (IL); Stephen W. Robertson represented by Karl Knable (IN); Chlor Lindley-Myers (MO): Mike Causey represented by Ted Hamby (NC); Bruce R. Ramge represented by Rhonda Ahrens (NE); Marlene Caride represented by Seong-min Eom (NJ); Jillian Froment represented by Laura Miller (OH); Jessica K. Altman represented by Tracie Gray (PA); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. Adopted a 2021 ACA Rates COVID-19 Guideline

Mr. Sundberg presented comment letters from America’s Health Insurance Plans (AHIP) (Attachment One-A), the Blue Cross Blue Shield Association (BCBSA) (Attachment One-B), and Risk & Regulatory Consulting LLC (RRC) (Attachment One-C) that were submitted in response to the Task Force’s public exposure of a draft guideline that state insurance regulators may use to assist the states in assessing the impact of COVID-19 on 2021 federal Affordable Care Act (ACA) health insurance rates. He said the guideline is not intended to be prescriptive and is not proposed as a requirement, but is offered by the Task Force only as a guidance document.

Ray Nelson (AHIP) gave an overview of AHIP’s comment letter. He said AHIP member companies agree that the guideline may be helpful, but its use should not be mandatory. He suggested that wording be added to the guideline to stress that it may be used as a guide, but it is not required as a checklist for required information. Mr. Trexler said individual states should be given the discretion and flexibility to use the guideline as they see fit, including making it a requirement. The Task Force decided that the language included on the Overview & Contents tab, which indicates that the guideline is not prescriptive, but a state may require its use, is sufficient. The Task Force agreed to make changes related to mislabeled items and add Milliman’s 2021 COVID Impact document to the Table of Actuarial Resources tab as noted in the comment letter.

Barb Klever (BCSA) gave an overview of the BCBSA’s comment letter.

Becky Sheppard (RRC) gave an overview of RRC’s comment letter. The Task Force agreed to make changes related to making the Table of Actuarial Resources tab a standalone document, additions to the Impact to Risk Adjustment 2021 tab, and fixing various typographical errors as noted in the comment letter.

Mr. Kupferman made a motion, seconded by Mr. Ostlund, to adopt the guideline with the changes described above. Mr. Sundberg said the guideline will be forwarded to the Health Insurance and Managed Care (B) Committee for its consideration.

Having no further business, the Health Actuarial (B) Task Force adjourned.
May 22, 2020

Mr. Jaakob Sundberg, Chair
Health Actuarial (B) Task Force
National Association of Insurance Commissioners
100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Submitted via email: eking@naic.org

Re: AHIP’s Comments on the May 2020 Exposure of ACA 2021 COVID-19 Rate Review Guideline

Dear Mr. Sundberg:

On behalf of America’s Health Insurance Plans (AHIP),1 we appreciate the opportunity to provide comments on behalf of our member companies regarding the draft ACA 2021 Coronavirus (“COVID-19”) Rate Review Guideline excel template.

There is significant uncertainty around the potential impacts COVID-19 may have on 2021 health care costs, creating a unique challenge for health insurance providers and regulators as they work to finalize 2021 premiums. We appreciate NAIC’s efforts to provide state regulators with an optional resource to assist in assessing the impact of COVID-19 on 2021 ACA premiums. This tool provides a listing of actuarial resources that can be helpful to carriers and regulators when considering the impact of COVID-19 on 2021 ACA rates, and provides a common format for measuring the impact of numerous factors on proposed rates.

We appreciate the importance of providing optional tools to help regulators and health insurance providers account for the various impacts COVID may have for 2021 rates. However, we recommend the template be used as an optional resource only and not be adopted as a required tool for finalizing rates. We are concerned a standard template is overly prescriptive and the fields are too granular. As a result, requiring such a template could limit the ability of actuaries to adopt an actuarially sound method of estimating COVID cost impacts based on their analyses. At this point in the rate filing and approval timeline, requiring use of the template could create additional challenges for issuers. We are specifically concerned about the following:

1 AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Visit www.ahip.org for more information.
May 22, 2020

- A “one-size-fits-all” template limits the ability of carriers to appropriately assess and price for the potential impacts of COVID. Carriers must develop actuarially-sound rates but do so through different assessments of underlying assumptions and actuarial pricing methods, which in many cases do not fit into the structure of the Excel template.

- The level of granularity suggested by the model does not reflect the various methods used by carriers when developing rates. Actual carrier projections are based on higher level aggregate claims analysis than what is contained in the template. Furthermore, plan actuaries and epidemiologists are unlikely to have the information at the level included in the template.

- The template does not allow issuers to add, modify, or omit COVID-related cost factors to reflect their analyses of projected impacts.

- The level of detail would be onerous for carriers if a state required completion of the template, especially at this point in the rate filing timeline with many initial filing deadlines past or quickly approaching.

Thus, we recommend the Task Force emphasize the template is intended as an optional resource for both carriers and regulatory actuaries and not a prescriptive data collection tool to be mandated by states. We suggest that the spreadsheet be marked as “For Voluntary Use By Carriers” and that the following language be added to the purpose of the template:

This template is not intended to be, and should not be used as, a checklist for rate filings. States should have the option to use this document as a guide only, and should rely in the first instance on the assumptions and underlying requests from issuers. Issuers should describe the basis for the COVID impact in their rate development in whatever level of detail is reasonable for the rate action being requested and should not be required to provide data for elements not material to that issuer.

We recognize that some states are already pursuing state-specific guidance on COVID cost assumptions. We recommend states considering such an approach seek input from their carriers before finalizing guidance.

In addition to the primary concerns discussed above, we have the following detailed comments and questions regarding the spreadsheet:

- The data provided in the spreadsheet—particularly in the “COVID-19 Rate & Factor Impacts” and “COVID Issuer Impact estimates” tabs—is proprietary carrier information that should remain confidential. The “Overview and Contents” tab of the spreadsheet should include a statement that this data is proprietary and will remain confidential and protected from open record disclosures.

- The Premium PMPM calculations in cells R25:R27 on tab “COVID-19 Rate & Factor Impact” appear to hard code an 80% loss ratio. If 80% is not the target loss ratio, are carriers to revise the formula to be consistent with their actual premium development or use the default 80%?
May 22, 2020
Page 3

- Cell B15 on the same tab notes additional scenarios than ‘Most-Likely’ can be added to the spreadsheet. We recommend the template allow for more updated scenarios to be added at a later date as the final pricing scenario will include more updated information and modeling that what was included in the initial filing.
- The factor support tabs for impacts (12), (13) and (14) appear to be mis-numbered in cell B2 on each tab’s sheet.
- The Milliman 2021 COVID Impact should be added to the Table of Actuarial resources since many issuers in the market engage Milliman for pricing work. Thus, the inclusion of this resource will assist in the credibility of the estimates for issuers who utilize Milliman: https://www.milliman.com/en/insight/COVID19-Considerations-for-commercial-health-insurance-rates-in-2021-and-beyond

We appreciate the opportunity to respond to your request for comments. If you have any questions, or would like to discuss any of these comments, please contact me at (501) 333-2621 or contact AHIP consultant Ray Nelson at (rnelson@tripluservices.com).

Sincerely,

Bob Ridgeway
Senior Government Relations Counsel
America’s Health Insurance Plans
May 22, 2020

The Honorable Todd Kiser  
Health Actuarial (B) Task Force  
National Association of Insurance Commissioners  
444 North Capitol St., NW Ste 700  
Washington, D.C. 20001-1512

Submitted via email, Eric King, EKing@naic.org

RE: Health Actuarial Task Force COVID-19 Rate Review Guideline Exposure

Dear Commissioner Kiser:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Health Actuarial Task Force COVID-19 Rate Review Guideline Exposure posted on May 14, 2020.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide healthcare coverage for one in three Americans. For 90 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

The Rate Review Guideline Exposure is an excel template that state DOIs may use to assist in assessing the impact of COVID-19 on 2021 ACA rates. The template includes a resource list and a list of assumptions to be considered in developing the impact of COVID-19 on rates.

BCBSA believes the template could be useful to promote a common understanding between issuers and regulators on the assumptions to be considered in rate development for the COVID-19 impact. However, BCBSA recommends that the template be used only as a guide for issuer and regulatory actuaries on the assumptions related to COVID-19 and not as a prescriptive data collection tool.

We are concerned that the tabs with the rate and factor impacts and projected 2021 claims experience are too detailed and prescriptive for the kinds of projections actuaries could reliably make right now. The template assumes a level of detail in projections that can’t be supported by claims data or scientific studies by the time issuers need to submit their 2021 ACA rate filings. For example, the tab on projected 2021 claims experience includes providing overall claims impact for sixteen assumptions related to COVID-19. This display makes it appear that these factors do not interact with one another and that issuers know the COVID-19 impact to that level of precision. We note that requiring issuers to provide assumptions at this granular level may result in inconsistent responses across carriers because of differing actuarial methods to pricing.
and not due to true actuarial impacts. This, in turn, would devalue one of the stated goals of assessing the impact of COVID-19.

We recommend that regulators provide flexibility in how issuers document and submit the factors related to COVID-19. Issuers have been working on rate filings and may have laid out their assumptions in a different manner than presented in the template. Requiring issuers to fill out the template in a prescriptive manner will add to the administrative burden and may not add value to the process. A more practical solution for the NAIC would be to require commentary in the actuarial memorandum regarding how COVID-19 was recognized in the rating. It would be reasonable to require issuers to provide an explanation within the rate filing of impact of COVID-19 on the overall rate change and the documentation of assumptions related to COVID-19.

In addition, BCBSA recommends that issuers only be required to file one set of rates and not be required to file dual sets of rates – with and without COVID-19. As mentioned above, we think it is reasonable for the rate filing to contain information on the overall impact of COVID-19 on the rates. However, we do not believe that requiring issuers to submit a full rate filing without COVID-19 is useful. We note that a separate rate filing creates administrative burden for rates that do not reflect the reality of the COVID-19 pandemic.

We commend the Task Force for compiling the resources list and the list of assumptions. We note that the resources available will likely continue to evolve over the summer, and both issuer and regulatory actuaries will need to keep up-to-date on the changing situation.

We appreciate your consideration of our comments. If you have any questions or want additional information, please contact Barb Klever at barbara.klever@bcbsa.com.

Sincerely,

Barbara Klever, FSA, MAAA
Senior Actuary, Policy
Memo

To: Eric King, NAIC and Todd E. Kiser, HATF Chair, Commissioner Utah Insurance Department
From: Tricia Matson, Partner and Becky Sheppard, Senior Associate & Actuary
Date: May 22, 2020
Subject: RRC comments regarding the draft template that state DOIs may use to assist in assessing the impact of COVID-19 on 2021 ACA rates

Background

The April 23rd, 2020 Health Actuarial (B) Task Force (HATF) meeting included multiple presentations regarding the potential impact of the ongoing COVID-19 pandemic on the health insurance marketplace. The meeting provided an opportunity for members of HATF, interested regulators, and Interested Parties to gain perspective on considerations that may impact the 2021 Patient Protection and Affordable Care Act (ACA) rate review, and ask questions. Following that meeting, HATF sent out an Excel template titled “ACA 2021 Coronavirus Rate Review Guideline – May 15th.xlsx” (the Guideline) which contained an overview of considerations regarding COVID-19 that may impact the review of 2021 rates. The Guideline is not prescriptive but rather provides potential considerations and possible resources. The Guideline does NOT include estimate values or impacts.

RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and the HATF members.

RRC Comments

- Overall comments:
  - We appreciate that HATF quickly compiled these comprehensive guidelines and feel that they will be a useful tool in preparation for ACA 2021 rate review. The pace and magnitude with which the COVID-19 pandemic is evolving can make it difficult to have timely resources and we appreciate that HATF made the necessary resources available.
  - We agree with the approach of not including actual values or ranges in the guidelines since there is a great deal of uncertainty and the results may have wide variation across issuers.

- Regarding the “Table of Actuarial Resources” tab
  - Given that these resources will likely be evolving during the rate review cycle, we believe it may be beneficial to use this tab as a standalone document that could be updated more frequently.
  - It is unclear whether the intent is for the “Information Contained in Resource” column to be fully populated. It may be helpful and time-saving to know what type of information is in the resource, so we would recommend that if possible.
Regarding the “COVID-19 Rate & Factor Impact” tab
  o It may be helpful to add a cell for the Issuer to describe the “Most-Likely” scenario assumption. For example, they may say “Assumes second wave occurs in 2Q2021 and no vaccine in 2021.”
  o It may be helpful to add formulas to calculate the “COVID-19 impact” in the detailed rate components sections so that reviewers can quickly identify which components had the biggest change.

Regarding the “COVID Issuer Impact Estimates” tab
  o We believe that it may be beneficial to state on this spreadsheet the inherent assumption that the impact for each potential COVID-19 item would be the same at the market level (or that variations by metal level/plan design will be consolidated on this tab).
  o This tab could be quite time consuming for an issuer and reviewer since the results may not align with the Unified Rate Review Template (URRT) or pricing process so we strongly agree with not making these Guidelines prescriptive.
  o We believe that it may be helpful to ask each Issuer to explain how they are defining COVID-19 claims and claimants. For example, is the Issuer using the CPT code 87635 (which was available beginning March 13, 2020) or some other methodology to identify COVID-19 claims? Testing claims should not be used to identify a COVID-19 claimant unless the corresponding lab data confirms the diagnosis. This could be collected in a cell on this tab.

Regarding the detailed COVID-19 Factors Support tabs:
  o On the “(1) COVID Treatment Assumptions” tab, it may be helpful to add a calculation of the percentage in each category based on the counts entered in column C so that reviewers can easily compare the percentages across issuers who may have different counts.
  o On the “(4) Conditions Caused by COVID” tab, an additional item that may be helpful to include is the impact from COVID-19 on existing underlying conditions (for example diabetes, obesity, and heart disease). These co-morbidities can have a long term health impact.
  o We observed minor typographical errors on tab “(6) Pop Movements & Morbidity” (the cell B4 title is incorrect and cell B7 should say “who” rather than “eho”).
  o We observed minor typographical errors on tabs (7) through (11) (cell B4 title is missing).
  o Regarding the “(16) Risk Adjustment” tab, some additional items that may be helpful to include are:
    ▪ How COVID-19 claims will be valued in the ACA risk adjustment model (if assumed 2021 cases actually occur). Will there be a separate COVID-19 HCC or will existing HCCs be utilized.
    ▪ Whether business/provider interruptions impact the 2019 risk adjustment data collections (CMS has allowed an additional 2 weeks), and therefore require different projection assumptions than prior years.
    ▪ Whether changes in the risk pool in 2020 remain in 2021 and, if so, whether that impacts the 2021 Risk Adjustment.

Other comments:
  o The Task Force may want to consider structuring requests for very granular claim impact analyses such that each item provided by the issuer is mutually exclusive. For example, an
issuer may have permanent network changes because a provider goes out of business which
would be a “Provider Network Disruption” and that could also cause an impact to the “Area
Factor Mix” if the removal of that provider impacts the relative cost. We recommend adding
a note in the Guidelines that states some of the COVID-19 considerations may overlap.

o The Task Force may want to consider including in the guidance that some assumptions will be
more or less difficult to be measured in the future. For example, an assumption about when
a vaccine is available, when a second wave occurs, or the distribution of COVID-19 cases by
highest level of treatment can be validated, at least in part, by the future data. However,
other items like how much pent-up demand returns, the long term impacts of COVID-
19/complications, and general morbidity assumptions will be harder to attribute to COVID-19
and measure.

o Provider risk sharing arrangements have led to some anomalies in 2020 (payers making early
payments to providers, etc.). We recommend adding a note on the “(9) Provider NW
Disruption” tab to state that risk sharing arrangements impacted by COVID-19 should be
considered to the extent they are expected or not expected to occur in 2021 and may have
an impact on total claim payment (i.e. if it’s not just timing).
The Health Actuarial (B) Task Force met via conference call April 23, 2020. The following Task Force members participated:

Todd E. Kiser, Chair, represented by Jaakob Sundberg (UT); Eric A. Cioppa, Vice Chair, represented by Marti Hooper (ME); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway (CO); Andrew N. Mais represented by Paul Lombardo (CT); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Eric Anderson (IL); Vicki Schmidt represented by Nicole Boyd (KS); Chlora Lindley-Myers (MO); Mike Causey represented by David Yetter (NC); Bruce R. Ramge represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Tracie Gray (PA); Kent Sullivan represented by Raja Malkani (TX); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. Discussed the Impact of COVID-19 on 2021 ACA Rates

Mr. Sundberg said the Task Force will hear presentations on factors arising from COVID-19 testing and treatment that may affect the pricing of 2021 federal Affordable Care Act (ACA) health insurance policies.

a. Academy

Cori Uccello (American Academy of Actuaries—Academy) gave a presentation (Attachment Two-A) on the effects that COVID-19 may have on 2020 claims experience, changes in enrollment in various health insurance markets, 2021 premium development, and 2021 rate filing deadlines.

Mr. Sundberg asked if the economic downturn and its impact on small businesses may create anti-selection in the small group market or have effects on the individual market if small employers direct employees to obtain individual or Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) coverage.

Ms. Uccello said she is not sure, but Small Business Administration loans that are part of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act provide funds for small businesses to continue payment of small group insurance premiums.

Mr. Shea said employees who lose small group coverage may experience financial hardship when presented with the cost of individual market or COBRA coverage.

b. Oliver Wyman

Kurt Giesa (Oliver Wyman) gave a presentation (Attachment Two-B) on behalf of the Blue Cross and Blue Shield Association (BCBSA) related to health plans’ pricing for COVID-19.

Commissioner Conway said he presumes that the Medicare and Medicaid markets will experience greater COVID-19 impacts than commercial markets, and he asked Mr. Giesa if the modeling of this using state-level data has begun.

Mr. Giesa confirmed that work has begun on this, and he agreed with Commissioner Conway’s presumption.

Mr. Sundberg asked if insurers with knowledge of each other’s COVID-19-related pricing assumptions before filing rates will enhance pricing accuracy.

Mr. Giesa said there are advantages and disadvantages to this approach, but he is unable to answer the question.
c. Georgetown University

Justin Giovannelli (Georgetown University) gave a presentation (Attachment Two-C) on behalf of the NAIC consumer representatives regarding their concerns related to the impact of COVID-19 on state insurance markets.

Mr. Sundberg said if a multiple-scenario, multiple-filing system is used, there will still be uncertainties associated with whichever scenario is chosen.

Mr. Giovannelli said the later that the decision is made, the less that uncertainty will be present.

Mr. Muldoon said the Nebraska Department of Insurance supports insurers making a single rate filing that reflects scenarios with no, low, medium and high COVID-19 incidence. He said he does not understand why separate rate filings with each scenario being approved and implemented at an insurer’s discretion will be necessary, and he believes this may be burdensome. He stated that the date for final rate approval would need to be later than the Aug. 19 date currently prescribed by the federal Centers for Medicare & Medicaid Services (CMS) in order for this plan to be feasible.

Director Lindley-Meyers and Mr. Shea agreed that the date of Aug. 19 will need to be extended for a multiple-scenario system to work.

d. AHIP


Commissioner Conway asked if it will enhance pricing accuracy if insurers can know each other’s COVID-19-related pricing assumptions before filing rates.

Ms. Thornton said she will present this question to AHIP member companies, and she has concerns about competitive issues that may arise if this is allowed.

e. SOA, Lewis & Ellis and Axene Health Partners

R. Dale Hall (Society of Actuaries—SOA), Dave Dillon (Lewis & Ellis Inc.) and Greg Fann (Axene Health Partners) gave a presentation (Attachment Two-E) on the SOA’s COVID-19 research and its impact on 2021 pricing.

Having no further business, the Health Actuarial (B) Task Force adjourned.
NAIC Health Actuarial Task Force
April 23, 2020

Comments by Cori Uccello, Senior Health Fellow, American Academy of Actuaries

**2020 Claims Experience**

- COVID-19 is resulting in high-cost hospital utilization. These costs can be significant.
- Because of social distancing (and to a lesser extent freeing up space for COVID-19 patients), utilization of lower cost services such as office visits has declined dramatically. In addition, non-emergency hospital services, including high revenue producing elective surgeries, have also declined.
- There is uncertainty as to the net effect on 2020 claims (could be higher or lower total costs than expected).
- The net effect depends in part on whether deferred services are provided later in 2020, are delayed to 2021, or avoided altogether. Which in turn depends on if there is another wave of the outbreak this year, or perhaps rather how severe the next outbreak is.
- Cost sharing for COVID-19 testing and related services is being waived. And some carriers are waiving cost sharing for COVID-19 treatments as well. But it’s not necessarily clear what services qualify for cost-sharing waivers; depends on how terms are defined. Cost-sharing waivers are probably a less important driver of claims compared to the degree of deferred services, but they will still have an effect.
- Expanded availability of telehealth services is filling in some of the gaps in office visits. But many services can’t be provided through telemedicine, especially those elective surgeries.
- Some carriers are advancing payments to providers, typically on a month-to-month basis, with reconciliation. This will likely have only a minor effect on 2020 plan costs and shouldn’t affect 2021 premium development. In other words these advanced payments address providers’ short-term cash flow concerns but are not meant to act as larger or longer-term loans.
- Prescription drug spending is probably the least affected health spending component, at least for now. Drug spending could decrease if people can’t afford their prescriptions due to loss of income. On the other hand, prescription drug spending could increase if and when there are new COVID-19 drug therapies and/or a vaccine become available.

**The economic effects of the outbreak are resulting in changes in insurance enrollment.**

**Enrollment changes in the individual market**

- Some individuals could drop coverage, even if coverage is subsidized, if they can no longer pay premiums. Insurers already provide long grace periods for subsidized enrollees and many are also extending grace periods for unsubsidized enrollees, either voluntarily or due to state requirements. Although important to help enrollees stay covered, long grace periods could expose insurers to more adverse selection risk. On the other hand, previously uninsured individuals have enrolled during special enrollment periods, where available. New enrollees could include healthy individuals who now see more value in being covered.
- New enrollees could also enter the individual market upon loss of employer coverage. Again, there is potential adverse selection risk, offset in part if individuals are subsidy eligible. But subsidy eligibility depends on annual income, as opposed to Medicaid, which determines eligibility on a monthly basis. COBRA experience during the great recession could provide
some insights on the potential for adverse selection. But again, it’s possible that even those not eligible for subsidies see value in obtaining coverage, which could mitigate adverse selection.

- One aspect of enrollment uncertainty is the extent to which there will be efforts to facilitate workers and their families keeping employer coverage, such as through COBRA premium subsidies.
- The number and risk profile of new enrollees could also depend on whether the state has expanded Medicaid. It may be more difficult for individuals losing jobs to be eligible for Medicaid in non-expansion states, leaving the individual market as the only available option.

**Enrollment changes in the small group market**

- Enrollment in the small group market could decline due to employers going out of business, small employers dropping coverage, and partial layoffs.
- Small employers considering whether to keep or drop coverage could tend to keep coverage if they thought they or a family member (or perhaps other workers) have health care needs. This would tend to increase morbidity. In past recessions, some insurers saw morbidity increases in the small group market along with enrollment declines. But again, this could be a different situation as there may be a greater recognition of the value of coverage, regardless of health status.

**2021 premium development**

- Current uncertainty regarding COVID-19 per case treatment costs.
- Providers, especially hospitals, may have success negotiating (and renegotiating) higher payments from payers (depending in part on what federal relief they receive). Some increases in payment may be temporary in nature, thereby affecting 2021 costs only minimally.
- Services deferred during 2020 could be performed in 2021. Also, because some essential services are also being deferred, individuals with chronic conditions could worsen, resulting in higher future costs.
- Costs of new treatment therapies, antibody tests, and/or vaccines need to be considered for 2021.
- With the increase of telehealth being used to fill some gaps in 2020, there is a question of whether that increase will continue to replace certain office visits or whether treatment patterns will return to pre-COVID trends. [Telemedicine could have lower unit costs than office visits, but a sustained shift to telemedicine could result in telemedicine providers pushing for higher prices. Could also increase utilization.]
- When developing 2021 rates, carriers will run multiple scenarios involving different assumptions on whether new COVID waves will emerge in 2021, the degree of deferred services, the amount of testing (including antibody testing), the availability of vaccines, seasonality, etc. to inform their premium development.
- Greater degrees of uncertainty could lead to more conservative assumptions and risk margins.

**2021 Rate Filing Deadlines**

- More information regarding COVID-19 claims, service deferrals, new enrollment, and risk pool profiles is becoming available every day.
- Allowing carriers to revise initial filings and delaying final filings as much as possible would allow carriers to incorporate the latest information available.
Other Issues
- If claims in 2020 are much below expectations, premium rebates may be required under the MLR. As a reminder, the MLR calculation is done as a 3-year average. Also, the MLR is one-sided; carriers do not receive payments if claims are much higher than 2020 expectations.
- COVID-19 is not a factor in the risk adjustment formula.
- Changes to federal and state rules implemented in reaction to COVID-19 have increased administrative burden, especially for carriers that need to adhere to different rules among states.
- It’s appropriate for regulators to consider the relationship between changes in risk-based capital and profit margins in rate filings.
- 1332 waivers could be affected. For instance, some states fund their reinsurance program through insurer assessments, and these assessments fall primarily on group insurance. The economic downturn could result in declines in group market enrollment and an increase in individual market enrollment. This could lead to a decrease in reinsurance funding with a likely increase in reinsurance claims. For states that are allowed to retrospectively adjust the coinsurance or other reinsurance program parameters to either achieve a specified cost to the state (e.g., $50M) or so that the state’s cost matches the assessments collected, reinsurance payments would go down and carriers would therefore bear more of the risk.
HEALTH PLANS PRICING FOR COVID-19

An unprecedented challenge

April 23, 2020

Kurt Gossa, FSA, MAIA
Marc Lembright, FSA, MAIA

THE CHALLENGE FOR PRICING ACTUARIES

Pricing for COVID-19 will be more difficult than pricing the early years of the ACA.

Key questions:
- How many will be infected?
- What services will be required for those infected, at what cost?
- How much and what type of care will be delayed and how much forgone – over what period of time and with what consequences?
- Impact on risk-adjusted markets?
- Timing and cost of a vaccine?
- Impact of economic consequences?

Answers depend upon:
- Public policy – reopening the economy
- Individual behaviors
- Governmental actions
- Provider policies and capacity
- Local conditions

MODELING THE DIRECT COSTS OF TREATING COVID-19

Uncertainty around modeling the cost of COVID-19:
- Ultimate infection rates and percent treated are uncertain – estimate ranging from less than 1% to more than 50%
- What services will those who are infected require?
- Cost of care depends on patient’s market (Medicare, Medicaid, commercial) and health plan’s contracts (DRG vs per diem)
- Long-term costs of COVID-19 are not well understood
- Timing and cost of testing and effective treatments, uncertain at this time

Assumed utilization patterns in treating COVID-19:

<table>
<thead>
<tr>
<th></th>
<th>Treated</th>
<th>Untreated</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Treated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MODELING THE IMPACT OF DELAYED AND DEFERRED CARE DUE TO COVID-19

Uncertainty around modeling cost offsets:
- Forgone and delayed care is occurring.

Complicating factors:
- Second wave – geographic variation in size and timing of the wave
- Public willingness to seek care
- Health status after delays
- Provider capacity and pricing in recovery
- Effective treatment – when

The cost of COVID-19 over time:

A portion of this delayed care will return, and depending on timing, health plans may need to build it into their pricing for 2021.

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ECONOMIC CONSEQUENCES OF THE PANDEMIC

Weekly Unemployment Claims

<table>
<thead>
<tr>
<th>Weekly Unemployment Claims</th>
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<th>1,000.00</th>
<th>2,000.00</th>
<th>3,000.00</th>
<th>4,000.00</th>
<th>5,000.00</th>
<th>6,000.00</th>
<th>7,000.00</th>
<th>8,000.00</th>
<th>9,000.00</th>
</tr>
</thead>
</table>

Potential consequences of job loss

Impact of non-payment of premiums in the individual and group markets, and extended grace periods – 39 states have extended their grace periods or halted terminations.

Potential negative impact on the risk pool from adverse selective lapse.

Loss of insured lives and for those that remain, a shift of business away from employer group to COBRA, Medicaid or the individual market.

Regional variations

Qualifications, Assumptions and Limiting Conditions

This report has been prepared by the authors in the course of their professional duties. The report is based on the best available information and analysis. The authors have made every effort to ensure the accuracy and completeness of the report. However, the authors do not guarantee the accuracy of the information contained herein.

The opinions expressed in this report are the authors' personal opinions and do not necessarily reflect the views of NAIC or any of its members. No part of this report may be reproduced or transmitted in any form without the written consent of the authors.

The authors of this report are members of the American Academy of Actuaries and meet the academy's qualifications standards for performing this work.

CONSIDERATIONS

1. **Filing deadlines**
   - Allowing health plans to file premiums with the most up-to-date information available would be helpful to them in navigating through this time of unprecedented uncertainty and in maintaining stable markets.

2. **MLR**
   - The MLR requirements provide a limit on health plans' profits, but make it difficult for health plans to rebuild surplus once it is depleted.

3. **Capital**
   - Health plans’ capital is essential to protect the plans, their customers, and providers from the risk of unprofitable claims and potential insolvency.

4. **2021 premiums**
   - Health plans are in the process of developing premiums for 2021. They and their regulators will have to work in partnership to serve their customers and the public.

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FROM THE NAIC CONSUMER REPRESENTATIVES

To: Health Actuarial (B) Task Force
Eric King
Date: April 23, 2020
Re: Impact of COVID-19 on State Insurance Markets

As NAIC consumer representatives, we share your concerns about the impact of the COVID-19 pandemic on patients, insurers, the health care system, and the economy. The crisis has compromised the health, safety, and well-being of millions of Americans, and we are particularly concerned about those who have lost their jobs and may be uninsured at a moment when their health could be at grave risk.

This period of great uncertainty is affecting all NAIC stakeholders, and we are grateful to the members of the Health Actuarial (B) Task Force (HATF) for addressing the impact of COVID-19. To that end, we write to provide resources on projected costs of COVID-19 and two recommendations for the 2021 rate filing process.

Projected Costs of COVID-19

The costs of COVID-19 testing and treatment are expected to be billions of dollars, but there is extreme variation in estimates due to uncertainty about the extent of the crisis. Key factors include the severity of the outbreak, reduced costs as a result of many procedures and services being cancelled, pent-up demand for procedures in 2021, a transition to telehealth services, the cost of a future vaccine once developed, and longer-term effects on network dynamics. Although projections necessarily will be refined as more information becomes available, we hope this compilation of resources is helpful.

- **How Health Costs Might Change with COVID-19.** The Kaiser Family Foundation estimates that about 15 percent of people infected by coronavirus could require hospitalization, with a smaller share needing invasive mechanical ventilation. Costs will vary by severity and payer, but hospitalization will cost about $20,000, with treatment of the most severe cases costing up to $88,000. The brief includes an extended discussion on how delayed or foregone care could offset some costs, with data on how elective procedures represent a substantial share of hospital spending.

- **Health Insurers Do Not Yet Feel the Impact of COVID-19.** Comprehensive data on insurer experience is not available. However, insurer perspectives are becoming clearer in media reports and earnings calls. In mid-March, several health insurance executives reported that insurers were not yet concerned that COVID-19 was going to dramatically increase medical claims and spending. Executives viewed the outbreak as an “extension of the flu season” and noted that leaders were “not expecting a material financial impact.” In a recent earnings call, UnitedHealth Group Inc. played down the effects of COVID-19 on its first quarter performance and announced that it will not adjust its guidance for the remainder of 2020.
A separate analysis from S&P Global found that health insurers are performing better than expected during the first quarter, due primarily to the deferral of elective or discretionary medical services. Although COVID-19 claims are expected to rise in the second quarter, especially in hard-hit regions of the country, the authors expect earnings to revert to normal for full-year 2020 and note that “the attack/infection rate through the majority of the first quarter doesn’t indicate a meaningful strain on medical claims.”

- **Potential Costs of COVID-19 Treatment for People With Employer Coverage.** Comparing the costs of COVID-19 treatment to pneumonia, the Kaiser Family Foundation estimates costs for people insured through a large employer’s private health plan. Hospitalization costs would range from $20,000 to $88,000, depending on severity and comorbidities. Treatment costs for Medicare and Medicaid will be lower due to lower provider reimbursement rates: average hospitalization costs would range from $10,000 to $40,000 under Medicare, depending on severity. The brief includes a discussion of the typical length of hospital stays associated with pneumonia and out-of-pocket costs for pneumonia admissions.

- **COVID-19 Cost Scenario Modeling: Estimating the Cost of COVID-19 Treatment for U.S. Private Insurers.** Wakely, on behalf of America’s Health Insurance Plans, estimates direct costs for COVID-19 testing and treatment may range from $84 to $139 billion in 2020 and $28 to $46 billion in 2021. The analysis assumes an infection rate of 20 percent and reflects costs for private insurers (commercial insurers, Medicaid managed care organizations, and Medicare Advantage plans). Different infection rates would yield dramatically different costs, ranging from a total of $56 to $556 billion. For the commercial group and non-group markets, costs could range from $44.6 billion to $438.5 billion over the next two years.

- **Covered California Releases the First National Projection of the Coronavirus Pandemic’s Cost to Millions of Americans with Employer or Individual Insurance Coverage.** Covered California expects the cost of COVID-19 treatment and testing costs to range from $34 to $251 billion for commercial insurers. These are one-year projected costs in the commercial market, with a premium impact that ranges from 2 percent to 21 percent if built into 2020 premiums. Covered California estimates that individual and employer premiums for 2021 could be 40 percent higher due to COVID-19 costs.

- **Morbidity Stress Test: How A Hypothetical Pandemic Could Affect U.S. Health Insurers.** S&P Global Ratings conducted a stress test for a hypothetical pandemic. Assuming a moderate morbidity, insurers would face a 3 to 4 percent increase in medical claims costs and medical loss ratios would be boosted to 88 to 89 percent. This, S&P concludes, would be manageable for most insurers. More severe morbidity, however, means insurers would face a 10 to 12 percent increase in medical claims costs, increasing medical loss ratios to 95 to 97 percent.

- **COVID-19: The Projected Economic Impact of the COVID-19 Pandemic on the U.S. Healthcare System.** Leveraging its database of private health care claim records, FAIR Health estimates that the total average charge per COVID-19 patient that requires a hospital stay will be more than $73,000, with an average estimated allowed amount per commercially insured patient of $38,000. Total charges for all hospitalized COVID-19 patients range from $362 billion to $1.45 trillion, with $139 to...
$558 billion in estimated allowed amounts. This range varies based on the expected infection rate and the expectation that 4.9 million to 19.8 million people with COVID-19 may require hospitalization.

**Recommendations for the 2021 Rate Filing Process**

Our top priority is to ensure that as many consumers as possible continue to have access to affordable, comprehensive coverage and that insurance markets are stable. This is particularly true for the individual market, which may need to accommodate millions of new enrollees this year and next. We also acknowledge very real concerns about solvency in some states and that regulators must balance premium affordability with solvency. To best protect consumers as insurers develop 2021 rates, we urge HATF and state regulators to consider the two recommendations below and provide guidance to insurers in their states.

**Recommendation #1: Instruct insurers to prepare multiple rate filings to reflect COVID-19 assumptions based on different degrees of severity**

There is a high degree of uncertainty about what the future holds. As reflected in the data above, the impact of the COVID-19 pandemic on commercial insurers could vary significantly based on the ultimate infection rate, morbidity and mortality, geographic variation, the age of those most affected, long-term effects of the virus, and more. We recognize this uncertainty and the challenge that insurers and state regulators face in preparing and reviewing rates for 2021.

We are, however, concerned that consumers could face rate increases for 2021 that are out of sync with actual costs if a worst-case scenario does not materialize. Insurers may be especially prone to overprice their products in the individual market, where many enrollees receive subsidies and are relatively insulated from premium increases.

To address this uncertainty, we encourage HATF and state regulators to instruct insurers to file multiple rates with varying assumptions about the impact of COVID-19 in 2021. While rates are due this spring (when much information remains unknown), multiple filings—that reflect low, medium, and high levels of severity—would provide state regulators with the information to adjust rates as needed in the fall of 2020. These filings would also help regulators compare rate assumptions across insurers to ensure relatively consistent assumptions about COVID-19 costs and pent-up demand.

Multiple rate filings have been used before in response to uncertainty, including in 2017 to anticipate the potential elimination of cost-sharing reduction payments. HATF was instrumental as a forum during this time. During 2017, many state regulators instructed insurers to file dual rates: one rate reflected the assumption that cost-sharing reduction payments would be made and the other assumed that the payments would not be made. Having dual rate filings on hand allowed state insurance regulators and insurers to be nimble when the payments were eliminated in October 2017. Insurers were able to quickly and easily adjust their rates mere weeks before 2018 rates went live.

We believe the uncertainty here calls for similar advance planning and flexibility. Insurers should know more about their actual costs for 2020 later this year, and we should have better predictions about how widespread the pandemic will be by that time. Multi-rate filing will help ensure that all rates for 2021
Recommendation #2: Direct insurers to submit 2021 individual market rate filings that specify the projected amount of rate increase due to COVID-19

Uncertainty related to COVID-19 will likely contribute to higher premiums. However, we believe that consumers would be best served by greater transparency about how much rate impact insurers expect COVID-19 to have in 2021.

To address this concern, we urge HATF and state regulators to require insurers to clearly specify the projected amount of rate increase due to COVID-19. General statements or premium surcharges based on uncertainty provide insufficient information for regulators and the public to evaluate. The inclusion of specific information—ideally alongside assumptions about the COVID-19 infection rate, assumed morbidity rate, and other data—will also help insurers demonstrate to regulators that they are adequately preparing in response to the COVID-19 crisis.

Thank you for everything you are doing to protect consumers during this unprecedented crisis and in the midst of significant uncertainty and economic stress. If you have any further questions, please contact Justin Giovannelli (Justin.Giovannelli@georgetown.edu) or Sarah Lueck (lueck@cbpp.org).

Sincerely,
Justin Giovannelli
Sarah Lueck
Ashley Blackburn
Courtney Bullard
Bonnie Burns
Benjamin Chandhok
Laura Colbert
Lucy Culp
Deborah Darcy
Anna Schwamlein Howard
Katie Keith
Amy Killelea, JD
Matthew J. Smith, Esq.
Andrew Sperling
Harold Ting
Wayne Turner
Caitlin Westerson
Silvia Yee
The Wakely Report

- Commissioned by AHIP
- Published March 30, 2020
- Estimating Cost of COVID-19 Treatment for U.S. Private Insurers over 2 yrs

### Estimates on Treatment & Testing Costs

- **New Study: COVID-19 Health Care Costs Could Reach $600 Billion Over Two Years**

### Estimates on Population Impacted

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Medicare Advantage</th>
<th>Commercial Group</th>
<th>Commercial Non-Group</th>
<th>Medicaid MCO</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total enrollee</td>
<td>26,480,000</td>
<td>176,710,000</td>
<td>184,000</td>
<td>205,360,000</td>
<td></td>
</tr>
<tr>
<td>Total Number Infected (includes non-tested)</td>
<td>3,380,000</td>
<td>24,690,000</td>
<td>7,540,000</td>
<td>35,610,000</td>
<td></td>
</tr>
<tr>
<td>Number Confirmed Cases</td>
<td>4,896,000</td>
<td>35,340,000</td>
<td>10,836,000</td>
<td>51,072,000</td>
<td></td>
</tr>
</tbody>
</table>

**Links:**
- Press Release
- Blog Post
- Full Report
Estimates on Costs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Infection Rate (10%)</td>
<td>$42.2 – 69.5</td>
<td>$14.1 – 23.2</td>
<td>$56.2 – 92.7</td>
<td>$10.0 – 13.0</td>
</tr>
<tr>
<td>Baseline Infection Rate (20%)</td>
<td>$84.4 – 139.0</td>
<td>$28.1 – 46.3</td>
<td>$112.5 – 185.4</td>
<td>$20.0 – 26.0</td>
</tr>
<tr>
<td>High Infection Rate (60%)</td>
<td>$253.1 – 417.1</td>
<td>$84.4 – 139.0</td>
<td>$337.5 – 556.1</td>
<td>$59.9 – 78.0</td>
</tr>
</tbody>
</table>

- Estimated costs range from $56 to $556 billion over 2 yrs
- All costs above are in billions

The Wakely Report did NOT Include:

- Variations by localities and states
- Real-time information on actual length of stays and costs for COVID patients
- The impact of delayed and deferred care
- Mandate to cover antibody testing without cost sharing

Estimates on Treatment & Testing Costs

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Medicare Advantage</th>
<th>Commercial (Group + Non-Group)</th>
<th>Medicaid MCO Total / Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP Hospital Services</td>
<td>920,000</td>
<td>3,780,000</td>
<td>800,000 – 1,380,000</td>
</tr>
<tr>
<td>Non-ICU</td>
<td>660,000</td>
<td>2,930,000</td>
<td>610,000 – 1,420,000</td>
</tr>
<tr>
<td>ICU</td>
<td>260,000</td>
<td>850,000</td>
<td>190,000 – 2,190,000</td>
</tr>
<tr>
<td>IP Hospital Services</td>
<td>2,030,000</td>
<td>14,820,000</td>
<td>4,520,000 – 21,370,000</td>
</tr>
<tr>
<td>Non-ICU</td>
<td>1,150,000</td>
<td>11,040,000</td>
<td>3,750,000 – 16,970,000</td>
</tr>
<tr>
<td>OP Hospital Services</td>
<td>2,030,000</td>
<td>14,820,000</td>
<td>4,520,000 – 21,370,000</td>
</tr>
<tr>
<td>Professional Cost</td>
<td>2,030,000</td>
<td>14,820,000</td>
<td>4,520,000 – 21,370,000</td>
</tr>
<tr>
<td>All Other Services</td>
<td>120,000</td>
<td>220,000</td>
<td>40,000 – 380,000</td>
</tr>
<tr>
<td>Rx Services</td>
<td>1,110,000</td>
<td>11,040,000</td>
<td>3,750,000 – 16,970,000</td>
</tr>
</tbody>
</table>

| IP Hospital Cost  |                    |                               |                             |
| Non-ICU          | $8,850             | $12,450                       | $6,800 – $11,050            |
| ICU              | $17,000            | $38,450                       | $16,250 – $30,950           |
| OP Hospital Cost  | $600               | $1,000                        | $460 – $850                 |
| Professional Cost | $170               | $140                          | $70 – $130                  |
| All Other Cost    | $4,850             | N/A                           | $20                        |
| Rx Services      | $90                | $110                          | $130 – $120                 |

Gathering Data On:

AHIP updating due mid-May
- Claims experience
- Population impacted
- Testing costs
- Treatment costs – short & long term
- Drug studies
- Epidemiological studies
- Stimulus additions/changes

AHIP requests States to extend rate filing deadlines to July 22
AHIP/BCBSA Legislative Recommendations

1. Premium Affordability
   - Employer Support - Premiums
   - Employee Support - COBRA
   - Enhanced APTC
2. Stability for Consumers
   - Tailored Approach
   - Risk mitigation (commercial, MA/Part D and MCO)
   - MA RA changes
   - Ensure actuarially sound rates (MCO)
3. Access to Coverage
   - Special Enrollment Period

Contacts @ AHIP:
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COVID-19 Research and Impact on 2021 Pricing

HEALTH ACTUARIAL (B) TASK FORCE
THURSDAY, APRIL 23, 2020

R. Dale Hall, FSA, MAAA, CERA - Society of Actuaries
Dave Dillon, FSA, MAAA - Lewis & Ellis, Inc.
Gregory G. Fann, FSA, FCA, MAAA - Assen Health Partners

SOA Research Projects
- COVID-19 Costs to Commercial Health Insurers
- Summary of levels of COVID-19 conditions and range of types of care needed
- Cost estimates of services associated with COVID-19
- Some cost levels dependent on provider reimbursement arrangements

- COVID-19 Cases and Deaths Database

- Deferred Services: Research Examples

EARLY INDICATORS
- Overall claims down ~30% over the last month
- No significant geographical differences
- ER claims also down ~30%
- Will lower claims cause MLR impact?
- 2021 uncertainties include
  - ER visit stickiness
  - Deferred services costs
  - Vaccination costs
  - Wellness check costs

EARLY INDICATORS
- Based on discussions with national and large regional carriers
- Overall claims down ~30% over the last month
- No significant geographical differences
- ER claims also down ~30%
- Will lower claims cause MLR impact?
- 2021 uncertainties include
  - ER visit stickiness
  - Deferred services costs
  - Vaccination costs
  - Wellness check costs

COVID-19 2021 PRICING: MARKET DIFFERENCES
1. General uncertainty --> Rate Pressure, Volatility
2. Population Shifts
   - Group --> Individual --> Medicaid
   - Individual --> Uninsured
   - Uninsured --> Individual (12 states)
3. Adverse Selection Potential
   - COBRA, Small Group Market Furloughs/Layoffs
4. Benefit/Population Differences
   - Comorbidities, Urban/Rural, Network Breadth, AV & Waived Cost-Sharing, Federal Funding Mitigation, Grace Period, 1st Market Metal Level Dynamics
5. Pent-up Demand
   - Delayed or Cancelled?
   - Timing (e.g. 2020 or 2021)?

SOA COVID-19 Research Summary Page
https://www.soa.org/programs/covid-19/research-podcast/

SOA COVID-19 Research Brief, April 16
The Health Actuarial (B) Task Force met via conference call Feb. 14, 2020. The following Task Force members participated:
Todd E. Kiser, Chair, represented by Jaakob Sundberg (UT); Eric A. Cioppa, Vice Chair, represented by Marti Hooper (ME); Lori K. Wing-Heier represented by Jacob Lauten (AK); Ricardo Lara represented by Perry Kupferman (CA); Vicki Schmidt represented by Nicole Boyd (KS); Chlora Lindley-Myers represented by William Leung (MO); Mike Causey represented by David Yetter (NC); Bruce R. Ramge represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Tracie Gray (PA); Kent Sullivan represented by Mike Boerner (TX); Mike Kreidler represented by Lichiou Lee (WA); and James A. Dodrill represented by Joylynn Fix (WV).

1. Adopted its 2019 Fall National Meeting Minutes

Mr. Lauten made a motion, seconded by Ms. Eom, to adopt the Task Force’s Dec. 6, 2019, minutes (see NAIC Proceedings–Fall 2019, Health Actuarial (B) Task Force). The motion passed unanimously.

2. Adopted a Draft of Revisions to the Forms

Mr. Kupferman presented a draft of revisions (Attachment Three-A) to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions (Attachment Three-B) for the revised forms as forwarded to the Task Force by the Long-Term Care Actuarial (B) Working Group. He also presented comments (Attachment Three-C) on the revisions submitted by Utah.

Mr. Kupferman gave an overview of the revisions and said the changes suggested in the Utah comment letter will be incorporated into the draft.

Bob Yee (PricewaterhouseCoopers LLP—PwC) suggested that the reserves reported on Form 3 should be recast using current assumptions. Ray Nelson (America’s Health Insurance Plans—AHIP) said AHIP member companies think Form 3 should reflect the actual history of reserves held. He said requiring reserves to be recast would make completion of the forms more difficult and may create systems programming issues. Mr. Sundberg said he agrees with Mr. Nelson. Mr. Yee suggested companies be given the option of recasting reserves, with a checkbox to indicate this has been done on Form 3. The Task Force agreed to this change.

Mr. Nelson suggested that policies that have received contingent nonforfeiture benefits be considered as in-force policies for Forms reporting purposes, as they are still eligible to receive benefits and require a reserve to be held. The Task Force agreed to this classification.

Mr. Nelson suggested that the Form 2 instructions not prescribe the classification of comprehensive policies that later drop rider coverage. The Task Force agreed to this change.

Mr. Sundberg suggested the Forms include a way for companies to indicate whether waiver of premium amounts are included in claims and premium reporting. The Task Force agreed to this change.

Mr. Kupferman made a motion, seconded by Mr. Muldoon, to adopt the revised draft Forms and instructions with the changes discussed. The motion passed unanimously.

Mr. Sundberg said the revised draft forms (Attachment Three-D) and instructions (Attachment Three-E) will be forwarded to the Senior Issues (B) Task Force and the Health Insurance and Managed Care (B) Committee for their consideration.

Having no further business, the Health Actuarial (B) Task Force adjourned.
# LTC Experience Reporting Form 1 ($000 Omitted)

## Stand-Alone LTC Only

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<th>Line</th>
<th>$ Earned Premiums</th>
<th>$ Incurred Claims</th>
<th># Claims Opened</th>
<th># Claims Closed</th>
<th># Claims Remaining Open</th>
<th># Terminations</th>
<th># Policies In-force Year End</th>
<th>Lives In-force Year End</th>
<th>$ Active Life Reserves</th>
<th>$ Claim Reserves</th>
<th>$ Other Reserves</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### Individual

#### Direct

- Current

#### Assumed

- Current

#### Ceded

- Current

- Net (Direct + Assumed - Ceded)

- Current

### Group

#### Direct

- Current

#### Assumed

- Current

#### Ceded

- Current

- Net (Direct + Assumed - Ceded)

- Current
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<thead>
<tr>
<th>Line</th>
<th>Calendar Year of Peak Issues</th>
<th>% Male Lives Insured</th>
<th>Average Attained Age</th>
<th>$ Earned Premium</th>
<th>$ Incurred Claims</th>
<th>Lives In-force Year End</th>
<th># Terminations</th>
<th># New Lives Insured</th>
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</thead>
<tbody>
<tr>
<td>Primarily 2002 and Prior Issue Years</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Current (Comprehensive)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total Inception-to-date (Comprehensive)</td>
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Indicate whether policies are assigned to a Primary Issue Period on a per-policy or per-policy form basis:
- [ ] Policy
- [ ] Policy Form
# Long-Term Care Experience Reporting Form 3 (LTC Experience Development)

**Reporting Year:** 20__

*To Be Filed By April 1*

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## Part 2 - Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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#### PART 3 - Transferred Reserves

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Stand-alone LTC Current
Life/LTC Hybrid Policies and Riders Current (Acceleration only)
Total Inception-to-Date (Acceleration only)
Current (Extended Benefits Policies)
Total Inception-to-Date (Extended Benefits)
**Long-Term Care Insurance Experience Reporting Forms 1 Through 5**

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.

Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods:
(1) If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

(2) If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve would be the paid-up value and future incurred claims will be only for LTC benefits.

Report using (1) above unless there are system limitations which require data to be entered under assumption (2).

When reporting dollar amounts, report the amount in thousands ($000 omitted). For non-dollar values, do not truncate the amounts.

Definition of Incurred Claims:

The amount of developed claims incurred during the calendar year is equal to the present value of all claim payments during the year and any changes in claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurreal are discounted one-quarter year.
- Paid claims subsequent to the year of incurreal are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 of Form 3 are discounted from the valuation date to the midpoint of the incurred year.

If

\[ iy = \text{Incurred year} \]
\[ T = \text{Report year – incurred year} \]
\[ v = \text{Discount rate} \]
\[ t_{\text{Paid Claims}_{iy}} = \text{Paid claims during current or prior calendar year } t \text{ from claims incurred in year } iy \]
\[ t_{\text{Case Reserve}_{iy}} = \text{Case reserve at end of calendar year } t \text{ from claims incurred in } iy \]
\[ t_{\text{Transferred Reserve}_{iy}} = \text{Transferred reserve at end of calendar year } t \text{ from claims incurred in } iy \]
\[ t = iy, iy+1, iy+2, \ldots, iy + T \]

then the Present Value of Incurred Claims for incurred year \( iy \):

For T=0

\[ t_{\text{Paid Claims}_{iy}} \times v^{\frac{1}{4}} + t_{\text{Case Reserve}_{iy}} \times v^{\frac{1}{2}} + t_{\text{IBNR}_{iy}} \times v^{\frac{1}{2}} + t_{\text{Transferred Reserve}_{iy}} \times v^{\frac{1}{2}} \]
For $T>0$

$$\gamma_i \text{Paid Claims}_i \times v^i + \gamma_{i+1} \text{Paid Claims}_{i+1} \times v^{i+1} + \gamma_{i+2} \text{Paid Claims}_{i+2} \times v^{i+2} + \ldots + \gamma_{i+T} \text{Paid Claims}_{i+T} \times v^T +$$

$$\gamma_{i+1} \text{Case Reserve}_{i+1} \times v^{i+1} + (\gamma_{i+1} \text{IBNR}_i \times v^{i+1}) + \gamma_{i+1} \text{Transferred Reserve}_{i+1} \times v^{i+1}$$

If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the total direct liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only.

This amount includes accrued and unaccrued claims liabilities that are incurred but not yet paid, both reported and not reported.
Instructions for Form 1

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual premium, claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons for direct, assumed, and ceded business are exhibited.

Form 1: Stand-Alone LTC Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Assumed/Ceded Rows
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 2 - Incurred Claims
Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 3 – Claims Opened
The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed
Number of claims that had been opened, which became closed during the year due to recovery, exhaustion of benefits, or death.
Column 5 – Claims Remaining Open

Open claims are all claims that have been opened at any date, but have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, benefit exhaustion, or conversion to non-forfeiture status.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year, not including any in non-forfeiture status.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders, including those in non-forfeiture status. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid, including claims on policies in non-forfeiture status.

Column 11 – Other Reserves

Total amount of any other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Instructions for Form 2

Form 2: Direct Individual Experience – Stand-Alone Only

Primary Issue Period Splits

Experience data for each policy should be aggregated in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policies that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders. Policies remain classified as comprehensive after optional riders have been dropped.

Institutional Only
Policies that provide institutional coverage only.

Non-Institutional Only
Policies that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain inforce as of 12/31.

Column 2 – % Male Lives Insured

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.

Column 3 – Average Attained Age

Arithmetic mean of the attained ages of all inforce policyholders in the block at year end.
Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

**Life, Accident & Health, Fraternal and Property/Casualty Only**
- Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

**Health Companies**
- Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, benefit exhaustion, or conversion to non-forfeiture status.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of claim reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses by incurred calendar year. This form is aggregated on a nationwide basis.

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X. All reserves are based on the underlying assumptions for the current reserves.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.

Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year). The discount rate is the statutory valuation interest rate for case reserves.
Instructions for Form 4

Form 4: Direct Group Experience – Stand-Alone Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of certificates.

Comprehensive
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

Institutional Only
Certificates that provide institutional coverage only.

Non-Institutional Only
Certificates that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain in force as of 12/31.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Calculate this in aggregate as \(\text{[Third Party Premiums ÷ Total Premiums]}\)

Column 3 – Average Attained Age
Unweighted average of the attained ages of all in force certificate holders in the block.

Column 4 – Earned Premium
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Column 5 – Incurred Claims
Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve.

Column 6 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.
Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 provides LTC sales and claims experience on a state-by-state basis. These are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on life policies or annuity contracts.

Form 5: Standalone and Hybrid Products – Direct State Reporting

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Stand-alone LTC
An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code
The state in which the policy was issued. Example: CA for California

Column 2 – New Lives Insured
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

Column 3 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 4 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 7 – Claims Remaining Open

Open claims are all claims that have been opened at any date, but have not been closed as of the end of the year.

Column 8 – Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available

Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available

Maximum amount of extended benefits available to policyholders with extension of benefit riders.
Long-Term Care Insurance Experience Reporting Forms 1 Through 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.

Commented [JS1]: It looks like there were no changes to form 3 instructions or template. Was any decision made about how to handle changes in the calculation of DLR (whether to implement them only in that year, or to recalculate the DLR on past years under the current newest methodology)?

I recommend adding a paragraph to the form 3 instructions that says if you change DLR reserve bases, don’t go back and recast the prior years using the new basis. Just use the new basis for the current and future years (until the reserve basis changes again).
Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve and experience fund would be the paid-up value and future incurred claims will be only for LTC benefits. If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve and experience fund will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

Commented [JS2]: I don’t understand this paragraph. I think it is saying the company needs to be aware of how they are planning to handle waiver of premium. I also don’t know what the “experience fund” is. The paragraph suggests two methods of handling waiver of premium (if I’m reading it right) but none of the spreadsheet forms allow the company to express which method was used.

If you want waiver of premium handled consistently between companies you are better off to explain specifically how you want it handled (including the discounting associated).

There are different reasons for waived premium: on claim in a facility, death of spouse triggers paid-up survivor benefit, policy is h-pay and is already paid up. Addressing how you want each situation handled in the reporting would provide greater consistency in company reporting. I’m not certain if there is a reason to handle them differently.

I recommend that the reports exclude the waiver of premium from both claims and premiums. I recommend a separate column in Form 1 for waiver of premium reserve. Whether you ask the companies to discount the waivers as a present value of paid waived premiums, or discount them based on the incurral date of the claim with which they are associated – I don’t have a preference. But I think the instructions should say one way or the other so that it’s calculated consistently.
Instructions for Form 1

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons are exhibited.

Form 1: Stand-Alone LTC Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Assumed/Ceded Rows
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 2 - Incurred Claims
Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 3 – Claims Opened
The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed
Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.

Commented [JS3]: Claim reserves are usually made up of a few parts: PVFB on open claims, IBNR, and CBER (closed but expected to reopen). For the CBER, the company is likely holding an ALR (because the person moves from claim status back to active). Do you want the CBER included in the incurred claims if there is a separate ALR held?

Commented [JS4]: Forms 1, 2, 4, and 5 all reference back to form 3 for determining how incurred claims should be considered. We might explain the treatment of incurred claims in the general instructions rather than in the middle form with all others referencing the middle form.

Commented [JS5]: Is it intended here to say that if a claim never exits the elimination period it should never be counted as a claim (open or closed)? It is stated fairly explicitly here in the opened claims, but it isn’t stated that way in the closed claims. The instructions are ambiguous as to whether or not you want them counted at least as closed claims.

How should an IBNR claim be handled? Do you want the company to estimate the number of IBNR claims, or just report actual opened claims for the current year. What about next year – do you want the unreported IBNR claims included only in the total inception to date?

If you want prior year exhibits to tie to the current by some formula like:
Prior year claims remaining open + current year opened claims – current year closed claims = current year claims remaining open It won’t happen if you don’t explain how to handle IBNR and re-opened claims.

Commented [JS6]: What about claims that never get out of the elimination period? Do these count as closed claims?
Column 5 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
**Instructions for Form 2**

Form 2 provides data on direct individual LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 2: Direct Individual Experience – Stand-Alone Only

**Primary Issue Period Splits**

Experience data for each policy form should be included in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

**Definitions and Formulas**

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Comprehensive**
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

**Institutional Only**
Policy forms that provide institutional coverage only.

**Non-Institutional Only**
Policy forms that provide only non-institutional coverage.

**Column 1 – Calendar Year of Peak Issues**

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain in force as of 12/31.

**Column 2 – % Male Lives Insured**

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.
Column 3 – Average Attained Age

Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses incurred by a specific year group of claimants. This form is to be prepared on a nationwide basis.

Report all dollar amounts in thousands ($000 omitted).

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurred year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.
Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year).

- Paid claims in the year of incurrence are discounted one-quarter year.
- Paid claims subsequent to the year of incurrence are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

Commented [JS27]: Form 1 and 2 describe which discount rate to use, but this form never says what discount rate to use.
Instructions for Form 4

Form 4 provides data on direct group LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 4: Direct Group Experience – Stand-Alone Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of certificates.

Comprehensive
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

Institutional Only
Certificates that provide institutional coverage only.

Non-Institutional Only
Certificates that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain inforce as of 12/31.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Calculate this in aggregate as [Third Party Premiums + Total Premiums]

Column 3 – Average Attained Age
Unweighted average of the attained ages of all inforce certificate holders in the block.

Column 4 – Earned Premium
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.
Column 5 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve. Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.

Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 is intended to provide data on a state-by-state basis in relation to LTC sales and claims experience. These lines are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on what is primarily a life policy or annuity contract.

Form 5: Standalone and Hybrid Products – Direct State Reporting

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Stand-alone LTC
An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code
The state for which data is being reported. Example: CA for California

Column 2 – New Lives Insured
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

Column 3 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

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Column 4 – Earned Premiums
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims
Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.
Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Incurred Extended Benefits Claims
Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.
Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 7 – Claims Remaining Open
Open claims are all claims that have not been closed as of the end of the year.

Column 8 – Claims Opened
The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims
The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available
Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available
Maximum amount of extended benefits available to policyholders with extension of benefit riders.
### LTC Experience Reporting Form 1 ($000 Omitted)
#### Stand-Alone LTC Only

<table>
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<tr>
<th>Line</th>
<th>$ Earned Premiums</th>
<th>$ Incurred Claims</th>
<th># Claims Opened</th>
<th># Claims Closed</th>
<th># Claims Remaining Open</th>
<th># Terminations</th>
<th># Policies In-force Year End</th>
<th>Lives In-force Year End</th>
<th>$ Active Life Reserves</th>
<th>$ Claim Reserves</th>
<th>$ Other Reserves</th>
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**Individual**

**Direct**

- Current
- Total Inception-to-date

**Assumed**

- Current

**Ceded**

- Current

**Net (Direct + Assumed - Ceded)**

- Current

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### Group

**Direct**

- Current
- Total Inception-to-date

**Assumed**

- Current

**Ceded**

- Current

**Net (Direct + Assumed - Ceded)**

- Current

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Indicate whether policies on claim that have triggered waiver of premium are considered paid-up or paid by waiver.

- [ ] Paid by Waiver
- [ ] Paid Up
### LTC Experience Reporting Form 2 ($000 Omitted)
**Direct Individual Experience - Stand-Alone Only**

<table>
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<tr>
<th>Line</th>
<th>Calendar Year of Peak Issues</th>
<th>% Male Lives Insured</th>
<th>Average Attained Age</th>
<th>$ Earned Premium</th>
<th>$ Incurred Claims</th>
<th>Lives In-force Year End</th>
<th># Terminations</th>
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</table>

#### Primarily 2002 and Prior Issue Years
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)

#### Primarily 2003 to 2010 Issue Years
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)

#### Primarily 2011 and Later Issue Years
- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)

Indicate whether policies are assigned to a Primary Issue Period on a per-policy or per-policy form basis:
- ☐ Policy
- ☐ Policy Form
### A. Individual

#### PART 1 - Total (Direct and Transferred) Amount Paid Policyholders

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#### PART 2 - Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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### PART 2 - Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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Health Actuarial (B) Task Force

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### PART 4 - Present Value of Incurred Claims

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</tbody>
</table>

Indicate whether claim reserves and liabilities for prior years are based on historical or current reserving assumptions:

- [ ] Historical
- [ ] Current
### LTC Experience Reporting Form 4 ($000 Omitted)

**Direct Group Experience - Stand-Alone Only**

<table>
<thead>
<tr>
<th>Line</th>
<th>1</th>
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<tr>
<td>Calendar Year of Peak Issues</td>
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<td>Third Party Funding (%)</td>
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<td># Lives In-force Year End</td>
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<td># Terminations</td>
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<td>Current (Non-Institutional only)</td>
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<td>Total Inception-to-date (Non-Institutional only)</td>
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<td>Current (Grand Total)</td>
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<td>Total Inception-to-date (Grand Total)</td>
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</tbody>
</table>

**Stand-alone LTC**

**Current (Acceleration only)**

**Current (Extended Benefits Policies)**

**Total Inception-to-Date (Acceleration only)**

**Total Inception-to-Date (Extended Benefits)**
Long-Term Care Insurance Experience Reporting Forms 1 Through 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.

Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods:
(1) If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

(2) If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve would be the paid-up value and future incurred claims will be only for LTC benefits.

Report using (1) above unless there are system limitations which require data to be entered under assumption (2).

When reporting dollar amounts, report the amount in thousands ($000 omitted). For non-dollar values, do not truncate the amounts.

Definition of Incurred Claims:

The amount of developed claims incurred during the calendar year is equal to the present value of all claim payments during the year and any changes in claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 of Form 3 are discounted from the valuation date to the midpoint of the incurred year.

If

\[ iy = \text{Incurred year} \]
\[ T = \text{Report year} - \text{incurred year} \]
\[ v = \text{Discount rate} \]
\[ \text{Paid Claims}_{iy} = \text{Paid claims during current or prior calendar year} t \text{ from claims incurred in year} iy \]
\[ \text{Case Reserve}_{iy} = \text{Case reserve at end of calendar year} t \text{ from claims incurred in} iy \]
\[ \text{Transferred Reserve}_{iy} = \text{Transferred reserve at end of calendar year} t \text{ from claims incurred in} iy \text{ and} \]
\[ t = iy, iy+1, iy+2, \ldots, iy + T \]

then the Present Value of Incurred Claims for incurred year iy:

For \( T=0 \)

\[ \text{Paid Claims}_{iy} \times v^{\frac{T}{4}} + \text{Case Reserve}_{iy} \times v^{\frac{T}{2}} + \text{IBNR}_{iy} \times v^{\frac{T}{2}} + \text{Transferred Reserve}_{iy} \times v^{\frac{T}{2}} \]
For $T > 0$

$$\sum_{y=0}^{T} \text{Paid Claims}_{y} \times v^y + \sum_{y=1}^{T} \text{Paid Claims}_{y} \times v^{y+1} + \ldots + \sum_{y=T}^{T+T} \text{Paid Claims}_{y} \times v^{T} +$$

$$\sum_{y=T}^{T+T} \text{Case Reserve}_{y} \times v^{T+y} \times \left( \sum_{y=T+1}^{T+T} \text{IBNR}_{y} \times v^{T+y} \right) + \sum_{y=T+1}^{T+T} \text{Transferred Reserve}_{y} \times v^{T+y}$$

If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the total direct liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only.

This amount includes accrued and unaccrued claims liabilities that are incurred but not yet paid, both reported and not reported.
**Instructions for Form 1**

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual premium, claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons for direct, assumed, and ceded business are exhibited.

**Form 1: Stand-Alone LTC Only**

**Definitions and Formulas**

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Assumed/Ceded Rows**
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

**Column 1 – Earned Premiums**
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

*Life, Accident & Health, Fraternal and Property/Casualty Only*
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

*Health Companies*
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

**Column 2 - Incurred Claims**
Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

**Column 3 – Claims Opened**
The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

**Column 4 - Claims Closed**
Number of claims that had been opened, which became closed during the year due to recovery, exhaustion of benefits, or death.
Column 5 – Claims Remaining Open

Open claims are all claims that have been opened at any date, but have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders, including those in non-forfeiture status. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid, including claims on policies in non-forfeiture status.

Column 11 – Other Reserves

Total amount of any other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Instructions for Form 2

Form 2: Direct Individual Experience – Stand-Alone Only

Primary Issue Period Splits

Experience data for each policy should be aggregated in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policies that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policies that provide institutional coverage only.

Non-Institutional Only
Policies that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain inforce as of 12/31.

Column 2 – % Male Lives Insured

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.

Column 3 – Average Attained Age

Arithmetic mean of the attained ages of all inforce policyholders in the block at year end.
Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.  

**Life, Accident & Health, Fraternal and Property/Casualty Only**
- Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

**Health Companies**
- Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of claim reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses by incurred calendar year. This form is aggregated on a nationwide basis.

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.

Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year). The discount rate is the statutory valuation interest rate for case reserves.
Instructions for Form 4

Form 4: Direct Group Experience – Stand-Alone Only

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of certificates.

**Comprehensive**
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

**Institutional Only**
Certificates that provide institutional coverage only.

**Non-Institutional Only**
Certificates that provide only non-institutional coverage.

**Column 1 – Calendar Year of Peak Issues**
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain in force as of 12/31.

**Column 2 – Third Party Funding**
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25" in this column.

Calculate this in aggregate as [Third Party Premiums ÷ Total Premiums]

**Column 3 – Average Attained Age**
Arithmetic mean of the attained ages of all in force certificate holders in the block at year end.

**Column 4 – Earned Premium**
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

**Column 5 – Incurred Claims**
Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve.

**Column 6 – Lives In-force Year End**
Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.
Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
**Instructions for Form 5**

Form 5 provides LTC sales and claims experience on a state-by-state basis. These are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on life policies or annuity contracts.

**Form 5: Standalone and Hybrid Products – Direct State Reporting**

Definitions and Formulas

**Current**
Current calendar year of reporting.

**Total Inception-to-Date**
Aggregate experience data since issuance of policies.

**Stand-alone LTC**
An LTC product that is sold by itself, not as a rider on another type of insurance.

**Life/LTC Accelerated Benefits Riders**
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

**LTC Extension of Benefit Riders**
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

**Column 1 – State Code**
The state in which the policy was issued. Example: CA for California

**Column 2 – New Lives Insured**
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

**Column 3 – Lives In-force Year End**
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 4 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 7 – Claims Remaining Open

Open claims are all claims that have been opened at any date, but have not been closed as of the end of the year.

Column 8 – Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available

Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available

Maximum amount of extended benefits available to policyholders with extension of benefit riders.
2021 Health Care Cost Model

Goal: To Assist Regulators, Insurance Company Actuaries and Consulting Actuaries in estimating the impact of COVID-19 on claim costs.

- VBA Excel Model projecting future monthly costs with user inputs
- Commercial Group and Individual, Medicare and Medicaid LOBs
- Model includes different types of trended costs; Updated in July
  - Base Costs
    - Includes Foregone, Deferred, and Recouped Expenses subject to Return Stages
  - Direct COVID-19 Costs
  - SIR Model can generate infection rate scenarios
  - Behavioral Health Costs Due to Social Distancing
  - COVID-19 Testing and Vaccine Costs

SOA Experience Studies

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-2011 LTC Lapse and Mortality Valuation Assumptions</td>
<td>Develop a replacement mortality LTC valuation table and a proposal to replace the current LTC voluntary lapse parameters. Work done in conjunction with the AAA.</td>
<td>10/31/2020</td>
</tr>
</tbody>
</table>

1 https://www.soa.org/resources/research-reports/2020/us-individual-disability/
2 https://www.soa.org/resources/experience-studies/2019/claim-incidence-report/
# SOA Practice Research & DDIR

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
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<td>Health Care Cost Model v1.0</td>
<td>Release a model that will enable users to estimate health care cost levels in insured plans across a wide variety of return stage scenarios (Robert Wood Johnson Foundation funded project).</td>
<td>7/13/2020</td>
</tr>
<tr>
<td>Direct Primary Care – Evaluating a New Model of Delivery and Financing</td>
<td>Conduct market survey and literature review to define DPC and examine its expected efficacy. Interview physicians who operate under a DPC model. Create a case study to quantify the impact of DPCs.</td>
<td>Complete. On SOA website.</td>
</tr>
<tr>
<td>State of ACA Marketplace</td>
<td>Examine the success of the ACA to different stakeholders in the individual and Medicaid Marketplaces.</td>
<td>Complete. On SOA website.</td>
</tr>
<tr>
<td>Health Care Cost Model v2.0</td>
<td>Release a model that will enable users to estimate health care cost levels in insured plans across a wide variety of return stage scenarios (Robert Wood Johnson Foundation funded project).</td>
<td>7/13/2020</td>
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<tr>
<td>Comparing Measures of Social Determinants of Health to Assess Population Risk</td>
<td>Assess how well different measures of SDOH quantify and characterize patient risk status in order to optimize a variety of population health and payment purposes.</td>
<td>8/15/2020</td>
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<td>PrEP Toolkit</td>
<td>Create a toolkit to help actuaries estimate the costs of covering HIV related Pre-Exposure and Post-Exposure Prophylaxis drugs.</td>
<td>11/30/2020</td>
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<tr>
<td>Initiative 18/11 - 5/50 Project - Analyzing Characteristics of the top 5% members by cost who drive 50% of Medical Expenses</td>
<td>Validate the 5/50 premise through % of total costs and average allowed annual costs by percentile grouping. Calculate transition probabilities between different groups. Develop a methodology for identifying and remarking those at risk.</td>
<td>9/15/2020</td>
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The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Aug. 4, 2020. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Paul Lombardo (CT); Benjamin Ben (FL); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Bill Carmello (NY); Laura Miller (OH); Tracie Gray (PA); Andrew Dvorine (SC); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Adopted its Jan. 23, 2020, and 2019 Fall National Meeting Minutes

The Working Group met Jan. 23 to adopt a draft of changes to the Long-Term Care Insurance Experience Reporting Forms of the annual financial statement.

Mr. Ostlund made a motion, seconded by Mr. Lombardo, to adopt the Working Group’s Jan. 23, 2020 (Attachment Five-A) and Dec. 6, 2019 (see NAIC Proceedings – Fall 2019, Health Actuarial (B) Task Force, Attachment Four) minutes. The motion passed unanimously.

2. Heard an Update from the Academy on LTC Work Group Activities

Warren Jones (PricewaterhouseCoopers LLP) gave an update (Attachment Five-B) on the American Academy of Actuaries (Academy) Long-Term Care Valuation Work Group’s development of mortality and lapse valuation tables.

Mr. Kupferman asked why, for issue ages 80 and greater, the same mortality table marital status adjustment factors are used for married and single policyholders.

Mr. Jones said this is because a difference between married and single policyholder experience was not observed for issue ages 80 and greater. He said there are other apparently anomalous relationships in the proposed tables and adjustment factors that can be explained by the actual observed experience, and that these will be detailed in the final report to the Working Group.

3. Heard an Update on SOA LTCI Research

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Five-C) on recent work on the SOA’s Long-Term Care Experience Study.

4. Adopted the Report of the Long-Term Care Pricing (B) Subgroup

Mr. Lombardo said the Long-Term Care Pricing (B) Subgroup met Feb. 6 and Jan. 6. He said the Subgroup discussed long-term care insurance (LTCI) cash value buyouts (CVBs) to policyholders in lieu of rate increases, and recent discussions in the Connecticut legislature concerning the ability of stand-alone LTCI policyholders to convert their policies to some form of hybrid LTCI policy, using some of the accumulated value of the stand-alone policy to offset the cost of the hybrid policy. He said state insurance regulators’ main concern expressed is the possibility of antiselection by policyholders that elect CVBs affecting remaining policyholders. He said the Subgroup will continue CVB discussions during an upcoming conference call.

Mr. Lombardo made a motion, seconded by Mr. Schallhorn, to adopt the report of the Long-Term Care Pricing (B) Subgroup, including its Feb. 6 (Attachment Five-D) and Jan. 6 (Attachment Five-E) minutes. The motion passed unanimously.
5. **Adopted the Report of the Long-Term Care Valuation (B) Subgroup**

Mr. Andersen said the Subgroup has not met since the 2019 Fall National Meeting. He said a review group composed of Subgroup members continues to review *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)* year-end 2019 filings. He said this is the third year for such reviews. He said the first year of reviews focused on ultimate lapse rates, mortality tables, reliance on future rate increases, morbidity improvement and future investment performance assumptions used for reserve calculations. He said the second year of reviews took a closer look at morbidity assumptions by developing an inquiry letter that resulted in more useful morbidity information being collected related to claim cost, incidence, termination and benefit utilization.

Mr. Andersen said Subgroup members have engaged with insurers, the SOA and actuarial consulting firms to assess the impact of COVID-19 on LTCI valuation. He said initial findings indicate the presence of COVID-19 impacts on claims costs, situs of long-term care (LTC) services and consumer attitudes toward receiving LTC services during the pandemic. He said there will likely be a hesitation among the elderly to enter an LTC facility and that it is unknown if this will be a short-term or long-term change in LTC service utilization. He said COVID-19 mortality is affecting LTCI reserves, and the extent of the impact needs to be analyzed. He said if there is a continued shift in use of facility-based LTC services, the financial impact on LTCI may be greater than that from increased mortality. He said the most certain impact to LTCI reserves over the past five months has been the further decline in interest rates. He said that any past financial concerns for insurers will likely be worse than they were prior to COVID-19. He said the Subgroup will coordinate with the Long-Term Care Pricing (B) Subgroup, as many of the COVID-19 related issues that affect valuation will also affect pricing. He said the Subgroup will be in contact with the Academy and the SOA to determine how its recent work relates to LTCI valuation. He said the Subgroup will present any findings related to COVID-19 during future conference calls over the next few months.

Mr. Andersen made a motion, seconded by Mr. Boerner, to adopt the report of the Long-Term Care Valuation (B) Subgroup. The motion passed unanimously.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.

W:\National Meetings\2020\Summer\TF\HA\LTCAWG 08-04-20.docx
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Jan. 23, 2020. The following Working Group members participated: Perry Kupferman, Chair (CA); Steve Ostlund (AL); Benjamin Ben (FL); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Laura Miller (OH); Andrew Schallhorn (OK); Andrew Dvorine (SC); Raja Malkani (TX); and Jaakob Sundberg (UT).

1. Adopted a Draft of Revisions to the Forms

Mr. Kupferman presented draft of revisions (Attachment Five-A1) to the Long-Term Care Experience Reporting Forms (Forms) found in the annual financial statement and instructions (Attachment Five-A2) for the revised Forms.

Mr. Kupferman said the draft was produced as a response to a referral from the Financial Analysis (E) Working Group that requests assistance from the Long-Term Care Actuarial (B) Working Group with long-term care insurance (LTCI) total reserve reporting in the Forms and the annual financial statement.

Mr. Kupferman said the draft revisions were exposed for public comment, and he presented a comment letter (Attachment Five-A3) from the American Council of Life Insurers (ACLI) and America’s Health Insurance Plans (AHIP).

Ms. Ahrens suggested that the Total Inception-to-Date rows be deleted for the Assumed and Ceded sections of Form 1. The Working Group agreed to these changes.

Jan Graeber (ACLI) asked if the current Form 3 will be retained in the set of Forms. Mr. Kupferman said Form 3 will be retained, and no changes to it have been proposed.

Mr. Ostlund made a motion, seconded by Ms. Ahrens, to adopt the draft Forms (Attachment Five-A4) and instructions (Attachment Five-A5) with changes agreed to during the discussion. The motion passed unanimously.

Mr. Kupferman said the draft Forms and instructions will be forwarded to the Health Actuarial (B) Task Force for its consideration.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
### LTC Experience Reporting Form 1 ($000's)

#### Stand-Alone LTC Only

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<th>Line</th>
<th>Earned Premiums</th>
<th>Incurred Claims</th>
<th># Claims Opened</th>
<th># Claims Closed</th>
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<th># Terminations</th>
<th># Policies In-force Year End</th>
<th># Lives In-force Year End</th>
<th>$ Active Life Reserves</th>
<th>$ Claim Reserves</th>
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#### Individual

- **Direct**
  - Current
  - Total Inception-to-date
- **Assumed**
  - Current
  - Total Inception-to-date
- **Ceded**
  - Current
  - Total Inception-to-date

#### Net (Direct + Assumed - Ceded)

- Current
  - Total Inception-to-date

### Group

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<th>Incurred Claims</th>
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#### Direct

- Current
  - Total Inception-to-date

#### Assumed

- Current
  - Total Inception-to-date

#### Ceded

- Current
  - Total Inception-to-date

#### Net (Direct + Assumed - Ceded)

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  - Total Inception-to-date
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**LTC Experience Reporting Form 4 ($000's)**

**Direct Group Experience - Stand-Alone Only**

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**Stand-alone LTC**
- Current
- Total Inception-to-Date

**Life/LTC Hybrid Policies and Riders**
- Current (Acceleration only)
- Total Inception-to-Date (Acceleration only)
- Current (Extended Benefits Policies)
- Total Inception-to-Date (Extended Benefits)
Long-Term Care Insurance Experience Reporting Forms 1 Through 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2009, and 2010 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.
Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve and experience fund would be the paid-up value and future incurred claims will be only for LTC benefits. If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve and experience fund will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.
Instructions for Form 1

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons are exhibited.

Form 1: Stand-Alone LTC Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Assumed/Ceded Rows
Does not include YRT reinsurance transactions. For columns that are designated with a # rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 2 - Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 3 – Claims Opened

The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed

Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.
Column 5 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Instructions for Form 2

Form 2 provides data on direct individual LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 2: Direct Individual Experience – Stand-Alone Only

Primary Issue Period Splits

Experience data for each policy form should be included in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive

Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain inforce as of 12/31.

Column 2 – % Male Lives Insured

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.
Column 3 – Average Attained Age

Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

*Life, Accident & Health, Fraternal and Property/Casualty Only*

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

*Health Companies*

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
**Instructions for Form 4**

Form 4 provides data on direct group LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

**Form 4: Direct Group Experience – Stand-Alone Only**

**Definitions and Formulas**

**Current**  
Current calendar year of reporting.

**Total Inception-to-Date**  
Aggregate experience data since issuance of certificates.

**Comprehensive**  
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

**Institutional Only**  
Certificates that provide institutional coverage only.

**Non-Institutional Only**  
Certificates that provide only non-institutional coverage.

**Column 1 – Calendar Year of Peak Issues**  
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain in force as of 12/31.

**Column 2 – Third Party Funding**  
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Calculate this in aggregate as \[\text{Third Party Premiums} \div \text{Total Premiums}\]

**Column 3 – Average Attained Age**  
Unweighted average of the attained ages of all in force certificate holders in the block.

**Column 4 – Earned Premium**  
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.
Column 5 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve. Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.

Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 is intended to provide data on a state-by-state basis in relation to LTC sales and claims experience. These lines are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on what is primarily a life policy or annuity contract.

Form 5: Hybrid Products and Direct State Reporting

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Stand-alone LTC
An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code
The state for which data is being reported. Example: CA for California

Column 2 – New Lives Insured
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

Column 3 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 4 – Earned Premiums
Collect premiums + change in due premiums – change in advanced premiums – change in unearned premium reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims
Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Incurred Extended Benefits Claims
Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 7 – Claims Remaining Open
Open claims are all claims that have not been closed as of the end of the year.

Column 8 – Claims Opened
The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims
The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available
Maximum amount of remaining death benefit available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available
Maximum amount of remaining extended benefits available to policyholders with extension of benefit riders.
December 11, 2019

Perry Kupferman – Chair of NAIC Long-Term Care Actuarial Working Group (LTCAWG)
Eric King – NAIC Staff

Sent via Email

Re: LTC Experience Reporting Forms and Instructions Exposed November 11, 2019 by the LTCAWG

Dear Mr. Kupferman and Mr. King,

Thank you for the time you and other regulators have spent on the proposed revisions to the NAIC Long-Term Care Experience Reporting Forms. ACLI and AHIP appreciate the opportunity to provide suggestions/comments regarding the version of the LTC Experience Reporting Forms and Instructions exposed for comment on November 11, 2019.

Form Specific Technical Comments:

Form 1
1) We believe that Form 1 is intended to apply to stand-alone only LTC policies. We request that this be added to the form’s header and/or made clear in the Form 1 instructions.
2) In the Instructions for Column 5 (“# Claims Remaining Open”), we suggest adding “as of the end of the year” to the end of the draft definition so it will read “Open claims are all claims that have not been closed as of the end of the year.”
3) It has been noted by some member companies that current reinsurance agreements may not have been in force in all prior years. It is not clear how “Total Inception-to-date” data should be calculated under “Assumed”, “Ceded” and “Net” when the current reinsurance agreement has not been in place for all prior years. We believe that the “Total Inception-to-date” data is only meaningful for the “Direct” portion of the Form and would suggest that the “Total Inception-to-date” rows be removed in the “Assumed”, “Ceded”, and “Net” subsections for both “Individual” and “Group” business.
4) The Instructions for Column 11 (“Other Reserves”) note that this value should be “The amount reported in annual statement Exhibit 6, Line 2 . . .”. We believe this is not the correct reference. It appears this might be the correct reference for Column 9. Column 11 appears to be Exhibit 6, Line 1 plus Line 3? Since Exhibit 6 is being modified for the 2019 Annual Statement, we suggest reviewing the revised form to assure that the proper references are present for the Instructions.
5) The Instructions for Column 9 (“Active Life Reserves”) read that this is the total of the reserves “held for policyholders who are not currently on claim”. Please note that many insurers continue to hold active live reserves for policyholders that are on claim. We suggest
removing the current definition and inserting a reference to the correct Annual Statement value (which in this case does appear to be Exhibit 6, Line 2.

6) We believe it would make sense for the new instructions for Column 2 (“Incurred Claims”) to be shown at the level of detail as the current Form 1 Instructions? We believe the “Incurred Claims” to be illustrated are intended to be the same developed claim amounts as shown in the Current Form 1. These previous instructions provided more detail and would thus allow for less misunderstanding in completing the Form. Please also amend the Instructions for Forms 2, 4 and 5 “Incurred Claims” to refer back to the definition of Incurred Claims for Form 1.

Form 2
1) We believe that Form 2 is also intended to apply to stand-alone only LTC policies. We request that this be added to the form’s header and/or made clear in the Form 2 instructions. (Please note that this same comment is applicable to Form 4.)

2) We recommend some additional clarification of the Primary Issue Year Periods be included in the Instructions. It would be preferable to clarify the intent that the data for a policy form/series can be included 100% in one of the three Issue Year periods based upon the primary issue years of the form. In addition, some companies might prefer to split the experience of a policy form by issue year. Perhaps an additional Definition along the following lines could be added to the Form 2 Instructions:

Primary Issue Period Splits
Experience data for each policy form should be included in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

3) In Column 8 on the Experience Reporting Form (“# New Lives Insured”) it appears that the three “Total Inception to Date” cells in the “Primarily 2010 and Later Issues” section should also be X’ed out.

Form 5.
1) We wish to note that the reporting of Column 4 (“Earned Premiums”) is likely to present challenges in the “Life/LTC Hybrid” section. In some policies, the premiums may not be separate for the LTC portion of the policy. It is likely that the data provided from company to company will not be consistent. Can more direction be provided in the Instructions for cases where the LTC portion of the premium is not identifiable?

2) In the Instructions for Column 7 (“# Claims Remaining Open”), we suggest adding “as of the end of the year” to the end of the draft definition so it will read “Open claims are all claims that have not been closed as of the end of the year.
3) In Column 10 on the Experience Reporting Form (“$ Accelerated Benefits Available”) it appears that the cell for “Current (Extended Benefit Policies)” should also be X’ed out.

4) In the Instructions for Columns 10 and 11 we suggest removing the word “remaining”. This implies that a company would need to compute the remaining benefit available for policies where a claim is in process and add to the total benefits available for policies not currently on claim. Company administrative systems vary, and inforce policy listings may show the full benefit and not the remaining benefit. Keeping the word ‘remaining’ could cause significant difficulties in reporting for some insurers while the difference between full and remaining benefits will likely not be material for most companies.

5) Companies have concern regarding the providing of LTC claims data at the state level. This data is generally not credible. We believe that Form 5 is most useful for showing market share and volume of new sales data. We would suggest either the removal of the state level Incurred Claims, or at the very least the addition of a footnote along the following lines: “Nationwide data is generally viewed as more representative and credible than individual state data.”

General Instructions
The instructions for the currently used LTC Experience Reporting Forms contains a lengthy introduction before the individual form instructions are reached. In light of the changes to the Experience Reporting Forms, we believe that this introduction in the Instructions needs to be revisited as well.

We would be happy to answer any questions that the Working Group has regarding these comments and suggested changes.

Sincerely,

Raymond Nelson
Consultant to AHIP

Jan Graeber
ACLI
LTC Experience Reporting Form 1 ($000 Omitted)
Stand-Alone LTC Only

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Individual

Direct

Current

Total Inception-to-date

Assumed

Current

Ceded

Current

Net (Direct + Assumed - Ceded)

Current

Group

Direct

Current

Total Inception-to-date

Assumed

Current

Ceded

Current

Net (Direct + Assumed - Ceded)

Current
## LTC Experience Reporting Form 2 ($000 Omitted)
### Direct Individual Experience - Stand-Alone Only

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## LONG-TERM CARE EXPERIENCE REPORTING FORM 3 LTC EXPERIENCE DEVELOPMENT ($000 OMITTED)

**REPORTING YEAR:** 20__

(To Be Filed By April 1)

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| PART 3 - Transferred Reserves |
|---|---|
| 1 Prior | | | | | | | | |
| 2 2012 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 3 2013 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 4 2014 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 5 2015 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 6 2016 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 7 2017 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 8 2018 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 9 2019 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |

| PART 4 - Present Value of Incurred Claims |
|---|---|
| 1 Prior | | | | | | | | |
| 2 2012 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 3 2013 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 4 2014 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 5 2015 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 6 2016 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 7 2017 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 8 2018 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
| 9 2019 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |
## LTC Experience Reporting Form 4 ($000 Omitted)

Direct Group Experience - Stand-Alone Only

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- Current (Comprehensive)
- Total Inception-to-date (Comprehensive)
- Current (Institutional only)
- Total Inception-to-date (Institutional only)
- Current (Non-Institutional only)
- Total Inception-to-date (Non-Institutional only)
- Current (Grand Total)
- Total Inception-to-date (Grand Total)
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Long-Term Care Insurance Experience Reporting Forms 1 Through 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue).

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident & health, and fraternal annual statement. The list of the various annual statements is: life, accident & health, and fraternal; property/casualty; and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.
Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve and experience fund would be the paid-up value and future incurred claims will be only for LTC benefits. If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve and experience fund will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.
Instructions for Form 1

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons are exhibited.

Form 1: Stand-Alone LTC Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Assumed/Ceded Rows
Does not include YRT reinsurance transactions. For columns that are designated with a $ rather than a $, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only
Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Health Companies
Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 2 - Incurred Claims
Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 3 – Claims Opened
The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 4 - Claims Closed
Number of claims that were closed during the year due to recovery, exhaustion of benefits, or death.
Column 5 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 6 – Terminations

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.

Column 7 – Policies/Certificates In-force at Year End

Total number of policies or certificates in force at the end of the year.

Column 8 – Lives In-force at Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 9 – Active Life Reserves

Total amount of active life reserves held for policyholders. The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health, and fraternal only.

The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.

Column 10 – Claim Reserves

Total amount of reserves held for payment of claims that have been incurred but not yet paid.

Column 11 – Other Reserves

Total amount of other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business.

A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.
Instructions for Form 2

Form 2 provides data on direct individual LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 2: Direct Individual Experience – Stand-Alone Only

Primary Issue Period Splits

Experience data for each policy form should be included in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Comprehensive
Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only
Policy forms that provide institutional coverage only.

Non-Institutional Only
Policy forms that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain inforce as of 12/31.

Column 2 – % Male Lives Insured

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.
Column 3 – Average Attained Age

Unweighted average of the attained ages of all inforce policyholders in the block.

Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

*Life, Accident & Health, Fraternal and Property/Casualty Only*

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

*Health Companies*

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, line 10.3

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses incurred by a specific year group of claimants. This form is to be prepared on a nationwide basis.

Report all dollar amounts in thousands ($000 omitted).

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.
Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year).

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.
Instructions for Form 4

Form 4 provides data on direct group LTC experience. Data are to be reported by base policy form. Rider forms will be reported with the base forms to which they are attached. Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

Form 4: Direct Group Experience – Stand-Alone Only

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of certificates.

Comprehensive
Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

Institutional Only
Certificates that provide institutional coverage only.

Non-Institutional Only
Certificates that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues
Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain inforce as of 12/31.

Column 2 – Third Party Funding
Indicate whether premiums are paid in whole or in part by a third party such as an employer. Example: If the level of third party funding is 25%, enter “25” in this column.

Calculate this in aggregate as [Third Party Premiums ÷ Total Premiums]

Column 3 – Average Attained Age
Unweighted average of the attained ages of all inforce certificate holders in the block.

Column 4 – Earned Premium
Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.
Column 5 – Incurred Claims

Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve. Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Lives In-force Year End

Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.

Column 7 – Terminations

Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – New Lives Insured

Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Instructions for Form 5

Form 5 is intended to provide data on a state-by-state basis in relation to LTC sales and claims experience. These lines are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on what is primarily a life policy or annuity contract.

Form 5: Standalone and Hybrid Products – Direct State Reporting

Definitions and Formulas

Current
Current calendar year of reporting.

Total Inception-to-Date
Aggregate experience data since issuance of policies.

Stand-alone LTC
An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Accelerated Benefits Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Extension of Benefit Riders
Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – State Code
The state for which data is being reported. Example: CA for California

Column 2 – New Lives Insured
Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

Column 3 – Lives In-force Year End
Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.
Column 4 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.

Column 5 – Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 6 – Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Refer to the instructions for incurred claims included in Form 3, Part 4.

Column 7 – Claims Remaining Open

Open claims are all claims that have not been closed as of the end of the year.

Column 8 – Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 9 - New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits, but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 10 – Accelerated Benefits Available

Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders.

Column 11 – Extended Benefits Available

Maximum amount of extended benefits available to policyholders with extension of benefit riders.
Requests of the LTC Valuation Work Group

- Develop a replacement mortality table for LTC active life reserves
  - Based on the 2012 Annuitant Mortality Table
  - Recommend a margin for conservatism
- Develop a replacement lapse table
  - Recommend a margin for conservatism
- Consider developing tables for valuation on total lives basis as well as active lives basis

Progress Since Fall National Meeting
- Completed review of actual-to-expected lapse on total lives basis
- Completed review of reasonableness of total terminations on total lives basis
- Developed mortality improvement from mid-point of exposure period, 2008 – 2011, to 2020 using scale G2
- Developed margins for lapse and mortality
- Developed lapse tables on an active lives basis

Remaining Tasks
- Develop mortality tables on an active lives basis
- Complete Report
### Recommended Underwriting Class Adjustment Factors for Mortality Table (Total Lives)

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### Recommended Group Lapse Table (Total Lives)

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### Data Credibility for Individual Lapses

- Minimum of Number of Individual Lapses and 1,082 (Full Credibility) by Issue Age Group and Policy Duration

### Data Credibility for Group Lapses

- Minimum of Number of Group Lapses and 1,082 (Full Credibility) by Issue Age Group and Policy Duration
Mortality Improvement to 2020

Recommended Mortality Improvement

- The study period is 2008 through 2011
- Recommend to apply improvement trend using the 2012 IAM G2 scale from 2010 to 2020 (11 years)
- Recommended tables represent industry experience as of 2020
- G2 scale applies to both total lives and active lives

Alternatives for Mortality Improvement

- The mortality tables can be made dynamic by continuing to apply the G2 scale to future valuation dates
- For first principle valuation approach, G2 scale can be applied to both active lives and disabled lives

Recommended Margins
Recommended Margins

- 10% for mortality
- 15% for lapse
- Same for total lives and active lives

Actual Total Lives Mortality to Expected (Based on Recommended Tables) By Company

Actual Individual Total Lives Lapses to Expected (Based on Recommended Tables) By Company

Actual to Expected Mortality Rates
(Expected Based on Recommended Tables)
Actual Total Lives Mortality to Expected By Policy Year

- Total Lives Actual to Expected Mortality
- Without and With Margins

- Policy Year

Actual Total Lives Mortality to Expected By Issue Age Group

- Total Lives Actual to Expected Mortality
- Without and With Margins

- Issue Age Group

Actual Total Lives Mortality to Expected By Marital Status and Underwriting Class

- Total Lives Actual to Expected Mortality
- Without and With Margins

- Marital Status
- Underwriting Class

Actual to Expected Lapse Rates

(Expected Based on Recommended)
Actual Individual Total Lives Lapses to Expected By Policy Year

- Without Margins
- With Margins

Policy Year

Without Margins
With Margins

Greater actual to expected ratios in later policy years are due to restricting non-increasing pattern in recommended rates by policy year.

Actual Individual Total Lives Lapses to Expected By Issue Age Group

- Without Margins
- With Margins

Issue Age Group

Without Margins
With Margins

Actual Individual Total Lives Lapses to Expected By Marital Status and Underwriting Class

- Married
- Not Married
- Preferred
- Standard
- Substandard

Actual Group Total Lives Lapses to Expected By Policy Year

- Without Margins
- With Margins
Actual Group Total Lives Lapses to Expected By Issue Age Group

Actual Individual Active Lives Lapses to Lapses By Policy Year

Actual Individual Active Lives Lapses to Expected Lapses By Issue Age Group

Actual Individual Active Lives Lapses to Expected Lapses By Marital Status and Underwriting Class
Actual Group Active Lives Lapses to Expected By Policy Year

Actual Group Active Lives Lapses to Expected By Issue Age Group

Actual to Expected Total Policy Termination Rates
(Mortality and Lapse Combined – Total Lives Only)

Actual Individual Total Lives to Expected by Mortality and Lapse
### Actual Group Total Lives Total Terminations to Expected by Issue Age Group

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### Additional Information

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Presentation Disclaimer

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Data

- Data collected on policies exposed between 1/1/2000 and 12/31/2016
- 18 companies submitted data
- Over 80% of all 2016 LTC Earned Premium
- Data requested was expanded from the previous study.
  New data collected:
  - Additional underwriting information
  - Expanded benefit information
  - ICD-9-CM/ICD-10-CM claim information

Status Update

- Completed steps
  - Validation and logic checks defined and programmed
  - Exposure calculations defined and implemented
  - Data validation
  - Contributor data has been validated, exposure calculated and initial database built
- To be completed
  - Build final database
  - Review of aggregated results
  - Database released
Deliverables

- A database of claim termination and incidence data including:
  - Report that defines the database and calculations
  - Summary of data collected
  - High-level results
  - Data will be HIPAA compliant and follow safe harbor reporting rules
    - Results for ages 90+ required to be grouped
    - Other grouping added to satisfy Safe Harbor while maintaining the highest level of detail as the prior study
  - Expected completion date: July 31, 2020
    - Four year lag between latest data collected and publication
    - Comparable to past LTC studies

Challenges of the current study

- Heightened awareness of HIPAA compliance by participating companies
  - Additional research into HIPAA compliance options
  - Contracting between data compiler and contributors
  - Data restrictions
  - Delays in data collection and reporting phases
The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Feb. 6, 2020. The following Subgroup members participated: Paul Lombardo, Chair (CT); Steve Ostlund (AL); Perry Kupferman (CA); Benjamin Ben (FL); Weston Trexler (ID); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); David Yetter (NC); Rhonda Ahrens (NE); David Sky (NH); Anna Krylova (NM); Laura Miller (OH); Tomasz Serbinowski (UT); and Joylynn Fix (WV). Also participating was: Sarah Neil (RI).

1. Discussed LTCI Cash Value Buyouts

Mr. Lombardo said the Subgroup will continue its discussion of pricing considerations for long-term care insurance (LTCI) cash value buyouts (CVBs) to policyholders in lieu of rate increases from its Jan. 6 conference call. He said CVBs offer policyholders an additional option that is beyond the scope of their existing LTCI contracts. He said most LTCI policies were not initially priced assuming CVBs would be offered. He said the amount of the CVB will likely be calculated as a percentage of the statutory reserve held for the given policy and that the percentage used is an important aspect of CVB considerations. He said the percentage needs to be high enough to appeal to policyholders, but not so high that it affects policyholders that continue their LTCI coverage.

Mr. Lombardo said possible factors influencing the CVB take-up rate by policyholders are: 1) the policyholder’s financial situation; 2) the policyholder’s attained age; and 3) the policyholder’s perception of needing long-term care (LTC) in the future. He said state insurance regulators have a responsibility to ensure that the election of CVBs does not result in harm to remaining policyholders or financial harm to insurers due to potential unpriced for increases in claims costs to the remaining block of policyholders. He said he thinks the balance of the statutory reserve that remains after the percentage of it is paid to policyholders electing CVBs should be earmarked for supporting the block of remaining policyholders. Mr. Andersen agreed that these reserve balances should be earmarked.

Mr. Lombardo said insurers that pay out CVBs should consider the effect of morbidity on the remaining block of policyholders for subsequent valuations of liabilities. Mr. Lombardo agreed and said he understands “morbidity” to include claim incidence, claim continuance and percent of maximum allowable benefit utilization. Mr. Andersen agreed with the components of morbidity.

Mr. Lombardo said the Subgroup should discuss whether CVBs should be one-time offers and how long after the offer of a CVB will policyholders be given to decide whether to elect it. He said the number and frequency of CVB offers have the potential to influence the degree of antiselection.

Jan Graeber (American Council of Life Insurers—ACLI) said the ACLI will meet with some of its member companies to discuss the issues above, as well as potential legal issues associated with the offering of CVBs. She said there are concerns that a policyholder or representative could sue an insurer if a CVB were elected, and the CVB recipient later required LTC, or that remaining policyholders could sue the insurer in response to rate increases or financial instability resulting from antiselection against the remaining block. She said ACLI members will also discuss potential tax ramifications to policyholders with tax-qualified LTCI policies upon election of a CVB. She said she will report the results of the ACLI member meeting to the Subgroup during a future conference call.

Ray Nelson (America’s Health Insurance Plans—AHIP) said discussions he has had with AHIP member companies indicate companies are interested in possibly offering CVBs and do not want this option to be prohibited. He said AHIP member companies have expressed the same concerns as those identified by the Subgroup.

Mr. Lombardo said he has discussed the possibility of offering CVBs to policyholders with three insurers. He said one insurer has analyzed the issues associated with CVBs and is interested in further consideration, and two insurers have not analyzed CVBs but are interested in considering offering them.

Ms. Neil asked Ms. Graeber and Mr. Nelson if either are aware of insurers currently offering CVBs. Ms. Graeber and Mr. Nelson said they are not aware if any insurers are or are not. Mr. Lombardo asked Ms. Graeber to ask ACLI members at
the upcoming ACLI meeting if any are currently offering CVBs. Ms. Graeber said she will consult with ACLI legal staff to determine if this is information she can share with the Subgroup.

Mr. Lombardo said the concept of CVBs is also being discussed in one of the workstreams of the Long-Term Care Insurance (EX) Task Force and that Subgroup members might assist the Task Force in this effort.

2. Discussed LTCI Hybrid Products

Mr. Lombardo said there have been recent discussions in the Connecticut Legislature concerning the ability of stand-alone LTCI policyholders to convert their policies to some form of hybrid LTCI policy, using some of the accumulated value of the stand-alone policy to offset the cost of the hybrid policy. He asked if others think this proposal is feasible.

Birny Birnbaum (Center for Economic Justice—CEJ) said there may be issues with calculating what value will be assigned to cancelling the stand-alone coverage that will be transferred to the hybrid coverage that are similar to calculating a CVB value.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.

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The Long-Term Care Pricing (B) Subgroup of the Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met via conference call Jan. 6, 2020. The following Subgroup members participated: Paul Lombardo, Chair (CT); Steve Ostlund (AL); Perry Kupferman (CA); Marti Hooper (ME); Fred Andersen (MN); William Leung (MO); Rhonda Ahrens (NE); Anna Krylova (NM); David Yetter (NC); Laura Miller (OH); Raja Malkani (TX); Tomasz Serbinowski (UT); and Joylynn Fix (WV).

1. Discussed LTCI Cash Value Buyouts

Mr. Lombardo said the Subgroup will discuss pricing considerations for long-term care insurance (LTCI) cash value buyouts (CVBs) to policyholders in lieu of rate increases. He said he does not believe most LTCI carriers account for the option of CVBs to policyholders in their initial pricing. He said this may subject carriers to antiselection, and they may become financially disadvantaged in the event policyholders elect CVBs.

Mr. Andersen said he and other state insurance regulators have begun a study of the mathematical aspects of the impacts on policyholders who elect a CVB and the effect on the remaining block of policyholders. He said state insurance regulators’ main concern is that the remaining policyholders may be in a worse position after others have opted for CVBs. He said preliminary findings indicate three factors may influence whether CVB election will harm remaining policyholders. He said the first factor is the amount of the CVB, such as if it is calculated as a percentage of held statutory reserves within a given rating cell, where the risk of harm to remaining policyholders increases as the percentage applied increases. He said the second factor is the percentage of policyholders opting for CVBs, with increasing percentages increasing the risk to remaining policyholders. He said the third factor is the degree of antiselection that may occur if healthier policyholders opt for CVBs, resulting in higher-than-anticipated claims costs among the pool of remaining policyholders.

Mr. Andersen said three factors were identified that may contribute to antiselection in the presence of CVBs. He said it is possible that policyholders that elect CVBs tend to be more likely to lapse in general, whether or not a CVB is offered. He said there may be a tendency for policyholders that are aware that they are likely to die soon to elect CVBs, and when such individuals are no longer in the pool of remaining policyholders, the reduction in remaining pool mortality may result in claims costs in excess of those initially priced for. He said there may be a tendency for policyholders that have expectations that they will have lower-than-average long-term care (LTC) claims costs to elect CVBs, and when such individuals are no longer in the pool of remaining policyholders, the reduction in remaining pool morbidity may result in claims costs in excess of those initially priced for.

Ms. Ahrens said the Nebraska Department of Insurance (DOI) is generally not in favor of CVBs, as it is difficult to determine the effect that policyholder election of CVBs will have on the remaining policyholder block’s experience. She said there are other options for policyholders, and the DOI questions what purpose offering CVBs serves. She said CVBs are extra-contractual benefits and do not preserve insurance benefits.

Mr. Kupferman said he thinks the percentage of policyholders that opt for CVBs is very small. Mr. Serbinowski said since the percentage of policyholders that will elect CVBs is likely small, the Utah Insurance Department likely would not prohibit an insurer from offering CVBs.

Mr. Lombardo said that some policyholders that are eligible for CVBs may also be eligible for nonforfeiture benefits (NFBs), and the CVB will likely be much greater than the NFB amount. He asked if the CVB is in lieu of, and not in addition to, the NFB. Mr. Andersen said he believes the CVB is in lieu of the NFB.

Mr. Andersen said he and other state insurance regulators discussed a scenario where the offered CVB is a low percentage of the held statutory reserve, and the insurer expects to experience a financial gain when the CVB is elected. He asked if state insurance regulators should require the insurer to hold this gain as a reserve for the block of remaining policyholders. He said if this is required, state insurance regulators will need to determine how to measure the amount of the gain.
Jan Graeber (American Council of Life Insurers—ACLI) said she will survey ACLI member companies for their input related to offering CVBs to policyholders, and policyholder take-up rates on the various reduced benefit and nonforfeiture options offered. She said she estimates, in general, that 92% of policyholders presented with a rate increase choose to continue coverage at the unmodified increased premium level. Ray Nelson (America’s Health Insurance Plans—AHIP) said he will survey AHIP member companies for the same information.

Mr. Lombardo said the Subgroup will continue to discuss and analyze CVB options.

Having no further business, the Long-Term Care Pricing (B) Subgroup adjourned.
ACADEMY PROFESSIONALISM TALKING POINTS FOR HATF

Immediate Past President of the American Academy of Actuaries Shawna Ackerman said that the Academy will host a professionalism webinar, “In Times of Uncertainty, Professionalism is Certain,” on August 20, and noted that government regulators are invited free of charge. She also highlighted the Academy’s Annual Meeting and Public Policy Forum on November 5-6 in Washington, D.C., the Life and Health Qualifications Seminar, to be held November 9 – 12 in Arlington, VA, and the Academy’s COVID-19 Resource Page.

Actuarial Standards Board (ASB) Chairperson Kathy Riley gave an overview of revisions to actuarial standards of practice in the health area. ASOP No. 28, now titled Statements of Actuarial Opinion Regarding Health Insurance Assets and Liabilities is open for comment through November 13, 2020. The ASB is requesting that comments be submitted via the new Comment Template, which is designed to encourage commentators to provide suggested edits and the rationale for those edits to enable the ASB to better understand the commentators’ concerns.

The ASB will review exposure drafts of revisions to ASOP No. 3, Continuing Care Retirement Communities, in September, and ASOP No. 18, Long-Term Care Insurance, in December.

The comment period on the first exposure draft of a revision to ASOP No. 11, Reinsurance Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports, ended on June 30, 2020. Two comments were received, one each from the Academy’s Life Practice Council and Health Practice Council. The ASB is scheduled to review the next version of the ASOP at its December meeting.

With respect to cross-practice ASOPs, ASOP No. 56, Modeling, will be effective for work performed on or after October 1, 2020. The ASB began a review of a third exposure draft of the new ASOP on assumptions at its March meeting and will continue the review in September.

In 2014, the ASB had reviewed and approved a revision to ASOP No. 38, now titled Catastrophe Modeling (for all Practice Areas). The revised ASOP No. 38 was held while the Modeling ASOP was developed. The ASOP No. 38 Task Force has reconvened and is reviewing the ASOP in light of the guidance in ASOP No. 56. The ASB expects to review an exposure draft of ASOP No. 38 at its September meeting.

Actuarial Board for Counseling and Discipline (ABCD) member Godfrey Perrott reviewed ABCD activity since the Dec. 2019. The complaints the ABCD completed do not raise issues germane to the NAIC, as most were pension specific. The requests for guidance (RFGs) the ABCD has addressed (72) have covered a wide range of issues. In the health practice area, RFGs have covered qualification for the NAIC Health Blank, disclosure (missing data, optimistic assumptions, etc.), steps to resign as Appointed Actuary, and contingent fees.
American Academy of Actuaries
Health Practice Council Highlights
To the National Association of Insurance Commissioners (NAIC)
Health Actuarial Task Force (HATF)
Tuesday, Aug. 4

- The Health Practice Council (HPC) has continued to actively engage policymakers and regulators in the months since the last NAIC national meeting where HATF has met.

- The HPC has, not surprisingly, been actively engaged in work streams to address implications surrounding the COVID-19 pandemic and its impact on health care including the potential effects of COVID-19 on health insurance markets, consumers, and public programs. The HPC has produced two sets of frequently asked questions (FAQs), on the coronavirus’ effect on the individual and small group markets and on Medicaid.

- In addition HPC committee members have been having conversations with public policy makers including congressional members and committee offices, the Congressional Budget Office, and Congressional Research Service.

- The HPC has also been offering informational virtual forums on COVID-19-related issues, including participating in webinars covering cross-actuarial-practice issues and on a focused regulatory perspective on 2021 ratefilings.

- In addition, the HPC hosted a web briefing in late June for policymakers on issues involved in these 2021 health insurance premium drivers and risk mitigation mechanisms. We had previously published issue briefs on those topics.

- Another focus of the HPC is exploring Health Equity. We are planning on a webinar exploring issues involved in that in the next month or so.

- Before the stay at home orders took effect earlier this year, the HPC held its annual Capitol Hill visits, where volunteers and Academy staff met with congressional leadership, and committee and personal offices, along with a number of federal agencies/departments. Much of this year’s Hill discussions focused on recent HPC publications, including Telehealth, Surprise Medical Bills, Long-Term Care Insurance, and Medicaid. The rising costs of health care, especially on prescription drugs, was a topic of discussion in the meetings as well as the implications of recent legislative and regulatory actions on the individual, small, and large group markets.

- In the May/June edition of Contingencies, members of the Social Determinates of Health (SDOH) subcommittee had an article published, “Toward a More Holistic Look at Wellness,” examining a broad array of issues contributing to an individual’s health and wellness. Also, in the same issue, the Health Practice International Committee (HPIC) submitted a published article, “It’s an Opioid World,” a look at the international opioid crisis.

We also have many initiatives under way within the HPC and its committees, including:

- We have exposed for comment a new practice note on ASOP No. 6 (*Development of Age-Specific Retiree Health Cost Assumptions for Pooled Health Plans, Including Applications to Non-Pooled Health Plans*), to provide information for actuaries valuing retiree health benefit plans. Comments on the exposure draft are due to the Academy by September 30, 2020.

- With the exposure period for the Actuarial Memorandum Practice Note now concluded, the drafting group is now reviewing comments received and expects to public a final practice note soon.

- We have multiple projects underway under Long-term Care: including groups working on LTC Actuarial Equivalence and on COVID-19 papers.

- We are developing a paper on Telehealth with a renewed focus now on the impact of COVID-19. We had previously published an issue brief in 2019, but given the experience of the past few months have decided that we need to revisit the topic.

- Other coronavirus possible workstreams underway include a focus on Medicare and on an international comparison study of how different countries have responded to the pandemic.

- Also on the international front, the Academy’s Health Practice International Committee along with the SOA International Section, and the International Actuarial Association Health Section have been compiling we are nearing completion of schematic diagrams, or a grid, if you will, to capture the main features of health financing systems and funding schemes for about 30 countries.

- The Academy’s 2020 Annual Meeting and Public Policy Forum is November 5-6 will feature sessions on the Future of Health Care Delivery as impacted by COVID-19, a session on International Health Funding, and regulatory changes including those precipitated by the pandemic on ACA markets, Medicare and Medicaid.

- Finally, I am pleased to inform you, if you have not already received the news, that Al Schmitz will be the next Academy Vice President, taking over from Audrey Halvorson during the annual meeting.
REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Aug. 4, 2020, Minutes ................................................................. 7-186
Regulatory Framework (B) Task Force Feb. 20, 2020, Minutes (Attachment One) ................................. 7-190
Regulatory Framework (B) Task Force 2020 Revised Charges (Attachment One-A) ........................... 7-191
Accident and Sickness Insurance Minimum Standards (B) Subgroup Dec. 16, 2019, Minutes
(Attachment Two) ....................................................................................................................................... 7-193
ERISA (B) Working Group July 31, 2020, Minutes (Attachment Three) ....................................................... 7-195
HMO Issues (B) Subgroup July 13, 2020, Minutes (Attachment Four) ............................................................. 7-197
HMO Issues (B) Subgroup June 11, 2020, Minutes (Attachment Four-A) ...................................................... 7-198
Health Maintenance Organization Model Act (#430), July 13, 2020, Draft (Attachment Four-B) .......... 7-200
MHPAEA (B) Working Group July 28, 2020, Minutes (Attachment Five) ...................................................... 7-232
MHPAEA (B) Working Group June 24, 2020, Minutes (Attachment Five-A) ................................................. 7-234
MHPAEA (B) Working Group June 5, 2020, Minutes (Attachment Five-A1) ............................................... 7-236
MHPAEA (B) Working Group March 19, 2020, Minutes (Attachment Five-A1a) ...................................... 7-238
MHPAEA (B) Working Group March 9, 2020, Minutes (Attachment Five-A1b) ........................................ 7-240
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup July 16, 2020, Minutes (Attachment Six) .... 7-242
[State] Pharmacy Benefit Manager Licensure and Regulation Model Act, July 6, 2020, Draft
(Attachment Six-A) .................................................................................................................................. 7-244
The Regulatory Framework (B) Task Force met Aug. 4, 2020. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramge, Vice Chair (NE); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Steve Ostlund and Yada Horace (AL); Alan McClain (AR); Ricardo Lara represented by Tyler McKinney (CA); Karima M. Woods (DC); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Robert H. Muriel represented by Kate Morthland (IL); Vicki Schmidt represented by Justin McFarland and Craig Van Aalst (KS); Sharon P. Clark represented by DJ Wasson (KY); Gary Anderson represented by Kevin Beagan (MA); Eric A. Cioppa (ME); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread (ND); Chris Nicolopoulos represented by Maureen Belanger (NH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Northrup and Jaakob Sundberg (UT); Scott A. White represented by Julie Blauvelt and Don Beatty (VA); Mike Kreidler (WA); Mark Afable represented by Nathan Houdek (WI); and James A. Dodrill (WV).

1. **Adopted its Feb. 20 and 2019 Fall National Meeting Minutes**

The Task Force met Feb. 20 and Dec. 7, 2019. During its Feb. 20 meeting, the Task Force appointed the MHPAEA (B) Working Group and adopted its 2020 proposed charges.

Ms. Kruger made a motion, seconded by Commissioner Godfread, to adopt the Task Force’s Feb. 20 (Attachment One) and Dec. 7, 2019, (see NAIC Proceedings – Fall 2019, Regulatory Framework (B) Task Force) minutes. The motion passed unanimously.

2. **Adopted its Subgroup and Working Group Reports**

Director Ramge made a motion, seconded by Mr. Trexler, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Dec. 16, 2019, minutes (Attachment Two); the ERISA (B) Working Group (Attachment Three); the HMO Issues (B) Subgroup, including its July 13 minutes (Attachment Four); the MHPAEA (B) Working Group (Attachment Five); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 16 minutes (Attachment Six). The motion passed unanimously.

Commissioner Conway said in adopting the HMO Issues (B) Subgroup report, the Task Force is not adopting the proposed revisions to the Health Maintenance Organization Model Act (#430). He said the Task Force will meet via conference call in September to consider adoption of the proposed revisions.

3. **Heard an Update on the CHIR’s Work Related to the ACA**

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR’s work related to the federal Affordable Care Act (ACA) and other issues of interest to state insurance regulators. He highlighted the work the CHIR has been doing related to the COVID-19 pandemic. He said the CHIR has set up a tracking map and database concerning state decisions related to coverage requirements during the pandemic. He said the CHIR has written several issue briefs related to the COVID-19 pandemic. With the support of the Robert Wood Johnson Foundation (RWJF), the CHIR recently issued a research brief trying to gain insight into the insurer perspective regarding coverage decisions during the pandemic. The research brief is based on interviews conducted between late April and June with 25 executives from health insurance plans.

Mr. Giovannelli said the CHIR is continuing its work to track and analyze state regulatory approaches to short-term, limited-duration (STLD) plans in the wake of recent federal rule changes with respect to these products. He said the CHIR is also continuing to track state reforms affecting the individual market, including state actions involving the ACA’s section 1332 waiver program and improving the affordability of comprehensive coverage. He said the CHIR anticipates publishing an issue brief examining state reinsurance programs developed under the section 1332 waiver program. He said initial findings have shown that state reinsurance programs have had a positive effect in terms of creating individual market stability because such programs make coverage more affordable for individuals not eligible for premium subsidies. He suggested that state insurance...
regulators may want to consider looking beyond reinsurance programs and/or looking at options to provide additional individual market stability that might work in tandem with state reinsurance programs to provide stability and benefits to all market participants, including those who are receiving premium subsidies.

Mr. Giovannelli discussed the CHIR’s ongoing state technical assistance regarding insurance regulatory matters with the support of the RWJF through its State Health and Value Strategies Program. He also highlighted the CHIR’s assistance, provided with the support by the Laura and John Arnold Foundation (LJAF), to state and federal policymakers regarding regulatory approaches to balance billing.

Commissioner Conway said Colorado enacted legislation last year providing additional funding to allow the Colorado Department of Insurance (DOI) to look at ways to use its reinsurance program in tandem with other initiatives to provide additional individual market stability. He expressed interest in having additional discussions with the CHIR and other experts on this topic.

4. Heard a Panel Presentation on HCSMs

Mr. Giovannelli provided an overview of health care sharing ministries (HCSMs). He discussed consumer confusion involving HCSMs. He said although HCSMs are careful to say they are not insurance, to consumers, they look like traditional health insurance coverage for a number of reasons, including: 1) the use of defined benefit packages; 2) monthly payment requirements similar to premiums; 3) the use of provider networks; and 4) cost-sharing requirements, such as deductibles, copayment and co-insurance limits. In addition, he said some HCSMs use insurance brokers to sell their plans, and they have marketing campaigns that describe HCSM plans as a replacement for insurance or suggest that consumers can rely on HCSMs for financial protection. He highlighted some examples from HCSM advertising and marketing materials illustrating these concerns and why consumers may be led to believe HCSM plans are traditional health insurance plans.

Mr. Giovannelli discussed potential harms to consumers and the individual health insurance market related to HCSMs, such as: 1) misaligned expectations that their claims will be paid; and 2) risk segmentation and undermining the traditional health insurance market. He also discussed the current regulatory framework for HCSMs, noting that neither the federal mandate exemption under the ACA nor any other federal provision preempts state regulatory authority over HCSMs, and that states can, and some do, set standards for HCSMs, which they enforce.

Mr. Giovannelli offered several regulatory options regarding the regulation of HCSMs, including: 1) active, ongoing oversight to ensure compliance with state standards, such as including demonstration of compliance at the front-end through a registration requirement; 2) prohibiting HCSMs from offering financial incentives for enrollment; and 3) prohibiting marketing materials that suggest that an HCSM is operating in a financially sound manner or that it has had a successful history of meeting subscribers’ financial or medical needs.

Joel Noble (Samaritan Ministries) described Samaritan Ministries’ approach to meeting its members’ health care needs. He said Samaritan Ministries coordinates and connects members to care for the whole need with prayer, encouragement and financial support. Samaritan Ministries believes health care needs are multi-dimensional—emotional and spiritual—as much as physical and financial. Samaritan Ministries has been operating for just over 25 years. Currently, over $30 million is shared each month among over 270,000 members nationwide.

Mr. Noble discussed Samaritan Ministries’ best practices, found at https://www.samaritanministries.org/bestpractices, that it believes all HCSMs should follow. The best practices suggest that an HCSM should: 1) act primarily as a facilitator for the bearing of medical burdens through the voluntary medical burden-sharing process, which does not include the pooling of funds; 2) not assume any transfer of medical risk form its members or make any guarantee of payment for any member medical expenses; 3) conform with the statutory definition of a qualifying HCSM, as required under the ACA; 4) not require its members to apply for government assistance or state aid as part of the ministry’s sharing; 5) ideally not use health insurance agents or brokers to enroll members into the ministry; and 6) clearly communicate in its marketing and advertising materials that the HCSM is not an insurance company. The sharing of medical costs is completely voluntary, and members maintain their legal responsibility to pay their medical bills irrespective of whether they receive payment from the voluntary actions of other members of the ministry through the sharing process.

Mr. Noble said Samaritan Ministries values transparency, and it would not find it burdensome to report information annually if a state mandates such a requirement for HCSMs. He explained that Samaritan Ministries routinely shares financial and other information with state agencies, upon request, and its members. However, he expressed concern with non-insurance entities, such as HCSMs, registering with a state DOI because HCSMs are section 501(c)(3) charities, and they should not be subject...
to any portion of the insurance code. As a charity, HCSMs should be regulated by the state attorney general’s office, and they should be subject to the same state laws that apply to other charities. However, Mr. Noble acknowledged that state DOIs do receive calls from consumers about HCSMs. To address this, he suggested that any information a HCSM shares with the state attorney general’s office should be shared with the state DOI.

Commissioner Conway discussed problems that Colorado has had with the marketing by some HCSMs that lead consumers to believe that they are offering a traditional insurance product. He asked Mr. Noble why Samaritan Ministries’ best practices do not specifically address this issue by specifically suggesting that an HCSM should not use insurance terms in their marketing materials. Mr. Noble said an HCSM’s marketing material should make it clear that the HCSM product is not an insurance product and not use insurance terms. He said Massachusetts has included in its HCSM regulations a prohibition on the use of confusion language and the use insurance terms like “coverage” or “deductible.” He agreed with Commissioner Conway’s concerns related to this issue.

Mr. Sundberg asked Mr. Noble if Samaritan Ministries used actuaries to set the level of monthly members sharing. Mr. Noble said Samaritan Ministries does not use actuaries. He said Samaritan Ministries looks at health care trends and monitors health care costs. Commissioner Conway asked what Samaritan Ministries uses to price the product if it does not employ actuaries. Mr. Noble said because the sharing is member-to-member, Samaritan Ministries is dealing with medical bills after they have been incurred. He said actuaries make assumptions about future events and set premium rates based on those assumptions. HCSMs are dealing with actual medical events after they have happened. Mr. Noble said Samaritan Ministries deals with this situation by including a pro rata provision in its member agreements, such that if the sharing needs exceed the monthly shares, then the sharing is at a pro rata rate. He explained that if such a short fall occurs three times in a row, then under Samaritan Ministries’ guidelines, its members can vote to increase their monthly share amounts to address the current shortfall and avoid future shortfalls.

Commissioner Conway asked Mr. Noble about Samaritan Ministries’ position on the payment of commissions to individuals who enroll people into its HCSM products. Mr. Noble said Samaritan Ministries does not support the payment of commissions because it could lead to possible fraudulent and deceptive practices surrounding enrollment that could be harmful to consumers.

5. Heard a Discussion on Premium Holidays, Early MLR Rebate Payments, and Adjustments to Cost-Sharing Benefits as a Result of Fewer Claims Filings in 2020 Due to COVID-19

Jason Levitis (Levitis Strategies LLC) said as many know, the COVID-19 pandemic has led to a substantial reduction in commercial health insurance claims, partly because consumers are avoiding non-urgent health care. He said some health insurers, particularly in the Medicare market, have responded with premium holidays or rebates. He said with respect to premium holidays and rebates, many state insurance regulators have been supportive of providing rebates and premium holidays to consumers, but it is unclear whether federal rules permit it, particularly with respect to individuals receiving coverage through the health insurance exchanges. He noted that the federal Centers for Medicare & Medicaid Services (CMS) have said subject to the states allowing it, pre-payment of medical loss ratio (MLR) rebates are allowed as an avenue for providing premium discounts; but again, the issue is how to apply it and its implications for those receiving coverage through the health insurance exchanges in light of advanced premium tax credits (APTCs). He said if the CMS does not address the premium holiday and rebating issue, then insurers could be receiving too much money when the rebate lowers the premium amount due; and consumers may be on the hook for paying back the excess amount when they file their taxes. He posed several questions that the CMS needs to consider in issuing any guidance to address this issue, including: 1) the financial impact on consumers; 2) the potential administrative burden on consumers; and 3) the impact on carriers.

Randy Pate (Center for Consumer Information and Insurance Oversight—CCIIO) discussed the CMS’s current work related to the COVID-19 health emergency. He said while focusing on the health emergency, the CMS and the CCIIO are also focusing on the upcoming open enrollment period for 2021, and they are continuing their focus on increasing competition in the individual market and lowering premiums to make health care coverage more affordable. Mr. Pate said while he was speaking, the CMS just released guidance on a new temporary policy that will allow issuers to offer temporary premium reductions for individuals with 2020 coverage in the individual and small group markets. The guidance can be found at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Premium-Credit-Guidance.pdf. Mr. Pate provided a general overview of the guidance provisions, noting that it touches on the questions Mr. Levitis posed, such as how the premium reductions will be reported to the Internal Revenue Service (IRS). Mr. Pate said the guidance requires that the premium reduction be a fixed percentage and be prospective only. He also said that he anticipates future rulemaking to address some of the questions that Mr. Levitis raised.
Commissioner Conway asked about carriers who have already provided rebates or premium holidays. Mr. Pate said these carriers should submit the template to the CMS outlining what they have done, which the CMS will review. He said he anticipates the CMS providing flexibility to these insurers. Commissioner Conway asked Mr. Pate what he anticipates will be included in future rulemaking that he anticipates the CMS issuing. Mr. Pate said future rulemaking will most likely address risk adjustment issues.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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The Regulatory Framework (B) Task Force met via conference call Feb. 20, 2020. The following Task Force members participated: Michael Conway, Chair (CO); Bruce R. Ramge, Vice Chair, represented by Martin Swanson (NE); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Anthony Williams (AL); Allen W. Kerr represented by Mel Anderson and William Lacy (AR); Ricardo Lara represented by Tyler McKinney (CA); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Kathy McGill, Fernanda Vallejo and October Nickel (ID); Robert H. Muriel represented by Eric Anderson and Sara Stanberry (IL); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary Anderson represented by Kevin Beagan (MA); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska and Sara Gerving (ND); Alexander K. Feldvebel represented by Karen McCallister (NH); Andrew R. Stolli represented by Gayle L. Woods (OR); Jessica K. Altman represented by Michael Humphreys and Katie Dzurec (PA); Raymond G. Farmer represented by Shari Miles (SC); Larry D. Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Rachel Bowden and Matthew Tarpley (TX); Todd E. Kiser represented by Jaakob Sundberg and Heidi Clausen (UT); Scott A. White represented by Yolanda Tennyson (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and James A. Dodrill represented by Ellen Potter and Tonya Gillespie (WV).

1. Appointed the MHPAEA (B) Working Group and Adopted its 2020 Revised Charges

Commissioner Conway said that prior to the conference call, NAIC staff distributed revised Task Force 2020 charges. He explained that the revised charges add charges for the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group. He said that during this call, the Task Force will consider two motions: 1) a motion to appoint the MHPAEA (B) Working Group; and 2) a motion to adopt the Task Force’s revised 2020 charges adding the charges for the Working Group.

Ms. Kruger made a motion, seconded by Director Lindley-Myers, to appoint the MHPAEA (B) Working Group. The motion passed unanimously.

Director Lindley-Myers made a motion, seconded by Ms. Kruger, to adopt the Task Force’s 2020 revised charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
2020 REVISED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

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

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

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

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

5. The MHPAEA (B) Working Group will:
   A. Monitor, report and analyze developments related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate and coordinate best practices with the states, the DOL and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.
6. The **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup** will:
   A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call Dec. 16, 2019. The following Subgroup members participated: Melinda Domzalski-Hansen, Co-Chair (MN); Glen Mulready, Co-Chair, represented by Buddy Combs (OK); Debra Judy (CO); Chris Struk (FL); Gayle Woods (OR); Katie Dzurec (PA); Shari Miles (SC); Rachel Bowden (TX); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet (VT); Andrea Philhower (WA); and Jennifer Stegall (WI).

1. Continued Discussion of the July 30 Comments on Sections 1–5 of Model #171

Ms. Domzalski-Hansen said the purpose of today’s conference call is for the Subgroup to continue its discussion section-by-section of the comments received by the July 30 public comment deadline on Sections 1–5 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), beginning with Section 5L, the definition of “preexisting condition.” She reminded the Subgroup of its discussion of Section 5L during its Nov. 25 conference call.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) reiterated the purpose of the NAIC consumer representatives’ suggested revisions to the definition of “preexisting condition,” which is to provide an objective definition of the term for consumers because the prudent layperson standard is hard for consumers to understand when completing an application with respect to previous or current health conditions, and the suggested revised language is easier for consumers to understand. She reiterated the concern that consumers may not know they have a medical condition, but after completing an application, the consumer discovers he or her physician included the possibility of a consumer having a certain medical condition in the physician’s notes. Chris Petersen (Arbor Strategies LLC) said the Subgroup needed to review Section 7 of the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170), which establishes standards related to coverage of preexisting conditions. He suggested that this provision affects the changes the Subgroup can make to the definition of “preexisting condition” in Section 5L. The Subgroup discussed Mr. Petersen’s comments. After discussion, the Subgroup agreed to move the provision highlighted by the Missouri DOI to the appropriate provision or provisions in Section 7—Accident and Sickness Minimum Standards for Benefits.

The Subgroup next discussed Section 5M, the definition of “residual disability.” Ms. Domzalski-Hansen said the Missouri Department of Insurance (DOI) submitted comments on Section 5M suggesting that certain language in the definition should be moved to a substantive provision in Model #171. After discussion, the Subgroup agreed to move the language in Section 7-193.

The Subgroup next discussed Section 5N, the definition of “sickness.” The Subgroup discussed the Missouri DOI’s comments on Section 5N suggesting clarifying changes to the language and moving some of the language to a substantive provision in Model #171. Ms. Lueck said the NAIC consumer representatives also submitted comments on Section 5N suggesting the addition of a drafting note related to the application of any probationary period to a preexisting condition exclusion period. The Subgroup discussed the meaning of probationary period versus waiting period. Ms. Lueck asked about the impact of the Subgroup moving provisions in the various definitions in Section 5 to substantive provisions in Model #171 and whether, after moving the language, if the language would still be considered a minimum standard. The Subgroup discussed and agreed that such language would still be considered a minimum standard.

The Subgroup discussed whether to add the NAIC consumer representatives’ suggested drafting note to Section 5N. The Subgroup decided to add the drafting note. J.P. Wieske (Horizon Government Affairs—HGA) suggested that the proposed drafting note may not be needed if the Subgroup reworks the language in Section 5N to clarify the difference between a probationary period and a waiting period. Ms. Domzalski-Hansen suggested that the Subgroup revisit the language in Section 5N.
Section 5N when it discusses Section 6—Prohibited Policy Provisions. Mr. Petersen volunteered to poll his membership about the appropriate terms, “probationary period” versus “waiting period,” currently being used by industry.

Mollie Zito (UnitedHealthcare) said UnitedHealthcare is withdrawing its comments on Section 5N.

Ms. Domzalski-Hansen said that in order to keep the Subgroup’s discussion moving forward following completion of its review of Section 5, she suggests the Subgroup set a public comment period ending Feb. 7, 2020, to receive comments on Section 6—Prohibited Policy Provisions and Section 7—Accident and Sickness Minimum Standards for Benefits. There was no objection to her suggestion.

Ms. Domzalski-Hansen reiterated the Subgroup’s request for additional information on the issues it discussed related to Section 5L, the definition of “preexisting condition.” She said that following the Subgroup conference call, she would work with NAIC staff to compose an email requesting the information for distribution to Subgroup members and interested parties.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call July 31, 2020. The following Working Group members participated: Robert Wake, Chair (ME); Steve Ostlund (AL); Jim Brader (AR); Kate Harris and Jason Lapham (CO); Howard Liebers (DC); Angela Burke Boston (IA); Mark McCallin and Craig Van Aalst (KS); Grace Arnold and Jonathan Kelly (MN); Camille Anderson-Weddle, Danielle K. Smith and Carrie Couch (MO); Laura Arp (NE); Alexia Emmermann (NV); Laura Miller (OH); Cuc Nguyen (OK); Travis Jordan (SD); Raja Malkani, Rachel Bowden and David Bolduc (TX); Tanji Northrup (UT); Molly Nollette (WA); and Richard Wicka (WI). Also participating were: Sarah Bailey (AK) Bruce Hinze and Sheirin Ghoddoucy (CA); Fleur McKendell (DE); James Dunn III (FL); Arlene Ige and Jason Asaeda (HI); Weston Trexler and October Nickel (ID); Elizabeth Nunes (IL); Claire Szpara (IN); Glynda Daniels and Mary Kwei (MD); Karen Dennis (MI); Mike Chaney (MS); Diana Sherman (NJ); Paige Duhamel (NM); Colleen Runsey (NY); Tasha Sizemore (OR); Katie Dzurec (PA); Thomas Baldwin, Daniel Morris and Ryan Basnett (SC); Brian Hoffmeister and Bill Huddleston (TN); Julie Blauvelt (VA); Marcia Violette and Jill Rickard (VT); Greg Elam and Ellen Potter (WV); and Denise Burke and Amanda Tarr (WY).

1. **Adopted its 2019 Fall National Meeting Minutes**

   Mr. Wicka made a motion, seconded by Ms. Arp, to adopt the Working Group’s Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Regulatory Framework Task Force, Attachment Eight). The motion passed unanimously.

2. **Discussed the Working Group’s Focus for 2021**

   Mr. Wake said the single item on the Working Group’s open agenda was to discuss what projects the Working Group might want to focus on in the coming year. He said that the Working Group had discussed developing a best practices document for state regulation of multiple employer welfare arrangements (MEWAs) and association health plans (AHPs), both fully insured and self-funded. He said up to this point, there was not clear support to pursue this task pending the appeal of the District Court for the District of Columbia ruling in *New York v. U.S. Department of Labor*, which vacated critical portions of the U.S. Department of Labor’s (DOL) final rule on AHPs.

   Mr. Wake also mentioned the *Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220)*. This model was developed by the ERISA (B) Working Group and adopted by the NAIC in 2010. It has not been adopted in the states, but Mr. Wake suggested that it might be worth taking another look at this model to see if it contains any tools that could be helpful to states as they look to address illegal MEWAs. Mr. Wake explained that the genesis for Model #220 is that often licensed entities, whether deliberately or unwittingly, are involved with sham health plans. Model #220 is designed to require licensed persons and entities to establish and follow responsible procedures to identify and report illegal health insurers. Jennifer Cook (NAIC) also mentioned that at about the same time that this model was adopted, the Working Group developed an insurer and producer bulletin, as well as a consumer alert, on the same topic. Ms. Cook offered to distribute them to the Working Group.

   Mr. Wake asked for feedback on the idea of looking at Model #220. Ms. Seip asked about the harm that Model #220 is designed to address. Mr. Wake said the harm is that people will be defrauded by illegal and unlicensed health plans, and by having licensed entities undertake the procedures in Model #220, consumers will be protected from entities offering fraudulent or otherwise illegal health care coverage. Mr. Lapham said when legitimate players in the market align themselves with questionable, or illegitimate, entities, those bad actors capitalize on the respectability of the legitimate entities and are able to influence not only their potential customers, but also state insurance regulators investigating an entity. Ms. Arp said that provider networks often contract with multiple entities, both fully insured and self-insured, some legitimate, others not and some in between. She said it would certainly make investigating some of these entities a lot easier if there was a way to see a list of the entities a provider network has relationships with. Mr. Wake said that often carriers rent out their networks to self-funded plans and sometimes can have hundreds of clients, so they will not necessarily know exactly who all of them are, but they should have some kind of vetting process in place. He said he would be interested in hearing from the industry about what best practices might be and what state insurance regulators might be able to learn from that. Mr. Wake mentioned that the M-
filings have turned out to be hugely helpful in identifying entities operating in a state without that state’s knowledge. Mr. Wake pointed out that finding illegal health plans can be complicated. He mentioned a case in Maine where a nationwide plan advertised that it had the best provider network, except that the network did not actually have any providers in Maine. Or a plan that advertises that it does not have any copays or deductibles, but it does not have any coverage either. He explained that he mentions these cases to illustrate that there is not always a single answer to what is a complicated, multi-faceted problem of illegal and fraudulent health plans.

Having no further business, the ERISA (B) Working Group adjourned.
The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 13, 2020. The following Subgroup members participated: Don Beatty, Chair (VA); Keith Warburton (CO); Toma Wilkerson (FL); Ryan Gillespie (IL); DJ Wasson (KY); Robert Wake (ME); Chlora Lindley-Myers (MO); Martin Swanson (NE); Nathan Houdek (WI); and Joylynn Fix (WV).

1. **Adopted its June 11 Minutes**

The Subgroup met June 11 to review and discuss the comments received by the March 18 public comment deadline on the proposed revisions to the *Health Maintenance Organization Model Act* (#430).

Ms. Wilkerson made a motion, seconded by Ms. Fix, to adopt the Subgroup’s June 11 minutes (Attachment Four-A). The motion passed unanimously.

2. **Adopted a Motion to Forward Draft Model #430 Revisions to the Regulatory Framework (B) Task Force**

Mr. Beatty said the purpose of the call is for the Subgroup to discuss the draft of proposed revisions to Model #430 which reflect the Subgroup’s discussion during its June 11 conference call and consider forwarding the draft to the Regulatory Framework (B) Task Force for its consideration. He requested comments. There were no comments.

Mr. Wake made a motion, seconded by Ms. Wilkerson, to forward the draft of proposed revisions to Model #430 (Attachment Four-B) to the Regulatory Framework (B) Task Force for its consideration. The motion passed unanimously.

Having no further business, the HMO Issues (B) Subgroup adjourned.
1. Discussed March 18 Comments on Proposed Revisions to Model #430

Mr. Beatty said the purpose of the call is for the Subgroup to discuss the comments received on the proposed revisions to the Health Maintenance Organization Model Act (#430) for consistency with the revised Life and Health Insurance Guaranty Association Model Act (#520). He said the Subgroup received comments from the NAIC consumer representatives, the Blue Cross and Blue Shield Association (BCBSA), and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA).

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said the NAIC consumer representatives strongly urge the Subgroup to retain Section 14—Continuation of Benefits and Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency because of the explicit consumer protections these sections provide. She said the NAIC consumer representatives have provided language for a potential drafting note for Section 14 suggesting that those states that have adopted the revised Model #520 consider alternative continuation of benefits language for Section 14 to ensure that enrollees’ claims are paid during the transition period and/or while waiting for the commencement of alternative coverage.

Mr. Wake agreed that retaining Section 14 is important for those states that have not adopted the revised Model #520, which added health maintenance organizations (HMOs) as members of the guaranty association. He said, however, that for those states that have adopted the revised Model #520, it is unnecessary to retain Section 14 because continuation of benefits is covered through the guaranty association procedures. He also noted that the proposed drafting note for Section 2—Purpose and Intent alerts those states that have not adopted the revised Model #520 to retain Section 14. Mr. Wake said Section 21 is obsolete because of the guaranteed issue provision and other provisions in the federal Affordable Care Act (ACA). He said this is true regardless of whether a state has adopted the revised Model #520.

Mr. Beatty asked Joni Forsythe (NOLHGA) if the Subgroup needed to address a gap in coverage and retain Section 14. Ms. Forsyth said NOLHGA has not identified any gap in coverage that would require retaining Section 14. Ms. Howard said the NAIC consumer representatives are apprehensive about removing Section 14 just in case there is an issue. Chris Petersen (Arbor Strategies LLC) expressed support for the NAIC consumer representatives’ concern, noting comments he had previously submitted to the Subgroup on this issue. He said, however, that he could support the Subgroup’s decision to remove Section 14 if that is what it decides. Mr. Beatty said the Subgroup would proceed with deleting Section 14, but he urged anyone who believes that there will be a gap in coverage to alert the Subgroup.

Ms. Forsyth said NOLHGA takes no position on the proposed revisions to Model #430 as whole, but it has a few technical comments for the Subgroup’s consideration. She said NOLHGA’s first technical comment concerns the use of the word “conformity” in both option 1 and option 2 of the proposed drafting note to Section 2. She said NOLHGA believes the term “conformity” suggests a higher standard of assimilation with Model #520 than what the Subgroup intends with respect to the Model #430 revisions. To address this concern, she said NOLHGA suggests using the term “reconcile” instead. Ms. Forsyth also said NOLHGA does not understand why neither option 1 nor option 2 of the drafting note explains why Section 21 is being deleted. She said NOLHGA also suggests the Subgroup consider including the full text of the repealed provisions as an appendix to Model #430 in order to preserve the text.

Ms. Forsyth said that if the Subgroup decides to proceed with option 2, NOLHGA suggests clarifying language in option 2 concerning the purpose of the repealed Model #430 provisions by replacing the language “addressed issues arising from the lack of guaranty association protection” with “provided consumer protection for HMO enrollees in the event of an HMO insolvency, in the absence of guaranty association protection.” She said NOLHGA’s final technical comment concerns an additional section in Model #430 the Subgroup has not discussed, but which could conflict with the revised Model #520. She said Section 31—Statutory Construction and Relationship to Other Laws (formerly section 34) provides that, except as provided
in Model Act #430, provisions of state insurance laws do not apply to HMOs. She said Section 28—Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations (formerly section 31) provides that HMOs are subject to state receivership laws, but it does not include any reference to state guaranty association laws. Ms. Forsyth said this potential conflict could be resolved by adding “or other applicable laws” in the opening sentence of Section 31.

John Troy (BCBSA) said the BCBSA supports the Subgroup’s proposed revisions. He said the BCBSA supports including option 2 in the proposed revisions instead of option 1 because it is briefer and more to the point and, as such, more likely to be reasonably well understood.

The Subgroup discussed NOLHGA’s comments. Mr. Wake said he could support NOLHGA’s suggested revision to Section 31 with one change. He suggested the Subgroup add the language “or in other laws expressly referring to health maintenance organizations.” He said he suggests this language because it specifies the type of applicable law. Ms. Arp expressed support for Mr. Wake’s suggested revision because of its similarity to Nebraska law. Mr. Wake also expressed support for NOLHGA’s other suggested technical revisions. Ms. Wilkerson expressed similar support, but she asked if any other NAIC models included an appendix as NOLHGA suggests. Jolie H. Matthews (NAIC) said she has not seen similar appendices in other NAIC models, but that this would not preclude the Subgroup from adding such an appendix as part of the Model #430 revisions.

After additional discussion, the Subgroup directed NAIC staff to prepare another draft of proposed revisions to Model #430 that would include the following: 1) option 2 of the proposed drafting note for Section 2 with NOLHGA’s suggested revisions; 2) NOLHGA’s suggested revision to Section 31, with Mr. Wake’s additional suggested revision; and 3) NOLHGA’s suggestion to add an appendix with the repealed provisions. Mr. Beatty said the Subgroup would hold another conference call sometime in July to consider adopting the proposed revisions and forwarding the revised Model #430 to the Regulatory Framework (B) Task Force for its consideration.

Having no further business, the HMO Issues (B) Subgroup adjourned.

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HEALTH MAINTENANCE ORGANIZATION MODEL ACT

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Section 1. Short Title

This Act may be cited as the Health Maintenance Organization Act of [insert year].
Section 2. Purpose and Intent

The purpose of this Act is to provide for a system of regulation for health maintenance organizations that is fair and efficient, and promotes the continued solvency of health maintenance organizations. This Act is designed to operate in conjunction with and as a companion to other state laws that establish standards for the regulation of health maintenance organizations, such as [insert state law equivalent to the Managed Care Plan Network Adequacy Model Act, the Quality Assessment and Improvement Model Act, the Health Care Professional Credentialing Verification Model Act, the Utilization Review and Benefit Determination Model Act, the Health Carrier Grievance Procedure Model Act, the Health Carrier External Review Model Act, the Health Information Privacy Model Act, the Unfair Trade Practices Model Act, the Unfair Claims Settlement Practices Model Act, the Insurance Holding Company System Regulatory Act and the Risk-Based Capital (RBC) for Health Organizations Model Act].

Drafting Note: This model act presumes the existence of state laws that are based on the listed NAIC model acts described in this section. States that have not already adopted these laws should consider adopting them to ensure that a comprehensive system of regulation for health maintenance organizations is in place.

Drafting Note: Former Section 14—Continuation of Benefits and Section 20—Uncovered Expenditures provide consumer protections for health maintenance organization enrollees in the event of a health maintenance organization insolvency in the absence of guaranty association protection for health maintenance organization enrollees. Those sections (along with Section 3HH, defining the term “uncovered expenditures”) have been repealed to reconcile this Act with the Life and Health Insurance Guaranty Association Model Act (#520), which was amended in 2017 to make health maintenance organizations members of the guaranty association. States that continue to exclude health maintenance organizations from guaranty association membership should retain provisions, comparable to former Sections 3HH, 14 and 20, requiring health maintenance organizations to develop advance insolvency plans that include procedures to facilitate continuation of benefits after an insolvency, and to post deposits to secure any uncovered expenditures in excess of 10% of total health care expenditures. The language from former Section 14, former Section 20 and the former definition of “uncovered expenditures” in Section 3HH can be found in Appendix A. Former Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency was repealed as obsolete due to the provisions of the federal Affordable Care Act (ACA).

Section 3. Definitions

A. “Adverse determination” means a determination by a health maintenance organization or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health maintenance organization’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

B. “Basic health care services” includes the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

C. “Capitated basis” means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

D. “Coinsurance” means the percentage amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

Drafting Note: States that do not allow HMOs to impose a coinsurance requirement should not adopt this definition nor include the term when it is referenced throughout the model.

E. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction
of health maintenance organizations lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

F. “Copayment” means a specified dollar amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

G. “Covered benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

H. “Covered person” means any person eligible to receive covered benefits under the terms of a health benefit plan.

I. “Deductible” means the amount a covered person is responsible to pay out-of-pocket before the health maintenance organization begins to pay the covered expenses associated with treatment.

J. “Enrollee” means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

K. “Evidence of coverage” means a statement that sets out the coverage and other rights to which the covered person is entitled under the health benefit plan and that may be issued by the health maintenance organization or by the group contract holder to an enrollee electronically or, upon request, in writing.

L. “Extension of benefits” means the continuation of coverage under a particular benefit provided under a contract following termination with respect to a covered person who is totally disabled on the date of termination.

M. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

N. “Grievance” means a written complaint submitted by or on behalf of a covered person regarding:

1. The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

2. Claims payment, handling or reimbursement for health care services; or

3. Matters pertaining to the contractual relationship between a covered person and a health maintenance organization.

O. “Group contract” means a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

P. “Group contract holder” means a person, other than an individual, to which a group contract has been issued.

Q. “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

R. “Health care professional” means a physician or other health care practitioner license, accredited or certified to perform specified health services consistent with state law.

S. “Health care provider” or “provider” means a health care professional or facility.

T. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
“Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, managed care organization, health maintenance organization, a nonprofit hospital or medical service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

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

**Drafting Note:** The term “hospital or medical service corporation,” as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as “Blue Cross Blue Shield-type” plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

“Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.

“Individual contract” means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.

“Insolvent” or “insolvency” shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

“Intermediary organization” means a person, other than an individual, authorized to negotiate and execute provider contracts with health maintenance organizations on behalf of a group of health care providers or on behalf of a network, but does not include a provider or group of providers negotiating on its own behalf.

“Network” means the group of participating providers providing services to a health maintenance organization.

“Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

“Participating provider” means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.

“Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or a combination of the foregoing.

“Policyholder” means, for individual contracts, the individual in whose name the contract is issued, and for group contracts, the group contract holder.

“Qualified actuary” means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the commissioner may require.

“Replacement coverage” means the benefits provided by a succeeding carrier.
GG. “Risk bearing entity” means an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.

HH. “Uncovered expenditures” means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization’s insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

Drafting Note: Subsection HH defines uncovered expenditures for use in Section 20. They will vary in type and amount, depending on the arrangements of the health maintenance organization. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the covered person even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

HHH. “Utilization review” means a set of formal techniques utilized by or on behalf of the health maintenance organization designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Section 4. Applicability and Scope

This Act applies to all health maintenance organizations and risk bearing entities doing business in this state.

Section 5. Establishment of Health Maintenance Organizations

Option A:

A. Notwithstanding any law of this state to the contrary, any person other than an individual may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this Act. A foreign corporation may qualify under this Act, subject to its registration to do business in this state as a foreign corporation under [insert reference to applicable state law] and compliance with all provisions of this Act and other applicable state laws.

Drafting Note: State laws differ as to whether a health maintenance organization is required to be a domestic corporation. This provision should be adopted if your state wants to permit a foreign corporation to qualify under this Act if it registers to do business in a state as a foreign corporation and complies with all provisions of this Act and other applicable state laws.

Option B:

A. Notwithstanding any law of this state to the contrary, any organization may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. A person shall not establish or operate a health maintenance organization in this state without obtaining a certificate of authority under this Act.

Drafting Note: State laws differ as to whether a health maintenance organization may be a foreign corporation. This option does not differentiate between foreign and domestic corporations. Whether or not to allow foreign corporations to become health maintenance organizations should be determined in light of a particular state’s regulatory framework.

B. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall demonstrate, set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation,
articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) (a) A disclosure of the internal organizational structure identifying senior management employees;

(b) A disclosure of the external organizational structure identifying all parent, subsidiary and affiliate organizations; and

(c) If the applicant is a member of a holding company:

(i) Identification of the holding company; and

(ii) A copy of the most recent holding company Form B that includes current financial information for the ultimate controlling party;

(4) The applicant's federal identification number, NAIC number if applicable, corporate address and mailing address;

(5) (a) The names, addresses, official positions and biographical affidavit of the individuals who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to all members of the board of directors, executive committee, and the principal officers accompanied by a completed release of information for each of these individuals, on forms acceptable to the commissioner; and

(b) A disclosure of any person owning or having the right to acquire five percent (5%) or more of the voting securities or subordinated debt of the applicant;

(6) A detailed plan of operation for [insert state name];

(7) A description of the applicant and its personnel, and, where applicable, its facilities, including, but not limited to, location, hours of operation and telephone numbers;

(8) A copy of:

(a) Any contract made or to be made between the applicant and an affiliated or unaffiliated person for managerial or administrative services, including, third party administrators, marketing consultants or persons listed in Paragraph (5); and

(b) Sample contract forms proposed for use between the applicant and persons providing health care services to covered persons, including, participating providers and intermediary organizations.

Drafting Note: Section 811A of the Managed Care Plan Network Adequacy Health Benefit Plan Network Access and Adequacy Model Act requires the filing of substantially similar information to the filing of sample provider contracts required in Paragraph (8)(b). States that have adopted the Managed Care Plan Network Adequacy Health Benefit Plan Network Access and Adequacy Model Act should consider whether it is necessary to include a similar requirement in this Act as well.

(9) A copy of each type of evidence of coverage and identification card or similar document to be issued to the enrollees;

(10) A copy of each type of individual or group policy, contract or agreement to be used;
(11) A copy of all marketing materials;

(12) A copy, if applicable, of the most recent financial examination report made of the health maintenance organization within the previous three (3) years, certified by the insurance regulatory agency of the applicant’s state of domicile;

(13) (a) A copy of the applicant’s financial statements showing the applicant’s assets, liabilities and sources of financial support, including a copy of the applicant’s most recent audited financial statement that complies with [insert reference to state law equivalent to Model Regulation Requiring Annual Audited Financial Reports] and an unaudited current financial statement; or

(b) If the information in Subparagraph (a) of this paragraph is not applicable to the applicant, a list of the assets representing the initial net worth of the applicant;

**Drafting Note:** States should ensure that the state law equivalent to the Model Regulation Requiring Annual Audited Financial Reports is applicable to health maintenance organizations before referencing it in Paragraph (13)(a).

(14) A financial plan that provides a three-year projection of operating results, including:

(a) A projection of balance sheets;

(b) Income and expense statements anticipated from the start of operations until the organization has had net income for at least one year;

(c) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state;

(d) Detailed enrollment projections;

(e) The methodology for determining premium rates to be charged that has been certified by a qualified actuary; and

(f) A statement as to the sources of working capital as well as any other sources of funding;

(15) The names and addresses of the applicant’s qualified actuary and external auditors;

(16) If the applicant has a parent company and the commissioner determines that additional solvency guarantees are necessary, the parent company’s guaranty, on a form acceptable to the commissioner, that the applicant will maintain the minimum net worth required under this Act. If no parent company exists, a statement regarding the availability of future funds if needed;

(17) A description of the nature and extent of any reinsurance program to be implemented, including a detailed risk retention schedule indicating direct, assumed, ceded and net maximum risk exposures on any one risk;

(18) A demonstration that errors and omission insurance or other arrangements satisfactory to the commissioner will be in place upon the applicant’s receipt of a certificate of authority;

(19) Information regarding the proposed fidelity bond required pursuant to Section 24B21B of this Act;

(20) If the applicant is a foreign corporation, a statement from the appropriate regulatory agency of the applicant's state of domicile stating that:

(a) The applicant is authorized to operate as a health maintenance organization in the state of domicile;
Section 6. Issuance or Denial of Certificate of Authority

A. Within ninety (90) days of receipt of a completed application, the commissioner shall issue a certificate of authority when the commissioner is satisfied that:

(b) The regulatory agency has no objection to the applicant applying for a certificate of authority in this state; and

(c) The applicant is in good standing in the applicant's state of domicile;

(21) The name and address of the applicant’s [insert state name] statutory agent for service of process, notice, or demand, or if not domiciled in this state, a power of attorney duly executed by the applicant, appointing the commissioner and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(22) A description of the proposed policies, standards and procedures for the management of health information, including proposed policies, standards and procedures that guard against the unauthorized collection, use or disclosure of protected health information, that complies with [insert reference to state law equivalent to the Health Information Privacy Model Act];

(23) A description of the proposed quality assessment and improvement activities that comply with [insert reference to state law equivalent to the Quality Assessment and Improvement Model Act] regarding the maintenance and improvement of the quality of health care services provided to covered persons;

(24) If the health maintenance organization will not operate statewide, a statement or map describing the service area;

(25) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;

(26) A description of the proposed network adequacy standards that assure the adequacy, accessibility and quality of health care that complies with [insert reference to state law equivalent to the Managed Care Plan Network Adequacy Act];

(27) A description of the proposed health care provider credentialing program in compliance with [insert reference to state law equivalent to the Health Care Professional Credentialing Verification Model Act];

(28) If the health maintenance organization will provide or perform utilization review services, a description of the proposed utilization review procedures that comply with [insert reference to state law equivalent to the Utilization Review and Benefit Determination Model Act] regarding the ongoing assessment and management of health care services;

(29) A description of the proposed internal grievance procedures that comply with [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] regarding the investigation and resolution of covered persons’ complaints and grievances;

(30) A description of the proposed external review procedures that comply with [insert reference to state law equivalent to the Health Carrier External Review Model Act] regarding the external independent review of covered persons’ grievances; and

(31) Any other information the commissioner may require.
(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) The name of the health maintenance organization is not the same as, or deceptively similar to, the name of a domestic insurer, or of a foreign or alien company authorized to transact business in this state, nor does the name of the health maintenance organization tend to deceive or mislead as to the authorization of the health maintenance organization to engage in a specific line of business;

(3) The health maintenance organization will provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments, coinsurance or deductibles; and

(4) The health maintenance organization is in compliance with the requirements of this Act.

B. A certificate of authority shall be denied only after the commissioner complies with the requirements of Section 2926 of this Act.

Section 7. Powers of Health Maintenance Organizations

A. The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and property reasonably required for its principal office or for purposes necessary to the transaction of the business of the organization;

(2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, subscriber, etc.) between affiliates or between the health maintenance organization and its parent;

(3) The furnishing of health care services through providers, provider associations, intermediary organizations or agents for providers which are under contract with or employed by the health maintenance organization;

(4) The contracting with a person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(5) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) The offering of other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(7) The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

Drafting Note: States that allow health maintenance organizations to offer a point of services contract may wish to consider additional requirements for those organizations, including but not limited to, additional ongoing net worth and capital, additional deposits, more detailed annual and quarterly financial statement filings, limitations on out-of-plan expenditures and additional reinsurance coverage.

B. (1) A health maintenance organization shall file notice, with adequate supporting information, with the
commissioner prior to the exercise of any power granted in Subsection A(1), (2) or (4) that may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove the exercise of power only if, in the commissioner’s opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within thirty (30) days of the filing, it shall be deemed approved.

(2) The commissioner may promulgate rules and regulations exempting from the filing requirement of Paragraph (1) those activities having a *de minimis* effect.

(3) Transactions between affiliated entities shall be subject to [insert reference to state law equivalent to NAIC *Insurance Holding Company System Regulatory Act*].

Section 8. Contract Requirements

A. Each group or individual contract holder is entitled to a group or individual contract within thirty (30) days of the effective date of a new or amended contract.

B. The contract shall not contain provisions or statements that:

(1) Are unjust, unfair, inequitable, misleading, or deceptive; or

(2) Encourage misrepresentation as defined by [reference to state law equivalent to the NAIC *Unfair Trade Practices Act*].

C. The contract shall contain a clear statement of the following:

(a) Name and address of the health maintenance organization;

(b) Eligibility requirements;

(c) Benefits and services within the service area;

(d) Emergency care benefits and services;

(e) Out of area benefits and services (if any);

(f) Copayments, coinsurance, deductibles or other out-of-pocket expenses, the financial responsibility of the covered person and how the covered person’s obligation is determined;

(g) Provider hold harmless provisions;

(h) Limitations and exclusions;

(i) covered person termination;

(j) covered person reinstatement (if any);

(k) Claims procedures;

(l) Utilization review procedures;

(m) Grievance procedures;

(n) Procedures for requesting independent external review;
(o) Continuation of coverage;
(p) Conversion;
(q) Extension of benefits (if any);
(r) Coordination of benefits (if applicable);
(s) Subrogation (if any);
(t) Description of the service area;
(u) Procedures for obtaining a provider directory;
(v) The existence of a formulary and procedures for obtaining a copy of the formulary list (if applicable);
(w) Entire contract provision;
(x) Term of coverage;
(y) Cancellation of group or individual contract holder;
(z) Renewal;
(aa) Reinstatement of group or individual contract holder (if any);
(bb) Grace period; and
(cc) Conformity with state law.

(2) An evidence of coverage may be filed as part of the group contract to describe the provisions required in Paragraph (1).

D. (1) In addition to the provisions required in Subsection C(1), an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded.

(2) If services were received during the ten-day period, and the individual returns the contract to receive a refund of the premium paid, the individual must pay for those services.

E. The commissioner may adopt regulations establishing readability standards for individual and group contract forms.

**Drafting Note:** The commissioner may adopt standards in the NAIC *Life and Health Insurance Policy Language Simplification Act.*

**Section 9. Risk Bearing Entity Registration and Contracting Requirements**

A. Registration Requirements.

(1) All risk bearing entities shall register annually with the commissioner in this state unless already subject to state insurance regulation.

**Drafting Note:** A state may wish to exempt a risk bearing entity from the registration requirements of this subsection, or modify the provisions of this subsection as they apply to a risk bearing entity, where a risk bearing entity accepts risk exclusively from
a single health maintenance organization, provides direct care to covered persons of that health maintenance organization, and where detail of claims payments is available for examination from the health maintenance organization. A state may want to require the health maintenance organization to demonstrate to the commissioner that the contractual arrangement with the risk bearing entity will allow it to fulfill the provisions of its contract for the contract year. Health maintenance organizations contracting with risk bearing entities that are exempt from this subsection, or subject to modified registration requirements, should be subject to Subsections C and D of this section and Section 4918 of this Act.

(2) The registration shall be in a form approved by the commissioner and shall include:

(a) The name of the risk bearing entity;
(b) The business address of the risk bearing entity;
(c) The principal contact person for risk bearing entity;
(d) The names and positions of senior officers of risk bearing entity, including, President, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Executive Vice Presidents, Treasurer and Secretary;
(e) A list of all entities on whose behalf the risk bearing entity has contracts or agreements to provide health care services;
(f) A matrix listing of all major categories of health care services provided by the risk bearing entity;
(g) An approximate number of total covered persons served in all the risk bearing entity’s contracts or agreements;
(h) An annual audited Generally Accepted Accounting Principles (GAAP) financial statement;
(i) A list of all subcontractors of the risk bearing entity;
(j) Sample contract forms proposed for use between subcontractors and the risk bearing entity;
(k) A list of all stop loss arrangements; and
(l) Any other information or financial information requested by the commissioner.

(3) The commissioner may charge a registration fee sufficient to cover the cost of implementing this section.

(4) The risk bearing entity shall permit the commissioner to:

(a) Inspect the risk bearing entity’s books and records; and
(b) Examine, under oath, any officer or agent of the risk bearing entity with respect to the use of its funds and compliance with the terms and conditions of its contracts to provide covered benefits under the health benefit plan.

(5) A risk bearing entity shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this section, together with such supporting documents as are necessary to explain the modification.

B. Contracting Requirements

(1) Except as provided in Paragraph (2), a health maintenance organization shall not contract with a risk bearing entity that has not registered in accordance with this section.
(2) The requirements of this section shall apply to any contract entered into, amended or renewed after the effective date of this section and shall apply to all contracts no later than two (2) years after the effective date of this section.

(3) A health maintenance organization shall:

(a) Unless already specified in the contract with the risk bearing entity, provide the following, upon request, to the risk bearing entity with which it contracts:

(i) At the time the contract is entered into, a written statement describing the amount or method of remuneration to be paid to the risk bearing entity. If any part of the remuneration is a calculated amount based on variable factors, the payment methodology upon which the calculated amount will be determined. The statement shall specify the services and expenses for which the risk bearing entity is financially liable in whole or part;

(ii) At the time payment is made, the basis of the calculation of that payment;

(iii) For health benefit plans in which the covered persons are assigned to the risk bearing entity under a capitated payment arrangement, a list of enrollees and payments due to the risk bearing entity, to be provided monthly if not already available to the risk bearing entity;

(iv) At the time the contract is entered into, a copy of the health maintenance organization’s most recent annual statement filed with the NAIC;

(v) Once the contract is in effect, the quarterly or annual statement filed with the NAIC; and

(vi) Any other information requested by the commissioner.

(b) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization at the time a contract is entered into and annually thereafter:

(i) Annual audited GAAP report;

(ii) Documentation that satisfies the health maintenance organization that the risk bearing entity has sufficient ability to accept risk; and

(iii) Documentation that satisfies the health maintenance organization that the risk bearing entity has appropriate management expertise and infrastructure;

(c) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization a quarterly status report that includes:

(i) GAAP financial statements;

(ii) An aging report of the percentage of claims that have been paid, pended or denied, across all contracts with risk bearing entities; and

(iii) On a monthly basis, a report of the estimated reported claims and incurred but not reported claims liability of the risk bearing entity; and
(d) Require that a risk bearing entity with which the health maintenance organization contracts provide notice within thirty (30) days to the health maintenance organization of:

(i) Any changes involving the ownership structure of the risk bearing entity;

(ii) Financial or operational concerns regarding the financial viability of the risk bearing entity; or

(iii) Loss of registration.

(4) A health maintenance organization shall provide to the commissioner on a quarterly basis a list of all risk bearing entities with which it has an agreement or contract and the number of covered persons assigned or selected by each risk bearing entity, and any additional information the commissioner may require.

(5) A health maintenance organization shall include in its contracts with a risk bearing entity a provision that allows the commissioner, in the event that a risk bearing entity fails to comply with any provision of this Act, to assign for six (6) months, the risk bearing entity’s contract with providers to furnish covered services.

C. Oversight Responsibility

(1) A health maintenance organization shall have procedures in place to notify the commissioner within a reasonable time that a risk bearing entity has materially failed to perform under its contract with the health maintenance organization. A health maintenance organization is not in violation of this paragraph if it acts in good faith in its attempt to comply. The commissioner may by rule enumerate more specific circumstances under which a report may be filed.

(2) A health maintenance organization shall maintain systems and controls for, including but not limited to, reviewing the information provided to the health maintenance organization by the risk bearing entity pursuant to this Act.

(3) Any information that has been provided to the commissioner by a health maintenance organization pursuant to this subsection is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act and as allowed by state law, regardless of whether the information is in the form of paper, is preserved on microfilm or is stored in computer readable form. If the information is disclosed pursuant this subsection, the health maintenance organization providing the notice shall not be liable for the disclosure or any subsequent use or misuse of the information. The health maintenance organization shall be entitled to claim any statutory privileges against disclosure that the entity that provided the information to the health maintenance organization is entitled to claim.

(4) Any person acting as a director, officer, employee, contractor or agent of a health maintenance organization, who, in good faith and without malice, makes any decision or takes any action to provide a notice of the type contemplated by this subsection shall not be subject to liability for civil damages or any legal action in consequence of that decision or action, nor shall the health maintenance organization, or any other director, officer, employee, contractor or agent be liable for the activities of the person.

(5) In the event that a health maintenance organization has been notified that the registration of a risk bearing entity has been terminated, revoked, non-renewed or forfeited for any reason, a health maintenance organization shall terminate its contract with the risk bearing entity unless specific permission is provided by the commissioner to maintain the contract at the request of both parties, or enter into an agreement pursuant to which the risk bearing entity ceases to bear risk. The commissioner may set conditions on any agreements between the risk bearing entity and the health maintenance organization.
(6) This subsection is not intended to create a private right of action.

D. Continuity of Care.

Notwithstanding any agreement to the contrary, the health maintenance organization shall:

(1) Retain full responsibility on a prospective basis for the provision of health care services pursuant to any applicable health benefit plan; and

(2) At all times, be able to demonstrate to the satisfaction of the commissioner that the health maintenance organization can fulfill its non-transferable obligation to provide health care services to covered persons in any event, including the failure, for any reason, of a risk bearing entity.

E. Enforcement Against Risk Bearing Entities.

(1) If the commissioner determines that a risk bearing entity has not complied with any provision of this Act, the commissioner may terminate the risk bearing entity’s registration, institute a corrective action against the risk bearing entity, or use any of the commissioner’s other enforcement powers to obtain compliance with this Act.

(2) The commissioner shall, within five (5) business days, inform each health maintenance organization with which a risk bearing entity contracts, in writing:

(a) Of any corrective action undertaken by the commissioner against a risk bearing entity; and

(b) If the registration of a risk bearing entity has been revoked, non-renewed, forfeited or terminated.

(3) The commissioner may, in the event that a risk bearing entity fails to comply with any provision of this Act, require the assignment of the risk bearing entity’s contract to furnish covered services for a period not to exceed six (6) months.

(4) The commissioner may assess fines on a risk bearing entity for every day that the entity has failed to meet the registration requirements of this section.

Section 10. Form and Rate Filing Requirements

Drafting Note: States that require prior approval of policy forms and premium rates should adopt Option A. States that have a system of file and use for policy forms and premium rates should adopt Option B.

Option A. Prior Approval

A. Subject to Subsections B and C, no group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the commissioner.

B. (1) Every form required by this section shall be filed with the commissioner not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty-day period, the commissioner may extend the period for review for an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the commissioner has taken no action. The filer must notify the commissioner in writing prior to using a form that is deemed approved.

(2) At any time, after thirty (30) days notice and for cause shown, the commissioner may withdraw approval of a form, effective at the end of the thirty-day period.
Whenever the commissioner disapproves a form or withdraws approval of a form, the commissioner shall notify the health maintenance organization in writing of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing.

C. (1) A health maintenance organization shall not use a premium rate until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.

(2) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.

(3) Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person’s health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

(4) The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of Paragraph (2) are met. If the commissioner disapproves the filing, the commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. If the commissioner does not take action on the schedule or methodology within thirty (30) days of the date of the filing of the schedule or methodology, it shall be deemed approved.

D. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a form or rate filing made pursuant to this section.

Option B. File and Use

A. No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form and rates have been filed with the commissioner at least thirty (30) days prior to its issuance or delivery.

B. (1) At any time, after its issuance and delivery, and for cause shown, the commissioner may disapprove the use of a form. The disapproval shall be effective thirty (30) days after the health maintenance organization receives the notice described in Paragraph (2).

(2) The commissioner shall notify the health maintenance organization, in writing, of the reasons for disapproval of the form. The notice shall inform the health maintenance organization that the health
A health maintenance organization shall not use a premium rate unless the premium rate or a methodology for determining the premium rate has been filed with the commissioner at least thirty (30) days prior to its use.

The health maintenance organization shall certify that the rates meet the requirements of Paragraph (4).

Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.

A specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person’s health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A qualified actuary or other qualified person acceptable to the commissioner must certify the appropriateness of the use of the methodology, based on reasonable assumptions, backed by adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

At any time after its implementation, and for good cause shown, the commissioner may disapprove the use of a specific rate or rating methodology. The commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for hearing shall stay the effect of the disapproval.

Section 11. Evidence of Coverage

A. (1) Every enrollee shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive, or that encourage misrepresentation as defined by [insert reference to state law equivalent to the NAIC Unfair Trade Practices Act].

The evidence of coverage shall contain a clear statement of the provisions required in Section 8C of this Act.

B. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner of this state for approval.
Section 12. Marketing and Advertising Materials

A. The advertising and marketing materials of health maintenance organizations are subject to the requirements of [insert reference to state law equivalent to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation].

B. The advertising and marketing materials of health maintenance organizations marketing Medicare supplement insurance are subject to the requirements of [insert reference to state law equivalent to the NAIC Medicare Supplement Insurance Minimum Standards Model Act and the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act].

C. The advertising and marketing materials of health maintenance organizations marketing long-term care insurance are subject to the requirements of [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Regulation].

Section 13. Information to Enrollees and Covered Persons

A. A health maintenance organization shall provide, within thirty (30) days, notice to enrollees of any material change in the operation of the organization that will affect them directly.

B. (1) The health maintenance organization shall make written copies of provider directories available to enrollees upon enrollment and re-enrollment.

(2) The health maintenance organization shall provide written copies of provider directories to covered persons upon request.

(3) The health maintenance organization shall provide the directory and any updates to enrollees, in writing or by electronic means, in accordance with the terms of its contract.

C. (1) A health maintenance organization shall notify covered persons of the termination of the primary care provider who currently provides health care services to that covered person.

(2) A health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to receive notice in writing or by electronic means, of the termination of the primary care provider who currently provides health care services to that covered person.

(3) The health maintenance organization shall provide assistance to the covered person in transferring to another participating primary care provider.

D. The health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to obtain information in writing or by electronic means, on how services may be obtained, where additional information on access to services may be obtained and a telephone number where covered persons may contact the health maintenance organization, at no cost to the covered person.

Drafting Note: For the purpose of this section any major change in the provider network is considered a material change.

Section 14. Continuation of Benefits

A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

B. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;
Section 4514. Coordination of Benefits

A. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health benefit plans.

B. If a health maintenance organization adopts coordination of benefits provisions, the provisions shall be consistent with [insert reference to state law equivalent to NAIC Group Coordination of Benefits Model Regulation] in general use in the state for coordinating coverage between two (2) or more group health insurance or health benefit plans.

C. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination consistent with [insert reference to state law equivalent to NAIC Group Coordination of Benefits Model Regulation], health maintenance organizations shall make payments for services that are:

(1) Received from non-participating providers;

(2) Provided outside their service areas; or

(3) Not covered under the terms of their group contracts or evidence of coverage.

Section 4615. Initial Net Worth and Capital Requirements

A. Before the commissioner issues a certificate of authority in accordance with Section 6 of this Act, an applicant seeking to establish or operate a health maintenance organization shall have the greater of:

(1) The amount of capital required under [insert reference in state law equivalent to the Risk-Based Capital (RBC) for Health Organizations Model Act];

(2) An initial net worth of $3,000,000; or

(3) At the commissioner’s discretion, an amount greater than required under Paragraph (1) or (2), as indicated by a business plan and a projected risk-based capital calculation after the first full year of operation based on the most current NAIC Health Annual Statement Blank.

Section 4716. Ongoing Net Worth and Capital Requirements

A. A health maintenance organization shall maintain minimum net worth equal to the greater of $2,500,000 or the amount necessary to maintain capital required pursuant to [insert reference to state law equivalent to the Risk-Based Capital for Health Organizations Model Act].
B. The amount in Subsection A may be adjusted annually for inflation, at the commissioner’s discretion.

Drafting Note: The following definition of “managed hospital payment basis” and formulation for ongoing net worth, based on the 1989 amended version of HMO Model Act, have been included for the benefit of states that have not adopted the Risk-Based Capital for Health Organizations Model Act:

“Managed hospital payment basis” means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services. Examples of managed hospital payment basis agreements include but are not limited to payments on a DRG or per diem basis or where there is an agreement between a hospital and a health maintenance organization and which are under common ownership or control.

C. A health maintenance organization shall maintain a minimum net worth equal to the greater of $2,500,000; or an amount equal to the sum of:

(1) Eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(2) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

Section 1817. Deposit Requirements

A. Unless otherwise provided in this section, a health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a market value of not less than $1,000,000.

B. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

C. All income from deposits shall be an asset of the health maintenance organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted.

D. The deposit shall be used to protect the interests of the health maintenance organization’s covered persons and to assure continuation of health care services to covered persons of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a rehabilitation, receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

E. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, commissioner, or other official body of the state or jurisdiction of domicile for the protection of all covered persons, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

Section 1918. Hold Harmless Provision Requirements for Covered Persons

A. Except for coinsurance, deductibles or copayments as specifically provided in the evidence of coverage, in no event, including but not limited to nonpayment by the health maintenance organization, insolvency of the health maintenance organization or breach of contract among the health maintenance organization, risk
bearing entity or participating provider, shall a risk bearing entity or participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization) acting on behalf of the covered person for covered services provided. No risk bearing entity or participating provider, nor any agent, trustee or assignee of the risk bearing entity or participating provider may maintain an action at law against a covered person to collect sums owed by the health maintenance organization.

B. All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for covered persons. Any attempted waiver or amendment in a manner materially adverse to the interests of covered persons of a hold harmless provision shall be null and void and unenforceable.

C. The requirement of Subsection B shall be met by including a provision substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the covered person for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons.”

D. (1) Any statement sent to a covered person shall clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(2) All contracts among health maintenance organizations, risk bearing entities, and participating providers shall require that all statements sent to covered persons clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(3) The notice requirements in this subsection shall be met by including in the statement to covered persons a provision substantially similar the following:

NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION

E. Any violation of the provisions of this section shall constitute an unfair trade practice pursuant to [insert reference to state insurance fraud statute] and shall subject the health care provider to monetary penalties in accordance with [insert reference to state insurance fraud statute] and notification to the [insert reference to appropriate licensing entity for type of provider].

Drafting Note: States that do not authorize insurance departments to take action against providers should not adopt Subsection E and should consider other options such as contacting the state attorney general’s office or other appropriate state official.

Drafting Note: States with consumer protection acts that provide covered persons with a private right of action should consider including a reference in Subsection E.

Section 20. Uncovered Expenditures Deposit

A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner.
with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization’s outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

C. A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:
   (a) A substitute deposit of cash or securities of equal amount and value is made;
   (b) The fair market value exceeds the amount of the required deposit; or
   (c) The required deposit under Subsection A is reduced or eliminated.

D. Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.

F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

Section 21. Open Enrollment and Replacement Coverage in the Event of Insolvency

A. Enrollment Period
   (1) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group’s last regular enrollment period shall offer the group’s enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

   (2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient
health care delivery resources to assure that health care services will be available and accessible to all of the group covered persons of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization’s group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization’s service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization’s existing coverage that is most similar to each group’s coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization’s existing rating methodology and in accordance with state law.

(3) The commissioner shall also allocate equitably the insolvent health maintenance organization’s nongroup enrollees that are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization’s service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer the nongroup enrollees the health maintenance organization’s existing coverage for individual or conversion coverage as determined by the enrollee’s type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization’s existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

B. Replacement Coverage

(1) “Discontinuance” shall mean the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(2) A health maintenance organization providing replacement coverage hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization, shall immediately cover all covered persons who were validly covered under the previous health maintenance organization at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding health maintenance organization, regardless of any provisions of the contract relating to active employment, hospital confinement or pregnancy.

Drafting Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in the group market, a succeeding carrier, including a health maintenance organization, is prohibited from including any nonconfinement rules in its plan of benefits and any actively-at-work rules provided in the succeeding carrier’s plan of benefits must provide that absence from work due to any health status-related factor be treated as being actively-at-work.

(3) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier’s contract or policy, no provision in a succeeding health maintenance organization’s contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier’s contract shall be applied with respect to those covered persons validly covered under the prior carrier’s contract or policy on the date of discontinuance.

Section 2219. Investment Powers

With the exception of investments made in accordance with Section 7A(1) of this Act, the investment practices of a health maintenance organization shall be governed by [insert reference to state law equivalent to the NAIC Health Maintenance Organization Investment Guidelines].
Section 2320. Accounting Practices

Every health maintenance organization shall maintain its financial records in accordance with [insert reference to state law equivalent to NAIC Accounting Practices and Procedures Manual].

Section 2421. Fiduciary Responsibilities

A. A director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the health maintenance organization shall be responsible for the funds in a fiduciary relationship to the health maintenance organization.

B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on these employees and officers, directors and partners in an amount not less than $1,000,000 for each health maintenance organization or a maximum of $10,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the commissioner.

Drafting Note: As an optional additional subsection, language may be included that would make the appropriate provisions of the state’s insurance laws governing prohibitions or restrictions on activities of directors, officers and certain shareholders applicable to health maintenance organizations.

Section 2522. Annual and Quarterly Financial Statement Filing Requirements

A. (1) Every health maintenance organization shall file annual and quarterly financial statements, as provided in Paragraph (2), with the commissioner and with the National Association of Insurance Commissioners (NAIC).

(2) The annual statement shall be filed by March 1 for the preceding year and a quarterly financial statement by May, August and November 15 for the preceding quarter.

B. The annual and quarterly financial statements shall be prepared on the most current NAIC Health Annual Statement Blank in accordance with the NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual.

Section 2623. Reporting Requirements

A. (1) Every health maintenance organization shall annually, on or before March 1, file a report verified by at least two principal officers with the commissioner covering the preceding calendar year. The report shall be on forms prescribed by the commissioner.

(2) In addition, the health maintenance organization shall file by March 1, unless otherwise stated:

(a) Audited financial statements on or before June 1;

(b) A list of participating providers in a form approved by the commissioner; and

(c) (i) A description of the grievance procedures; and

(ii) The total number of grievances handled through these procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

B. (1) Unless otherwise provided in this Act, a health maintenance organization shall file notice with the commissioner within thirty (30) days of the effective date of a change, describing any material modifications to the documents required to be filed with the application for a certificate of authority as set forth in Section 5B(1) and (2) of this Act.
Unless otherwise provided in this Act, a health maintenance organization shall file with the commissioner advance notice, or if advance notice is not practicable, notice filed as soon as possible, but in no event more than thirty (30) days after the effective date of a change, describing any material modifications to the health maintenance organization’s operations as set forth in the information required by Section 5B of this Act that affects any of the following:

(a) The solvency of the health maintenance organization;

(b) The health maintenance organization’s continued provision of health care services that it has contracted to provide;

(c) The manner in which the health maintenance organization conducts its business; or

(d) Any other matters the commissioner may prescribe by regulation.

C. The commissioner may require additional reports as necessary to carry out the commissioner’s duties under this Act.

Section 2724. Powers of Insurers and [Hospital and Medical Service Corporations]

A. An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Act. Notwithstanding any other law, which may be inconsistent, any two (2) or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care services by a health maintenance organization owned or operated by an insurer or its subsidiary.

B. Notwithstanding any provision of insurance and hospital or medical service corporation laws [citations], an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The covered persons of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

Section 2825. Examinations

A. The commissioner may make an examination of the affairs of a health maintenance organization, providers and risk bearing entities with which the health maintenance organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state, but not less frequently than once every five (5) years.

B. An examination conducted under this section shall be performed in accordance with the provisions of [insert reference to state law equivalent to the NAIC Model Law on Examinations].

C. The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner.

D. In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state provided that the provisions of [insert state law equivalent to Section 3C of the NAIC Model Law on Examinations] are satisfied.
Section 2926. Suspension or Revocation of Certificate of Authority

A. A certificate of authority issued under this Act may be suspended or revoked, and an application for a certificate of authority may be denied, if the commissioner finds that any of the conditions listed below exist:

1. The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 5 of this Act, unless amendments to those submissions have been filed with and approved by the commissioner;

2. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 8 and 9 of this Act;

3. The health maintenance organization does not provide or arrange for basic health care services;

4. The health maintenance organization is unable to fulfill its obligations to furnish health care services;

5. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to covered persons or prospective covered persons;

6. The health maintenance organization has failed to correct any deficiency occurring due to the health maintenance organization’s prescribed minimum net worth being impaired;

Drafting Note: States that have not adopted Risk Based Capital for Health Organizations Model Act should consider including a provision that provides for early warning and correction of insufficient net worth by a health maintenance organization.

7. The health maintenance organization has failed to implement internal grievance procedures in compliance with [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act];

8. The health maintenance organization has failed to implement the external review procedures required by [insert reference to state law equivalent to the Health Carrier External Review Model Act];

Drafting Note: States that have adopted Options 1 or 2 of the NAIC Health Carrier External Review Model Act should not adopt this provision.

9. The health maintenance organization, or any person acting on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

10. The continued operation of the health maintenance organization would be hazardous to its covered persons;

11. The health maintenance organization has otherwise failed substantially to comply with this Act or any regulation adopted pursuant to this Act; or

12. The health maintenance organization or applicant has violated any other provision of the state insurance code.

Drafting Note: States that have adopted an Administrative Procedures Act should adopt Option A. States that have not adopted an Administrative Procedures Act should adopt Option B.

Option A.

B. The provisions of the [insert reference to state Administrative Procedure Act] of this state shall apply to proceedings under this section.
Option B.

B. (1) Suspension or revocation of a certificate of authority or the denial of an application pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges or conduct on which the suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of the thirty (30) day period.

(2) If the health maintenance organization or applicant requests a hearing pursuant to this subsection the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail stating:

(a) A specific time for the hearing, which may not be less than twenty (20) days nor more than thirty (30) days after mailing of the notice of hearing; and

(b) A specific place for the hearing, which may be either in [location of regulatory body] or in the county where the health maintenance organization’s or applicant’s principal place of business is located.

C. (1) With respect to individual contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall not:

(a) Enroll any additional covered persons except newborn children or other newly acquired dependents of existing covered persons; and

(b) Engage in any advertising or solicitation.

(2) With respect to group contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall enroll additional enrollees and their eligible dependents and newly acquired eligible dependents of existing enrollees, including individuals who become newly acquired eligible dependents of an enrollee through marriage, birth or adoption or placement for adoption, who meet the requirements for special enrollment in accordance with [cite section of state law or regulation implementing the provisions of Section 2701(f) of the Public Health Service Act] or are otherwise eligible under the health benefit plan.

Drafting Note: Under Section 2701(f) of the Public Health Service Act, as amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for the group market, health maintenance organizations are required during special enrollment periods to enroll individual eligible employees and dependents of eligible employees and newly acquired dependents of already enrolled eligible employees, including individuals who become dependents through marriage, birth or adoption or placement for adoption, who meet the requirements for special enrollment in accordance with [cite section of state law or regulation implementing the provisions of Section 2701(f) of the Public Health Service Act] or are otherwise eligible under the health benefit plan. The language in Paragraph (2) is intended to reflect this requirement.

D. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit further operation of the organization found to be in the best interest of covered persons, to the end that covered persons will be afforded the greatest practical opportunity to obtain continuing health care coverage.
E. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

Section 3027. Summary Orders and Supervision

A. Whenever the commissioner determines that the financial condition of a health maintenance organization is such that its continued operation might be hazardous to covered persons, creditors, or the general public, or that it has violated any provision of this Act, the commissioner may, after notice and hearing, order the health maintenance organization to take action reasonably necessary to rectify the condition or violation, including but not limited to one or more of the following:

1. Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;
2. Reduce the volume of new business being accepted;
3. Reduce expenses by specified methods;
4. Suspend or limit the writing of new business for a period of time;
5. Increase the health maintenance organization’s capital and surplus by contribution; or
6. Take other steps the commissioner may deem appropriate under the circumstances.

B. For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject shall be deemed a violation of this Act.

C. The commissioner is authorized to adopt regulations to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to covered persons, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization. The standards shall be consistent with the purposes expressed in Subsection A.

D. The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of [insert reference to state law equivalent to Section 10 of the NAIC Rehabilitation and Liquidation Model Act].

Section 3428. Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations

A. A rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in [insert reference to state rehabilitation law], or when in the commissioner’s opinion the continued operation of the health maintenance organization would be hazardous either to the covered persons or to the people of this state. Covered persons shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

B. For purpose of determining the priority of distribution of general assets, claims of covered persons shall have the same priority as established in [insert reference to state law relating to liquidation of insurers] for policyholders and beneficiaries of insureds of insurance companies. If a covered person is liable to a provider for services provided pursuant to and covered by the health benefit plan, that liability shall have the status of a covered person claim for distribution of general assets. A provider who is obligated by statute or agreement to hold covered persons harmless from liability for services provided pursuant to and covered by a health benefit plan shall have a priority of distribution of the general assets immediately following that of covered persons as described herein, and immediately preceding the priority of distribution described in [insert
Section 3229.  Penalties and Enforcement

A.  In addition to or in lieu of suspension or revocation of a certificate of authority or the denial of an application pursuant to Section 2926 of this Act, the applicant or the health maintenance organization may be subjected to an administrative penalty of up to $[insert number] for each cause for suspension or revocation or application denial.

B.  (1) If the commissioner shall for any reason have cause to believe that a violation of this Act has occurred or is threatened, the commissioner may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation; and, in the event it appears that a violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

(2)  Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section of this Act are satisfied.

C.  Notwithstanding any other provisions of this Act, if a health maintenance organization fails to comply with the net worth requirement of this Act or fails to correct its net worth to bring it into compliance with the requirements of this Act, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its covered persons.

Drafting Note: In addition to the actions provided in this section that a commissioner may use to enforce a health maintenance organization’s compliance with the provisions of this Act, some states may authorize the commissioner to issue an order to a health maintenance organization or a representative of the health maintenance organization to cease and desist from engaging in an act or practice that is violation of this Act. In addition, the commissioner may also be authorized to institute an action seeking to obtain injunctive or other relief if the health maintenance organization fails to comply with the order to cease and desist. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

Section 3330.  Regulations

The commissioner may promulgate regulations to carry out the provisions of this Act. The rules and regulations shall be subject to review in accordance with [insert reference to state law relating to administrative rulemaking and review of rules].

Section 3431.  Statutory Construction and Relationship to Other Laws

A.  Except as otherwise provided in this Act or in other laws expressly referring to health maintenance organizations, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to a health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.

B.  Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health care professionals.

C.  Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from the provision of [insert reference to state law relating to the practice of medicine].
Section 3532. Filings and Reports as Public Documents

All applications, filings and reports required under this Act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 3673 of this Act, and any other information that is considered privileged or confidential under state or federal law.

Section 3633. Insurance Holding Company System Regulatory Act

All health maintenance organizations shall meet the requirements of [insert reference to state law equivalent to NAIC Insurance Holding Company System Regulatory Act].

Drafting Note: States that have not included health maintenance organizations within the scope of their state law equivalent to the NAIC Insurance Holding Company System Regulatory Act should not adopt this section.

Section 3734. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 3835. Effective Date

This Act shall be effective [insert date].
APPENDIX A

Former Section 3HH, Section 14 and Section 20

Below are the sections deleted to reconcile the provisions of this model with the 2017 revisions to the Life and Health Insurance Guaranty Association Model Act (#520), which added health maintenance organizations as members of the guaranty association.

Section 3HH. Definition of Uncovered Expenditures

“Uncovered expenditures” means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization’s insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.

Section 14. Continuation of Benefits

A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

B. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider, after the health maintenance organization’s insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements to assure that benefits are continued as specified above.

Section 20. Uncovered Expenditures Deposit

A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization’s outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.
C. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(a) A substitute deposit of cash or securities of equal amount and value is made;

(b) The fair market value exceeds the amount of the required deposit; or

(c) The required deposit under Subsection A is reduced or eliminated.

(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of covered persons of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.

F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.
The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call July 28, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Donna Lambert (AR); Erin Klug (AZ); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Justin McFarland and Craig Van Aalst (KS); Kathleen A. Birrane and Theresa Morfe (MD); Andrew Kleinnendorst (MN); Jeannie Keller (MT); Crystal Bartuska and Sara Gerving (ND); Maureen Belanger (NH); Gale Simon (NJ); Margaret Pena (NM); Laura Miller (OH); Marie Ganim (RI); Shari Miles (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); James A. Dodrill, Tim Sigman and Joylynn Fix (WV); and Denise Burke (WY). Also participating were: Trinidad Navarro (DE); and Glen Mulready (OK).

1. **Adopted its June 24 Minutes**

The Working Group met June 24 to discuss the June 18 comments received on the draft quantitative treatment limitation (QTL) template and instructions.

Ms. Beyer made a motion, seconded by Ms. Northrup, to adopt the Working Group’s June 24 minutes (Attachment Five-A). The motion passed unanimously.

2. **Heard a Presentation on MHPAEA Compliance Work and Activities Involving Self-Funded Group Health Plans**

Henry Harbin (The Bowman Family Foundation—BFF), consultant to the BFF, and Beth Ann Middlebrook (B. Middlebrook Consulting LLC) discussed the activities of the BFF to improve plan compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Dr. Harbin highlighted the work the BFF has been doing with Path Forward, which is a five-year initiative undertaken by a number of partners, including the National Alliance of Healthcare Purchaser Coalitions (National Alliance), the American Psychiatric Association (APA), and the APA Foundation Center for Workplace Mental Health. He said employers overwhelmingly identify the need to improve access to effective, affordable and timely behavioral health care as a top priority. He described the five key priorities of Path Forward, which includes: 1) improving in-network access to behavioral health specialists; 2) expanding screening and testing for mental health/substance use disorders (MH/SUD); and 3) ensuring MHPAEA plan compliance.

Dr. Harbin said Path Forward’s main focus among its key priorities is improving access. He discussed Path Forward’s efforts to improve access and its recommendations to employers to address the issue. He also discussed Path Forward’s use of Regional Employer Stakeholder Engagement Teams (RESET Regions) to assist it with achieving improved access. He said Path Forward also sees itself as a partner with state departments of insurance (DOIs) and the U.S. Department of Labor (DOL) in improving MHPAEA plan compliance.

Ms. Middlebrook discussed the findings of the 2019 Milliman Report (Report). Based on claims data, the Report measured disparities in reimbursement rates and access to MH/SUD services with respect to employer-sponsored plans. Ms. Middlebrook also discussed the Mental Health Treatment and Research Institute’s (MHTARI’s) Model Data Request Form (MDRF), which is a tool for the collection of key data on certain MHPAEA plan compliance and network access issues that may exist for MH/SUD services.

Ms. Middlebrook explained that the MDRF contains specific, detailed instructions and definitions developed to elicit targeted, consistent and reliable responses from plans on quantitative measures for determining outcome disparities related to network adequacy and other non-quantitative treatment limitations (NQTLs). The MDRF requests data that measures the following: 1) disparities in out-of-network use for MH/SUD versus medical/surgical (M/S); 2) disparities in reimbursement rates for MH/SUD versus M/S providers; 3) disparities in denial rates for MH/SUD versus M/S services; and 4) the accuracy of network provider directories. Ms. Middlebrook discussed how some large private employers and states, such as Washington, have used the MDRF to assess these disparities and evaluate any red flags that may surface related to a plan’s MHPAEA plan compliance.
Ms. Beyer explained how Washington used the MDRF through its market conduct examination authority to evaluate disparities, particularly with respect to NQTLs, based on the data collected from plans. She said Washington plans to publish an aggregate level report on the findings and recommendations form the University of Washington. NAIC staff will post the report on the Working Group’s webpage.

Ms. Dzurec reminded Working Group members and interested parties about the purposes of establishing the Working Group. One such purpose is to have the Working Group facilitate information-sharing and discussion among state insurance regulators on the work they are doing related to MHPAEA plan compliance and share state best practices, such as what Ms. Beyer discussed related to Washington’s work with the MDRF.

3. **Heard a Presentation on State Legislative Trends in MHPAEA Reporting**

Tim Clement (APA) discussed state legislative action with respect to MHPAEA plan compliance. He said there has been significant and growing state legislative efforts to improve MHPAEA plan compliance. Most of the legislation has focused on NQTLs. Mr. Clement said state legislation has also required market conduct examinations as part of the effort to achieve MHPAEA plan compliance. He discussed state legislation that has been enacted since 2018 and legislation currently pending, noting that his presentation includes links to the legislation.

Mr. Clement advised state insurance regulators to be prepared for legislation to be introduced in their states concerning MHPAEA plan compliance. He said to date, 14 states have introduced legislation, with 13 requiring NQTL stepwise analyses to determine MHPAEA plan compliance. He encouraged state insurance regulators to ensure that any such introduced legislation works for them and is in line with the state DOI staffing and funding resources. He suggested a number of potential technical suggestions and/or amendments that state insurance regulators may want to consider with respect to any legislation introduced, including: 1) effective dates; 2) reporting submission dates; 3) defining terms; 4) specifying that NQTL reporting be staggered rather than one reporting date; and 5) adding provisions for quantitative treatment limitation/financial requirement (QTL/FR) reporting. He also suggested that state insurance regulators should talk to their fellow regulators, particularly those states that are implementing, or have undertaken, significant MHPAEA activities.

4. **Discussed Current MHPAEA Compliance Tools, How the States Can Leverage These Resources, and the Working Group’s Next Steps**

Ms. Dzurec discussed current MHPAEA plan compliance tools, including the MHPAEA chapter (Chapter) in the Market Regulation Handbook. She explained that in having this Chapter, she was able to cross-reference what is in the Chapter with the draft QTL template. She reiterated that the Working Group’s work is to supplement the existing MHPAEA plan compliance tools, such as the Chapter, not replace them. She said she is still working to revise the draft QTL template based on the June 18 comments and her current work cross-referencing the draft QTL template with the Chapter.

Ms. Beyer discussed the Working Group’s future work to develop NQTL compliance tools that the states can use to determine MHPAEA plan compliance. She asked for suggestions from Working Group members on what NQTL categories or types would be most helpful. Ms. Dzurec discussed what the Working Group has discussed to date about potential NQTL topics, such as reimbursement and network adequacy. She said the Working Group will continue this discussion in its upcoming meetings. She suggested that if any Working Group members have thoughts on specific NQTL topics the Working Group should work on to reach out to NAIC staff.

Having no further business, the MHPAEA (B) Working Group adjourned.
Draft: 7/22/20

MHPPAEA (B) Working Group
Conference Call
June 24, 2020

The MHPPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call June 24, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Mel Heaps (AR); Erin Klug (AZ); Sheirin Ghoddoucy (CA); Cara Cheevers (CO); Kurt Swan (CT); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Julie Holmes (KS); Erica Bailey (MD); Peter Brickwedde and Grace Arnold (MN); Jeannie Keller (MT); Ted Hamby (NC); Crystal Bartuska and Sara Gerving (ND); Gale Simon and Ralph Boeckman (NJ); Brittany ODell (NM); Laura Miller (OH); Shari Miles (SC); Jill Kruger (SD); Rachel Bowden (TX); Heidi Clausen and Jaakob Sundberg (UT); Brant Lyons (VA); Barbara Belling (VI); Tim Sigman and Joylynn Fix (WV); and Denise Burke (WY). Also participating was: Laura Arp (NE).

1. Adopted its June 5 Minutes

The Working Group met June 5 to review and discuss the draft quantitative treatment limitation (QTL) template and instructions.

Ms. Beyer made a motion, seconded by Mr. Swan, to adopt the Working Group’s June 5 minutes (Attachment Five-A1). The motion passed unanimously.

2. Heard an Update from the DOL on the Proposed 2020 MHPAEA Compliance Tool

Amber Rivers (U.S. Department of Labor—DOL) said the DOL’s Employee Benefits Security Administration (EBSA) released a proposed 2020 self-compliance tool on June 19 intended to help improve compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPPAEA) and additional related requirements under the federal Employee Retirement Income Security Act (ERISA). The EBSA is requesting public comments on the self-compliance tool proposed revisions by July 24. Ms. Rivers said the proposed revisions update the current 2018 MHPPAEA self-compliance tool. She said the proposed revisions generally fall into four categories: 1) integration of recent guidance; 2) revision of compliance examples; 3) best practices for establishing an internal compliance plan; and 4) warning signs. She said the DOL is hosting an MHPPAEA listening event July 16 focusing on compliance issues. She urged Working Group members to attend.

3. Discussed the June 18 Comments Received on the Draft QTL/FR Template and Instructions

Ms. Dzurec said the Working Group received comments on the draft QTL and financial requirement (QTL/FR) template by the June 18 public comment deadline from the Association for Behavioral Health and Wellness (ABHW); America’s Health Insurance Plans (AHIP); the American Medical Association (AMA); the Blue Cross Blue Shield Association (BCBSA); the Health Coalition in a joint comment submission from Anthem Inc., Cigna, CVS Health, Health Care Service Corporation (HCSC), and UnitedHealthcare; The Kennedy Forum; the Legal Action Center (LAC); the National Association of Health Underwriters (NAHU); the NAIC consumer representatives; the Parity Implementation Coalition (PIC); the Virginia Insurance Bureau; and URAC. She said she reviewed each comment letter, and during her review, she found that the comments generally fell into the following issue categories: 1) addressing plan networks; 2) grouping services; 3) certificate of coverage and schedule of benefits (SOB) cross-reference requirements; 4) a limitation on the number of plans per template; and 5) the addition of non-quantitative treatment limitation (NQTL) elements. She discussed how she planned to address some of these issues in the next draft of the QTL/FR template and instructions, including clarifying in the instructions how plans should account for networks, such as preferred and non-preferred networks; clarifying how plans may be able to group certain services together if the elements are the same; and making the certificate of coverage and SOB cross-references optional.

Ms. Dzurec said some commenters also requested clarification on the states’ use of the proposed QTL/FR template. She said Pennsylvania uses the template for market conduct examinations. However, she said the analysis needed to determine MHPPAEA plan parity compliance is the same regardless of whether the template is used for form review or market conduct examinations. Kris Hathaway (AHIP) asked about the Working Group’s timeline for completing the template. She noted that the states have other tools and templates to use to determine MHPPAEA mental health/substance use disorder (MH/SUD) parity compliance, such as the MHPPAEA chapter and tool in the NAIC Market Regulation Handbook (Handbook). She also expressed concern with the time it will take for a plan to complete the proposed QTL/FR template. Randi Reichel (Health Coalition)
expressed support for Ms. Hathaway’s comments concerning the potential time needed for a plan to complete the proposed template. Ms. Reichel explained that plans are currently doing the analysis to comply with the MHPAEA MH/SUD parity requirements, but operationally the proposed template will require plans to manually input the required information, which could take a lot of time because it cannot be automated.

Ms. Arp discussed her work in developing the MHPAEA chapter and tool in the Handbook. She discussed how she envisioned the proposed QTL/FR template working with the MHPAEA chapter and tools and the merits of having such a template particularly for those states with limited resources to resolve red flags. Ms. Dzurec agreed that the states can use the draft QTL/FR template for that purpose and any other purpose a state feels is appropriate. She noted that she personally would like to use such a template at the beginning of any MHPAEA MH/SUD plan parity analysis because she has seen a lot of violations. She expressed concern that plans are not getting it right and consumers are being harmed.

Ms. Dzurec emphasized that consistent with the Working Group’s charge, the draft QTL/FR template is meant to be supplemental to existing compliance tools. It is not intended to replace any of these existing compliance tools, including the MHPAEA chapter in the Handbook. She asked for comments.

Tim Clement (American Psychiatric Association—APA) said he understands industry concerns. However, he does not believe the draft QTL/FR template is overly burdensome. John Troy (BCBSA) expressed support for AHIP’s and the Health Coalition’s comments regarding their operational concerns with the draft QTL/FR template and its potential to be administratively burdensome for plans to complete. Pamela Greenberg (ABHW) reiterated the ABHW’s concerns with the draft QTL/FR template outlined in its comment letter, including its use, the Working Group’s process, flexibility in its use, and benefit services classifications. David Lloyd (The Kennedy Forum) agreed with Ms. Dzurec’s comments concerning the errors that plans continue to make in their MHPAEA MH/SUD parity analyses and the impact of such errors on consumers.

Ms. Hathaway suggested that the draft QTL/FR template should be something the Market Regulation and Consumer Affairs (D) Committee should be involved in given the year-long project conducted by one of the Committee’s working groups with respect to developing the MHPAEA chapter and tool in the Handbook. Ms. Dzurec explained the Working Group’s next steps with respect to the draft QTL/FR template and the template’s connection with the MHPAEA chapter and tool in the Handbook. She said after the Working Group completes its work on the template, it will not be formally voted on by the Regulatory Framework (B) Task Force or the Health Insurance and Managed Care (B) Committee. She reiterated that, consistent with the Working Group’s charge, the template would be an additional resource the states can use, if they choose to do so, to determine MHPAEA MH/SUD plan parity compliance. The template would not supplant the MHPAEA chapter and tool in the Handbook. Ms. Dzurec said the draft template is just a deeper dive into the analysis required to determine MHPAEA plan parity compliance. She also explained that the template was never meant to be an NAIC supported or endorsed product. However, she cautioned that even if it is not an NAIC supported or endorsed product, some states will still use it, and are currently using it, as part of their processes to determine MHPAEA plan parity compliance.

Ms. Beyer said the MHPAEA is a complex law and the analysis necessary to determine MHPAEA plan parity compliance is complex as well. She said state insurance regulators feel that they have a responsibility to consumers to ensure that they have access to the services they need. Ms. Cheevers expressed support for Ms. Dzurec’s and Ms. Beyer’s comments with respect to the proposed QTL/FR template being an additional tool states can use to dig deeper, particularly when there are red flags.

Ms. Dzurec said within the next few weeks, she will revise the draft QTL/FR template and instructions based on the comments received requesting clarity in some areas. She reiterated that after the Working Group completes its work, it will report on its work to the Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee for informational purposes only. Currently, she said the Working Group does not foresee the template being an NAIC supported or endorsed product. However, if the Task Force or the Committee decides that it should be, then the Working Group would go back to the beginning and use the NAIC’s traditional process to work on it. Ms. Dzurec said after the Working Group completes its work on the QTL/FR template, it will begin work on the NQTL models determining what NQTL topics to include.

Having no further business, the MHPAEA (B) Working Group adjourned.
The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call June 5, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Mel Anderson and Zane Chrisman (AR); Erin Klug (AZ); Jessica Ryan (CA); Cara Cheevers (CO); Kurt Swan (CT); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Julie Holmes (KS); Erica Bailey (MD); Julia Lyng (MN); Jeannie Keller (MT); Ted Hamby (NC); Chrystal Bartuska and Sara Gerving (ND); Gale Simon and Ralph Boeckman (NJ); Paige Duhamel and Viara Ianakieva (NM); Laura Miller (OH); Courtney Miner (RI); Kendell Buchanan (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman and Joylynn Fix (WV); and Tana Howard and Bill Cole (WY).

1. **Adopted its March 19 and March 9 Minutes**

The Working Group met March 19 and March 9 to discuss its 2020 activities.

Ms. Beyer made a motion, seconded by Ms. Kruger, to adopt the Working Group’s March 19 (Attachment Five-A1a) and March 9 (Attachment Five-A1b) minutes. The motion passed unanimously.

2. **Discussed the Draft Working Group Work Plan**

Ms. Dzurec discussed her draft work plan for the Working Group’s work related to complete two projects as additional resources and guidance for the states to use as part of their form reviews related to mental health/substance use disorder (MH/SUD) benefits parity requirements under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): 1) a quantitative treatment limit (QTL)/financial review (FR) template; and 2) non-quantitative treatment limit (NQTL) models. She said she anticipates the Working Group completing its work on the QTL/FR template by the end of June and sending it to the Regulatory Framework (B) Task Force. She said that because a state’s use of this template is voluntary, she does not anticipate the Task Force adopting it.

Ms. Dzurec said that after the Working Group completes its work on the QTL/FR template, it will begin work on the NQTL models. She said that after the Working Group determines what NQTL topics to include in the models, she anticipates the Working Group possibly forming smaller drafting groups to separately work on each NQTL model topic and complete work on each of the NQTL model topics on a rolling basis before the end of the year. She also discussed the specific timelines for each project.

Ms. Dzurec asked for comments on the proposed work plan. There were no comments.

3. **Reviewed the Draft QTL/FR Template**

Ms. Dzurec said she reviewed the QTL/FR draft template. She said Pennsylvania has been using this template for its MHPAEA parity form reviews. She emphasized that a state’s use of the template is voluntary, reiterating that its development is part of the Working Group’s charge to create additional resources and guidance for the states with respect to MHPAEA parity compliance tools.

Ms. Dzurec described the template’s uses, such as: 1) product development; 2) reporting; 3) form filing; and 4) market conduct examinations. She provided a step-by-step overview of how a state could use the template in its form review to determine plan MHPAEA parity compliance beginning with the input of plan information to the end of the form review. She explained the state’s activities in the review as well as the insurer’s activities, particularly with respect to covered services where the insurer would classify the covered services as medical/surgical services or MH/SUD services and the state would confirm that classification. She said the template does not permit an insurer to classify a covered service as both medical/surgical and MH/SUD. The covered services must be classified as one type of service or the other type of service, not both. She explained that when identifying limitations on a covered service, an insurer cannot include “medical necessity” as a limitation because for a service to be a covered service, it must be medically necessary. She said that at the end of the form review, the template
provides roles for the insurer and the state to adjust and correct any problematic areas that arise in the form review for the plan to comply with the MHPAEA parity requirements.

Ms. Dzurec requested comments. Ms. Beyer asked about the analysis required to determine MHPAEA parity compliance with respect to covered benefit plan limitations—copayments, coinsurance and deductibles. Ms. Dzurec confirmed that the analysis would be based on each QTL. Ms. Chrisman asked if there would be an issue with MHPAEA parity compliance if an MH/SUD benefit was more generous than a medical/surgical benefit. Ms. Dzurec said there would not be an issue with MHPAEA parity compliance in this situation because the federal regulations prohibit plans from imposing more restrictive requirements on MH/SUD benefits than medical/surgical benefits. This prohibition does not operate the other way.

Ms. Dzurec said the Working Group has set a public comment period ending June 18 to receive comments on the draft QTL/FR template. She urged stakeholders to submit comments in order to improve the draft and make it more efficient and helpful to the states as an additional tool in determining MHPAEA parity compliance.

Having no further business, the MHPAEA (B) Working Group adjourned.
The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call March 19, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); William Lacy (AR); Erin Klug (AZ); Jessica Ryan (CA); Cara Cheevers (CO); Kurt Swan (CT); Colin Johnson (DC); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Julie Holmes (KS); Erica Bailey (MD); Candace Gergen (MN); Jeannie Keller (MT); Ted Hamby (NC); Sara Gerving (ND); Maureen Belanger (NH); Ralph Boeckman (NJ); Paige Duhamel and Viara Ianakieva (NM); Marie Ganim (RI); Shari Miles (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman and Joylynn Fix (WV); and Denise Burke (WY). Also participating was: Laura Arp (NE).

1. Discussed Current and Potential MHPAEA Compliance State Tools

Ms. Dzurec said that currently there are two main Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) compliance tools available to the states: 1) the U.S. Department of Labor’s (DOL’s) compliance check list, which is updated every two years; and 2) the NAIC Market Regulation Handbook’s MHPAEA chapter. She asked the Working Group to consider the following questions: 1) how much detail is necessary for state insurance regulators to determine plan compliance with MHPAEA’s parity requirements; 2) whether instructions on how to use these tools and any additional tools the Working Group develops would be useful; and 3) what is working and what is not regarding state insurance regulators determining plan parity compliance.

Ms. Dzurec asked the Working Group members to share their experiences with evaluating plan parity compliance. Ms. Cheevers said that in accordance with state requirements, Colorado receives a robust set of data from plans to evaluate compliance. She said the receipt of such data has presented some challenges; as a result, in some cases, Colorado has relied on self-attestation in determining plan compliance. She said the department of insurance (DOI) is looking at ways to prioritize and streamline the data it receives. Ms. Dzurec said Pennsylvania has similar issues with the amount of data it receives. She said this is an area the Working Group could address as part of its work related to nonquantitative treatment limits (NQTLs) guidelines to determine what information state insurance regulators need and what questions they should ask in determining plan parity compliance.

Ms. Arp said that when working on the MHPAEA chapter of the Handbook, the Market Conduct Examination Standards (D) Working Group took a surgical approach in establishing the examination requirements because it realized that state DOIs have limited staff to perform these analyses. She suggested that one way to find out if plans are complying with MHPAEA parity requirements is to reach out to providers. She said Nebraska took such an approach—talking to providers about what the Nebraska DOI would be looking for with respect to MHPAEA violations. Ms. Dzurec agreed that the Working Group could look at utilizing a similar approach, but taking care not to overburden providers in reporting this information to state DOIs. Ms. Arp suggested that to avoid this, the Working Group could consider reaching out to provider associations. Ms. Duhamel said New Mexico has taken a similar approach in its provider outreach efforts. She said it might be useful for the Working Group to create provider outreach materials for the states to use. Ms. Arp said Nebraska has created such materials, including a provider outreach presentation. Ms. Dzurec asked Ms. Arp to share Nebraska’s provider outreach presentation with the Working Group. She suggested that any information the Working Group receives from such outreach could inform the Working Group’s work on identifying which NQTLs the Working Group should focus on. She noted that claim reviews are also helpful in identifying NQTLs and monitoring plan in-operation compliance.

Uma Dua (Dua Enterprises) said the Working Group should consider developing an NQTL data tool for pharmacy benefits. Ms. Beyer said the Bowman Family Foundation (BFF) has developed a model data request form, which the Working Group may want to look at to determine what information state DOIs would want from plans to determine parity compliance. The Working Group discussed additional suggestions on what additional tools the Working Group could create to assist the states in determining plan parity compliance and providing uniformity in responses among carriers, such as developing a standardized side-by-side comparison template of medical/surgical (M/S) benefits and mental health of substance use disorder (MH/SUD) benefits and/or an excel spreadsheet with tabs that pertain to a certain area of mental health.
Matthew Litton (DOL) said the DOL recently issued its 2020 Report (Report) to the U.S. Congress (Congress), as required by the MHPAEA, on compliance of group health plans and health insurance coverage offered in connection with such plans with the MHPAEA’s requirements. He said the DOL is required to submit this Report every two years. He said the Report discusses the DOL’s activities to further parity implementation since its 2018 Report to Congress. Most notably, the Report provides an overview of the DOL’s partnership efforts across the federal agencies, as well as with plans, issuers, consumers, providers, states and other stakeholders. The Report details the DOL’s intent to use the information gathered from these partnerships to develop a roadmap to compliance for the regulated community so that health plan participants and beneficiaries can realize the full benefits of the MHPAEA. Mr. Litton said the DOL also released its fiscal year (FY) 2019 Mental Health Parity and Addiction Equity Act Enforcement Fact Sheet. He said the enforcement fact sheet summarizes the DOL Employee Benefits Security Administration’s (EBSA’s) and the federal Centers for Medicare and Medicaid’s (CMS’s) closed investigations and public inquiries related to MHPAEA during FY 2019.

Ms. Dzurec said that given the states’ short-term focus on COVID-19 issues, she anticipated the Working Group’s work to be slowed somewhat as it moves forward over the next few months. She said her goal is to create a project plan for the Working Group for the remainder of the year consistent with its charges.

Having no further business, the MHPAEA (B) Working Group adjourned.
The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call March 9, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Mel Heaps (AR); Catherine O’Neil (AZ); Sheirin Ghoddoucy (CA); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie (IL); Julie Holmes (KS); Erica Bailey (MD); Sherri Mortensen-Brown and Peter Brickwedde (MN); Jeannie Keller (MT); Rosemary Gillespie (NC); Chrystal Bartuska and Sara Gerving (ND); Maureen Belanger (NH); Gale Simon (NJ); Paige Duhamel (NM); Marie Ganim (RI); Shari Miles and Kendell Buchanan (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Yolanda Tennyson (VA); Jane Beyer (WA); Barbara Belling (WI); Joylynn Fix (WV); and Denise Burke (WY). Also participating was: Tashia Sizemore (OR).

1. Discussed the Working Group’s 2020 Activities

Ms. Dzurec said the purpose of the Working Group’s conference call is to discuss how the Working Group plans to proceed with its work and how it will operate moving forward. She said she anticipates the Working Group operating similarly to the ERISA (B) Working Group. The Working Group’s main activity will be to review and develop tools for the states to use with respect to plan compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Ms. Dzurec requested suggestions from Working Group members and other stakeholders on what they believe the Working Group should focus on short-term and long-term consistent with the Working Group’s 2020 charges.

Ms. Dzurec described some of the tools and resources currently available to the states to assist in MHPAEA plan compliance, including the U.S. Department of Labor’s (DOL’s) MHPAEA self-compliance tool and the MHPAEA chapter in the NAIC Market Regulation Handbook. She explained that the MHPAEA is not a mandate, but if a plan covers mental health and substance use disorder (MH/SUD) benefits, then the plan is prohibited from imposing limitations on such benefits that are less favorable than the limitations imposed on medical/surgical (M/S) benefits. She said that to determine plan compliance with this parity requirement, state insurance regulators are required to conduct a comparability analysis both at inception and in-operation.

Andrew Sperling (National Alliance on Mental Illness—NAMI) expressed support for the Working Group’s appointment and its 2020 anticipated work. Tim Clement (American Psychiatric Association—APA) also expressed support for the Working Group’s 2020 work, particularly its anticipated work related to in-operation plan parity compliance.

Ms. Dzurec requested comments on issues the states have encountered with plan parity compliance. Ms. Sizemore said Oregon has been having problems with third-party administrators (TPAs) not disclosing their underlying algorithms to support their assertions of parity and compliance with the MHPAEA. Health Insurance Commissioner Ganim said the Rhode Island Office of the Health Insurance Commissioner (OHIC) recently completed three market conduct examinations related to behavioral health coverage. She also said that state departments of insurance (DOIs) welcome input from providers related to parity issues they have encountered with plans. Ms. Dzurec agreed. She said the Working Group might want to consider developing some best practices for ways providers can provide such information to DOIs in such a manner that it is not burdensome to providers. Daniel Blaney-Koen (American Medical Association—AMA) expressed support for any efforts the Working Group undertakes related to provider reporting of plan parity compliance issues.

Ms. Bailey said there is a bill currently pending in the Maryland Legislature to establish reporting requirements related to non-quantitative treatment limits (NQTLs) and associated data. She suggested that the Working Group might want to consider developing best practices related to such reporting requirements. Several Working Group members noted passage of or consideration of legislation like Maryland’s pending legislation, and they expressed support for the Working Group’s efforts to develop resources for the states in this area as Ms. Bailey suggests. Mr. Clement said he would provide the Working Group with a copy of the APA’s tracking of such legislation. Uma Dua (Dua Enterprises, Limited) suggested that the Working Group include a review of pharmacy benefits, particularly concerning pharmacy NQTLs and Pharmacy & Therapeutic (P&T) Committee actions in this area. Jeffrey M. Klein (McIntyre & Lemon) said the American Bankers Association’s (ABA’s) Health Savings Account (HSA) Council has been tracking state legislation related to behavioral services, and he warned the Working Group about potential compliance issues with high deductible health plans (HDHPs) and first dollar coverage for such services. Kris Hathaway (America’s Health Insurance Plans—AHIP) expressed support for the Working Group’s potential
work to develop best practices related to what data elements are most helpful to state insurance regulators to determine NQTL plan compliance.

Ms. Dzurec outlined the Working Group’s potential short-term goals for further discussion during the Working Group’s meeting at the Spring National Meeting. She volunteered to develop basic assumptions for the Working Group to use as it moves forward. She said the Pennsylvania DOI created an automated tool for the testing of quantitative treatment limits (QTLs) that she will share for discussion as another potential resource for the states in their analysis to determine plan parity compliance. Ms. Cheevers expressed support for having a uniform QTL tool for use among the states. Ms. Dzurec agreed, but reminded Working Group members that the intent is for the Working Group to develop resources and tools as an option for the states to use to supplement what they are already doing.

Ms. Dzurec said another short-term goal for the Working Group is to develop an NQTL process for the states to use when conducting their analyses to determine what red flags to look for, how to find them, what to do, and what questions to ask when a state finds them. She explained that the Working Group’s options are limitless in this area, and she suggested that the Working Group select a few NQTLs to start with that are already under review and look for best practices. She said she anticipated each NQTL would be a separate document. She suggested the following NQTLs to review first: 1) reimbursement for MH/SUD providers; 2) fraud, waste and abuse actions that have resulted in NQTLs, such as substance use disorder laboratory work; 3) pharmacy; and 4) soft caps; i.e. not actual visit limits. Working Group members expressed support for Ms. Dzurec’s suggested Working Group short-term goals. Ms. Sizemore said Oregon has been doing some work related to MH/SUD NQTL provider reimbursement that she would be happy to share with the Working Group when it is complete in a few months.

Having no further business, the MHPAEA (B) Working Group adjourned.

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The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 16, 2020. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson and Laura Arp, Vice Chairs (NE); Sarah Bailey (AK); Anthony L. Williams (AL); Marjorie Farmer (AR); Bruce Hinze (CA); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIIwain (KY); Jeffrey Zewe (LA); Mary Kwei (MD); Chad Arnold (MI); Candace Gergen (MN); Amy Hoyt (MO); Derek Oestreicher (MT); Gale Simon (NJ); Renee Blechner and Paige Duhamel (NM); Michael Humphreys (PA); Rachel Jrade-Rice (TN); James Young (VA); Jennifer Kreitler (WA); Nathan Houdek (WI); Ellen Potter (WV); and Denise Burke (WY).

1. Discussed and Exposed a Draft PBM Model

Mr. Keen said as directed by the Subgroup late last year, the ad hoc drafting group completed its work in developing a draft of a proposed new [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (Attachment Six-A). He reminded the Subgroup that it had directed the ad hoc drafting group to develop a draft pharmacy benefit manager (PBM) model addressing licensing and gag clauses. He explained that during its discussions, the ad hoc drafting group discussed many issues beyond the scope of its charge from the Subgroup, which in many respects is reflected in the draft.

Mr. Keen said the ad hoc drafting group used the National Conference of Insurance Legislators’ (NCOIL’s) Pharmacy Benefits Manager Licensure and Regulation Model Act as a base for the draft. He provided a high-level overview of the draft’s provisions. Ms. Seip asked if those states that have adopted provisions similar to the proposed Section 6—Gag Clauses Prohibited have had any issues with it and if they could share their experiences with its implementation. Ms. Farmer said Arkansas has had a similar provision in its law for years, and it has not experienced any implementation issues. Ms. Duhamel said New Mexico’s experience with its law is the same as Arkansas’ experience.

Mr. Keen said the ad hoc drafting group had a lot of discussion concerning Section 8—Regulations, particularly Section 8B, which includes a list of potential provisions the states could include in any regulations adopted to implement the proposed model’s provisions. Ms. Arp explained that Section 8B was crafted as a compromise between those states that are at the forefront of pharmacy benefit manager (PBM) regulation, as reflected in the discussions during the Subgroup’s information-gathering sessions, and those states that are just beginning to consider PBM regulation. Mr. Humphreys said he has concerns with the inclusion of Section 8B in an NAIC model, noting that his legislature most likely would not support such a provision. He suggested that the Subgroup consider developing a white paper on the topics outlined in Section 8B and a standalone PBM licensing model.

Mr. Oestreicher expressed support for Section 8B because he does not believe PBM licensure and gag clause provisions alone would lower prescription drugs costs for consumers. He said Section 8B gives the states the option to include provisions that would lower costs. He said the states that choose to add these provisions can find language in other state laws, such as Maine’s law and the National Academy for State Health Policy’s (NASHP’s) model legislation. Ms. Seip suggested that it would be useful for the Subgroup to know what language the states have on these topics and their experiences. Mr. Hinze said the ad hoc drafting group considers Section 8B to be a starting point, not the end. Mr. Houdek asked about the Subgroup’s next steps are if the Subgroup decides to move forward with the ad hoc drafting group’s draft. Mr. Keen said assuming the Subgroup decides to move forward with the ad hoc drafting group’s draft, the Subgroup’s next steps would be to expose the draft for public comment and then discuss and make revisions to the draft based on the comments received.

Mr. Keen requested comments from interested parties. Chris Petersen (Arbor Strategies LLC), representing the Pharmaceutical Care Management Association (PCMA), said the PCMA submitted a comment letter suggesting that Section 4—Applicability and Section 6 are in conflict. He also suggested that the Subgroup revise Section 6 to mirror the federal gag clause language. He also said the current draft would not meet the NAIC requirement for an NAIC model to be adopted in a majority of the states because of the proposed language in Section 8B. Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said PBM practices have a direct impact on consumer access and affordability; as such, the NAIC consumer representatives would be supportive of more substantive language in Section 8B. Kris Hathaway (America’s Health Insurance Plans—AHIP) said AHIP would be supportive of a PBM licensure model. However, she suggested that the Subgroup keep in mind that PBMs are partners in keeping prescription drug costs low. She said the proposed provisions in Section 8B

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would handcuff plans in lowering prescription drug costs. John Covello (Independent Pharmacy Cooperative) expressed concern with provisions in the draft, such as potential duplicative provisions in Section 3—Definitions and Section 4. Carl Schmid (HIV + Hepatitis Policy Institute) expressed support for Ms. Turner’s comments. He also expressed concerns that Section 5—Licensing Requirement does not include any enforcement or penalty provisions.

Mr. Hinze made a motion, seconded by Mr. Oestreicher, to accept the ad hoc drafting group’s draft as a starting point in the Subgroup work to develop a new NAIC model regulating PBMs. The motion passed unanimously.

Mr. Hinze made a motion, seconded by Ms. Farmer, to expose the draft for a 45-day public comment period. The motion passed unanimously.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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A new model

Comments are being requested on this draft by Tuesday, Sept. 1, 2020. Comments should be sent by email only to Jolie Matthews at jmatthews@naic.org.

[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as the [State] Pharmacy Benefit Manager Licensure and Regulation Act.

Section 2. Purpose

A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.

B. The purpose of this Act is to:

   (1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;

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

   (3) Provide for powers and duties of the commissioner; and

   (4) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

   (1) Receiving payments for pharmacist services;

   (2) Making payments to pharmacists or pharmacies for pharmacist services; or

   (3) Both paragraphs (1) and (2).
B. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

C. (1) “Covered entity” means:
   (a) A nonprofit hospital or medical service corporation, health insurer, health benefit plan or health maintenance organization;
   (b) A health program administered by a department or a state in the capacity of a provider of health coverage; or
   (c) An employer, a labor union or other group of persons organized in the state that provides health coverage to covered individuals who are employed or reside in the state.

(2) “Covered entity” does not include:
   (a) A self-funded plan that is exempt from state regulation pursuant to federal law;
   (b) A plan issued for coverage for federal employees; or
   (c) A health benefit plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts.

D. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

E. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:
   (1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;
   (2) Disbursing or distributing rebates;
   (3) Managing or participating in incentive programs or arrangements for pharmacist services;
   (4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
   (5) Developing and maintaining formularies;
   (6) Designing prescription benefit programs; or
   (7) Advertising or promoting services.

G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.

H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.
“Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.

“Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.

“Pharmacy benefit manager” does not include:

(a) A health care facility licensed in this state;

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

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

Section 4. Applicability

A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of this Act, including any covered entity that offers pharmacy benefits through a third party.

Drafting Note: States may want to consider adding language to Subsection A above or Section 10—Effective Date providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.

C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

Section 5. Licensing Requirement

A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without obtaining a license from the commissioner under this Act.

B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

Drafting Note: States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

Drafting Note: States may want to consider reviewing their third party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of $X.

E. The commissioner may refuse to issue a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.
Section 6. Gag Clauses Prohibited

A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

(1) The nature of treatment, risks or alternative thereto;
(2) The availability of alternate therapies, consultations, or tests;
(3) The decision of utilization reviewers or similar persons to authorize or deny services;
(4) The process that is used to authorize or deny healthcare services or benefits; or
(5) Information on financial incentives and structures used by the insurer.

B. A pharmacy or pharmacist may provide to a covered person information regarding the covered person’s total cost for pharmacist services for a prescription drug.

C. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

D. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements under this Act.

Section 7. Enforcement

A. The commissioner shall enforce compliance with the requirements of this Act.

B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.

Drafting Note: States may want to consider including a reference to the cost of examinations in the Model Law on Examinations (#390).

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

(a) Considered proprietary and confidential;
(b) Not subject to the [Freedom of Information Act] of this state;
Section 8. Regulations

A. The commissioner may adopt regulations regulating pharmacy benefit managers that are not inconsistent with this Act.

B. The regulations adopted pursuant to Subsection A may include but are not limited to the following:
   (1) Pharmacy benefit manager network adequacy;
   (2) Prohibited market conduct practices;
   (3) Data reporting requirements under state price-gouging laws;
   (4) Rebates;
   (5) Prohibitions and limitations on the corporate practice of medicine (CPOM);
   (6) Compensation;
   (7) Procedures for pharmacy audits conducted by or on behalf of a pharmacy benefit manager;
   (8) Medical loss ratio (MLR) compliance;
   (9) Affiliate information-sharing;
   (10) Lists of health benefit plans administered by a pharmacy benefit manager in this state;
   (11) Reimbursement lists or payment methodology used by pharmacy benefit managers;
   (12) Clawbacks prohibited. A pharmacy benefit manager or representative of a pharmacy benefit manager may not make or permit any reduction of payment for pharmacist services by a pharmacy benefit manager or a covered entity directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including but not limited to, generic effective rates, brand effective rates, direct and indirect remuneration fees or any other reduction or aggregate reduction of payment;
   (13) Affiliate compensation.
      (a) "Pharmacy benefit manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefit manager.
      (b) A pharmacy benefit manager may not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services; and
   (14) Spread pricing prohibited.
      (a) "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.
(b) A pharmacy benefit manager is prohibited from conducting spread pricing in this state.

**Drafting Note:** Subsection B lists options for a state to consider in adopting regulations to implement the provisions of this Act. Not every option listed will be appropriate for every state.

**Section 9. Severability**

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

**Section 10. Effective Date**

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have [six (6)] months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.
The Senior Issues (B) Task Force met via conference call Aug. 3, 2020. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Steve Ostlund (AL); Alan McClain represented by William Lacy (AR); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmaier (FL); John F. King (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Sonya Sellmeyer (IA); Dean L. Cameron represented by Weston Trexler (ID); Stephen W. Robertson represented by Rebecca Vaughan (IN); Vicki Schmidt represented Craig Van Aalst (KS); James J. Donelon represented by Ron Henderson (LA); Gary Anderson represented by Ruth Moritz (MA); Kathleen A. Birrane represented by Fern Thomas (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Renee Campbell (MI); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Mary Jo Wegenast (NC); Jon Godfread represented by Chrystal Bartsuka (ND); Bruce R. Ramge (NE); Chris Nicolopoulos represented by Maureen Belanger (NH); Russell Toal represented by Paige Duhamel (NM); Barbara D. Richardson represented by Jack Childress (NV); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Ron Kreiter (OK); Andrew R. Stolfi represented by Gayle L. Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Hodgen Mainda represented by Vickie Trice (TN); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Michael Bryant (WA); Mark Afable represented by Jennifer Stegall (WI); and James A. Dodrill (WV).

1. **Adopted its March 3 and 2019 Fall National Meeting Minutes**

Director Lindley-Myers made a motion, seconded by Mr. Henderson, to adopt the Task Force’s March 3 (Attachment One) and Dec. 7, 2019, minutes. The motion passed unanimously.

2. **Heard a Federal Legislative Update**

David Torian (NAIC) provided a federal legislative update, including an update on funding for the State Health Insurance Assistance Program (SHIP) and the pending release of the Federal Interagency Task Force on Long-Term Care Insurance’s final report.

3. **Discussed Other Matters**

Director Wing-Heier asked Task Force members about their experience with seniors and COVID-19 and any information that we might not be aware of in respect to the pandemic. She said there are some incidental and anecdotal stories that seniors may be putting off health care needs or the need to go into a long-term care (LTC) facility. She asked whether there is anything from an insurance perspective that we should be taking a look at this time.

Commissioner Caride said New Jersey has managed to control the crisis somewhat, but it is watching as the numbers are beginning to come up again as so many states are seeing resurgence of it. She said she has heard on numerous occasions about seniors who are refusing to go to nursing homes and not wanting to go to the hospital with the concern of getting COVID-19, even if their health requires them to see their doctors.

Commissioner Caride said New Jersey and hospitals are doing a push in marketing and advertising to seniors that they are open for business outside of dealing with a pandemic. She said the numbers have gone down drastically, and it is time for these seniors to come back for either an elective procedure they put off or just for a regular checkup. She said there is a lot of work to be done to encourage seniors not to be afraid to go to their doctors or to go to the hospital. She said one area of promotion is telehealth and telemedicine.

Bonnie Burns (California Health Advocates—CHA) highlighted fraud and COVID-19 among seniors, and she encouraged communication among all parties about any and all fraud circulating. She also said there is the problem with people who are getting home care under long-term care insurance (LTCI) policies. She said these people have family living in their homes who are able and available caregivers, but these family caregivers are excluded under almost all of the LTCI policies. She said the
The pandemic has increased the concern about an outside caregiver, and many are now going without care. She encouraged state insurance regulators and companies to look at the flexibility of having a family caregiver included on a month to month basis during this national emergency.

Director Wing-Heier asked Ms. Burns if there is anything state insurance regulators can do when they speak with carriers about these concerns. Ms. Burns replied that it is important for state insurance regulators to make carriers aware of this fraud and these problems and encourage them to make changes or alternatives during this national emergency.

Commissioner Caride said regarding fraud, she had heard about companies going and taking swabs of seniors and charging the seniors’ insurance. She said she knows the Task Force has talked about different things that are going on around the country regarding seniors. She said that is our watchlist, and it is interesting to hear how other states are handling different situations.

Ms. Burns raised the concern with a lot of emphasis on medical services that plans are able to provide, and while they may be valuable for people who qualify for it, it is not universally applicable to every senior. She said she is seeing a lot of evidence that agents are telling people to sign up for these plans, telling them about medical events and home delivered meals, for instance. But only a very small percentage of people would qualify and actually get that benefit, and that information is not communicated. Ms. Burns said there are all kinds of ads running on TV right now that emphasize these non-medical benefits to the broad population.

Mr. Henderson said he has noticed an uptick in advertisements enticing seniors with plans that offer additional benefits. He said his department is receiving more and more calls from seniors who have called the number of the advertisement and find out that they have been switched to another plan without their knowledge or consent. He said his department is spending a lot of time correcting these changes. He cited as an example, a senior who, unbeknownst to her, was removed from her company retirement plan and put into a Medicare Advantage plan.

Ms. Brown said she is seeing these ads, and they are on many cable channels and often on some specific channels. She said she cannot recall the names of the specific ads that cater to seniors. She said these ads are not from Colorado, but they are being beamed into Colorado, and its department receives calls every day about these ads.

Commissioner Caride asked if there was anything else anyone wished to discuss.

Marcy Buckner (National Association of Health Underwriters—NAHU) raised the issue of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and a senior may end up in a COBRA plan and then be penalized that 10% for life for going into COBRA when they should have been on Medicare. She said NAHU is working with Congressman Kurt Schrader of Oregon on a bill he has co-sponsored to allow seniors enrolled in COBRA coverage to transition to Medicare Part B without a penalty, the same as seniors who remain on similar employer-sponsored coverage, by providing for a one-time special enrollment period. She said there is hope that the bill could be brought into a larger Medicare bill later this year. She said she wanted to raise this with the Task Force, and if anyone wants additional information about this bill and topic, she would be happy to share it with the Task Force.

Ms. Burns said she has been dealing with this issue of COBRA and Medicare for three years. She said there are conflicts that exist regarding Medicare eligible individuals who have COBRA protection and Medicare eligible individuals who work for small employers. She said these conflicts between Medicare and COBRA rules have led to confusion about which system and which set of rules governs eligibility for coverage and how responsibility for payment of health care benefits for eligible individuals is determined. She said these conflicts have led to some Medicare eligible individuals being subject to Medicare premium penalties and delays in coverage, mistakes in benefit payment, and claims for recovery of mistakenly paid COBRA benefits. She said the U.S. Department of Labor (DOL) has made efforts to address this matter through notices, but it is far from perfect. She also said the Schrader bill is in the right direction, but it does not deal with late enrollment. She said there needs to be a change in the Coordination of Benefits Model Regulation (#120) to address health benefits based upon the model. She has provided the Task Force with language for the model, and she hopes the Task Force will seriously consider this very complex issue.

Having no further business, the Senior Issues (B) Task Force adjourned.
The Senior Issues (B) Task Force met via conference call March 3, 2020. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Steve Ostlund (AL); Allen W. Kerr represented by William Lacy (AR); Ricardo Lara represented by William Lacy (CA); Michael Conway represented by Peg Brown (CO); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmairer represented by Chris Struk (FL); John F. King represented by Teresa Winer (GA); Colin M. Hayashida represented by Martha Im (HI); Doug Omment represented by Andra Seip (IA); Dean L. Cameron represented by Kathy McGill (ID); Stephen W. Robertson represented by Rebecca Vaughan (IN); Vicki Schmidt (KS); Sharon P. Clark represented by Stephanie McNaughey-Bowker (KY); James J. Donelon represented by Alecia Johnson (LA); Gary Anderson represented by Rebecca Butler (MA); Al Redmer Jr. represented by Adam Zimmerman (MD); Anita G. Fox represented by Renee Campbell (MI); Steve Kelley represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Mike Causey represented by David Yetter (NC); Jon Godfread represented by Yuri Venjohn (ND); Bruce R. Range represented by Martin Swanson (NE); Chris Nicolopoulos represented by Karen McAllister (NH); Barbara D. Richardson represented by Jack Childress (NV); Jillian Froment represented by Laura Miller (OH); Glen Mulready represented by Ron Kreiter (OK); Andrew R. Stolfi represented by Gayle L. Woods (OR); Jessica K. Altman (PA); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Tomasz Serbinowski and Jaakob Sundberg (UT); Scott A. White represented by Craig Chupp (VA); Mike Kedler represented by Michael Bryant (WA); Mark Afable represented by Jennifer Segall (WI); and James A. Dodrill represented by Dena Wildman (WV). Also participating were: Vincent Gosz (AZ); Eric Anderson (IL); Bob Williams (MS); Troy Smith (MT); Martin Wojcik (NY); and Andrew Dvorine (SC).

1. Discussed the Task Force’s 2020 Agenda

Commissioner Caride said the Task Force should consider establishing a working group with the purpose of examining whether the Long-Term Care Insurance Model Act (#640) and Long-Term Care Insurance Model Regulation (#641) should be updated. She asked David Torian (NAIC) to explain this in greater detail.

Mr. Torian said one of the goals of the NAIC is for its committees to periodically review and update its models, as necessary. He said the Task Force’s own charge also states that purpose. He said the model was last reviewed and updated over a decade ago, except for the consumer disclosure sections, which were updated in 2016. He said the Working Group, to be tentatively named the LTCI Model Update (B) Working Group, would be charged with reviewing whether Model #640 and Model #641 should be updated. He said the Working Group would then report its findings to the Task Force and, if updates are necessary, the Working Group would then be charged with making those updates.

Mr. Torian also said that should the Long-Term Care Insurance (EX) Task Force adopt any provisions or suggestions that require a change to Model #640 and Model #641, the Working Group would be operational and prepared to make such changes.

Commissioner Caride asked if anyone had any questions or comments. Mr. Swanson said he supports the establishment of this Working Group. Bonnie Burns (California Health Advocates—CHA) asked about the format of the Working Group. Commissioner Caride asked Mr. Torian to respond, and he said that the Working Group would review the model, section-by-section if it so chooses, to determine what may need to be updated.

Mr. Andersen asked if the one of the reasons for the creation of the Working Group was to examine and address innovation in long-term care (LTC). Commissioner Caride asked Mr. Torian to respond, and he said that was not the intent behind the Working Group, but rather that the models had not been updated in over a decade, other than the consumer disclosure portions, and the main purpose was to do what the Task Force should do, periodically review its models. Director Wing-Heier said that she, Commissioner Caride and Mr. Torian had discussed that a model review would be a good item for the Task Force to embark on in 2020.

Ms. Burns asked who the members would be and whether the interested parties would be able to participate. Mr. Torian said that state insurance regulators should email him with their interest to become members of the new Working Group and to limit the number of members to a manageable number of 12; members would be selected on a “first email-first selected” basis. He
said all interested parties would be part of the new Working Group and receive all notifications of open conference calls and other notifications.

2. **Appointed the LTCI Model Update (B) Working Group**

   Director Wing-Heier made a motion, seconded by Mr. Swanson, to appoint the LTCI Model Update (B) Working Group with the charge to examine whether Model #640 and Model #641 should be updated. The motion passed.

   Having no further business, the Senior Issues (B) Task Force adjourned.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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The Property and Casualty Insurance (C) Committee met via conference Aug. 12, 2020. The following Committee members participated: Vicki Schmidt, Chair (KS); Mike Chaney, Vice Chair (MS); Jim L. Ridling (AL); Ricardo Lara and Bryant Henley (CA); Andrew N. Mais and George Bradner (CT); David Altmaier (FL); Colin M. Hayashida and Martha Im (HI); James J. Donelon and Warren Byrd (LA); Kathleen A. Birrane (MD); Jillian Froment (OH); Glen Mulready represented by Ron Kreiter and Shelly Scott  (OK); Larry D. Deiter (SD); Mike Kreidler (WA); and James A. Dodrill (WV). Also participating were: Travis Grassel (IA); and Andy Case (MS).

1. **Adopted its June 10 Minutes**

The Committee met June 10 and took the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) adopted edits to the NAIC Uniform Risk Retention Group Registration Form for inclusion in the Risk Retention and Purchasing Group Handbook; 3) discussed regulatory actions related to COVID-19; and 4) adopted the private passenger auto (PPA) insurance study.

Commissioner Lara made a motion, seconded by Commissioner Mais, to adopt the Committee’s June 10 minutes (Attachment One). The motion passed unanimously.

2. **Adopted the Reports of its Task Forces and Working Groups**

Commissioner Chaney made a motion, seconded by Commissioner Lara, to adopt the following task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers’ Compensation (C) Task Force; Cannabis Insurance (C) Working Group; Catastrophe Insurance (C) Working Group; Climate Risk and Resilience (C) Working Group (Attachment Three); Lender-Placed Insurance Model Act (C) Working Group; Pet Insurance (C) Working Group (Attachment Four); Terrorism Insurance Implementation (C) Working Group (Attachment Five); and Transparency and Readability of Consumer Information (C) Working Group (Attachment Six). The motion passed unanimously.

3. **Adopted an Extension for Revisions to the Proposed Real Property Lender-Placed Insurance Model Act**

Birny Birnbaum (Center for Economic Justice—CEJ) urged the Committee to redouble its efforts in finalizing revisions to the proposed Real Property Lender-Placed Insurance Model Act as there may be industry abuses such as kickbacks from insurers to servicers as economic conditions deteriorate.

Commissioner Chaney made a motion, seconded by Commissioner Birrane, to adopt an extension to the 2020 Fall National Meeting for revisions to the proposed Real Property Lender-Placed Insurance Model Act. The motion passed unanimously.

4. **Adopted the Workers’ Compensation Policy and the Changing Workforce White Paper**

Mr. Byrd said in 2018, the NAIC/IAIABC Joint (C) Working Group of the Workers’ Compensation (C) Task Force was charged with updating the 2009 white paper, *An Overview of Workers’ Compensation Independent Contractor Regulatory Approaches*. The Working Group expanded this charge to incorporate the draft of a white paper regarding workers’ compensation policy and the changing workforce, and it also updated the independent contractor state standards.

Mr. Byrd said the white paper explores how changes in work and the evolving landscape surrounding the legality of employment options are shifting responsibility for coverage and benefits related to occupational injuries, illnesses and fatalities. The white paper is divided into the following sections: 1) Changing Relationships with Work; 2) Determining Employment Status; and 3) Alternative Coverage Models. The white paper also includes an appendix that provides state standards used to determine independent contractor status. Mr. Byrd said the Workers’ Compensation (C) Task Force adopted the white paper July 22, 2020.

Mr. Byrd made a motion, seconded by Commissioner Mais, to adopt the white paper, *Workers’ Compensation Policy and the Changing Workforce* (Attachment Seven). The motion passed.
5. **Adopted Updates to the NAIC State Disaster Response Plan**

Mr. Bradner said the Catastrophe Insurance (C) Working Group was charged with updating the NAIC State Disaster Response Plan. He said states participating in the drafting group included: Alabama; Connecticut; Louisiana; Maryland; Missouri; and Rhode Island. The NAIC State Disaster Response Plan is a document the state insurance departments can use as a template to create a disaster response plan. Mr. Bradner said the document provides state insurance regulators with information regarding:

1) the purpose of the disaster response plan;
2) NAIC disaster assistance;
3) preparation steps and planning;
4) the data collection process;
5) the disaster response and incident management team and its roles and responsibilities;
6) business continuity organizational charts;
7) response levels and definitions; and
8) sample contact lists that state insurance departments can use.

Mr. Bradner said the state departments of insurance (DOIs) are able to edit and format the document to meet their needs. The Catastrophe Insurance (C) Working Group adopted the document May 26 via e-vote. He said there may be a need to go back to the document and explore the need to expand information regarding pandemics.

Mr. Bradner said in addition to the creation of the NAIC State Disaster Response Plan, it is important to note that the NAIC is creating a disaster program that will provide a “one-stop shop” for state insurance regulators. This resource will include sample bulletins, publications to help state DOIs educate consumers about catastrophic events, information regarding NAIC data calls and various other tools for regulators. The NAIC Communications Division will also help to create interactive tools and podcasts regarding topics around catastrophes.

The NAIC envisions there being a website where state insurance regulators can access information and tools prior to a disaster to be better able to help protect citizens. As part of this project, the NAIC would like to identify a point person in every DOI to be that state’s disaster representative, so someone will be reaching out to the states soon to identify such a person and add information to this online resource.

Mr. Bradner made a motion, seconded by Commissioner Lara, to adopt the NAIC State Disaster Response Plan (Attachment Eight). The motion passed.

6. **Heard a Recap of the FEMA and DOI Flood Workshops**

Mr. Grassel said the Midwest experienced catastrophic flooding in 2019. In September 2019, Federal Emergency Management Agency (FEMA) Region VII hosted a flood insurance roundtable that included FEMA and state DOI staff. A key takeaway was to develop an improved understanding of how states could better coordinate with FEMA. In January 2020, the NAIC Center for Insurance Policy and Research (CIPR) hosted a flood workshop with a goal of communication and coordination between FEMA and DOIs. Iowa, Kansas, Missouri, Nebraska, FEMA, state emergency management agencies and the University of Iowa Flood Center participated and discussed how they can all work together before, during and after a flood. Other topics covered were FEMA’s desk reference guide, FEMA’s flood event response, messaging and data sharing, the NAIC State Disaster Response Plan, and private flood data collection. Mr. Grassel said the Iowa Flood Center discussed capabilities of real-time flood data by using sensors on rivers and creeks to map out current and potential risks.

Jason Hunter (FEMA) said FEMA Region IV encompasses eight southeastern states and that 40% of NFIP policies are in those states. He said FEMA Region IV and CIPR hosted a disaster resilience roundtable in July 2020. State DOIs, emergency management agencies, and FEMA Region IV and national headquarters staff participated. Objectives included building on existing relationships, identifying new partnership opportunities and focusing on how COVID-19 has changed disaster response. The organizational structure of each entity was covered, with a focus on mitigation and recovery. FEMA covered the disaster declaration process, Risk Rating 2.0 and mitigation grants. An outcome of the roundtable was establishment of a working group of FEMA Region IV and the DOIs. A draft charter was subsequently created, with objectives such as the exploration of coordination opportunities, data sharing and messaging.

7. **Heard a Preview of the Southeast Zone Workshop**

Mr. Case said a private flood forum was originally scheduled ahead of a southeastern regulator conference in May, but that was cancelled due to COVID-19. The purpose was to identify barriers to a viable private flood and help states identify steps to take to improve the private flood market. The forum has been rescheduled as a virtual event for the afternoons of Sept. 29 and Sept. 30, and southeastern states and industry representatives will participate. Mr. Case said states will complete a self-assessment prior to the forum to identify where states stand in building the private flood market. An agenda will be created based on those assessments. He said eight states have already agreed to participate in the forum.
8. **Heard a Presentation from the ICC on Building Codes**

Ryan Colker (International Code Council—ICC) said the ICC is best known for development of model building codes, but it also conducts product evaluations, accreditation services, education and training, and the development of community resilience benchmarks. He said model building codes are available for communities to adopt. He said the ICC is interested in working with DOIs to address code-related issues.

Mr. Colker said the ICC has developed 16 different types of codes. He noted that some states’ responsibility for codes might sit within the insurance commissioner’s office. He explained that the National Institute of Building Sciences (NIBS) conducted a study showing a 4-to-1 benefit-cost ratio for investing in hazard mitigation. The initial study focused on federal grants, but an update has found a 6-to-1 benefit-cost ratio when looking at broader mitigation steps. The NIBS has also found adoption of building codes has resulted in an $11 benefit for every $1 in investment. Mr. Colker noted that NIBS also looked at benefit cost ratios of building codes at regional levels for wildfire, hurricane winds and earthquakes. When looking at which stakeholders benefit from building codes, the NIBS found that tenants and title holders were large beneficiaries in addition to builders and communities.

Mr. Colker explained that many communities have not updated building codes, although most consumers assume that their community has up-to-date building codes that will protect their homes. He said building codes and insurance intersect with the Building Code Effectiveness Grading Schedule (BCEGS), which is a score used by insurance companies to underwrite and rate risks. He noted that FEMA looks to provisions within building codes to meet National Flood Insurance Program (NFIP) requirements. Mr. Colker said the NIBS has an initiative regarding how to translate economic numbers into actions. He said the costs typically fall to building owners to make retrofits, but the benefits go to the community, insurers and the financial community. He said the NIBS is looking into how there can be incentives for investment in mitigation strategies.

Mr. Colker said the ICC has drafted white papers on how building codes contribute to resilience. He said energy efficiency codes can improve community and individual resilience. The Alliance for National and Community Resilience (ANCR) looks across the community at functions that can support resilience. He said there is an opportunity for increased collaboration that could include a best practice guide on insurance and codes and how to engage with code officials, including case studies on how commissioners use codes. He also noted that potential research on codes and insurance could be conducted by the CIPR.

Mr. Bradner asked how the ICC could look at the Insurance Institute for Business & Home Safety (IBHS) standards. He said there tends to be reluctance to adopt codes that are not adopted by the ICC but that are recommended by the IBHS. He said it would be helpful for the ICC to look at what the IBHS is doing and adopt some of those measures into codes. He said building trades push back on IBHS recommendations, and he would like to see the ICC adopt additional standards to strengthen homes.

Mr. Colker said the content within the code is generated by those subject matter experts (SMEs) that recommend changes. He said the ICC has strong, ongoing relationships with both the IBHS and the Federal Alliance for Safe Homes (FLASH) and is currently working with the IBHS on joint standards.

9. **Heard a Report on Business Interruption Policies and Claims**

Aaron Brandenburg (NAIC) said state insurance regulators issued a business interruption data call in May, with the premiums portion of the data due June 1. The first part of the data call showed that nearly 8 million commercial insurance policies include business interruption coverage. Of that amount, 90% were for small businesses, as defined as having 100 or fewer employees; 8% for medium businesses; and 2% for large businesses, as defined as having more than 500 employees. Significantly, 83% of all policies included an exclusion for viral contamination, virus, disease or pandemic, and 98% of all policies had a requirement for physical loss. Smaller policyholders generally have a higher percentage of policies with exclusions.

Mr. Brandenburg said the second part of the data call collects claim and loss information on a monthly basis from June through November. As of the July submission, insurers reported approximately 185,000 claims. About 72% of claims have been closed without payment. Less than 1% of claims, about 1,100, have been closed with payment, with about $97 million being paid. Case incurred losses stand at about $1.56 billion. Mr. Brandenburg said cumulative claims data is being submitted by insurers every month, and reports are posted under the business interruption (BI) data call portion of the NAIC website.

Amy Bach (United Policyholders) said there are many questions about BI coverage, such as whether the policy covers COVID-related losses; whether forced closure, loss of use or infiltration of the insured premises constitute a direct physical loss; and whether losses due to mandatory closure qualify for typical 30 days of coverage under civil authority coverage.
Ms. Bach said regulators must balance insurer solvency and profitability with policyholders’ reasonable expectations and need for coverage. She said there is a question as to whether insurers properly communicated exclusions for pandemics when they were first developed and whether exclusions were accompanied by premium reductions. She said insurer trades have stressed that policies do not cover pandemics, but other policies do not include the word “pandemic.” She said each policy is different, and each claim should be evaluated on its merits.

Ms. Bach said total potential losses are unknown and speculative, although the state regulator data call will help discern some of these numbers. She noted there are three court rulings so far, each focused on the physical damage language within the policy. She said there are also some state and federal proposals to pay for business interruption losses. She explained small businesses are bearing the brunt of the losses because they either do not have business interruption coverage or they have a virus exemption.

Ms. Bach said it is important to know what regulators were told by insurers at the time the 2006 Insurance Services Office (ISO) virus exclusion was added and whether there was a rate decrease when the virus exclusion was adopted. She also said that claims that pandemic losses were never covered are contradicted by the fact that severe acute respiratory syndrome (SARS) claims were paid.

Ms. Bach said United Policyholders has a website with information including the tracking of litigation. She noted that the federal Business Interruption Relief Act of 2020 (H.R. 7412), unlike other legislation that looks forward, sets up a fund that assists current policyholders.

10. Discussed a Proposal to Collect Additional Homeowners and Auto Data

Mr. Birnbaum introduced a proposal that would assist in measuring average homeowner and auto premiums (Attachment Nine).

Mr. Birnbaum said there is great interest among stakeholders in understanding average premiums across states and over time. The NAIC publishes two reports that list average premium figures, but the data has about a two-year lag, which hinders its value. He said adding written and earned exposure data fields to the annual and quarterly annual statement for auto and homeowner lines of business will greatly increase the usefulness of the data. Adding exposure data will allow for average premium to be calculated on a written and earned basis.

Commissioner Schmidt said she would like to receive feedback on the proposal and would also like to hear from all parties about the need for additional, more granular, data.

11. Heard a Presentation on Race in the Property/Casualty Insurance Industry

Robert Klein (consultant) said recent events have refocused attention on race and insurance issues, which have been around a long time. He said prior to 1970, the record indicates that many insurers explicitly discriminated against certain groups (e.g., African Americans) in pricing and underwriting. He said the practice of “redlining” was common in property insurance, and certain urban areas were designated as too high-risk or otherwise undesirable for writing insurance. After 1970, explicit redlining and unfair discrimination diminished, but concerns with respect to implicit unfair discrimination have continued.

Mr. Klein said some contend that certain rating or underwriting factors, e.g., credit scores, are unfairly discriminatory because they have a disproportionately negative effect on certain groups and are not good measures of risk. Some also might contend that explicit unfair discrimination has continued to occur.

Mr. Klein said that after the 1992 Los Angeles riots, it was determined that many property owners in certain urban areas lacked “good” insurance coverage. He said this prompted the NAIC to appoint the Subgroup on Urban Insurance Issues, which investigated whether insurers engaged in unfair discrimination in home and auto insurance. Also, during the 1990s, several prominent insurers were the subject of class action lawsuits in which they were alleged to have engaged in redlining or unfair discrimination in home insurance. He said the Insurance Availability and Affordability Task Force in 1998 ultimately found that people living in high-minority, low-income areas tend to pay higher premiums, have less adequate coverage and are more likely to be insured through a residual market. However, the Task Force also asserted that these outcomes could be caused by various factors, including those related to risk as well as industry practices, intended or not. The Task Force recommended that investigation continue and that insurers, state insurance regulators and other stakeholders undertake initiatives to improve the availability and affordability of insurance for low-income and minority consumers.
Mr. Klein said certain academics, who have specialized in lending and housing issues, have published considerable research contending that redlining and unfair discrimination in home insurance was prevalent at least up to 2000. Using different methods, insurance economists have reached different conclusions. Mr. Klein noted that Harrington and Niehaus (1998) did not find evidence of unfair discrimination in pricing against minorities in auto insurance in Missouri. He said Grace and Klein (2001) did not find evidence of unfair discrimination in pricing in home insurance in Texas, but did find a greater predominance of dwelling fire policies in minority or poor areas but could not determine why this was the case. Mr. Klein said the differences in findings are due to differences in methodologies. The researchers who have found evidence of unfair discrimination have tended to focus on the practices of insurers, e.g., underwriting guidelines and using testing to assess agents’ responses to requests for insurance quotes. Insurance economists have tended to focus on outcomes, controlling for other factors (e.g., claim costs), such as loss ratios or the types of policies issued. Mr. Klein said the most rigorous studies were performed using data from the 1990s and have not been updated.

Mr. Klein said several insurance departments, as well as various other groups, think tanks and organizations, have published their own reports on insurers’ practices. Some reports contend the evidence indicates that insurers do engage in unfair discrimination (explicit or implicit), and others contend that the evidence indicates that insurers do not unfairly discriminate. He believes the primary issue faced now is whether the use of certain factors in pricing and underwriting (e.g., credit scores, occupation, education, etc.) are unfairly discriminatory and disproportionately affect certain groups, such as minorities and low-income populations. He said there would be value in updating and extending the studies that were done 20 years ago. One could also research how the use of the factors in question affect certain groups of interest and why. Potentially, such research, combined with proposed standards for unfair discrimination, could be used to develop opinions on how fair these factors are.

Mr. Klein also said regulators may be able to examine the efficiency and equity effects of the prohibition of certain factors. Another potential topic for research is the ability of certain groups to effectively shop for insurance. Markets work better the more informed consumers are and the better able they are to obtain quotes from different carriers. Mr. Klein said another course of study would be to evaluate how well measures intended to improve insurance availability and affordability have worked and what more can be done. He said when a rating factor is prohibited, it compels insurers to place greater weight on the factors they are allowed to use. Assuming claim costs do not decrease, this means that some consumers will pay more and others will pay less due to the prohibited factor. Hence, the equity effects of restrictions on rating factors need to be considered. He also noted that what could be learned from new research will depend on the data that are available to researchers. He believes good research necessitates data at a ZIP code level on premiums, exposures, claim costs and the types of policies issued.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.
The Property and Casualty Insurance (C) Committee met via conference call June 10, 2020. The following Committee members participated: Vicki Schmidt, Chair, (KS); Mike Chaney, Vice Chair, (MS); Jim L. Ridling (AL); Ricardo Lara represented by Ken Allen (CA); Andrew N. Mais (CT); David Altmaier (FL); Colin M. Hayashida (HI); James J. Donelon represented by Warren Byrd (LA); Kathleen A. Birrane represented by Joy Hatchette and Robert Baron (MD); Jillian Froment (OH); Glen Mulready (OK); Larry D. Deiter (SD); and Mike Kreidler (WA). Also participating was: Gennady Stolyarov (NV); and Sandra Bigglestone (VT).

1. **Adopted its 2019 Fall National Meeting Minutes**

   Director Froment made a motion, seconded by Commissioner Kreidler, to adopt the Committee’s Dec. 9, 2019, minutes (see NAIC Proceedings – Fall 2019, Property and Casualty Insurance (C) Committee). The motion passed unanimously.

2. **Adopted Edits to the NAIC Uniform Risk Retention Group Registration Form for Inclusion in the Risk Retention and Purchasing Group Handbook**

   Ms. Bigglestone explained that the Risk Retention Group (E) Task Force worked with state insurance regulators and interested parties to address concerns from non-domiciliary states and industry regarding the registration process of risk retention groups (RRGs) in non-domiciliary states. Concerns were discussed regarding extensive registration processing time and fees imposed as well as RRGs attempting to register that were in a hazardous financial condition or were not compliant with the federal Liability Risk Retention Act (LRRA). To help address some of the concerns, the Task Force proposed updates to the NAIC Uniform Risk Retention Group Registration Form (Registration Form), as it is the main way to provide information to non-domiciliary states. The Registration Form was changed to indicate a clear connection to the LRRA. The Registration Form asks for basic information about the RRG to ensure the RRG is operating legally under the LRRA. Ms. Bigglestone said all states should be encouraged to use the Registration Form.

   Director Deiter made a motion, seconded by Commissioner Chaney, to adopt the revisions, as proposed by the Risk Retention Group (E) Task Force, to the Registration Form for inclusion in the Risk Retention and Purchasing Group Handbook (Attachment One-A). The motion passed unanimously.

3. **Discuss Regulatory Actions Related to COVID-19**

   Commissioner Schmidt said the COVID-19 pandemic has greatly affected the insurance world. She noted that state insurance regulators issued a data call in early May to collect information on business interruption policies, including the degree to which the policies have pandemic exclusions or requirements for physical loss. She said claims data is due June 15, and additional information on that data call can be found on the NAIC website. She said the NAIC will release some national aggregate data from this data call in the near future. She also noted that state insurance regulators will receive an email this week about how to access tools giving them the ability to analyze the data received in the data call.

   Commissioner Schmidt said the states quickly took action on a wide variety of property/casualty-related issues affected by COVID-19. She noted that the NAIC has been keeping track of state actions, and those can be found on the NAIC website. In addition, industry and consumer groups sent letters to the states asking for certain regulatory relief actions or actions to help policyholders.

   Commissioner Schmidt reported that the Committee met April 29 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities and individuals) of the NAIC Policy Statement on Open Meetings, to review actions the states had taken on various issues to see if there was a need for any Committee-level activity.

   Doug Heller (Consumer Federation of America—CFA) said the CFA and the Center for Economic Justice (CEJ) urged state insurance regulators to address auto insurance rates because they have become excessive as states have moved to lock downs. He said consumers need protections to ensure that they do not pay excessive auto premiums. He noted that most insurers gave some premium relief, but it was inconsistent and insufficient. He said about 30% average premium relief is needed, which is...
about double what most insurers have offered. California, Michigan and New Jersey have required refunds, but Mr. Heller believes all states should do this. He said driving has rebounded, but it is still down by 25%. He noted that only a few rate reductions go beyond May 31. He believes that rates remain excessive and a monthly refund program should be created and mandated. As consumer credit scores decline, Mr. Heller said the states should issue a moratorium on the use of credit scores. He said the states need a plan to ensure that future rates account for the new normal. He said state insurance regulators need more data and should collect auto insurance accident and loss data on a monthly basis.

Erin Collins (National Association of Mutual Insurance Companies—NAMIC) said NAMIC appreciates the way the states have adjusted their workflow during the COVID-19 pandemic. She noted that adjuster restrictions have been eased and e-commerce has helped consumers. She asked that the NAIC be a force for collaboration and uniformity. She said uniformity in financial reporting has helped, and she encouraged flexibility in general. She said auto insurers have returned billions of dollars in premiums to policyholders. She encouraged state insurance regulators to not increase mandates, as what the industry is doing is working. She asked state insurance regulators to review temporary emergency measures before they expire. She also said state insurance regulators should consider what has worked in terms of virtual inspection and notarization and consider maintaining some regulatory changes.

Keri Kish (Wholesale & Specialty Insurance Association—WSIA) said the WSIA agrees with what NAMIC said. She said the WSIA has a concern about retroactive business interruption coverage, and it is appreciative of the NAIC statements regarding retroactive coverage. She said the WSIA is appreciative of state insurance regulators working with industry on relief efforts related to the pandemic. She said state insurance regulators may wish to consider making some of the temporary relief measures, such as virtual delivery of policies and e-signatures, permanent.

David F. Snyder (American Property Casualty Insurance Association—APCIA) said industry members have seen a constructive relationship with state insurance regulators that has ensured market solvency. He said industry is appreciative that the NAIC opposed retroactive coverage for business interruption policies. He said auto insurers have refunded more than $10 billion in premium to policyholders. He said state insurance regulators allowed this while ensuring solvency. He emphasized that the states differ, and there should not be “one-size-fits-all” solution to these matters. He said some states have enacted the National Council of Insurance Legislators’ (NCOIL) model related to credit-based insurance scores, which includes extraordinary life situation language protecting individuals from declines in their credit-based insurance scores. He said the states without this model might consider it. He said efficiency could be enhanced by making some of the regulatory relief actions permanent.

Mr. Snyder also said the APCIA is in favor of adopting the Private Passenger Automobile Insurance Study and new tools allowing state insurance regulators to look at focused segments of the marketplace.

Mr. Stolyarov asked Mr. Snyder if there have been any federal mandates for lenders to offer forbearance on auto loans, credit cards or personal loans other than mortgages. He also asked whether the insurance industry has the capability to process hundreds of thousands of requests related to extraordinary life circumstances affecting credit.

Mr. Snyder said consumers should exercise those rights, and companies do have the ability to respond. He said he would follow up on the federal activity related to loans, but he said the states have gone beyond what the federal government has done.

Birny Birnbaum (CEJ) said consumer representatives will speak before the NAIC/Consumer Liaison Committee about consumer protections in a pandemic era. He said state insurance regulators have done a tremendous job on grace periods and extending claims deadlines. He noted that some states have gone further in not allowing risk characteristics like credit-based insurance scores. He said federal legislation put a moratorium on lenders reporting negative scores to credit bureaus, and forbearance was offered on federal mortgages. He said in the future, bad credit information will appear and harm individuals’ credit-based insurance scores. He said Pennsylvania issued a bulletin for insurers not to take action because of declining credit scores.

Mr. Birnbaum said the industry would not be able to field millions of requests for extraordinary life events related to credit-based insurance scores, and state insurance regulators would not be able to monitor these. He said consumers should not have the burden of notifying industry of declining scores. He said insurers need accountability, and data collection can help with accountability. He said a transition to a digital interface raises consumer protection issues. He also said protections are needed to protect against biases in algorithms.
Lisa Brown (AICPA) applauded the NAIC for prompt responses related to the business interruption data call.

Amy Bach (United Policyholders) asked whether results from the business interruption data call would be released.

Aaron Brandenburg (NAIC) said national aggregate data would be released soon.

4. **Adopted the Private Passenger Automobile Insurance Study**

Commissioner Schmidt said work on auto insurance affordability issues began seven or eight years ago, noting that several documents were produced prior to discussions related to data collection. She said the Auto Insurance (C/D) Working Group, before it was disbanded in 2018, had previously agreed to receive data from statistical agents in January 2018 that was meant to help analyze the private passenger auto insurance market such as reviewing differences in premiums, as well as losses, compared to incomes at a ZIP code level. She said the Working Group adopted an outline for the report at the 2018 Fall National Meeting, and NAIC staff completed an introductory narrative and a state-by-state analysis described in that outline in early 2019. The Committee then decided to update the study with more recent, 2016 and 2017, data that was received in 2019.

Commissioner Schmidt said the NAIC finalized an updated study in fall 2019, and the states reviewed the data through the end of the year. She said the NAIC has also loaded the data into an analytical tool on iSite, and the states are able to look at geographic areas to learn more about auto rates as they compare to demographic data. She said the Committee may wish to consider how to receive additional auto insurance data in the future, either through statistical agents, the annual financial statement, or some other mechanism such as data calls. She expressed her opinion that the Committee should adopt the study and move forward with future discussions about the possibility of getting additional data.

Commissioner Chaney agreed that it is time to adopt the study and consider additional data collection later.

Mr. Birnbaum said the NAIC has not taken action to address proxy discrimination. He said the report is not as useful as it could be, and the data is handpicked by industry. He said the report does not include prices quoted. He noted that the data is stale, as 2017 is the most recent data. He said it is unclear how the report can be used to address affordability. He said state insurance regulators should collect timely data like they did with the business interruption data call. He recommended that the annual financial statement add columns to the State Page for written and earned exposures for auto and homeowners on a quarterly and annual basis. He said state insurance regulators could have 2019 data in the first quarter of 2020. He also said the Market Conduct Annual Statement (MCAS) should be collected on a quarterly basis.

Commissioner Schmidt said Mr. Birnbaum should take his MCAS request to the Market Regulation and Consumer Affairs (D) Committee, and the Property and Casualty Insurance (C) Committee should consider additional data collection in future conversations.

Commissioner Chaney made a motion, seconded by Director Deiter, to adopt the *Private Passenger Automobile Insurance Study* (Attachment One-B). The motion passed unanimously.

5. **Discussed Other Matters**

Commissioner Schmidt said the Committee would hear an update at the Summer National Meeting on recent and upcoming workshops the states are holding with the Federal Emergency Management Agency (FEMA) regarding disaster preparedness and response.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.
MEMORANDUM

TO: Property and Casualty Insurance (C) Committee
FROM: Risk Retention Group (E) Task Force
DATE: December 7, 2019
RE: Revisions to the NAIC Uniform Risk Retention Group Registration Form

The Risk Retention Group (E) Task Force has worked to address concerns from non-domiciliary states and industry regarding the registration process of risk retention groups (RRGs) in non-domiciliary states.

Concerns were initially raised by the National Risk Retention Association (NRRA) in a letter to the Task Force dated Nov. 19, 2018. The letter specifically cited extensive registration processing time and fees imposed. In discussions that followed, non-domiciliary states also raised concerns, including RRGs attempting to register that were in a hazardous financial condition or were not compliant with the federal Liability Risk Retention Act (LRRA).

To help address some of the concerns, the Task Force proposed updates to the NAIC Uniform Risk Retention Group Registration Form (Registration Form). The revisions were exposed for two public comment periods before finalizing the attached recommendation to the Property and Casualty Insurance (C) Committee.

The Task Force requests that the Committee consider adopting the proposed revisions to the Registration Form for inclusion in the Risk Retention and Purchasing Group Handbook.

If you have any questions regarding this referral, please contact NAIC staff (Becky Meyer, bmeyer@naic.org).
The following is the uniform registration form adopted in 1991 by the NAIC. This registration form is being filed by a Risk Retention Group (RRG) operating in accordance with the Federal Liability Risk Retention Act of 1986 (LRRA), 15 USC 3901-3906, chartered or licensed to write only liability insurance by the state of domicile listed in #1e. The registration form and supplemental documents are provided in accordance with §3902(d)(2) of the LRRA. Under §3902 of the LRRA, with the exception of the domiciliary state, RRGs are exempt from any state laws, rules, regulations, or orders that would make unlawful, or would regulate, directly or indirectly, the operation of an RRG, except that any state may require an RRG to comply with those laws specified in §3902(a)(1)(A),(B),(C) and (G) of the LRRA. The domiciliary state regulates the formation and operation of the RRG.

**Part A**

**STATE OF [Insert State in which the Risk Retention Group intends to do business]**

**DEPARTMENT OF INSURANCE**

**RISK RETENTION GROUP - NOTICE AND REGISTRATION**

(All Information Should Be Typed)

1a. Name of the Risk Retention Group as it appears on its Certificate of Authority:

________________________________________________________________________

1b. **Address of the Risk Retention Group:**

________________________________________________________________________

1c. **NAIC Company Code:**

________________________________________________________________________

1d. **FEIN:**

________________________________________________________________________

1e. **State of domicile, date licensed and date chartered:**

________________________________________________________________________

1f. **Primary contact person for state of domicile to whom questions regarding the Risk Retention Group should be addressed (include name, phone number and email address):**

________________________________________________________________________
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

2. List any other name(s) by which the Risk Retention Group is known or may be doing business in this State or any other state:

________________________________________________________________________
________________________________________________________________________

3. The Risk Retention Group is chartered and licensed as a liability insurance company under the laws of the State of ________________, and is authorized to engage in the following lines and/or classifications of liability insurance under the laws of its chartering State:

________________________________________________________________________
________________________________________________________________________

4. Give a general description of the liability insurance coverages the Risk Retention Group plans to write in the state it is registering to do business in.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. Has the Risk Retention Group’s domiciliary state approved the Risk Retention Group to register and expand its writings in the state it is seeking to become registered in?

________________________________________________________________________

6. Ownership of the Risk Retention Group consists of one or the other of the following (check one):

a) _____ the owners of the Group are only persons who comprise the membership of the Group and who are provided insurance by the Group.

b) _____ the sole owner of the Group is: ____________________________

   (Name and Address of Organization)

   an organization which has as its members only persons who comprise the membership of the Group and which has as its owners only persons who comprise the membership of the Group and who are provided insurance by the Group.

7. The Risk Retention Group members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations. Give a general description of businesses or activities engaged in by the Group’s members:

________________________________________________________________________
________________________________________________________________________

8. (a) List the name, position with the Risk Retention Group, SS#, and address of each officer and
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

director of the Risk Retention Group: (Attach additional pages, if necessary.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
(b) Identify and give the telephone number of the officer or director of the Risk Retention Group who can be contacted for any information regarding the management of the insurance activities of the Group:

Name: ___________________________ Telephone Number: __________________

9. List the name, address, and telephone number and Federal Employer Identification Number (FEIN) of the company responsible for managing the insurance operations of the Risk Retention Group and the company contact person’s name, telephone number and email, at the company: (If none, answer none.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Contact Person: ___________________________ Telephone # __________________
Email: __________________________

10. List the name(s), SS#NPR#, and address(es) of the licensed insurance agent(s) or broker(s) who will be responsible for marketing the Risk Retention Group’s insurance policies in the State of [Insert State in which the Risk Retention Group intends to do business] and the current licensing status in the State(s) [Insert State in which the Risk Retention Group intends to do business] in which they are licensed: (If none, answer none. Attach additional pages, if necessary.)

<table>
<thead>
<tr>
<th>Name</th>
<th>SS#NPR#</th>
<th>Address</th>
<th>License Status in State Registering(s)</th>
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11. In accordance with the Liability Risk Retention Act, we verify the following:

A. The Risk Retention Group is a corporation or other limited liability association whose primary activity consists of assuming and spreading all, or any portion, of the liability
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

exposure of its members.

B. The Risk Retention Group is organized for the primary purpose of conducting the activity described under Item “A” above.

C. The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

D. The activities of the Risk Retention Group do not include the provision of insurance other than:
   
   i. liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its Group members; and
   
   ii. reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in business or activities so that such Risk Retention Group or member meets the requirement under Item #7 above for membership in the Risk Retention Group which provides such reinsurance.

12. In accordance with the LRRA, if the State in which the Risk Retention Group is registering requires compliance with the following laws and requirements, the RRG agrees to the following:

A. The Risk Retention Group will comply with the unfair claim settlement practices laws of this State.

B. The Risk Retention Group will pay, on a non-discriminatory basis, applicable premium and other taxes which are levied on admitted insurers, surplus line insurers, brokers or policyholders such Group under the laws of this State.

B.C. The Risk Retention Group will participate, on a nondiscriminatory basis, in any mechanism established or authorized under the law of the State for the equitable apportionment among insurers of liability insurance losses and expenses incurred on policies written through such mechanism.

C.D. The Risk Retention Group will designate the Insurance Commissioner [Director, Superintendent] of this State as its agent solely for the purpose of receiving service of legal documents or process by executing Part B of this form, attached hereto.

D.E. The Risk Retention Group will submit to examination by the Insurance Commissioner [Director, Superintendent] of this State to determine the Group’s financial condition, if:

   i. the Insurance Commissioner [Director, Superintendent] of the Group’s chartering State has not begun or has refused to initiate an examination of the Group; and
   
   ii. any such examination by the Insurance Commissioner [Director, Superintendent] shall be coordinated to avoid unjustified duplication and unjustified repetition.

E.F. The Risk Retention Group will comply with a lawful order issued in a delinquency proceeding commenced by the Insurance Commissioner [Director, Superintendent] of this State upon a finding of financial impairment, or in a voluntary dissolution proceeding.

F.G. The Risk Retention Group will comply with the laws of this State concerning regarding
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

deceptive, false or fraudulent acts or practices, including any injunctions regarding such conduct obtained from a court of competent jurisdiction.

G.H. The Risk Retention Group will comply with an injunction issued by a court of competent jurisdiction upon petition by the Insurance Commissioner [Director, Superintendent] of this State alleging that the Group is in hazardous financial condition or is financially impaired.

H.I. The Risk Retention Group will provide the following notice, in at least 10-point type, in any insurance policy issued by the Group:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

42-13. In accordance with the LRRA, the Risk Retention Group affirms that it has submitted to the Insurance Commissioner [Director, Superintendent] as part of this filing and before it has offered any insurance in this State, a copy of the plan of operation or feasibility study which it has filed with the Insurance Commissioner [Director, Superintendent] of its chartering State of domicile. This plan or study includes the name of the State in which the Group is chartered, as well as the Group’s principal place of business, and such plan of operation or feasibility study further includes the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of liability insurance the Group intends to offer. The Group has also will promptly submitted to the Insurance Commissioner [Director, Superintendent] of this State any revisions of such plan of operation or feasibility study to reflect any changes to the plan if the Group intends to offer any additional lines of liability insurance or, including any change in the designation of the State in which it is chartered.

13.14. The Risk Retention Group will submit a copy of its annual financial statement submitted to its chartering state, to the Insurance Commissioner [Director, Superintendent] of this State, by March 1 of each year. The annual financial statement will be certified by an independent public accountant and include a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist. The annual financial statement, certification and statement of opinion on loss and loss adjustment expense reserves will be submitted to the Insurance Commissioner [Director, Superintendent] of this State by the date it is required to be submitted to its chartering state.

14.15. The Risk Retention Group will not solicit or sell insurance to any person in this State who is not eligible for membership in the Group.

15.16. The Risk Retention Group will not solicit or sell insurance in this State, or otherwise operate in this State, if the Group is in hazardous financial condition or is financially impaired.

16.17. The Risk Retention Group will not issue any insurance policy in this State which provides coverage prohibited generally by statute of this State or declared unlawful by the highest court of this State whose law applies to such policy. In accordance with the LRRA, the terms of any insurance policy provided by the Risk Retention Group shall not provide or be construed to provide insurance policy coverage prohibited generally by State statute or declared unlawful by the highest court of the State whose law applies to such policy.

17. The Risk Retention Group has submitted a registration fee of $______________, if applicable, payable to the Insurance Commissioner [Director, Superintendent] of this State.
18. To the extent required by the LRRA, the Risk Retention Group will comply with all other applicable state laws.

19. The Risk Retention Group will notify the Insurance Commissioner [Director, Superintendent] as to any subsequent changes in any of the items included in this form (except for items #1f, #8 and #10).

The undersigned hereby swear and affirm that the foregoing statements and information regarding their principal, the ________________________________ (Name of Risk Retention Group) are true and correct.

President of the Risk Retention Group

Secretary of the Risk Retention Group

State of ____________ )
    ss:
County of ____________ )

Sworn before me this _____ day of __________________, 20__. 

___________________, Notary Public. My Commission Expires: _______________
NAIC UNIFORM RISK RETENTION GROUP REGISTRATION FORM

Part B

APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE AND DESIGNATION

The______________________________ (“the Group”), a risk retention group which is chartered and licensed as a liability insurance company under the laws of the State of ___________________________, having notified the Insurance Commissioner [Director, Superintendent] of the State of ___________________________ of its intention to do business in this State as a risk retention group pursuant to the federal Liability Risk Retention Act of 1986, hereby appoints the Insurance Commissioner [Director, Superintendent] of the State of ___________________________, any successor in office, and any authorized deputy its true and lawful attorney, in and for the State of ___________________________, upon whom all legal documents or process in any proceeding against it may be served. Such service of legal documents or process shall be of the same legal force and validity as if served personally upon the Group.

The Group designates:

________________________________________
(Name)

________________________________________
(Address)

________________________________________
(City, Town or Village)

________________________________________
(State and ZIP Code)

as its officer, agent or other person to whom shall be forwarded all legal documents or process served upon the Insurance Commissioner [Director, Superintendent] of the State of ____________________________, any successors in office, or any authorized deputy, for the Group. This designation shall continue in full force and effect until superseded by a new written designation filed with the Insurance Commissioner [Director, Superintendent].
This appointment and designation is made pursuant to a resolution by the Group’s governing body authorizing it, and a certified copy of the resolution is attached hereto. This appointment shall be binding upon any person or corporation which as successor acquires the Group’s assets or assumes its liabilities, by merger or consolidation or otherwise.

This appointment may be withdrawn only upon a written notice of termination and, in any event, shall not be terminated by the Group or its successor so long as any contracts or liabilities or duties arising out of contracts entered into by the Group while it was doing business in this State are in effect.

IN WITNESS OF THIS APPOINTMENT AND DESIGNATION, the Group, in accordance with the resolution of its Board of Directors duly passed on _________________, 20__, has affixed its corporate seal, and caused the same to be subscribed and attested in its name by its President and Secretary, at the City of ____________ in the State of ______________ on ________________, 20__.

____________________________________
(Name of Risk Retention Group)

By: ____________________________ President

______________________________ Secretary

State of __________________________

) ss:

County of _______________________

Sworn before me this_____ day of _________________________, 20__.

_______________________________, Notary Public. My Commission Expires: ____________
Private Passenger Automobile Study

(See Supplement to NAIC Proceedings – Summer 2020)
The Catastrophe Insurance (C) Working Group met virtually on July 31, 2020. The following Working Group members participated: Mike Chaney, Chair, David Browning, Andy Case, Kim Causey and John Wells (MS); David Altmair, Vice Chair, Ainsley Armstrong, Alexis Bakofsky, Nicole Altieri Crockett, Linda McWilliams, Susanne Murphy, Jane Nelson, Sheryl Parker, Erin Vansickle, Wendy Vincent and Christy Virginia (FL); Mark Fowler, Gina Hunt and Jerry Workman (AL); Katie Hegland and Katrina Kelly (AK); Ken Allen, Patrick Campbell, Wan Choi, Bryant Henley, Kim Hudson, Lucy Labourian, Saffir Rahman, Mirta Sanadajifar, Kenneth Schnoll, Lisbeth Landsman-Smith, Henry Tam, Lynne Wehmueiler and Tianhong Zhao (CA); Susan Andrews, George Bradner, Danny Chan, Wanchin Chou, Qing He and Doris Schirmacher (CT); Melanie Fujiwara, Colin M. Hayashi, Randy Jacobson, Andrew Kurata, Patrick P. Lo, Kathleen Nakasone, Cindy Neeley, Colin Okutsu, John Pang, Roland Teruya and Paul Yuen (HI); Travis Grassel (IA); Patrice Dzire, Judy Mottar, Lauren Peters, KC Straka and Erica Weyhenmeyer (IL); LeAnn Crow, Heather Droege and Tate Flott (KS); Charles Hansberray and Ron Henderson (LA); Caleb Huntington, Richard Looney and Matthew Mancini (MA); Joy Hatchette, Cheryl Kouns, James Mobyly and Joanna Noppenberger (MD); Cynthia Amann, LeAnn Cox, Nicole Huls, Teresa Kroll and Jeanna Thomas (MO); Fred Fuller (NC); Mark McGill and Diane Sherman (NJ); Tom Botsko and Karen Vourvopoulos (OH); Matthew Harmon, Landon Hubbard, Ron Kreiter, Cuc Nguyen and Andrew Schallhorn (OK); Brian Fordham (OR); David Buono, Shannen Logue and Michael McKenney (PA); Elizabeth Kelleher Dwyer and Beth Vollucci (RI); Katie Geer (SC); David Combs, Brian Hoffmeister, Bill Huddleston and Rachel Jade-Rice (TN); Marianne Baker, J’ne Byckovski, Miriam Fisk, sailoa Liao, David Muckequeide, Patty Otto, Bethany Sims, Amy Will and Mark Worman (TX); and David Forte, John Haworth, John Martinson and Eric Slavich (WA). Also participating were: William Lacy (AR); Vanessa Darrah and Brooke Lovallo (AZ); Mitchell Bronson, Peg Brown, Rolf Kaumann and Eric Unger (CO); Christina Miller (DE); Renee Campbell, Adam Goldhammer, Jonathan Kelly, Tammy Lohmann, Connor Meyer, Christine Peters, Alcyia Valento, Megan Verdeja and Phil Vigilatiuro (MN); Chris Aufenthie (ND); Gordon Hay, Bruce R. Range and Connie Vanslyke (NE); Robert Doucette and Anna Krylova (NM); Robert Kasinow, Sylvia Lawson, Rebecca Morrow, Leigh Solomon and Larry Wertel (NY); Carla Colon (PR); Maggie Dell (SD); Todd E. Kiser, Tracey Klausmeier and Tomasz Serbinowski (UT); Rebecca Nichols (VA); Isabelle Keiser and Rosemary Rasza (VT); Rebecca Rebholz (WI); Bill Cole, D’Anna Feurt, Kristi Alma Jose and Amanda Tarr (WY).

1. **Adopted its May 29 Minutes**

   The Working Group conducted an e-vote that concluded May 26 to: 1) adopt its 2019 Fall National Meeting minutes; and 2) adopt the NAIC’s State Disaster Response Plan.

   Commissioner Altmaier made a motion, seconded by Mr. Workman, to adopt the Working Group’s May 26 minutes (Attachment Two-A). The motion passed.

2. **Heard an Update Regarding Federal Flood Insurance**

   Brooke Stringer (NAIC) said the National Flood Insurance Program (NFIP) is currently operating under its 15th short-term extension, which is expiring Sept. 30. The last substantive action taken by the U.S. House Committee on Financial Services took place in June 2019. This action approved a five-year reauthorization bill. However, coastal state lawmakers objected to this bill and introduced an alternative bill as they did not feel the original bill substantially protected policyholders from rate hikes. Neither of these bills proceeded any further in the U.S. House of Representatives, and the U.S. Senate has not focused on any type of reauthorization bill.

   Ms. Stringer said the current NFIP extension is part of the last congressional annual spending packages, and it is likely the next extension will be temporarily extended in the next continuing resolution. She said with hurricane season underway and the focus on disaster preparation, the NAIC sent a letter to House and Senate leaders urging action on a long-term reauthorization. This letter is posted on the NAIC website and includes the following key priorities: 1) encouraging increased growth in the private flood insurance market as a complement to the NFIP to help provide consumers with more choices; 2) encouraging support for mitigation planning and legislative efforts to allow individuals to set aside funds in a tax-preferred savings account for disaster mitigation expenses; 3) support of the inclusion of H.R. 1666 by Rep. Kathy Castor (D-FL) and Blaine Luetkemeyer (R-MO) to ensure that private flood will satisfy the NFIP’s continuous coverage requirements, which allows policyholders who leave the NFIP and purchase a private flood insurance policy to return to the program without penalty or loss of subsidy; 4)
support of the inclusion of the Catastrophe Loss Mitigation Incentive and Tax Parity Act (H.R. 5494), which would ensure that state-based disaster mitigation grants receive the same treatment as federal grants; and 5) urging the Federal Emergency Management Association (FEMA) to provide increased transparency to all stakeholders regarding its decision-making process for developing and updating its flood maps.

Ms. Stringer said currently grants provided through FEMA are excluded from federal income tax, but state grants for the same purpose are not excluded from federal income tax. This means if homeowners receive a state-based grant for disaster mitigation work to protect their homes from catastrophe, they must pay federal income tax on the grant money, on top of their personal investment in these projects. Ms. Stringer said H.R. 5404 would fix this tax inconsistency and provide parity for residential mitigation grants provided by state public entities.

Ms. Stringer said the five federal banking agencies issued new and revised proposed interagency questions and answers (Q&A) regarding flood insurance at the end of June. The document is intended to help lenders meet their responsibilities pursuant to the federal flood insurance laws. The agencies note they are drafting new interagency Q&A related to the 2019 private flood insurance final rule and will propose those at a later date.

FEMA released a guide to help emergency managers and health officials prepare for disasters while continuing to respond to COVID-19. This guide was released at the end of May and outlines updated federal hurricane response and recovery planning in light of the pandemic. The guide, *COVID-19 Pandemic Operational Guidance for 2020 Hurricane Season*, describes anticipated challenges to disaster operations posed by COVID-19, as well as planning considerations for emergency managers. It also outlines how FEMA plans to adapt response and recovery operations to these new realities. FEMA says that while its guide focuses on hurricane season preparedness, most planning considerations can also be applied to any disaster in the COVID-19 environment, including flooding, wildfire and typhoon response.

Ms. Stringer said the guide states, “Due to the risks associated with COVID-19 and congregate sheltering, including standards for occupancy rates, equipment requirements and assessment of at-risk or vulnerable populations, this approach will be adjusted.” Per FEMA’s guidance, local governments are tasked with identifying structures that can be used as “non-congregate shelters,” where people can find shelter while following social distancing guidelines issued by the Centers for Disease Control and Prevention (CDC). According to FEMA, these non-congregate shelters can “include, but are not limited to, hotels, motels and dormitories.”

Ms. Stringer said FEMA released an “Exercise Starter Kit for Preparedness in a Pandemic” June 1 to provide sample documents to state and local governments to use to conduct their own workshops on preparedness in a pandemic. The questions and considerations contained in the guide were developed from FEMA’s *COVID-19 Pandemic Operational Guidance for the 2020 Hurricane Season*.

3. **Heard a Presentation from Milliman on the Concept of a Catastrophe Modeling Clearinghouse**

Nancy Watkins (Milliman) said she believes state insurance regulators are struggling with the use of catastrophe models in the rate-making process while at the same time balancing their need to ensure that rates are not excessive, inadequate or unfairly discriminatory. She said this is the language that guides most rate regulation in the states. The data needed to develop models regarding catastrophic events is typically sparse and volatile, which means past experience may not be a sufficient basis for accurate expectations of the future. Ms. Watkins said as a result, catastrophe models have been created and widely adopted, and there are some areas where insurers would like to use catastrophe models in their rate-making process. She said catastrophe rate-making regulation can affect insurance affordability and availability, which she believes is a concern for everyone attending the conference call today. Ms. Watkins said Milliman is seeing a lot of challenges for state insurance regulators, catastrophe modelers and the insurers that are trying to use the catastrophe models.

Ms. Watkins said catastrophe models start with historical experience and decompose the historical experience—i.e. what happened—and then they decompose that historical experience of the various catastrophic events into their component parts. The questions answered are: What kind of risks were exposed? What kind of insurance did those risks purchase? What kind of events would have happened for the risk? How intense were the events? How vulnerable were the risks that were affected by the events? What would be the calculated damage?

Ms. Watkins said if a catastrophe model is not being used, insurers have to base risk on historical data. She said there are only two ways to make rates: 1) you can use experience; or 2) you can use exposures, as this is the fundamental starting point. Ms. Watkins said catastrophe models do use experience. However, they move into the types of risks that there is exposure to
Ms. Watkins said there is a disconnect between insurance premiums and risk incentivizing property development in harm’s way. Ms. Watkins said one of the reasons wildfires are more damaging in California now is because more houses are in places experiencing wildfires. Ms. Watkins said this is the same issue that occurs with flooding on the coast; there are more houses on the coast. She said this is another reason historical experience alone does not provide an accurate picture.

Ms. Watkins said it is important to be able to measure mitigation. She said there is value and importance in mitigating the risk upfront. She said to provide policyholders with the benefit of making investments to reduce their risks, the change in premium reflecting mitigation needs to reflect the premium reduction due to the mitigation. Catastrophe models can reflect premium changes, while historical data cannot.

Ms. Watkins said catastrophe risk is costing more than it used to cost, and it is not good enough to treat catastrophe risk as it is immaterial. She said there are protection gaps due to a lack of proper measurement for flood risk, for example. Ms. Watkins said there are hardly any private flood insurance policies relative to what is needed. She said part of this is a failure of measurement, and the only way to close that gap is to allow the insurers and reinsurers the ability to use a flood catastrophe model to manage and measure flood risk.

Ms. Watkins said there are rating agencies requiring insurers to use more sophisticated modeling with their risk management process and risk disclosures. She said there are also real estate investors using catastrophe models to decide where to invest, and they are better considering future climate risk as important regarding where they are going to invest their money. Ms. Watkins said there is a disconnect between insurance premiums and risk incentivizing property development in harm’s way.

Ms. Watkins said there are a lot of regulatory challenges regarding catastrophe modeling and that catastrophe model treatment varies widely among states. She said the state of Florida is really the only state that has a government body that is tasked with scientific and technical review of hurricane models. Ms. Watkins said a lot of states do allow catastrophe modeling, but the states vary in terms of the type of validation and rules they require. However, there are some states that explicitly prohibit the use of catastrophe models when establishing rates. She said these states may also restrict catastrophe models to certain lines of business or certain perils.

Ms. Watkins said challenges for state insurance regulators include: 1) the lack of appropriate expertise and/or resources to review catastrophe models comprehensively; 2) the balancing of the needs of affordability, availability, insurance company solvency and consumer protection; and 3) the inability to protect proprietary information of the modelers and insurers.

Ms. Watkins said she has come up with the idea of a catastrophe modeling clearinghouse, and while it might not be the idea everyone agrees with, it is a good starting point for discussion. She said the catastrophe modeling clearinghouse would be available for states that wanted to voluntarily participate, and the clearinghouse would provide some type of expert model review for catastrophe models used in ratemaking. The clearinghouse would consist of a multidisciplinary panel that could develop standards and then select expert reviewers who would conduct the reviews. Ms. Watkins said the third-party experts could perform confidential and very rigorous reviews. She said flood models, for example, would be reviewed for two or three years by the same panel. She said the wildfire models would be reviewed by the same panel, etc. She said this would provide a consistent report card for all the different types of models for a given period of time. Ms. Watkins said some standardized disclosures state insurance regulators could rely on would be helpful for state insurance regulators so they could put them side-by-side between different models. She said validation of high-level items could be released publicly, whereas the private proprietary items would be seen only by the expert reviewers.
Ms. Watkins said there could be a questionnaire that is used by all states. However, states would be able to add their own special supplementary questions. These supplementary questions would include issues that are most important to a particular state. Ms. Watkins said the vision for catastrophe model usage in insurance would include a rigorous framework. She said there should also be continuous improvements in data, modeling and risk communication. Ms. Watkins said there should also be the ability to anticipate, measure and plan for future climate scenarios. It is important to figure out what type of mitigations options are going to be most effective to price risks and get sound actuarial rates in the end. Ms. Watkins said she believes risks can be reduced, which will make insurance more affordable and allow insurers to become more comfortable offering premiums that are accurately priced. This will make insurance more available.

Ms. Watkins said the minimum requirements for the success of a catastrophe modeling clearinghouse include: 1) widespread buy-in among state insurance regulators, insurers and catastrophe modelers; 2) cost and time efficiency; and 3) the flexibility to allow innovation and multiple perspectives.

4. **Heard a Presentation from the RAA on the Use of Catastrophe Models**

Dennis Burke (Reinsurance Association of America—RAA) said it is the RAA’s position that natural catastrophe risks are insurable in the free market as long as the free market is permitted to work. He said the best way for the free market to work is to share infrequent high-severity risks, like natural catastrophes across many balance sheets. Mr. Burke said when he evaluates the best tools available for understanding risk, he looks at demographics and asks if there is anything that is the same as it was 20 years ago. He said there are more homes and more people than there were 20 years ago, and people are moving to the risk and building houses that are much bigger. People have electronics now than were used 20 years ago and so their contents cost more now than the historical records show.

Mr. Burke said there are a lot of risks and considerations that indicate the use of historical data is not the best way to estimate and price risk. He said the extent that state insurance regulators could get comfortable with insurers using the best possible tools, which include catastrophe models, to support the rate filings, the RAA believes this would improve the resiliency of insurance and the ability for insurers to provide reasonably priced insurance in the U.S. and Europe.

Mr. Burke said the RAA encourages this dialogue and encourage state insurance regulators, insurers and models to come together to discuss this issue. He said the RAA believes it is important for the states that do not currently permit insurers to use catastrophe models in their rates to be willing to engage in the proposed process and whether or not that would provide them with the comfort to take steps to authorize insurers to use catastrophe models. Mr. Burke said he understands this might require regulatory changes. These issues need to be understood upfront to understand whether the cost and redundancy potentially involved in this process are worthwhile as a cost benefit. Mr. Burke said the RAA does not know if the Milliman proposal is the answer. However, it is an opening step and a process that will only work if all of the interested parties, including state insurance regulators, catastrophe modelers, insurers and consumer advocates who are stakeholders, to have a comfort level with the outcome of the process. He said confidentiality is important, so all involved need to find a way to deal with these issues without sacrificing trade secrets and the confidentiality of catastrophe models. Mr. Burke said redundancy also needs to be avoided to the extent possible, as work that has already been done needs to be used, as there is no need to reinvent the wheel and increase costs.

Mr. Burke said he thinks if state insurance regulators become comfortable with and understand catastrophe models, it will lead to their willingness to permit insurers to use catastrophe models. He said the RAA believes this proposal is a great way to start conversation with stakeholders, whether it ends up being the answer or not.

5. **Heard a Presentation from the APCIA on the Use of Catastrophe Models**

Lisa Brown (American Property Casualty Insurance Association—APCIA) said the APCIA agrees that historical experience may not be sufficient to measure future risk. She said she believes mitigation is a valuable tool in establishing appropriate pricing through the underwriting process. Ms. Brown said unlike other property perils coverage, be it for flood, wildfire or hurricane, it cannot be reliably priced based on historic loss information. It should be clear based on increased severity and levels of loss that insurers cannot accurately predict future losses based only on those incurred in the past. Ms. Brown said Mr. Burke’s point regarding the quickly changing demographics across the country, especially in catastrophe-prone areas, simply underscores this point. She said she believes everyone agrees catastrophe models are a valuable tool to help insurers manage their exposure to financial risks from an underwriting perspective.
Ms. Brown said one thing that differentiates insurers and the marketing and sales of their products is competition and the ability of one insurer to do things differently from another insurer. She said the catastrophe modeling clearinghouse proposal indicates there are different third-party models, which are not consistently regulated in the rate-making and underwriting context. Ms. Brown said the APCI would like to add that individual rate-making and underwriting practices, at least from a regulatory process, are not always regulated consistently either.

Ms. Brown said if the insurance industrywide standards governing catastrophe models are general and provide the basic framework from which to evaluate and use the model, the freedom should exist as it does in other aspects to the property/casualty (P/C) market to allow for creativity, innovation and specialization, without being subjected to a significant oversight, required standardization or other intrusion to the industry that uses the product. She said the regulation of the insurance industry is related to the products provided and the state insurance regulators’ evaluation of the fact that the rates charged are not inadequate, excessive nor unfairly discriminatory. Ms. Brown said this is not to say the methodology’s inputs, outputs and credibility should be assessed and centralized so that the models are all the same, contain the same data and end up with the same results. She said one of the great things about the process that drives the competition is the variability within that black box that everyone talks about exists. Therefore, different customer bases can be served, and insurers can have different programs and serve different customers.

Ms. Brown said the APCI fully supports the increased ability to insurers to use catastrophe models and would request the states that do not allow their use to amend their laws to allow the use of catastrophe models. She said Milliman’s presentation makes it clear there are several questions that would have to be resolved before moving forward with any type of clearinghouse or any alternative solution. Ms. Brown said the AIPCA can commit to the willingness to be part of ongoing conversations with state insurance regulators and other stakeholders.

6. **Heard an Overview from the CIPR on the CIPR Wildfire Catastrophe Modeling Project**

Jeff Czajkowski (Center for Insurance Policy Research—CIPR) said he will provide an update regarding a wildfire resiliency research project. He said the project has taken on some of the notions discussed head-on with a boots-on-the-ground approach working with state insurance regulators in California and Oregon, as well as the vendors in the catastrophe modeling community, particularly Risk Management Solutions (RMS), as well as organizations on the mitigation side, namely the Insurance Institute for Business Home & Safety (IBHS) and the National Fire Protection Association (NFPA) Firewise USA program.

Mr. Czajkowski said the wildfire risk is increasing for policyholders. He said this indicates an availability or affordability problem. One way to address this issue is through increasing the use of risk reduction. Mr. Czajkowski highlighted fire-resistant modifications to a structure and community-wide abatement. The applications of mitigation in the current use of fire risk models, particularly in California, do not allow for the accounting of this mitigation.

Mr. Czajkowski said one good thing about the use of catastrophe models is that one is able to account for mitigation within the modeling framework. He said for the research efforts of this project, it is important to address the issues of ratemaking, solvency and what is being done around mitigation.

Mr. Czajkowski said a paper released last year by the American Academy of Actuaries (Academy), *Acceptance and Widespread Usage of Wildfire Cat Models are in an Early Stage*, discusses the acceptance and widespread usage of wildfire catastrophe models as being in the relatively early stages as compared to hurricane and earthquake models. He said the paper indicates that vendors are critical partners in educating the insurance industry and state insurance regulators regarding the use of wildfire models. Mr. Czajkowski said state insurance regulators should also be encouraged to become more familiar with the wildfire models. He suggested state insurance regulators think about licensing catastrophe models themselves and begin working through the models if they have the capability to do this.

Mr. Czajkowski said there was a meeting in California with the California Department of Insurance (DOI). He said the Oregon DOI joined the meeting virtually. Mr. Czajkowski said the project has been ongoing and will culminate during the NAIC 2020 Insurance Summit in September. He said the project is focused on bringing the science to the operations and engaging the state insurance regulators around this issue. Mr. Czajkowski said the two main outputs of the project are: 1) to leave state insurance regulators with an educational or reference document they can have in terms of looking at the latest wildfire science; and 2) how this is being approached in the catastrophe modeling community. This reference guide is meant to be a blend between the NAIC *Catastrophe Computer Modeling Handbook* and the more traditional standard practice from the actuarial community.
Mr. Czajkowski said the CIPR wants to highlight how catastrophe models can be used by state insurance regulators in the decision-making perspective for public policy purposes, in particular regarding mitigation. Partnering with FireWise and IBHS in the process allows the ability to show state insurance regulators where the science from these entities is embedded in the catastrophe models, allowing the models to be run in different locations. This project involves three locations in California, three locations in Oregon and three more from a control environment in Colorado. Running these models illustrate both using mitigation and not using mitigation, and a cost-benefit analysis is run from this information.

Mr. Czajkowski said one of the ongoing project goals includes presenting the results of the study during the NAIC Insurance Summit in September. There will be a similar agenda for climate change to again highlight the science and the modeling.

Amy Bach (United Policyholders) said California has been in the middle of an availability and affordability crisis regarding insurance, as well as a legislative battle. She said California has two bills that the insurance lobby is pushing hard to get through this session. One of these bills will force the California DOI to allow catastrophe modeling over their objection. Ms. Bach said as a consumer advocate, she is worried about the dials on the catastrophe model being susceptible to being turned up and down for profit and business objectives. She asked Ms. Watkins if the California DOI should be facing a mandate that they are opposing to allow. Ms. Watkins said they are at a point where the current state of regulation could end up with an availability crisis that would not only affect the people in the most risky areas, but also could actually push insurers to pull their business out of the state of California. She said she believes the state is at a point where things have to change. There have been two years where the insurance industry lost $20 billion on its entire portfolio of California homeowners insurance business. Ms. Watkins said in the prior 26 years, the total profits for the insurance industry were $10 billion. She said there is a formula in California that allows one to recoup his or her bad year’s losses by using a 20-year average. Ms. Watkins asked if one lost two times of his or her 26 years of profit in two years, how many years of experience will it take to load that back in. She said there is not anyone who can defend the current California formula and say that it produces reasonable results. Ms. Watkins said if models would have been used all along, the models could have smoothed out all the rate shock by being implemented more gradually over time. She said the California DOI might have had a difficult time regulating this using its current staff. Ms. Watkins said it takes an enormous amount of manpower to vet numerous wildfire models.

John Huff (Association of Bermuda Insurers and Reinsurers—ABIR) said he believes everyone involved is dealing with catastrophe modeling modernization. He said he knows all of the pressure state insurance regulators are under to balance affordability and accessibility of insurance and believes this is the path to provide those tools. Mr. Huff said he does not know what the end product will look like, but he cannot think of a better use of the NAIC collective brainpower and resources than to help the states with this type of project.

Commissioner Chaney said many states allow the use of catastrophe modeling. However, some states restrict the use of certain models, such as those with warm sea surface temperature. He said he believes Alabama still restricts itself to the use of three models. Commissioner Chaney suggested finding out from states what models they are allowing to be used within their state.

Mr. Bradner said Connecticut has allowed models. He said there was some market disruption in 2008–2009, especially in its homeowners market, as insurers wanted to increase their rates by up to 50%–60%. Mr. Bradner said Connecticut has worked with insurers over the past eight to 10 years and gradually got them up to where insurers are in a good position. He said most insurers in Connecticut are sitting with a loss ratio of 30%–40%.

Mr. Bradner said where he has had problems with the models is that an insurer can project a 40%–50% or 80%–90% loss ratio to the DOI based on its model, catastrophe loads and reinsurance loads, and every year justify a rate increase. He said this is where he struggles and must start pushing back on insurers. Mr. Bradner says while he knows insurers need to have a cushion, it is difficult for state insurance regulators because they are public facing. He said state insurance regulators have to understand how to deal with this issue because it is not simple. Mr. Bradner said he believes insurers should start looking at the states where they are making money and investing in providing greater incentives for mitigation credits.

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.
Catastrophe Insurance (C) Working Group
E-Vote
May 26, 2020

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee conducted an e-vote that concluded May 26, 2020. The following Working Group members participated: Mike Chaney, Chair (MS); Jerry Workman (AL); George Bradner (CT); Colin Hayashida (HI); Travis Grassel (IA); Heather Droge (KS); Warren Byrd (LA); Joy Hatchette (MD); LeAnn Cox (MO); Timothy Johnson (NC); Cuc Nguyen (OK); Beth Vollucci (RI); J’ne Byckovski (TX); David Forte (WA); and James A. Dodrill (WV).

1. Adopted its 2019 Fall National Meeting Minutes

The Working Group conducted an e-vote to consider adoption of its 2019 Fall National Meeting minutes. The motion passed, with a majority of the Working Group members voting in favor of adopting its Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Property and Casualty Insurance (C) Committee, Attachment Three).

2. Adopted Updates to the NAIC State Disaster Response Plan

The Working Group conducted an e-vote to consider adoption of its updates to the NAIC State Disaster Response Plan. The motion passed, with a majority of the Working Group members voting in favor of adopting the NAIC State Disaster Response Plan (see NAIC Proceedings – Summer 2020, Property and Casualty Insurance (C) Committee, Attachment Eight).

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.

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The Climate Risk and Resilience (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call July 31, 2020. The following Working Group members participated: Mike Kreidler, Chair, and Jay Bruns (WA); Ricardo Lara, Vice Chair, represented by Michael Peterson (CA); Alex Romero (AK); Peg Brown (CO); George Bradner (CT); Colin Hayashida and Paul Yuen (HI); Travis Grassel (IA); Judy Mottar (IL); Joy Hatchette and Cheryl Kouns (MD); Peter Brickwede (MN); Brooke Larlo (MT); Bruce R. Ramege (NE); Anna Krylova (NM); Marshal Bozzo (NY); Tom Botsko (OH); Andrew R. Stolfi and Brian Fordham (OR); David Buono, Mike McKenney and Shannen Logue (PA); Rafael Cestero-Lopategui and Carla Colon (PR); and Kevin Gaffney (VT). Also participating were Barbara Richardson (NV) and Lorraine Ratchford (NY).

1. **Adopted its June 18 Minutes**

The Working Group met June 18 and took the following action: 1) received an update on the drafting of the *Insurance Regulatory Discussion Points on Catastrophic Events* document; 2) heard an update on California’s development of a Sustainable Insurance Roadmap; 3) heard a high-level summary of Ceres’ recently released *Addressing Climate as a Systemic Risk: A Call to Action for U.S. Financial Regulators* report; and 4) discussed its work plan for 2020.

Mr. Grassel made a motion, seconded by Mr. Botsko, to adopt the Working Group’s June 18 minutes (Attachment Three-A). The motion passed unanimously.

2. **Heard an Update on the NAIC Climate Risk Disclosure Survey Analyses Being Done by CIPR and the Academy**

Lisa Groshong, Ph.D. (NAIC) said the NAIC Climate Risk Disclosure Survey (Climate Survey) was adopted by the NAIC in 2010, and it is administered in a multi-state initiative—California, Connecticut, Minnesota, New Mexico, New York and Washington—with survey responses being held on a California Department of Insurance (DOI) database. Insurers with over $100 million in direct written premium are required to complete the Climate Survey. Currently, there are more than a thousand survey responses, representing about 70% of the U.S. insurance market. The 2018 Climate Survey responses included nearly 500,000 words. There are nine Yes/No questions and eight narrative responses that ask the respondent to discuss their: 1) plan to assess emissions; 2) risk management; 3) process for identifying risks; 4) risks posed by climate change; 5) investment strategy; 6) policyholder loss reduction efforts; 7) engagement with constituencies; and 8) actions to manage risks. Challenges to analyzing the responses include difficulty interpreting Yes/No questions, a high amount of time needed to digest narrative responses, and numerous duplications among legal entities. The multi-state initiative is currently working towards aligning climate reporting with the Financial Standards Board’s (FSB’s) Task Force on Climate-Related Financial Disclosures (TCFD). It would be helpful to know exactly what information is already being provided, so future surveys should be revised to incorporate findings from previous surveys. The NAIC’s Center for Insurance Policy and Research (CIPR) aims to report in September 2020 on the Climate Survey’s quantitative and qualitative responses for 2018. The focus will be on quantitative relationships and qualitative understanding of responses to individual questions. This is particularly relevant for question 6, which asks for the “steps the company has taken to encourage policyholders to reduce the losses caused by climate change-influenced events.” The CIPR’s research methodology will focus on two research questions: 1) how insurers across all lines of business assess and manage risks related to climate change; and 2) how these responses have changed over the past 10 years. Its quantitative analysis will focus on descriptive statistics of yes/no responses to survey questions. Its qualitative analysis will be a thematic analysis of open-ended responses to the survey questions to identify patterns of meaning across a dataset. The CIPR research team read survey responses for questions 4 through 8 and generated themes. These themes were coded using NVivo software, and the results are currently being compiled. Preliminary quantitative results focus on how to visualize responses to balance the number of companies versus premium dollars. Of the 1,245 responses, 63% were property and casualty insurers, 20% were life insurers, 13% were health insurers, and the remainder were from various other lines of business. Total premium for the six states participating in the multi-state initiative consisted of 40% life, 32% property and casualty, 26% health, and the remainder from various other lines. The analysis will examine distinct responses, rather than all legal entities. It will provide “building blocks” for assessments rather than “grades” for companies. It will also provide multiple-choice questions that might easily be included, capturing responses already being provided in a more easily accessible manner.
Steven Jackson, Ph.D. (American Academy of Actuaries—Academy) said the Academy plans to report its findings on the 2018, 2015 and 2012 Climate Survey responses in December 2020, and TCFD findings and other alternatives will be reported in 2021. The analysis is being conducted by the Academy’s ERM/ORSA Committee, chaired by Michelle Young. The focus is on quantitative relationships and a qualitative understanding of company responses. This may include question 5, which asks for the “impact of climate change on its investment portfolio and...alterations in investment strategy in response to these considerations.” The analysis will focus on addressing the following questions: 1) how companies prepare their responses and if they devote significant time to the task; 2) how much attention companies give to climate risk as reported; 3) what the most commonly and least commonly referenced risks and responses are; 4) With respect to Investment Strategy (question 5), what specific sub-questions companies are answering; and 5) how these answers differ by year, line of business, and size of company. Preliminary results indicate that 8.5% of responses switched from “No” to “Yes” and 4.4% switched from “Yes” to “No” between 2012 and 2015. It is anticipated that more responses will switch from “No” to “Yes” as climate risk gains attention. Explanations for companies’ switching responses from “Yes” to “No” over time are less straightforward, and answers to the questions raise further questions. Like the CIPR’s analyses, the Academy will examine distinct responses, rather than all legal entities. It will provide “building blocks” for assessments rather than “grades” for companies. It will also provide multiple-choice questions that might easily be included, capturing responses already being provided in a more easily accessible manner.

Dennis C. Burke (Reinsurance Association of America—RAA) asked for clarification on Mr. Jackson’s comments related to potential changes to the Climate Survey questions. Commissioner Kreidler said the most significant change is a move to align with the TCFD. Respondents to this year’s Climate Survey were advised that they can submit their TCFD in lieu of the Climate Survey. Those that submitted a Climate Survey were advised to refer to the TCFD guidelines when filling it out. The advantage of the TCFD is that it provides a source of uniform reporting for the insurance and financial services sectors that are not otherwise in place.

3. **Heard an Update on California’s Climate Smart Insurance Product Database**

Mr. Peterson stated that the California DOI partnered with the United Nations Environment Programme (UNEP) to develop a Sustainable Insurance Roadmap. As part of this Roadmap, it launched the Climate Smart Insurance Product Database (Climate Smart Database). The Climate Smart Database is the first consumer-oriented list of climate-related insurance products. There are more than 400 internationally available products that address climate risks, harness new technologies, and build resilience. The California DOI developed the database to help the public understand and access these products and encourage further insurance policy innovation in commercial, homeowners, auto and other lines. Products listed in the database provide green-rebuild coverage and promote fuel-efficiency by offering lower premiums for low-emission vehicles, discounts for green energy use/certification, and discounts for businesses that operate hydrogen and hybrid electric buses and protect low-income communities and natural ecosystems. It is hoped that insurers will explore the database as a starting place for innovative products. The database is searchable by product features and insurance category.

Commissioner Richardson asked if California’s Climate Smart Database provides the ability to search by insurance carriers who invest in green investments. Mr. Peterson said the database just searches products offered by insurers.

Mr. Grassel asked where the Climate Smart Database sources its data. Mr. Peterson said Evan Mills, a researcher from Lawrence Berkeley Labs, accumulated the data over years of research. Future updates will be maintained by the DOI.

4. **Heard a Presentation on Swiss Re’s Approach to Climate Change and Sustainable Insurance Products**

Yommy Chiu (Swiss Re) said Swiss Re created a Macroeconomic Resilience Index to measure the ability of economies to withstand shock events. In using the index to track and compare countries, Swiss Re has found that the world economy has less capacity to absorb shock events than it did a decade ago. Swiss Re also created an Insurance Resilience Index to measure the contribution of insurance to the financial stability of households and organizations. The index indicates that the U.S. insurance gap increased from 2000–2018, with the widest protection gap being health. Results are being driven by the U.S. health care system structure. Insurance supports macroeconomic resilience by funding recovery in an efficient manner. It also provides the public sector with a sustainable financial framework from which to build policy. Swiss Re has a public-private pilot project with the California DOI to address the health care protection gap.

Samantha Dunn (Swiss Re) said modelling dynamic risks like climate change comes with many uncertainties. In the absence of hard data, the approach should be to assess risk in terms of levels of confidence. Longer and more frequent heat waves, droughts, water scarcity and wildfires will increase health issues, mortality and potentially political conflicts. The increase in
frequency of perils, such as hail and tornado, will affect revenue earnings. Melting of glaciers and ice caps will result in sea level rise and storm surge, changing the magnitude of disasters and increasing the potential for epidemics.

Innovative products that support natural ecosystems and maintain biodiversity are important to preventing natural disasters. Biodiversity is also an important component in preserving the plants our medicines are made from and nature-based tourism. The flood protection gap is estimated to be $36 billion, with 40–60% of businesses never reopening after a natural disaster. Mangroves provide flood protection benefits exceeding $65 billion per year. Research from The Nature Conservancy (TNC) shows coastal wetlands can save communities hundreds of millions of dollars and reduce flood damage by up to 29%.

Swiss Re’s public-private partnership with the California DOI is aimed at concreting a solution that will build resiliency for hospitals and health care settings by addressing the scarcity of care capacity for vulnerable people. The pilot concept is to test if access to timely care for uninsured and underinsured vulnerable populations can be increased by offering an influx of cash during an extreme heat event.

5. **Heard a Presentation on Allianz’s Approach to Climate Change and Sustainable Insurance Products**

Nico Ahn (Allianz) said Allianz co-chairs the United Nations (UN)-convened initiative, Global Investors for Sustainable Development (GISD) Alliance, which scales up finance and investment in sustainable development. It is a leading insurer in the Dow Jones Sustainability Indices. It also co-led the Principles for Sustainable Insurance (PSI) initiative to develop the first global guidance on environmental, social and governance (ESG) in property and casualty underwriting. Allianz’s ESG strategy is based on the 17 UN Sustainable Development Goals, which affect its role as insurer, investor, employer and corporate citizen.

A group-wide climate change strategy has been in place since 2005. The strategy is governed by its Group ESG Board, which regularly reports to its Board of Management and Supervisory Board. It has a dedicated climate change center as part of its Corporate Responsibility department. Climate change as risk driver is managed as part of an overarching risk governance architecture, with emerging elements being dealt with separately. The climate change focus is on decarbonization of assets and climate analysis and disclosure. Allianz is committed to net-zero emissions in proprietary investments by 2050. Its Board of Management remuneration is tied to emission targets. It has joined forces with 26 asset owners in the UN-Convened Net-Zero Asset Owner Alliance. It has been reporting against the TCFD framework since 2017. It is working with the UNEP Finance Initiative (FI) to improve its scenario analysis and disclosure for property and casualty underwriting.

Thomas Liesch (Allianz) said Allianz has identified six criteria to identify products with a specific environmental and social added value. Sustainable solutions must: 1) support the development of sustainable technology; 2) conserve natural resources and biodiversity or mitigate climate change; 3) protect from environmental risks and adapt to climate change impacts; 4) support people tackling social challenges; 5) provide for socially disadvantaged groups; and 6) raise awareness via donations or communications campaigns. Allianz’s sustainable solutions fall into three main categories and form part of its action towards the UN Sustainable Development Goals: sustainable insurance, emerging consumers, and sustainable asset management. Its sustainable solutions include agriculture, mobility, environmental liability, sustainable lifestyle, renewables and energy efficiency.

Commissioner Hayashida said it was evident after Hurricane Maria that Puerto Rico had a high percentage of uninsured people. Based on Medicaid, about 47% of the population is at the poverty level. Puerto Rico responded by passing legislation to incorporate catastrophe microinsurance parametric products into the local market. Microinsurance products provide affordable private insurance for Puerto Rico’s low-income population to assist in recovering from catastrophic events. The maximum premium currently allowed is $250 a year. The microinsurance will be sold through places like credit unions to avoid the added expense of producer fees.

Ms. Dunn said Swiss Re’s products frequently have a parametric trigger on an indemnity base. In an ideal world, consumers would have parametric insurance in conjunction to traditional indemnity coverage.

6. **Heard a Presentation on the APCIA’s Domestic and International Climate Risk-Related Activities**

David F. Snyder (American Property Casualty Insurance Association—APCIA) said the APCIA engages on climate risk in many domestic and international forums. Its domestic-focused advocacy activities include a July 1 letter to the chairman and ranking member of the U.S. Senate (Senate) Committee on Environment and Public Works. The letter encourages states and communities to adopt land use measures, including optimizing natural infrastructure. It recommends that climate risk models and resilience standards be used in all public infrastructure projects. It also suggests committing additional funds for resilient
infrastructure and retrofitting for resilience, and it supports research and incentives for mitigation. The APCIA regularly engages at the state level on improving building codes and supporting other mitigation proposals, including the work of the Insurance Institute for Business & Home Safety (IBHS). The APCIA’s website regularly provides information to the public on climate risk mitigation and response. Recent examples include information on preparedness for Tropical Storm Hanna in July and Tropical Storm Cristobal in June and recovery after dam collapses in May. The APCIA annually sponsors the National Flood Conference. It also participates in multi-sector coalitions to improve resiliency efforts. For example, its SmarterSafer policy recommendations include: 1) encouraging efforts and funding for mitigation to reduce damage before disasters; 2) requiring federal standards and a focus on earthquake and wildfire risk; 3) reforming the National Flood Insurance Program (NFIP) to improve modeling and mapping; 4) moving toward risk-based rates with help for low income communities and individuals; 5) allowing private insurance and support mitigation; and 6) encouraging greater coordination among federal agencies. Its international activities are focused on industry coordination. It is a member of the Global Federation of Insurance Associations (GFIA) and an active participant in all climate risk-related activities. It leads the effort to draft positions and key points on climate risk mitigation and adaptation with the Insurance Bureau of Canada (IBC). The APCIA provides stakeholder input to international bodies such as the International Association of Insurance Supervisors (IAIS) and the Organization for Economic Co-operation and Development (OECD). It was a team member in a UN and Allianz sponsored project that created an ESG in non-life insurance guide.

Ms. Ratchford said the Ceres *Addressing Climate as a Systemic Risk: A Call to Action for U.S. Financial Regulators* report suggests that banks should consider reducing their investments and lending to carbon emitters with a target date of 2050. Climate scientists have said we have 10 years to address the problems. She asked what the NAIC and the various insurance departments can do regarding messaging on this issue. She also asked if the NAIC or APCIA could consider working with legislature and administrative agencies to author public policies to discourage development in high-risk zones. Ken Klein (California Western School of Law) said he echoes these ideas; the timeline necessitates very aggressive responses. Commissioner Kreidler said the speakers that the Working Group has heard from during the meeting are part of its efforts to address these concerns. One of the challenges that states insurance regulators have is to not allow major economic sectors to be ignored to the extent that there are no insurance products available to insure investments. It is important that state insurance regulators and insurers advocate for better land use practices and building codes. The creation of a climate task force at the NAIC’s Executive level is an important step in encouraging more state insurance regulators to take up these issues. State insurance regulators need to become much more aggressive at providing guidance to insurers on their investments. There is a lot of concern that certain investments could become stranded in the future, particularly those tied to carbon. State insurance regulators should also be evaluating the potential for stranded assets at the industry level and incorporating stress testing. They should work to make sure insurers do not incur any unnecessary barriers when investing in appropriate green investments.

Mr. Snyder said insurers work directly and indirectly to prevent building in geographically vulnerable areas. This is a great area for state insurance regulators and industry to work jointly. The APCIA believes that there is a large appetite for green investments, and it would like to see those markets grow rapidly.

John M. Huff (Association of Bermuda Insurers and Reinsurers—ABIR) said he encourages state insurance regulators to consider receiving a presentation by the SmarterSafer Coalition. It is a very broad-based coalition with practical approaches to climate risk solutions at the federal and state level.

Having no further business, the Climate Risk and Resilience (C) Working Group adjourned.
The Climate Risk and Resilience Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call June 18, 2020. The following Working Group members participated: Mike Kreidler, Chair, and Jay Bruns; Ricardo Lara, Vice Chair, represented by Michael Peterson (CA); Austin Childs and Alex Romero (AK); Peg Brown (CO); George Bradner (CT); Colin M. Hayashida (HI); Judy Mottar (IL); Travis Grassel (IA); Robert Baron (MD); Peter Brickwedde (MN); Nina Chen (NY); and Tom Botsko (OH).

1. Received an Update on the Drafting of the Insurance Regulatory Discussion Points on Catastrophic Events Document

Mr. Peterson stated the Working Group decided on its Oct. 2, 2019, conference call to develop a product that can assist insurance departments in fielding frequently asked questions (FAQ) related to resilience and catastrophe events. The product was referred to as the Insurance Regulatory Frequently Asked Questions at the time. It was in part inspired by California’s Wildfire Resilience Summit in April after the ferocious fires of the last couple of years in California. The document was designed to be a compilation of questions state insurance regulators find they are frequently being asked. Each insurance department could then voluntarily answer the questions as they relate to its specific state. The original intent was for the responses to be available for dissemination by each insurance department to inform the public and provide guidance to state and local efforts related to resilience and insurance. The Working Group also supported the compilation of each state’s responses for sharing purposes, so states can learn from each other’s efforts. It was decided questions should apply to all states, with the option to develop a more peril-specific version in the future. This makes sense considering the differences one can visualize almost immediately between states such as California and Connecticut.

Further development of the product occurred during informal drafting calls on May 22 and March 11. Summaries of those conference calls were provided in the materials (Attachment Three-A1 and Attachment Three-A2). The March 11 conference call expanded the questions in many of the existing sections and added new sections for adjuster licensure, department-stakeholder interactions and post-catastrophe regulatory response. During the May conference call, the product was converted from public to regulator-only and renamed Insurance Regulatory Discussion Points on Catastrophic Events (CAT Discussion Points). The change was to allow for more robust sharing among states, which is deemed to be the document’s strongest value. However, states can still choose to leverage their response information for public use as they deem appropriate. The Purpose section was revised to specify the questions are meant to be a list of potential discussion points for states to consider in crafting their unique response. States are not expected to answer every question. The May 22 conference call also added sections for technology and the idea of overlapping or sequential crises that occur in the same time period.

The informal drafting group has progressed substantially in its drafting. The next conference call will focus on reviewing the draft to ensure it is not peril-specific and adding questions to the Overlapping Crises section. The informal drafting group will also review catastrophe-related material shared by Minnesota to see if anything additional should be added to the draft.

Jeff Klein (McIntyre & Lemon) stated the CAT Discussion Points document is interesting and recommended it should include the need for states with natural disaster statutes to revisit these to ensure they take pandemic issues into account. He stated his company encountered a similar issue in North Carolina, which has a natural disaster statute affecting premium finance companies. Even with a three- or four-day hurricane occurring with the onset of a pandemic, such as the current one, the time period is a lot more elongated, especially when states had to extend their orders and moratorium. He expressed his willingness to discuss the implications of a prolonged disaster (such as on cancellation nonrenewal moratoriums) further during an informal drafting call.

Commissioner Kreidler agreed with Mr. Klein’s point. He stated the compounding implications of an event such as a pandemic does not necessarily fit the same mold of what state insurance regulators have historically dealt with and will irrevocably change our role as regulators. He also stated it is important to learn from our current circumstances so we can be better prepared for a second virus wave or future pandemic. The additional complications climate change brings to a pandemic are debated by some, but it is not unreasonable to assume climate change is bringing population mobility and thereby increasing transmission of the virus.
Dave Snyder (American Property Casualty Insurance Association—APCIA) asked if there would be an opportunity for interested parties to weigh in on the CAT Discussion Points. Commissioner Kreidler stated there would be an opportunity for anyone to provide comments on the document when it is exposed after the informal drafting group completes the draft.

2. **Heard an Update on California’s Development of a Sustainable Insurance Roadmap**

Mr. Peterson stated the California Department of Insurance (DOI) announced in July 2019 that it had partnered with the United Nations Environment Program (UNEP) to develop a Sustainable Insurance Roadmap. The goal is to provide a comprehensive and cohesive set of policies related to climate change and insurance that can serve as a guide. The Roadmap will enable California to use risk reduction measures, insurance solutions and insurer investments to reduce the magnitude of future events and insurance losses, stabilize rates and increase insurance availability. For example, new insurance products could be developed to promote cooler streets and renewable energy. There could also be insurance solutions designed to protect California’s natural infrastructure—such as wetlands and forests—to reduce climate and disaster risk. Mr. Peterson stated that as recommended by the Ceres report on the agenda today, California is currently developing a database and search tool to allow users to identify insurers offering insurance products that offer climate risk solutions.

3. **Heard a High-Level Summary of Ceres’ Recently Released *Addressing Climate as a Systemic Risk: A Call to Action for U.S. Financial Regulators* Report**

Steven Rothstein (Ceres) commended the six states that are administering the NAIC Climate Risk Disclosure Survey (Climate Survey) for supporting the option for insurers to submit a Task Force for Climate-Risk Financial Disclosure (TCFD) report in lieu of the Climate Survey. He stated Ceres recommends taking additional disclosure initiatives in its *Addressing Climate as a Systemic Risk: A Call to Action for U.S. Financial Regulators* report. The report outlines why and how key U.S. financial regulators can and should take action to protect the financial system and economy from potentially devastating climate-related shocks. The report makes a series of recommendations that build on the existing mandates of the relevant regulatory agencies. It also identifies similar actions being taken by global regulators that could serve as important models for U.S. agencies to consider.

The report’s key recommendations for state and federal insurance regulators include:

- Acknowledging and coordinating action to address the material risks of climate change.
- Assessing the adequacy of current insurer actions for addressing climate risks.
- Joining the Sustainable Insurance Forum.
- Requiring insurers to conduct climate-risk stress tests and scenario analyses.
- Requiring insurers to integrate climate change into their Enterprise Risk Management (ERM) and Own Risk and Solvency Assessments (ORSA) processes.
- State regulators requiring insurers to assess and manage their climate-risk exposure through their investments, and examining how climate trends affect company holdings and long-term solvency.
- State regulators encouraging insurers to develop products for the new technologies, practices and business models that will emerge in response to climate-risk that are responsive to both risks and opportunities.
- State regulators mandating insurer climate-risk disclosure using the TCFD recommendations.
- Assessing the sector’s vulnerabilities to climate change and reporting findings to the Financial Stability Oversight Council (FSOC).

4. **Discussed its Work Plan for 2020**

Mr. Bruns stated the proposed work plan for 2020 included finishing the drafting of the CAT Discussion Points document with adoption hopefully by the Spring National Meeting. It also included a proposal to review the Financial Condition Examiners Handbook for potential climate risk and resilience related revisions. Proposed revisions would then be referred to the Financial Examiners Handbook (E) Technical Group for consideration. The Working Group proposed similar revisions to the Technical Group in 2012 that were adopted into the 2013 Exam Handbook. The changes provided guidance, if needed, to examiners to ask questions about the impact of climate risk on solvency. There is also a proposal that came out of conversations with New York to gain a better understanding of how to effectively communicate climate-risk and the role of insurance, resilience and mitigation to elicit behavior change in consumers through presentations. This includes hearing from experts such as the Yale Program on Climate Change Communication, which performs research on how to identify and understand different audiences to more effectively educate and communicate on issues related to climate change. Presentations from insurers, modelers and climate research organizations on the use of products, incentives and technologies that support resilience in the insurance
industry is also proposed. Hearing from the American Academy of Actuaries (Academy) and Center for Insurance and Policy Research (CIPR) on research being done on the NAIC Climate Risk Disclosure Survey responses is also proposed. The final proposal is to better understand through presentations and dialogues how Moody’s and others, including other jurisdictions and the NAIC, incorporate climate risk into analysis and governance practices.

Commissioner Kreidler asked Mr. Rothstein to share his thoughts on the draft work plan. Mr. Rothstein stated he thinks the draft work plan is thoughtful and comprehensive and focuses on gathering information from lots of people. He stated he supports the Working Group gaining more insight on transparency and welcomes the opportunity to support the Working Group going forward.

Commissioner Kreidler stated he thinks webinars on rating agency actions will be important. He stated he has concerns on the reticence of rating agencies to become more engaged on the vulnerabilities associated with climate change.

Mr. Brickwedde noted the NAIC member call on June 25 included discussing the NAIC Climate Risk and Resilience Key Initiative and asked how that may affect the work plan.

Anne Obersteadt (NAIC) stated she was not sure what the agenda item pertained to, but that it was her understanding it would not include Property and Casualty Insurance (C) Committee activities.

Mr. Peterson stated he thinks the draft work plan included good components but considered climate change communication to be particularly important. The connection insurance regulators have with consumers does not often get mentioned, making the proposal to better communicate climate risk to the client very important. Insurance regulators tend to view risk as specific to perils, such as risk by fire zone or flood zone. It makes sense that the Working Group should investigate the potential of communicating broader shifting risks beyond this binary perspective. Commissioner Kreidler agreed on the importance of communicating climate change risk to consumers.

Mr. Snyder asked if there was a way to focus on climate resilience in post-pandemic rebuilding. Mr. Bradner stated the Working Group has discussed the need to work with industry and states on more aggressively adopting building codes and standards. It would be beneficial to get more states to recognize the advantages of the Insurance Institute for Business & Home Safety (IBHS) FORTIFIED program that helps homeowners protect their properties against weather events. The FORTIFIED program is more developed towards hurricane-prone jurisdictions, such as those in the Southeast, but there are still standards in the program that would benefit other regions of the country. State insurance regulators need to become more involved in their sister agencies’ meetings and advocate for industry to join these meetings as well. There is also a need to find data that illustrates the loss prevention savings of building-resilience measures, such as roof taping. This would be helpful in responding to pushback from builders on the additional costs they incur from such practices.

Commissioner Kreidler agreed building resilience should be added to the Working Group work plan. Mr. Bruns instructed NAIC staff to add “supporting insurance regulators resiliency efforts by holding dialogues with industry and other stakeholders on the importance of incorporating IBHS standards and adopting building codes” to the work plan.

Commissioner Kreidler stated Director Ramge recently discussed Nebraska’s activities in this area with him. Several bills have been introduced related to flooding or climate mitigation in response to Nebraska’s flood losses last year. Additionally, cities such as Lincoln, NE, are establishing Climate Resiliency Task Forces focused on mitigating flood and drought impact on agriculture and exploring renewable energy sources. There is also a bipartisan coalition of governors committed to upholding the provisions of the Paris Climate Agreement.

Commissioner Kreidler asked if any member had a concern on the draft work plan. Hearing none, he deemed a consensus on the work plan.

Having no further business, the Climate Risk and Resilience (C) Working Group adjourned.
Date: 5/22/20

Informal Drafting Call of the

CLIMATE RISK AND RESILIENCE (C) WORKING GROUP
Friday, May 22, 2020
2-3 p.m. CT

Summary Report

The informal drafting group of the Climate Risk and Resilience (C) Working Group met by conference call on Friday, May 22, 2020. The following states participated: Washington, Chair; California, Vice Chair; Alaska; Colorado; Illinois; Maryland; Minnesota; Montana; New York; New Mexico; Ohio; Pennsylvania; Puerto Rico; Vermont. The call was led by California.

During the call, the informal drafting group:

1. Discussed revisions to the Insurance Regulatory Frequently Asked Questions (FAQ) that had been implemented based on the Working Group’s March 11, 2020 conference call. (See 3/11/20 summary for specifics.)

2. Discussed additional revisions, including:
   a. Converting the document from public to regulator-only to allow for more robust sharing among states. States would still be able to leverage information from the FAQ for public use, as deemed appropriate.
   b. Revising the “Purpose” language to specify the questions are meant to be a list of potential discussion points for states to consider in crafting their state’s unique response. States are not expected to answer every question.
   c. Move technology related questions (III.F., IV.D., V.G.) to a newly created Technology section.
   d. Create a new section for Managing Overlapping Crises in a Time of Unknown.

3. Discussed post-call revisions
   a. Drafting members are asked to contemplate if additional revisions are needed to ensure the questions are not peril specific.
   b. Drafting members are asked to contemplate what additional questions are needed in the Overlapping Crises section.
   c. Revisions and additions are to be sent to NAIC staff (aubersteadt@naic.org)

4. Discussed information to be shared by drafting members post-call
   a. MN will share material they send to legislators and other public offices on tornadoes, hail and flood risks in their state.
   b. Getting input from TN on the impact of recent tornadoes in a time of COVID would be helpful.

5. Discussed state-specific disaster management activities.
   a. MN works to make consumers in higher risk areas more aware of proactive steps through sharing tools, such as home inventory lists, at community events and through social media, such as sending out consumer awareness tips on spring flooding in the winter.
b. CO partners with PCIAA, emergency managers and others on mitigation actions and standards. They are also developing a webpage devoted to disasters that can be easily shared with others, such as the Red Cross.

c. CO said responding to disasters in rural areas during the pandemic has had a negative impact on how effectively they can respond. Rural evacuations must be made to disaster centers further out, causing substantial dislocation to victims.

d. They have experienced an increase in concurrent and cascading events. Currently, they are contemplating the implications of fire risk and shelter in a time of COVID-19.

e. MD holds a webinar with the P&C industry to discuss regulatory expectations and company actions (like use of new claims technology) during/post catastrophe.
Date: 3/17/20

Informal Drafting Call of the

CLIMATE RISK AND RESILIENCE (C) WORKING GROUP
Wednesday, March 11, 2020
11 a.m. – 12 p.m.

Summary Report

The informal drafting group of the Climate Risk and Resilience (C) Working Group met by conference call on Wednesday, March 11, 2020. The following states participated: Washington, Chair; California, Vice Chair; Colorado; Maryland; Nevada; New Mexico; Oregon; Pennsylvania; Puerto Rico; Vermont. The call was led by California.

During the call, the informal drafting group:

1. Discussed revisions to the Insurance Regulatory Frequently Asked Questions (FAQ) that had been implemented based on the Working Group’s prior conference call. The FAQ aims to be a compilation of questions state insurance regulators find they are frequently being asked related to resiliency efforts and pre/post catastrophe activities.
   a. To address the suggestion the FAQ should be all-peril, rather than wildfire specific:
      i. Reference to the wildland urban interface was deleted from Section I
      ii. Reference to or questions specific to wildfire were deleted from Section III
   b. To address the suggestion questions on insurance coverages and exclusions be added
      i. The title of Section IV was changed to “Insurance Coverage Adequacy and Exclusions”
      ii. A question was added to Section IV asking if post-disaster studies were required to understand the adequacy of insurance coverages
   c. To address the suggestion a residual market section be added
      i. Section VII titled “Residual Market Questions” was added, with further questions to be drafted by the drafting group
      ii. Two questions were added to Section IV asking how recent building code upgrades are and how they are enforced

2. Discussed adding the following revisions:
   a. Add an introduction to describe the perils the FAQ could apply to.
   b. Add a question related to what data is needed to support mitigation incentives and how this data can be obtained.
   c. Add questions for how much is included in the state’s residual market and if there are any exclusions/inclusions to what is covered.
   d. Amend the question under “Insurance Coverage Adequacy and Exclusions” related to insurers’ requirements to provide estimates of replacement cost to include “and the corresponding change in premium resulting from it.”
   e. Add a question for how states work with building departments to adopt required standards for resiliency, such as taped roofs in Connecticut and updated maps in California. Add a question asking how successful or receptive building departments were when approached.
f. Add an Adjuster Licensure category. Add a question requesting the state’s licensure process. Add a question for steps taken to expedite adjuster’s ability to enter catastrophic areas. 

g. Add questions asking if states are required to upgrade to the newest building code and what state regulations trigger a retrofit of a home. 

h. Add a question on how the insurance department works with sister agencies to promote resilience and building standards. 

i. Add a question related to where consumers go if they can’t get coverage in the admitted market. 

j. Add questions related to proximate or concurrent cause issues. 

i. California noted difficulties related to determining if a mudslide was caused by a wildfire or occurred independently. Colorado noted the rule of if a flood or water caused a mud slide are unintelligible. 

ii. Storm surge or flood (wind vs. water) was an issue in Maryland after Hurricane Sandy (likely FL, SC, LA and TX too). 

iii. Colorado noted cancelations due to a second hail claim within a year from two different hail events. 

iv. Colorado, Iowa and New Mexico commented on the lengthy time it can take for damage to show. 

v. Colorado noted issues after the 2017 hail event included vehicle damage estimates taking a year, supply chain issues, issues with contracted adjusters and reliability of hail proof roofs by some manufactures. 

vi. Vermont noted identification of damage from a 2015 hail event was delayed by out-of-town rental property owners. 

3. General discussion 

a. Discussed the importance of the question related to safeguards against abrupt premium increases. Insurers tend to increase rates after a catastrophe and keep them high in good years. Shareholders benefit through high dividends in the good years, but policyholders do not benefit. 

4. Post-call revisions: 

a. Expanded “Purpose” section to function like an introduction 

5. Mitigation section changes: 

a. Added: 

i. Has the insurance department advocated and/or required insurers to offer incentives in the pricing of insurance policies? 

ii. What data is needed to help support resiliency incentives being built into insurance policies? 

iii. What mitigation tactics do insurers employ most frequently? 

iv. What state regulations trigger a retrofit of a home? 

b. Moved to the Insurance Coverage Adequacy and Exclusions section: 

i. Is there any scenario under which a consumer is “guaranteed” offer/renewal of insurance? 

6. Insurance Premiums section changes: 

a. Reordered from V. to IV. for spacing reasons
7. Insurance Coverage Adequacy and Exclusions section changes:
   a. Reordered from IV. to V. for spacing reasons
   b. Modified to include highlighted:
      i. Are insurers required to provide any regularly updated estimate of replacement cost and the corresponding change in premium to consumers?
   c. Added:
      i. Why do some homeowners policies require separate deductibles?
      ii. Is there parametric coverage available in your state for catastrophes? If so, for what coverages?
   d. Moved from the Mitigation section:
      i. Is there any scenario under which a consumer is “guaranteed” offer/renewal of insurance?

8. Rebuilding Restrictions and Requirements section
   a. Expanded the section name to include “and Requirements”
   b. Added:
      i. Are states required to upgrade to the newest building code?

9. Residual Markets section
   a. Added:
      i. Where do consumers go if they are not able to get coverage in the admitted market?
      ii. How much of the insurance coverage provided in your state comes from your residual market?
      iii. Are there exclusions or specified inclusions to what is covered in your residual market?

10. Adjuster Licensure section (new section)
    a. Added:
      i. What is the state licensure process?
      ii. What steps have you taken to expedite adjusters’ abilities to respond to catastrophic events?

11. Insurance Department Interactions with Stakeholders section (new section)
    a. Added:
      i. How does the insurance department help drive resilience efforts across state and local agencies and departments? This includes any work done with: i. Building departments to adopt more resilient standards requirements (such as roof taping); ii. Land use/development departments to implement resiliency into their planning; iii. Emergency management, natural resources, economic development and health agencies
      ii. What successes and challenges did you encounter in these efforts? How did you address the challenges?
      iii. What data is needed to help support adoption of more resilient standards?
      iv. How does the insurance department liaise with regional entities/organizations on resilience?
      v. How does the insurance department leverage outside research and data (such as from educational institutions, federal scientific agencies, etc.) to gather resilience data, upgrade hazard maps, etc.?
      vi. How do insurance departments help consumers and communities address their at-risk assets? What tools are available to help identify risk, estimate the costs and understand the benefits of protection?
vii. What risk-disclosures do regulators require or request from insurers? What is the most common metric used to disclose severity of impact?

12. Post-Catastrophe Regulatory Response section (new section)
   a. Added:
      i. Where there any post-catastrophe regulatory restrictions (such as on claims or underwriting) placed on the business practices of insurers?
      ii. Where there any post-catastrophe regulations that expanded requirements on insurers (such as mandated or retroactive expansion of benefits)?
      iii. Where there any post-catastrophe regulatory fines or actions taken related to compliance violations?
      iv. What proximate cause or concurrent event issues arose from the catastrophe? How did your insurance department handle them?
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call July 16, 2020. The following Working Group members participated: Don Beatty, Chair, and Jessica Baggarley (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); George Bradner and Kristin Fabian (CT); Angela King (DC); Warren Byrd and Tom Travis (LA); Sheri Cullen (MA); Linas Glemza and Rasheda Chairs (MD); LeAnn Cox (MO); Michael McKenney (PA); Matt Gendron (RI); Kathy Stajduhar (UT); Anna Van Fleet and Jamie Gile (VT); and David Forte and Eric Slavich (WA). Also participating were: Ken Williamson (AL); Michele Mackenzie (ID); Brenda Johnson, Heather Droge and Tate Flott (KS); Chris Aufenthie (ND); Tracy Burns (NE); Rick Campbell and Rodney Beetch (OH); Brian Ryder, J'ne Byckovski and Laura Machado (TX); Jody Ullman (WI); and D’Anna Feurt (WY).

1. **Adopted its March 5 Minutes**

Mr. Byrd made a motion, seconded by Mr. Forte, to adopt the Working Group’s March 5 minutes (Attachment Four-A). The motion passed unanimously.

2. **Discussed Section 4 of the Draft Pet Insurance Model Law**

Mr. Beatty said in Section 4—Disclosures of the draft model, there was a suggestion to add a disclosure regarding brand names. He asked if any Working Group member has any suggested language for this disclosure. Mr. Forte said the concern is to make sure the consumer is aware of who the brand name is and who the direct underwriter is. Mr. Byrd agreed with this concern. Mr. Beatty said NAIC staff will work on language for the proposed disclosure.

Mr. Beatty said in Section 4 of the draft model, there was a suggestion to add a disclosure regarding premium rate increases based on the age of the pet and the geographic location of the policyholder. Mr. Forte said this topic has been highly discussed in Washington, and it can be confusing to consumers. Mr. McKenney asked if this disclosure would include the actual rate changes. Mr. Forte said it would just be a general disclosure; the rate could change based on the age of pet or a change in location of the policyholder. Mr. McKenney said these issues are true over many lines of property and casualty insurance; they are not just characteristic of pet insurance. Lisa Brown (American Property Casualty Insurance Association—APCIA) said this disclosure would fit under the existing disclosure A(4). Brendan Bridgeland (Center for Insurance Research—CIR) agreed that this is a cause of confusion for consumers. He said rate changes may not be easily understood by those that do not often purchase insurance; therefore, he agreed with the proposed disclosure. Kate Jensen (North American Pet Health Insurance Association—NAPHIA) said this is an important issue for consumers and state insurance regulators, and it was highlighted in NAPHIA’s consumer document. Mr. Beatty said NAIC staff will work to draft language for the proposed disclosure.

Mr. Beatty said in Section 4 of the draft model, there was a suggestion to change references to the insurer’s website. Ms. Cox said there should be a link on the main page of the insurer’s website that shows disclosures and policy forms for the insured to review prior to purchasing a policy. Mr. Byrd asked if it would link different policy forms and endorsements, and he asked if that would be confusing to the consumer. Ms. Cox said during discussions, some carriers have said they would provide sample policies for each different policy option they offer. Ms. Salat-Kolm said she agreed that it would be helpful to have a visual of the sample policy. Mr. Bridgeland supported Ms. Cox’s proposal to give access to policy documents before purchase. Ms. Jensen asked if these documents would be in addition to the disclosures provided with the policy and available on the insurer’s website. Ms. Cox said it would be a policy or sample policy form before making payment for a policy. She said it would provide consumers the opportunity to compare policy coverages from different companies. Mr. McKenney said he agrees that it is a good idea to provide the opportunity to review a policy before purchase, but requiring insurers to put the documents on their websites may be too much of a burden, especially for companies that write in all 50 states. Ms. Cox said many websites ask for the consumer’s state, and the website should be able to pull policy forms for that specific state. She said there could be a disclosure that policy forms could change depending on state of residence. Mr. McKenney said there are many requirements in this model that do not exist in other lines of property and casualty insurance. He said he did not want to create requirements that keep smaller insurers out of the market. Mr. Bridgeland said since pet insurance is a relatively new product, it would be easier to require it to be more integrated into websites and technology than more established lines of insurance.
Ms. Brown said if a disclosure is added regarding the insurer’s website, then it should read “insurer or insurer’s program administrator’s website.” Mr. Beatty asked if any Working Group members oppose adding “insurer’s program administrator” to references to “insurer” throughout the draft model law. There was no opposition.

Mr. Beatty said in Section 4(D), there was a suggestion to change “usual and customary” to “reasonable and necessary.” Ms. Van Fleet said this change will occur in Vermont no matter what language passes in the model. Mr. Beatty said “reasonable and necessary” might be easier for companies to administer at this time. Ms. Jensen said NAPHIA has not had an opportunity to evaluate this suggestion.

Mr. Beatty said there was a suggestion to change the term “owner” to “insured.” Ms. Salat-Kolm asked to clarify if the insured is the pet or the owner. Mr. McKenney said “named insured” would be the correct term to use. Mr. Forte and Ms. Brown agreed. Mr. Bridgeland asked if the Working Group would consider adding the term “insured” to the definition section (Section 3). Ms. Salat-Kolm asked who would be defined as the insured in that definition. Mr. Forte said it would be the person named on the declaration page.

Mr. Beatty said on previous calls, there was discussion on the inclusion of the free look period in the draft model law. Mr. McKenney said he does not understand the need for a free look period since the consumer can cancel the policy and get a pro-rata refund and the underwriting company does not lose money for the expenses they incurred to write the policy. Mr. Beatty said the model law is requiring a lot of disclosures, so the consumer should be aware of what they are purchasing. Mr. Forte said there is a question of actuarial soundness for the free look period, and he would suggest not including the free look period. Ms. Salat-Kolm said California has a 30-day free look period. She said these are not typical policies, and the consumer does not have the opportunity to talk to an agent. Mr. Bradner said consumers are now able to buy auto and homeowners policies online without talking to an agent. Ms. Salat-Kolm said this is a newer product, and the consumer should have the opportunity to look over the policy. Mr. McKenney said any length of free look period allows the consumer to get back all their money, and that leads to other consumers paying higher premiums for the lost underwriting expenses of the free look period. Ms. Zoller said the free look period already exists in California, and the free look period was proposed by the industry. Mr. Bradner said this section may need to be left to the individual states to decide how to handle. He said he agrees that the free look period contributes to higher premiums for other consumers. Mr. Byrd said there is a concern from the actuarial perspective. He said having access to the policy, as suggested earlier in Section 4, would be a better option than a free look period. Ms. Jensen said a pre-sale evaluation tool will help consumers understand what they are purchasing, and it may help address common concerns that state insurance regulators are hearing.

Mr. Beatty said there was a suggestion to remove Section 4(H)(3). He said he would not want to discourage consumers from contacting state insurance regulators for any reason. Mr. Forte agreed. Mr. Beatty asked if any Working Group members oppose removing this item. There was no opposition.

Mr. Beatty asked for comments on Section 5 and Section 6 of the draft model law to be submitted prior to the Working Group’s next conference call.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call March 5, 2020. The following Working Group members participated: Don Beatty, Chair, Jessica Baggarley, and Phyllis Oates (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Angela King (DC); Warren Byrd (LA); Sheri Cullen (MA); Linas Glemza and Rasheda Chairs (MD); LeAnn Cox (MO); Michael McKenney (PA); Matt Gendron (RI); Kathy Stajduhar (UT); Anna Van Fleet (VT); and David Forte, Eric Slavich and John Haworth (WA). Also participating were: Ken Williamson (AL); Tom Zuppan (AZ); Brenda Johnson and Tate Flott (KS); Troy Smith (MT); Chris Aufenthie (ND); Rodney Beetch (OH); Cuc Nguyen (OK); and Jody Ullman (WI).

1. **Adopted its Feb. 19 Minutes**

The Working Group met Feb. 19 and took the following action: 1) adopted its Dec. 19, 2019, minutes; and 2) discussed Section 4—Disclosures of the draft Pet Insurance Model Act.

Mr. Byrd made a motion, seconded by Mr. Forte, to adopt the Working Group’s Feb. 19 minutes (Attachment Four-A1). The motion passed unanimously.

2. **Adopted Referrals Regarding Data Collection for Pet Insurance**

Mr. Beatty said the Working Group has previously discussed referrals to other working groups to collect data related to pet insurance. He said NAIC staff has drafted a referral to the Market Conduct Annual Statement (D) Working Group to create a line of business for pet insurance in the Market Conduct Annual Statement (MCAS) and a referral to the Market Information Systems Research and Development (D) Working Group to collect complaints data related to pet insurance.

Mr. Forte noted that the MCAS referral should go through the Market Analysis Procedures (D) Working Group.

Mr. Byrd said the recommendation of the need for data collection was pointed out in the *A Regulator’s Guide to Pet Insurance* white paper.

Mr. Gendron made a motion, seconded by Mr. Byrd, to adopt the referral memorandums and move them on to the appropriate working groups (Attachment Four-A2). The motion passed unanimously.

Birny Birnbaum (Center for Economic Justice—CEJ) said there is a process for adding a line of business to the MCAS, and there would need to be a full proposal developed to present to the Market Analysis Procedures (D) Working Group.

3. **Discussed a Draft Supplement to the Annual Financial Statement**

Mr. Beatty said the Working Group has discussed collecting data related to pet insurance through the NAIC annual financial statement. He said NAIC staff has drafted a preliminary supplement to the annual financial statement to collect that data. He asked for comments to be submitted regarding the supplement, and those comments will be discussed during the next Working Group conference call.

4. **Discussed Section 2 and Section 3 of the Draft Pet Insurance Model Act**

a. **Section 2**

Mr. Beatty said in Section 2—Scope and Purpose, of the draft model there was a suggestion to clarify the term “resident.” He said the *Travel Insurance Model Act* (#632) states, “covers any resident of this state.” Mr. Byrd said the language in Model #632 makes sense for this model, as well.

Mr. Gendron said some of the words would need to be changed because it deals with property owned, rather than a person.
Mr. Forte suggested using the language, “policy issued to any resident of this state.”

b. Section 3

Mr. Beatty said that in Section 3—Definitions, there was a question about whether definitions in the model should be prescribed or if the language could be broadened to use definitions that are substantially similar but not less favorable.

Ms. Zoller asked if that language is common in other model laws.

Mr. Beatty said similar language exists with regard to the Interstate Insurance Product Regulation Commission (Compact), that any standards adopted by the Compact be at least as good as NAIC models, and they could not be any less favorable.

Mr. Byrd clarified that the definitions would be no less favorable to the insured.

John Fielding (North American Pet Health Insurance Association—NAPHIA) said that NAPHIA members do like the idea of flexibility with the definitions.

Mr. Forte said the requirement for the information on pet insurance to be on the “main page” of an insurer’s website may be too stringent, and he suggested instead to say, “product site.”

Lisa Brown (American Property Casualty Insurance Association—ACPIA) said in a different section of the model, the language had been changed to include both the insurer and insurer’s program administrator’s site.

Mr. Fielding asked for time to speak with NAPHIA members about where that information would be best found on their web pages so that consumers can easily find the information.

c. Section 3, “Chronic Condition”

Mr. Beatty said there was a request for a clearer definition for “chronic condition.” He asked if the American Veterinary Medical Association (AVMA) had thoughts or suggested language for the definition.

Isham Jones (AVMA) asked for time to submit written comments on the “chronic condition” definition.

Mr. Haworth said the definition should be clear enough to distinguish from acute conditions that also cannot be cured.

Mr. Fielding said this definition is currently in place in California law, and it does not currently cause any problems.

Mr. Beatty said that, after receiving comments, it has been determined that pet insurance policies are not written as true group policies, but they are written similar to affinity policies.

Mr. Fielding said the policies may evolve into group policies, so they do not want to remove language from the model that refers to group policies.

Mr. Byrd asked if it would be better to remove the references to both individual and group, so as not to limit the language.

Mr. Fielding and Mr. Forte agreed with that suggestion.

d. Section 3, “Veterinary Expenses”

Mr. Beatty said there is a suggestion to replace “veterinary expenses” with “eligible expenses” in the definition of pet insurance.

Mr. Fielding said the definition of veterinary expenses is both too broad and too narrow. He said veterinary expenses are not necessarily the only expenses covered under a pet insurance policy. He said there could also be veterinary expenses that are not covered under the policy. He said the term “eligible expenses” better describes what is covered by the policy. He suggested that the definition of pet insurance read as, “an individual or group insurance policy that primarily provides coverage for eligible medical expenses arising from (1) the covered pet’s sickness or (2) an accident involving the covered pet.”

Ms. Zoller asked for an example of an ineligible expense.

Gavin Friedman (Trupanion) said a veterinarian may sell food or toys at the front desk that would not be eligible under the policy.
Mr. Gendron said things like dental cleanings and organ transplants could be excluded as eligible expenses.

Mr. Fielding said there may be exclusions under medical expenses, but there are other expenses that are not medical expenses that are not covered by the policy but not specifically excluded.

Mr. Forte and Mr. McKenney agreed with using the term “eligible expenses.”

Mr. McKenney said the term “veterinary expenses” is too broad.

Ms. Zoller said the language in the current definition does not preclude an insurer from excluding certain expenses.

Ms. Oates asked if some of the policies include wellness programs.

Mr. Gendron said that in Rhode Island, these policies are referred to as indemnity policies.

Mr. Beatty asked for those that do not agree with the proposed definition to submit alternative language.

   e. Section 3, “Preexisting Condition”

Mr. Beatty said the AVMA had suggested using the term “clinical signs” instead of “signs or symptoms.” He said the Working Group should work to make the policy language clear so that the insured is not surprised that a preexisting clinical sign is not covered by the policy.

Mr. Fielding said the phrase clinical signs needs to be clearly understood and defined.

Mr. Byrd asked if clinical signs is more veterinarian based and signs or symptoms is more owner-based.

Mr. Fielding said it is important to make clear that the clinical sign of an injury or illness, even if not seen by a veterinarian, would not be covered under a policy that is purchased after that clinical sign has been observed. He said claim denials based on preexisting conditions are a low percentage of claim denials.

Mr. Forte asked if the industry would be open to the suggestion by the AVMA to change language in the definition of “preexisting condition” from “consistent with” to “related to.” He said that an upset stomach in a dog due to eating something unagreeable could be seen as consistent with signs of a later diagnosis of stomach cancer, even though the two instances are not related.

Mr. Byrd suggested the language, “related to and contemporaneous with the stated condition.”

Mr. Forte agreed with that suggestion.

Mr. Fielding said he will ask NAPHIA members whether they would agree with that language and if the current language has led to issues with claim denials.

   f. Section 3, “Waiting or Affiliation Period”

Mr. Byrd said the term “affiliation period” does not need to be included, as the term “waiting period” covers the meaning of the time period.

Ms. Salat-Kolm said she agreed that it did not need to be included.

The Working Group will continue discussion on the first four sections of the model draft during future conference calls.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call Feb. 19, 2020. The following Working Group members participated: Don Beatty, Chair, and Phyllis Oates (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); George Bradner and Kristin Fabian (CT); Angela King (DC); Warren Byrd and Tom Travis (LA); Sheri Cullen (MA); Shirley Corbin and Rasheda Chairs (MD); Carrie Couch and Lockey Travis (MO); Michael McKenney (PA); Elizabeth Kelleher Dwyer, Matt Gendron, and Beth Vollucci (RI); Anna Van Fleet (VT); and David Forte, Eric Slavich and John Haworth (WA). Also participating were: Erick Wright (AL); Vincent Gosz (AZ); Heather Droge (KS); Troy Smith (MT); Chris Aufenthie (ND); Rodney Beetch (OH); Jody Ullman (WI); and Donna Stewart (WY).

1. **Adopted its Dec. 19, 2019, Minutes**

Mr. Byrd made a motion, seconded by Mr. Forte, to adopt the Working Group’s Dec. 19, 2019, minutes (Attachment Four-A1). The motion passed unanimously.

2. **Discussed Section 4 of the Draft Pet Insurance Model Law**

Mr. Beatty asked for those who submitted comments on Section 4—Disclosures to speak to those comments. Ms. Zoller said California law requires policies to disclose the actual insurer name and contact information for that insurer if the policy is sold under a brand name. Mr. McKenney asked if this should be on the declarations page or if it needs to be in a separate disclosure. Ms. Zoller said requiring a separate disclosure page makes the information more visible to the consumer. Mr. McKenney said brand names are commonly used in other lines of business. Ms. Salat-Kolm said the Working Group cares about adequate disclosure. Ms. Zoller said the disclosure needs to be large and clear enough for the consumer to read and understand. Mr. Byrd said there needs to be clear disclosure of who the underwriting entity is and whether it is in the policy or through an endorsement. Mr. Forte said the disclosure allows the consumer to make a proper complaint against the correct company. John Fielding (North American Pet Health Insurance Association—NAPHIA) said any additional disclosures to what is currently in the model law should be included in the “Insurer Disclosure of Important Policy Provisions,” which is provided to the consumer purchasing a new pet insurance policy and posted on the insurer website.

Mr. Forte said it is important to add a disclosure that premiums will increase as the pet ages and that rates are affected based on where the consumer lives. Mr. McKenney said the wording for a disclosure about premium increases should state: “[i]f the premium increases as your pet ages,” because not all pet insurance products currently offered increase the premium due to age. Mr. Fielding said the specificity of the premium increase would change with the type of policy and animal.

Mr. Forte said Washington’s position on free look periods is that it is free insurance and the cost of offering that is absorbed by other policyholders; therefore, he said mention of the free look period should be removed from this model. Mr. Byrd said free look periods are not actuarially sound. Mr. McKenney agreed that the free look period should be removed. Mr. Fielding said NAPHIA has supported the free look period because it is a good way for consumers to look at and understand the policy to the extent that they have not done that at the time of purchasing the policy. Mr. Gendron said the free look period is a common practice in life and annuity insurance, and it acts as consumer protection. Mr. Forte said the cost of the free look policies must be accounted for in the rates of those that do not have free look policies. He also said in the property and casualty lines of business they would commonly be able to cancel the policy and have their unearned premiums returned on a pro-rata basis. Ms. Salat-Kolm asked how much of an increase the free look period would cause to other policy’s rates, and she said if it is negligible, then the free look period should still be included in the model law. Ms. Zoller said the free look period will help consumers that may not know exactly what they are buying, but having strong disclosures will help this problem as well. Mr. Fielding said as soon as a policyholder makes a claim under a policy, then the free look period is ended. Mr. Byrd asked if the free look period is being used in place of correctly marketing the product. Mr. Forte said if a consumer cannot make a claim, then the consumer does not have insurance. Mr. Fielding said the free look period is standard practice on a nationwide basis, apart from one or two states. Mr. McKenney said Pennsylvania does not allow the free look, and this is not comparable to the use of free look in other lines business. Mr. Gendron asked if there is data on whether people have utilized the free look period. Mr. Beatty asked for industry representatives to investigate the experience on the free look period. Ms. Zoller said the requirement to get the policyholder’s signature on the disclosures was too burdensome, which is what led to the free look period.
Mr. Byrd asked for a clarification about the premium payment within the free look period. Mr. Fielding explained that the premium would be fully paid, but if at the end of the free look period the consumer decides they do not want the policy, they would receive a full refund of the premium. Ms. King asked if there was a concern about the administrative costs during the free look period being refunded to the consumer. Mr. Fielding said the industry believes that the free look period is a good idea. Mr. McKenney said there would be expenses associated with issuing the policy, and loss portion would be based on expected value. Ms. King said issues with free look periods have been resolved by requiring pro-rate refunds to cover the expenses. Mr. McKenney said all other lines in property and casualty are handled this way.

Ms. Van Fleet asked if the disclosure requirement regarding premium increases allowed for increases mid-policy or if it applied only at renewal. Mr. Beatty said there would be no intent to permit mid-term increases. Mr. Byrd agreed that this applies only at renewal.

Lisa Brown (American Property Casualty Insurance Association—ACPIA) said she has heard from members that they use program administrators for the pet insurance program, and the language in the model should reflect both insurers and insurer’s program administrators. Mr. Forte agreed with this change.

Mr. Fielding said NAPHIA suggests that the disclosure section should be adjusted so that all the disclosures are listed together, the free look period is discussed in its own section, and the complaints are discussed in their own section. He said under subsection H(2) the language should be changed from “delivering or mailing” to “notifying in writing.” He said in subsection H(2)(a), the second sentence should be deleted, as it is redundant.

Mr. Forte said the Working Group’s submitted comments about group insurance have been previously discussed. Mr. Beatty asked for clarification on the offering of group pet insurance as an employee benefit. Mr. Fielding said he is not aware of group policies that are underwritten on an individual basis. Ms. Brown said as an employee benefit, the policies are offered for purchase to all employees, with a flat rate and no individual underwriting. Mr. Forte said in Washington, policies are labeled as employee benefit group policies, but they are individual policies with a discount for being an employee.

Ms. Zoller said the language in subsection H(2) should be clarified regarding the owner and the insured. She said the language in subsection I(3) may no longer be necessary in the model and could be removed.

The Working Group will continue discussion on the first four sections of the model draft during future conference calls.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call Nov. 7, 2019. The following Working Group members participated: Don Beatty, Chair, and Jessica Baggarley (VA); Kendra Zoller, Vice Chair, and Risa Salat-Kolm (CA); Kristin Fabian (CT); Warren Byrd (LA); Sheri Cullen (MA); Shirley Corbin (MD); LeAnn Cox (MO); Elizabeth Kelleher Dwyer, Matt Gendron and Beth Vollucci (RI); Anna Van Fleet and Jessica Sherpa (VT); and David Forte and Eric Slavich (WA). Also participating were: Heather Droge (KS); Chris Aufenthie (ND); Anna Krylova (NM); Rodney Beetch (OH); Brian Fordham (OR); Kathy Stajduhar (UT); Jody Ullman (WI); and Donna Stewart (WY).

1. Discussed Section 3 of the Draft Pet Insurance Model Law

Mr. Beatty asked for those who submitted comments on Section 3—Definitions to speak to those comments. Ms. Sherpa said in reference to Section 3E—Preexisting Condition, it would be more objective to have a preexisting condition be something that somebody received care for by a veterinarian as opposed to putting the onus on the owner to recognize signs or symptoms they are not trained to recognize. John Fielding (North American Pet Health Insurance Association—NAPHIA) said NAPHIA supports the current definition, but the end of the definition needs to change from “waiting period” to “waiting or affiliation period.” He said the current definition has worked in California, and there is a concern that tightening down the definition would increase the cost of the pet insurance policy. Lynne Hennessey (Nationwide Insurance) said the proposed change by Ms. Sherpa could increase the chance for policyholder fraud. Mr. Byrd said those instances of fraud would decrease the carrier’s rate of return and, therefore, increase the price for the consumer. He said there had been mention of a baseline medical exam required at policy inception. Ms. Baggarley said Virginia is seeing a growing number of policies that require an exam soon after policy inception. Ms. Sherpa said the carrier could require a recent examination of the animal for consideration of writing the policy. Mr. Fielding said the requirement of an exam prior to underwriting could be a disincentive for buying insurance. He said there is a robust disclosure requirement in the model to require that policy purchasers know what the preexisting conditions are. Superintendent Dwyer asked how often there are denials based on preexisting conditions that have not been treated by a veterinarian. Mr. Beatty said it would be helpful to know that answer before the Working Group decides on the changes to this definition. Isham Jones (American Veterinary Medical Association—AVMA) said multiple conditions can result in the same clinical signs, which should be considered when talking about preexisting conditions. Gail Golab (AVMA) said this could be a concern for those looking to purchase pet insurance that their claim may be denied because clinical signs due to a preexisting condition can reappear due to another condition. She said that the references to symptoms should be changed to “clinical signs.”

Lisa Brown (American Property Casualty Insurance Association—ACPIA) said APCIA has at least one member company that writes pet insurance on a group basis as an employee benefit. Ms. Zoller said MetLife is doing group pet insurance policies through an employer. Mr. Forte said that just because industry already writes group policies does not mean it should be included in the model. He said as a Working Group, they should discuss what would happen if a customer leaves his or her employer but still needed the pet insurance product. He said many states have adopted inland marine definitions, and group coverage would conflict with that definition. Mr. Beatty said he believes they have group policy in property/casualty (P/C) lines. Mr. Fielding confirmed at least eight states have group policy filings in P/C lines. Mr. Beatty said the Working Group could consider a drafting note for including group policies.

Mr. Fielding suggested taking out the California-specific legislation language in Section 3F—Veterinarian. Mr. Beatty said the Working Group would make that change to the model.

Ms. Sherpa said the definition in Section 3G—Veterinary Expenses should include fees, as currently many policies exclude fees that the policyholder would not be able to control. Mr. Gendron asked if that could be addressed in the balance billing section of the model. Ms. Brown said the comment from Ms. Sherpa could be addressed by using the suggestion from Mr. Fielding and NAPHIA that the model should use the term “eligible expenses” instead of “veterinary expenses.” Ms. Zoller asked for examples of other expenses. Ms. Brown said member companies reported expenses from services that may not be provided by the veterinarian but was suggested by the veterinarian, such as behavioral therapies and specialized dog foods. Ms. Sherpa said she does not believe the definition of veterinary expenses precluded a company from offering more benefits. Ms. Brown said the definition currently covers only expenses associated with treatment provided by a veterinarian. Ms. Brown
suggested changing the language to “provided, prescribed or suggested by a veterinarian.” Ms. Zoller asked how the insured would prove an expense that was not specifically prescribed. Gavin Friedman (Trupanion) said the recommendation would be included in the medical records. Ms. Golab suggested changing “provided” to “recommended.” Mr. Gendron asked if the file would identify recommendations from veterinarians. Ms. Golab said the AVMA would encourage veterinarians to put all treatment suggestions into the patient file.

Mr. Fielding said the current definition may be limiting what expenses are covered by pet insurance. He recommended using the term “eligible expenses” and then disclose what is and is not covered in the policy. Superintendent Dwyer said they are currently addressing an issue with a company providing a wellness plan that the company does not believe is an insurance policy. She said that by not defining the expenses, it may leave open the interpretation of what pet insurance is. Ms. Brown suggested adding “which shall include treatment provided, prescribed or suggested by a veterinarian” to Section 3D—Pet Insurance.

The Working Group will continue discussion on these sections during future conference calls.

Having no further business, the Pet Insurance (C) Working Group adjourned.
MEMORANDUM

TO: Market Information Systems Research & Development (D) Working Group
FROM: Pet Insurance (C) Working Group
DATE: February 19, 2020
RE: Collection of Complaints Data for Pet Insurance

The Pet Insurance (C) Working Group has identified that state regulators need to understand the type and volume of complaints received for the pet insurance line of business.

Pet insurance data is currently provided to the NAIC and state insurance departments under the inland marine line of business. With growing company participation and a large potential market of consumers, the Pet Insurance (C) Working Group sees the need to collect pet insurance data separate from the inland marine line.

The Working Group requests that the Market Information Systems Research & Development (D) Working Group consider adding a code allowing for the separate collection of pet insurance complaints within the Market Information Systems’ Complaint Database System.

If you have any questions regarding this referral, please contact NAIC staff (Aaron Brandenburg abrandenburg@naic.org and Libby Crews ecrews@naic.org).

If you have any questions regarding this referral, please contact NAIC staff (Aaron Brandenburg abrandenburg@naic.org and Libby Crews ecrews@naic.org).

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MEMORANDUM

TO: Market Conduct Annual Statement Blanks (D) Working Group
FROM: Pet Insurance (C) Working Group
DATE: February 19, 2020
RE: Collection of MCAS Data for Pet Insurance

The Pet Insurance (C) Working Group and state insurance regulators have a need to understand the market for the pet insurance line of business, including information related to number of policies, claims handling and other market behavior.

Market related data for pet insurance is not currently collected through the Market Conduct Annual Statement (MCAS). The Working Group requests that the Market Conduct Annual Statement Blanks (D) Working group consider developing a data collection worksheet and instructions for the purpose of collecting pet insurance data through MCAS.

If you have any questions regarding this referral, please contact NAIC staff (Aaron Brandenburg abrandenburg@naic.org and Libby Crews ecrews@naic.org).

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Terrorism Insurance Implementation (C) Working Group
Virtual Summer National Meeting
July 31, 2020

The Terrorism Insurance Implementation (C) Working Group of the Property and Casualty Insurance (C) Committee met virtually July 31, 2020. The following Working Group members participated: Martha Lees, Chair (NY); Joanne Bennett (AK); Ken Allen (CA); Rolf Kaumann (CO); George Bradner (CT); Angela King (DC); Virginia Christy (FL); Judy Mottar (IL); Heather Droge (KS); Matthew Mancini (MA); Cynthia Amann and Jeana Thomas (MO); Fred Fuller (NC); Carl Sornson (NJ); Cuc Nguyen (OK); Jan Vitus (OR); Beth Vollucci (RI); J’ne Byckovski (TX); David Provost (VT); and Rebecca Nichols (VA).

1. Adopted its March 12 Minutes

The Working Group met March 12 to adopt its Feb. 11 minutes, model bulletin and policyholder disclosures.

Mr. Bradner made a motion, seconded by Ms. Nguyen, to adopt the Working Group’s March 12 minutes (Attachment Five-A). The motion passed unanimously.

2. Heard an Update on the 2020 State Regulator Terrorism Risk Insurance Data Call

Ms. Lees provided an update on the 2020 state regulator terrorism risk insurance data call. She said as in prior years, state regulators issued a joint data call with the U.S. Department of the Treasury (Treasury Department) with data due May 15. She said there were minor changes to the data call, including collecting some information about terrorism insurance for places of worship. Ms. Lees said the NAIC is reviewing the data filed before conducting analysis.

Ms. Lees said the State Supplement was revised in 2019 to greatly simplify the data requested. She said no changes were made for the 2020 State Supplement. She said the letter requesting data for the State Supplement was sent to all insurers on July 1, and data is due Sept. 30.

3. Received an Overview of Data Related to Workers’ Compensation Terrorism Risk

Aaron Brandenburg (NAIC) reported on terrorism risk insurance data concerning workers’ compensation. He said data for the workers’ compensation portion of the data call was received from the National Council on Compensation Insurance (NCCI) and independent bureaus for the 47 non-monopolistic states. Data for 2017 was due to state insurance regulators by March 1, 2020.

The percentage of workers’ compensation policies that have an explicit terrorism charge has fallen slightly, from a little more than 84% in 2011 to about 82.4% in 2017. This means about 17% to 18% of policies cover workers’ compensation terrorism coverage for no charge. The Northeast Zone had the highest percentage of workers’ compensation policies with an explicit charge for terrorism risk.

The analysis next looked at the percentage of the terrorism premium as compared to the total earned premium for policies indicating an explicit terrorism charge. This percentage fell slightly, from about 1.4% in 2011 to 1.3% in 2017, although this percentage rose in the most recent year. The District of Columbia had the highest percentage, with more than 9% of the premium being a terrorism charge. This percentage has fallen slightly since 2015. The Northeast Zone had the highest percentage of terrorism premium compared to the total earned premium for policies indicating an explicit terrorism charge.

The average terrorism premium per policy has risen slightly, from $171 in 2011 to $187 in 2017. The average terrorism premium when there is an explicit charge rose from $210 in 2011 to $227 in 2017. The Northeast Zone had the highest average terrorism premium in the period 2011–2017.

When looking at payroll categories, only the lowest payroll category had fewer than 89% of policies with an explicit terrorism charge. The terrorism premium moved up substantially as the payroll category grew higher. Terrorism premium for
insureds with a payroll category greater than $5 million experienced a drop in average premium of nearly 10% from 2011 to 2017.

4. Received an Overview of Terrorism Data from the 2019 State Supplement

Mr. Brandenburg said the State Supplement portion of the state regulator terrorism risk insurance data call collects ZIP code level data and has had data quality issues in the past. He said the granularity of the data requested was reduced in 2019 and led to better quality data, although some insurers did still struggle with submitting exposure data.

Analysis was presented showing key metrics for several states. The take-up rate across all business lines for New York was 78% for 2018. This is a slight reduction from the prior year. The percent of premium paid was about 7.4%. Most terrorism premium shows up in commercial multi-peril followed by commercial fire and allied lines for New York. Most insurers do show a very high take-up rate, with most insurers above 90%. For California, the take-up rate was 69% and fell slightly from the prior year, with 6.6% of premium being for terrorism risk. Texas showed a take-up rate of 61%, which was a large increase from the prior year. The percent of premium for terrorism coverage was 3.6% for Texas. Missouri had a take-up rate of 71%, which was a large increase from the prior year. The percent of premium for terrorism coverage was about 5% for Missouri.

Mr. Brandenburg also presented an analysis tool that was created for state insurance regulators. He said it will soon be available on iSite. He said it will allow state insurance regulators to access the raw data so comparisons can be made more easily at a ZIP code level for several metrics.

Mr. Brandenburg showed that numerous metrics can be shown at a ZIP code level on a colored map. Those metrics include take-up rate, exposures at risk, average terrorism premium per $1000 of exposure and percent of terrorism exposures covered. Differences in these metrics were shown throughout the state of New York.

Having no further business, the Terrorism Insurance Implementation (C) Working Group adjourned.
Terrorism Insurance Implementation (C) Working Group
Conference Call
March 12, 2020

The Terrorism Insurance Implementation (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call March 12, 2020. The following Working Group members participated: Martha Lees, Chair (NY); Joanne Bennett (AK); Susan Stapp (CA); Rolf Kaumann (CO); Angela King (DC); Heather Droge (KS); Matthew Mancini (MA); Jeana Thomas (MO); Timothy Johnson (NC); Jan Vitus (OR); Mark Worman and J’ne Byckovski (TX); and David Provost (VT).

1. **Adopted its Feb. 11 Minutes**

The Working met Feb. 11 and took the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) discussed the status of the 2020 data call; 3) discussed updates to the federal Terrorism Risk Insurance Act (TRIA) model bulletin and policyholder disclosures.

Ms. Vitus made a motion, seconded by Ms. Bennett, to adopt the Working Group’s Feb. 11 minutes (Attachment Five-A1). The motion passed unanimously.

2. **Adopted the TRIA Model Bulletin and Policyholder Disclosures**

Ms. Lees explained that the changes agreed to during the Feb. 11 conference call were made to the most recent draft of the TRIA model bulletin and policyholder disclosures. She said the Background section: 1) changed the description of the reauthorized acts to include 2019; 2) eliminated the 2015 changes in the bullets; and 3) described the few changes in the Terrorism Risk Insurance Program Reauthorization Act of 2019 (TRIPRA).

Ms. Lees noted that under “Submission of Rates, Policy Form Language and Disclosure Notices,” two paragraphs were eliminated describing the lapse in the previous act and the expedited NAIC System for Electronic Rate and Form Filing (SERFF) filing transmittal documents. An edit was made to say that SERFF can be used for revised terrorism product filings in support of speed to market initiatives, rather than for expedited review.

Ms. Lees said the policyholder disclosures were edited to eliminate references to dates prior to 2020.

Ms. Vitus noted that the policyholder disclosures inadvertently eliminated the reference to when the current federal share came into effect. She also said the model bulletin should note that the 80% federal share is now fixed.

Aaron Brandenburg (NAIC) said the Working Group had originally decided to only note the changes that occurred in TRIPRA 2019.

Robert Woody (American Property Casualty Insurance Association—APCIA) said that because there is no longer a sliding scale for the federal compensation portion, the model bulletin should note that this 80% figure is now fixed. The Working Group agreed to add a bullet-point item indicating that the U.S. government reimbursement level of covered terrorism losses exceeding the statutorily established deductible is now, as of Jan. 1, 2020, a fixed 80%.

Ms. Vitus said she sent in written comments regarding insurers that file in standard fire states. She said if the cause of loss is fire, then limits will be paid up to the limits. She asked if there should be a policyholder notice as an example with consistent language for the industry to use.

Ms. Lees noted that the model bulletin mentions an optional provision for standard fire states.

Stephen C. Clarke (Insurance Services Office—ISO) cautioned against adding a policyholder notice related to standard fire policy states. He said the standard fire policy does present unique issues to consider. He said the ISO has built into its forms with terrorism exclusions policy provisions that deal with the fact that standard fire policies may affect losses caused by fire. He said exceptions do not apply across the entire policy. For example, if the policy covers extra expenses or business income, even under the commercial policy, the standard fire policy does not traditionally extend to those coverages at all. Out of
states with standard fire policies, there are many ways it applies. Mr. Clarke said some states have standard fire policies that do not apply to commercial coverage in marine policies.

Mr. Clarke said a notice may delay release of the model bulletin and a notice that does not include all the state differences may add to confusion. He noted that the policyholder notice satisfies the requirement that insurers advise policyholders of government participation and the cost.

Ms. Vitus agreed, and she said Oregon will address its specific details in its own model bulletin.

Ms. Byckovski pointed out a grammatical correction noting that “this Annual Report” should be changed to “the Secretary’s Annual Report.”

Mr. Kaumann made a motion, seconded by Mr. Mancini, to adopt the TRIA model bulletin and policyholder disclosures with the edits agreed to during the meeting (Attachment Five-A2). The motion passed.

Having no further business, the Terrorism Insurance Implementation (C) Working Group adjourned.
The Terrorism Insurance Implementation (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call Feb. 11, 2020. The following Working Group members participated: Martha Lees, Chair (NY); Joanne Bennett (AK); Susan Stapp (CA); Peter Galasyn (CT); Angela King (DC); Virginia Christy (FL); Keith Fanning (IL); Matthew Mancini (MA); Brent Kabler (MO); Bill Horner (NJ); Timothy Johnson (NC); Cuc Nguyen (OK); Jan Vitus (OR); Beth Vollucci (RI); and J’ne Byckovski (TX). Also participating was: Maureen Motter (OH).

1. Adopted its 2019 Fall National Meeting Minutes

Mr. Galasyn made a motion, seconded by Mr. Mancini, to adopt the Working Group’s Dec. 8, 2019, minutes (see NAIC Proceedings – Fall 2019, Property and Casualty Insurance (C) Committee, Attachment Six). The motion passed unanimously.

2. Discussed the Status of the 2020 Data Call

Ms. Lees said the New York State Department of Financial Services sent a letter to the National Council on Compensation Insurance (NCCI) and independent bureaus on Jan. 30 asking for updated 2017 workers’ compensation data related to terrorism coverage. This data is due by March 1, and NAIC staff plan to provide an overview of the data at the Spring National Meeting.

Ms. Lees said the U.S. Department of the Treasury (Treasury Department) is working on revisions to the joint state insurance regulator/Treasury Department data call template. The data template will be posted on the NAIC website when available, and companies will be asked to submit data by May 15 to the New York portal, as they have in the past. The state supplement data will be due Sept. 30.

3. Discussed Updates to the TRIA Model Bulletin and Policyholder Disclosures

Ms. Lees said state insurance regulators issued a model bulletin in 2015 concerning filing procedures for compliance with the provisions of the federal Terrorism Risk Insurance Program Reauthorization Act of 2015. Many changes were made to the federal Terrorism Risk Insurance Act (TRIA) in 2015, and the Terrorism Risk Insurance Program (Program) had a brief lapse at the end of 2014.

Ms. Lees said the Terrorism Risk Insurance Program Reauthorization Act of 2019 was adopted in late 2019, well in advance of the Program’s expiration in December 2020. The reauthorized act (2019 Act) changed the termination date of the Program from Dec. 31, 2020, to Dec. 31, 2027. There were also changes to Section 103 having to do with timing of the mandatory recoupment that changed each referenced year by moving the date back five years. Two new reports were called for in the 2019 Act. The first is an evaluation of the availability and affordability of terrorism risk insurance, specifically for places of worship. The second is a study on overall vulnerabilities and potential costs of cyber attacks on the U.S., whether state-defined cyber liability under a property/casualty (P/C) line of insurance is adequate coverage for an act of cyber terrorism, whether such risks can be adequately priced by the private market, and whether the current risk-share systems under TRIA are appropriate for a cyber terrorism event.

Aaron Brandenburg (NAIC) reviewed the 2015 model bulletin, noting possible changes to: 1) the subject line noting the year of the 2019 Act; 2) the name of the 2019 Act in the first paragraph; 3) updates to the history of reauthorization bills under “Background”; and 4) updates describing changes made in the 2019 Act under “Background.”

The Working Group agreed that no changes were needed to the section of the model bulletin describing the definition of terrorism. The Working Group reviewed language related to expedited filings. Because the act was reauthorized well in advance of expiration, the Working Group agreed that there was not a need for expedited filings. However, the Working Group agreed that the NAIC System for Electronic Rate and Form Filing (SERFF) should allow for a designation of “TRIA2019” to be used in the product name field to indicate a filing related to terrorism made in connection with the 2019 Act.
Ms. Nguyen asked whether states were having insurers file under the line of business of the underlying policy.

Ms. Vitus said Oregon requires filings under the line of business of the underlying policy.

Ms. Motter said state insurance regulators are only expecting to receive policyholder disclosures, so perhaps a drafting note would be needed to indicate whether a state allows interline filings in order to limit the number of filing submissions.

Ms. Nguyen said Oklahoma will request filings by line of business.

Ms. King said this could be indicated within SERFF instructions instead of within the model bulletin.

Ms. Nguyen said Oklahoma could change the SERFF instructions, if that is how other states are handling it.

Ms. Motter said if state insurance regulators anticipate just policyholder disclosures, perhaps states would want just interline filing submissions so there is only one filing with the policyholder disclosures.

Ms. Vitus said Oregon gets filings with endorsement forms as well.

Steve Clarke (Insurance Services Office—ISO) said states may receive endorsement filings because one way to disclose is by a notice, but another way is through an endorsement or rules filings.

Ms. Motter said SERFF will allow for the identification of speed to market filings.

Ms. Motter said in the past, insurers were filing conditional as well as post-TRIA endorsements. She said the state position is the same as pre-TRIA in that in a post-TRIA world, the only permissible exclusions would be those that are now permitted for noncertified acts of terrorism. She said there was pushback from insurers that in a post-TRIA world with an expired bulletin, insurers could do whatever they wanted.

Ms. Vitus said she would like to see something address what to do in a post-TRIA environment.

Bob Woody (American Property Casualty Insurance Association—APCIA) noted that in a post-TRIA environment, many changes would be needed regarding how insurance coverage for terrorism would work. He said it does not seem helpful to anticipate those changes with this model bulletin, as the model bulletin should focus on the 2019 Act and changes to the Program. He said when dealing with a noncertified act of terrorism, the definition of such an act within the policy would apply.

Mr. Clarke said the ISO’s program has terrorism exclusions with a detailed definition that applies to noncertified acts. He said the model bulletin should focus on the 2019 Act alone. He said conditional and post-TRIA exclusions have existed since 2004. Ms. Motter said the issue is not urgent but as 2027 gets closer with a potential expiration of the Program, state insurance regulators could prepare for post-TRIA and conditional endorsements.

The Working Group agreed to make changes to the policyholder disclosures to eliminate references to government reimbursement percentages prior to 2020.

Mr. Brandenburg said he would make changes to the model bulletin as discussed during the conference call and distribute a revised model bulletin within two weeks.

Ms. Lees said the Working Group would then consider adoption of the TRIA model bulletin and policyholder disclosures during a conference call or at the Spring National Meeting.

Having no further business, the Terrorism Insurance Implementation (C) Working Group adjourned.
MODEL BULLETIN

TO: ALL PROPERTY AND CASUALTY INSURERS WRITING COMMERCIAL LINES INSURANCE PRODUCTS
ALL INSURERS ON THE NAIC QUARTERLY LISTING OF ALIEN INSURERS

RE: FILING PROCEDURES FOR COMPLIANCE WITH THE PROVISIONS OF THE TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2019

FROM: [Insert name and title]

DRAFTING NOTE: This bulletin was drafted to expedite the delivery of a common message to insurers related to implementation issues that have developed as a result of the extension of the Terrorism Risk Insurance Act. The basic bulletin recognizes that most jurisdictions have allowed some coverage limitations related to non-certified acts of terrorism that are affected by the reauthorization of the Act. A few jurisdictions have not generally allowed coverage limitations related to other acts of terrorism. Each state needs to review the provisions of the bulletin as they relate to the Act and to existing state regulatory requirements and determine which of its provisions relate to their specific situation. Please note that states might wish to distinguish between filing requirements that apply to admitted insurers and those applicable to surplus lines insurers.

The purpose of this bulletin is to advise you of certain provisions of the Terrorism Risk Insurance Program Reauthorization Act of 2019 amending and extending the Terrorism Risk Insurance Act of 2002 (the Act) by reauthorization, which may require insurers to submit a filing in this state of disclosure notices, policy language, and applicable rates as a result of the Act. For further details related to the Act, please consult the Act itself.

Background

Uncertainty in the markets for commercial lines property and casualty insurance coverage arose following the substantial loss of lives and property experienced on September 11, 2001. Soon after these tragic events, many reinsurers announced that they would no longer provide coverage for acts of terrorism in future reinsurance contracts. This led to a concerted effort on behalf of all interested parties to seek a federal backstop to facilitate the ability of the insurance industry to continue to provide coverage for these unpredictable and potentially catastrophic events. As a result, Congress enacted and the President signed into law in November 2002, the Terrorism Risk Insurance Act of 2002. This federal law provided a federal backstop for defined acts of terrorism and imposed certain obligations on insurers. The Act was extended for a two-year period covering Program Years 2006 and 2007, and for an additional seven years through December 31, 2014 with the enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2007. The Act was extended again with the enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2015, which made substantial changes to the program parameters, including to the insurer deductible, the mandatory recoupment percentage, and the insurance marketplace aggregate retention amount. Most recently, the Act was extended through 2027 with the enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2019, which made no major changes to the parameters of the program.

The reauthorized Act, as amended and extended, contains minimal changes, including:

- Extending the program through December 31, 2027.
- Changing the timing of the mandatory recoupment by moving the date of each referenced year back five years.
- Requiring the Secretary of the Treasury to include in the Secretary’s annual report an evaluation of the availability and affordability of terrorism risk insurance, including specifically for places of worship.
• Requiring the Comptroller General of the United States to conduct a study on: overall vulnerabilities and potential costs of cyber attacks on the U.S.; whether state-defined cyber liability under a property/casualty (P/C) line of insurance is adequate coverage for an act of cyber terrorism; whether such risks can be adequately priced by the private market; and whether the current risk-share systems under TRIA are appropriate for a cyber terrorism event.

• Eliminating outdated language relating to past United States Government reimbursement levels. The reimbursement level of covered terrorism losses exceeding the statutory established deductible is now (as of January 1, 2020) a fixed 80%.

**Definition of Act of Terrorism**

Section 102(1) defines an act of terrorism for purposes of the Act. Please note that the unmodified reference to “the Secretary” refers to the Secretary of the Treasury. The revised Section 102(1)(A) states, “The term ‘act of terrorism’ means any act that is certified by the Secretary, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—(i) to be an act of terrorism; (ii) to be a violent act or an act that is dangerous to—(I) human life; (II) property; or (III) infrastructure; (iii) to have resulted in damage within the United States, or outside the United States in the case of—(I) an air carrier or vessel described in paragraph (5)(B); or (II) the premises of a United States mission; and (iv) to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.” Section 102(1)(B) states, “No act shall be certified by the Secretary as an act of terrorism if—(i) the act is committed as part of a war declared by the Congress, except that this clause shall not apply with respect to any coverage for workers’ compensation; or (ii) property and casualty insurance losses resulting from the act, in the aggregate, do not exceed $5,000,000.” Section 102(1)(C) and (E) specify that the determinations are final and not subject to judicial review and that the Secretary of the Treasury cannot delegate the determination to anyone.

**Submission of Rates, Policy Form Language and Disclosure Notices**

If an insurer relies on an advisory organization to file loss costs and related rating systems on its behalf, no rate filing is required unless an insurer plans to use a different loss cost multiplier than is currently on file for coverage for certified losses. Insurers that develop and file rates independently may choose to maintain their currently filed rates or submit a new filing. The rate filing should provide sufficient information for the reviewer to determine what price would be charged to a business seeking to cover certified losses. This state will accept filings that contain a specified percentage of premium to provide for coverage for certified losses. Insurers may also choose to use rating plans that take into account other factors such as geography, building profile, proximity to target risks, and other reasonable rating factors. The insurer should state in the filing the basis that it has for selection of the rates and rating systems that it chooses to apply. The supporting documentation should be sufficient for the reviewer to determine whether the rates are excessive, inadequate or unfairly discriminatory. For the convenience of insurers, this state will waive its requirements for supporting documentation for rates for certified losses for filings that apply an increased premium charge of between 0% and [insert percentage of premium]% and do not vary by application of other rating factors.

**DRAFTING NOTE:** Your state may find that it is in its best interest to waive supporting documentation requirements for filings within a specified range. If not, the last sentence should be eliminated.

**DRAFTING NOTE:** In past bulletins, some states included language similar to what is in the following paragraph concerning non-certified acts. Your state may wish to evaluate whether such language is needed.

This state will not allow exclusions of coverage for acts of terrorism that fail to be certified losses solely because they fall below the $5,000,000 threshold in Section 102(1)(B) on any policy that provides coverage for acts of terrorism that fail to be certified. Insurers required to file policy forms may submit language containing coverage limitations for certified losses that exceed $100 billion in the aggregate.

Insurers subject to policy form regulation must submit the policy language that they intend to use in this state. The policy should define acts of terrorism in ways that are consistent with the Act, as amended, state law and the guidance provided in this bulletin. The definitions, terms and conditions should be complete and accurately describe the coverage that will be provided in the policy. Insurers may conclude that current filings are in compliance with the Act, as amended, state law and the requirements of this bulletin.

**DRAFTING NOTE:** Additional filings may be necessary under state law.
A change introduced in the Terrorism Risk Insurance Program Reauthorization Act of 2007 was a disclosure requirement for any policy issued after the enactment of the Act. Specifically, in addition to other disclosure requirements previously contained in TRIA, insurers since 2007 have had to provide clear and conspicuous disclosure to the policyholder of the existence of the $100 billion cap under Section 103(e)(2), at the time of offer, purchase, and renewal of the policy.

The [insert applicable term—commissioner, director, superintendent, insurance administrator] requests that the disclosure notices be filed for informational purposes, along with the policy forms, rates and rating systems as they are an integral part of the process for notification of policyholders in this state and should be clear and not misleading to business owners in this state. The disclosures should comply with the requirements of the Act, as amended, and should be consistent with the policy language and rates filed by the insurer.

*Drafting Note: Your state may require disclosure notices be filed as a policy form, and not for informational purposes. If so, the second to the last sentence should be modified to eliminate the reference to informational purposes.*

**For states mandating SERFF:**
Filers should use the SERFF system for submitting revised terrorism product filings. In support of speed to market initiatives, filers should use the term “TRIA2019” in the product name field in SERFF to indicate a filing related to terrorism made in connection with the Terrorism Risk Insurance Program Reauthorization Act of 2019. The SERFF system alleviates the need to provide additional information in support of a speed to market tool, although some states may have additional requirements.

**For other states:**
We encourage filers to take advantage of the SERFF system for submitting revised terrorism product filings. Filers should use the term “TRIA2019” in the product name field in SERFF to indicate a filing related to terrorism made in connection with the Terrorism Risk Insurance Program Reauthorization Act of 2019. The SERFF system alleviates the need to provide additional information in support of a speed to market tool, although some states may have additional requirements.

**Optional Provision for Standard Fire Policy States**

*Drafting Note: This is an optional section for those states that have a statutory Standard Fire Policy that does not permit terrorism exclusions. States should also consider whether their Standard Fire Policy includes or excludes commercial inland marine coverages and inform insurers concerning this subject.*

In this state, the requirements for fire coverage are established by law and where applicable, must meet or exceed the provisions of the Standard Fire Policy. These legal requirements cannot be waived. Thus, a business cannot voluntarily waive this statutorily mandated coverage.

**Provision for Workers’ Compensation Policies**

Workers’ compensation insurance coverage is statutorily mandated for nearly all U.S. employers and exemptions are barred in all states. Thus, a business cannot voluntarily waive workers’ compensation insurance (or terrorism coverage provided by a workers’ compensation insurance policy), nor can an insurer exempt terrorism risk from a workers’ compensation policy.

**Effective Date**

This bulletin shall take immediate effect and shall expire on December 31, 2027, unless Congress extends the duration of the Act.
POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, you have a right to purchase insurance coverage for losses resulting from acts of terrorism. As defined in Section 102(1) of the Act: The term “act of terrorism” means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THE FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 80% BEGINNING ON JANUARY 1, 2020, OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A $100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS’ LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS $100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED $100 BILLION, YOUR COVERAGE MAY BE REDUCED.

Acceptance or Rejection of Terrorism Insurance Coverage

| I hereby elect to purchase terrorism coverage for a prospective premium of $____________. |
| I hereby decline to purchase terrorism coverage for certified acts of terrorism. I understand that I will have no coverage for losses resulting from certified acts of terrorism. |

Policyholder/Applicant’s Signature ______________________  Insurance Company ______________________

Print Name ______________________  Policy Number ______________________

Date ______________________
POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism is included in your policy. You are hereby notified that the Terrorism Risk Insurance Act, as amended in 2019, defines an act of terrorism in Section 102(1) of the Act: The term “act of terrorism” means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a $100 billion cap that limits U.S. Government reimbursement as well as insurers’ liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds $100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed $100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is ____________, and does not include any charges for the portion of losses covered by the United States government under the Act.

I ACKNOWLEDGE THAT I HAVE BEEN NOTIFIED THAT UNDER THE TERRORISM RISK INSURANCE ACT, AS AMENDED, ANY LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM UNDER MY POLICY COVERAGE MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT AND MAY BE SUBJECT TO A $100 BILLION CAP THAT MAY REDUCE MY COVERAGE, AND I HAVE BEEN NOTIFIED OF THE PORTION OF MY PREMIUM ATTRIBUTABLE TO SUCH COVERAGE.

Policyholder/Applicant’s Signature

Print Name

Date

Name of Insurer: __________________________________ Policy Number: ________

DRAFTING NOTE: An insurer may choose not to use the acknowledgement section for workers’ compensation.
The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call July 30, 2020. The following Working Group members participated: Joy Hatchette, Chair, Rashida Chairs, Cheryl Kouns, James Mobley, Joanna Noppenberger, Jocelyn Strand, Kejuan Walton and Gia Wilkerson (MD); Daniel Gates, Yada Horace and Jerry Workman (AL); Brooke Lovallo (AZ); Ken Allen and Joel Laucher (CA); Bobbie Baca and Peg Brown (CO); George Bradner and Doris Schirmacher (CT); Cheryl Wade, Angela King, Arthur Slade and Debra Wadley (DC); Patrice Dziire, Keith Fanning, Litza Mavrothalasitis, Laura Peters, KC Stralka, Andi VanderKolk and Erica Weyhenmeyer (IL); Heather Droge and Shannon Lloyd (KS); Ron Henderson (LA); Rick Cruz, Jonathan Kelly, Jacqueline Olson, Matthew Vatter and Megan Verdeja (MN); Jeania Thomas (MO); Tracy Biehn, Kathy Shortt and Lisa Volpe (NC); Chris Aufenthie, Chrystal Bartuska and John Arnold (ND); Matthew Harmon and Cuc Nguyen (OK); Tricia Goldsmith (OR); David Buono, David Kelly and Shannen Logue (PA); and Marianne Baker, J’ne Byckovski, Allison Eberhart, Regan Ellmer, Randall Evans, Shawn Martin, Kenisha Schuster and Amy Wills (TX). Also participating were: Katie Hegland, Katrina Kelly and Michael Ricker (AK); William Lacy and Taryn Lewis (AR); Vanessa Darrah (AZ); Robin David (DE); Sandra Starnes and Alison Sterrett (FL); Tiffany Chang (HI); Sonya Sellmeyer (IA); Ronda Ankney, Jenifer Groth, Kate Kixmiller, Karl Knable and Claire Szpara (IN); Matthew Mancini and Michael Powers (MA); Renee Campbell (MI); Andy Case and Mike Cheney (MS); Laura Arp and Martin Swanson (NE); Ellen Walsh (NH); Carl Sornson (NJ); Erin Summers (NV); Leigh Solomon (NY); Tynesia Dorsey and Jana Jarrett (OH); Joe Cregan and Katie Greer (SC); Jill Kruger (SD); David Combs, Shelli Isiminger, Joy Little, Jennifer Ramcharan and Vickie Trice (TN); Tracey Klausmeier (UT); Vicki Ayers and Rebecca Nichols (VA); Katie Humphrey, Isabelle Turpin Keiser, Christine Menard-O’Neil, Jessica Sherpa, Anna Van Fleet and Marcia Violette (VT); Lisa Brandt and Lynn Welsh (WI); and Bill Cole, D’Anna Feurt, Kristi Alma Jose, Donna Stewart and Amanda Tarr (WY).

1. **Adopted its July 16 and June 16 Minutes**

   Ms. Shortt made a motion, seconded by Mr. Bradner, to adopt the Working Group’s July 16 (Attachment Six-A) and June 16 (Attachment Six-B) minutes. The motion passed unanimously.

2. **Discussed the Need for Consumer Disclosures Regarding Significant Premium Increases on P/C Insurance Products**

   Ms. Hatchette said the Working Group received permission from the Property and Casualty Insurance (C) Committee to discuss premium increase disclosures in an effort to determine if there is something the Working Group can do to help consumers understand premium increase notices. Consumers do not always understand why their premiums are increasing and departments of insurance (DOIs) oftentimes receive questions from consumers regarding premium increases. Consumers need to be able to make informed decisions regarding whether notices correctly reflect the premium increases. Ms. Hatchette said the discussion today should allow the Working Group to inform the Committee regarding next steps.

   Mr. Bradner said state insurance regulators receive inquiries from consumers regarding premium increases. Oftentimes, the consumer does not have a lot of information regarding the reason for the premium increase or the factors involved in causing the premium increase. Mr. Bradner said consumers might see significant premium increases, which further complicates consumer understanding. He said DOIs have seen rate changes from various insurers that have exceeded 50% at times. Oftentimes, consumers affected by these rate changes do not know what precipitated this change or the degree of the change.

   Mr. Bradner said as insurers are increasingly using big data, state insurance regulators are seeing larger rate increases that are impacting the individual policyholder. He said it is important for consumers to have a better understanding of the key elements causing insurers to increase rates, which in turn cause a consumer’s premium to increase. He said it would be optimal to provide a consumer with the top five characteristics contributing to their premium increase. This would provide consumers with a more transparent understanding, help consumers to identity risky behavior and the potential for incorrect or incomplete information that the consumer may be able to address with the insurer, and educate consumers.

   Mr. Bradner said many states allow an insurer the flexibility to transition a rate over a period of time if they are moving a book of business to one of their other companies. The period of time a state allows an insurer to transition a rate varies by state; some states may allow a three-year period, while another state may allow a five-year period. Mr. Bradner said a consumer should understand that over the next three to five years, their premium will increase on average a certain percentage each year as the
insurer transitions the policyholder to a new rating plan. He said consumers also need to understand that the premium may increase more due to other factors during this transition period. It would be helpful for consumers to receive information broken down by transition increases, as well as other increases. In this way, there is transparency and consumers understand what is guiding increases.

Mr. Bradner said the Working Group is not looking for a recommendation to create a model law; instead, the idea is to try to provide better disclosure to consumers so they understand what is driving their overall premium.

Mr. Allen said California’s consumer services department gets numerous questions from consumers regarding why their premium increased. He said consumers research the increase online and see that there was actually a decrease filing, and they want to know why they received a premium increase. He said he believes there needs to be better disclosures regarding these types of issues and a threshold regarding what triggers explanation needs to be set. He said he believes this is something the Working Group needs to pursue. Mr. Bradner agreed, and he said the Working Group will need to have discussions regarding where the threshold is set.

Ms. Ramcharan said Tennessee gets a lot of questions from consumers regarding premium increase as well. She said she believes this is a topic worth pursuing. Mr. Henderson said Louisiana gets these questions as well. He said the feedback received in Louisiana from consumers is that the state insurance regulators allow the insurers to increase premiums for unknown reasons.

Ms. Baca said Colorado encounters these same issues. She said one thing that is unique to Colorado is that they do have a disclosure requirement for a premium that has increased as a result to adverse activity, such as a motor vehicle violation, an at-fault accident, or a credit-based insurance score going up. She said the insurer has to notify the consumer that the amount of the premium increase is a result of the adverse activity. She said she does not oppose disclosures regarding general rate increases, but she is unsure of how state insurance regulators would be able to enforce them without some type of a model regulation.

Ms. Sherpa said Vermont does not require giving a policyholder a specific breakdown regarding premium increases; however, it does have a statutory requirement stating that if an insurer is renewing a policy, they have to provide notice regarding premium increases. She said she does not believe Vermont has any requirements that state that the insurer has to specify the reason if the premium is increasing. She said she is also unsure how they would enforce a requirement regarding disclosures.

Mr. Bradner said he believes it would be of interest to the Working Group for states to provide specific statutes regarding the notification process of premium increases if they have them in place. He asked states on the call to share this information with NAIC staff so the Working Group can review what other states are doing. He said Washington may have something in place, and NAIC staff will reach out following this call. Ms. Baca said she would send information regarding the process used in Colorado.

Mr. Mancini said prior to making changes to regulation, it might be prudent to provide some overall education to the consumer regarding the difference between “rate” and “premium.” He said most consumers do not understand the correlation between rate and premium. Mr. Bradner agreed. Ms. Hatchette asked the states to provide copies of any frequently asked questions (FAQ) or educational materials they are currently using to inform consumers about the difference between rate increases and premium increases or anything else they are doing to educate consumers regarding this topic.

Ms. Droge said Kansas has the top 30 writers of automobile and homeowners insurance in the state submit what they call an extraordinary memo. She said they provide this memo to their consumer assistance division. She said these memos reduce the questions they receive from consumers. She said they require the insurer to provide detailed information about their maximum increase and what is driving the increase. The insurer has to provide talking points to the consumer for the DOI to use to pass the information on to the consumer to specifically explain the cause of a premium increase. Ms. Droge said this has helped the DOI address consumer complaints regarding premium increases. She said she will share this information with NAIC staff to disseminate to the Working Group. Ms. Sherpa said she is interested in receiving this information, as she believes the consumer division in her DOI could benefit from this model.

Ms. Droge said Kansas also requires each insurer to submit a rate rule checklist, which provides an explanation of the maximum and minimum increase, the maximum dollar change, a histogram, etc. She said it requires a lot of detail from the insurer, and the rating division also provides rating information to the consumer assistance division. Mr. Bradner said this type of supplement would be helpful to a DOI.
Mr. Bradner said an insurer may change its tiering structure. A policyholder may have been in tier A, and due to a rating element or risk factor that has changed, this moves the policyholder to tier C. This can cause a significant premium increase, and it is important for the policyholder to understand what happened. Ms. Droge said it has been helpful to educate the consumer assistance division regarding the factors involved in approving a rate increase. Mr. Bradner asked if the market conduct division uses the tools as well. Ms. Droge said the market conduct division also uses the tools. She said the information is distributed to the financial surveillance, consumer assistance and market conduct divisions. She said if any of these divisions have any questions, they can reach out with questions. She said she would send this information to NAIC staff for distribution.

Ms. Sherpa asked Ms. Droge if the insurers provide them with the rate changes based on the filings that were filed and either approved or marked use and file, so that if a consumer contacts the consumer services division, the consumer services division can look back to the filings for more information. Ms. Droge said they do keep all this information, as well as the System for Electronic Rate and Form Filing (SERFF) numbers. She said they often go back and refer to older filings. For example, there was an insurer for which the state of Kansas received a lot of complaints. It was helpful to go back and look at the historical information.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she would contact her state filing subcommittee and ask about states that are asking for insurers to report additional information.

Brenda J. Cude (University of Georgia) said it is important for consumers to get notices that they can read and understand in a timely fashion. She volunteered to help with this effort.

Kimberly Donavan (Consumer Representative) said she has received some calls from consumers in which the consumers have called their insurer regarding rate increases. Consumers have reported that insurer representatives are oftentimes unable to explain why their premiums increased. Ms. Donavan said she believes this conversation is important.

Ms. Hatchette asked the states that have information regarding this topic to send in by Sept. 1. NAIC staff will compile this information to distribute to the Working Group. Ms. Hatchette asked the Working Group members to reach out to other states if they have heard of anything they have been doing regarding this topic.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.
The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call July 16, 2020. The following Working Group members participated: Joy Hatchette, Chair (MD); Bobbie Baca (CO); George Bradner (CT); Ron Henderson (LA); Carrie Couch (MO); Kathy Shortt (NC); Chris Aufenthie (ND); Sarah Graves (OR); and Marianne Baker (TX). Also participating were: Jennifer Ramcharan (TN); and Manabu Mizushima (WA).

1. **Heard a Presentation from the APCIA**

Ms. Hatchette said the purpose of this call is to hear some presentations to help the Working Group determine some best practices regarding ways to enhance a department of insurance’s (DOI’s) communication to consumers.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said consumers may not follow their state DOI on social media, but they may follow their insurer on social media. She said many people are currently working from home during the COVID-19 pandemic, which makes consumers and businesses more dependent upon social media. She said insurers have recently done a lot of work to expand their social media reach.

Lauren Pavluk (APCIA) said social media focuses on a business’s individual brand, and the social media page needs to identify the organization’s brand and top public priorities and positions. Insurers are primarily using social media as a central hub to define their brand and tell their story through messages geared toward consumer education and preparedness, industry and talent promotion, diversity and inclusion, and societal good and philanthropy. Associations also provide information regarding advocacy.

Ms. Pavluk said each social media platform has its own niche. For example, Twitter’s platform is used to promote advocacy and relay news; Facebook’s platform encompasses more consumer-based family and personal content; and LinkedIn’s platform embodies the business community. When tailoring communication that an organization drafts, it should do so based on the platform it is using.

Ms. Pavluk said the APCIA and its member companies are running various campaigns to promote consumer education and preparedness throughout the year. Currently, the APCIA is running campaigns regarding wildfire safety and preparation, hurricane preparedness, and auto safety; it is also providing information regarding general insurance policy tips. The APCIA also uses social media to promote events it hosts, such as the National Flood Conference held in June.

Ms. Pavluk said the challenge is for insurers and associations to get the content in front of the appropriate audience. She said it is important to be creative about how the message is relayed to the target audience.

Ms. Pavluk said associations, such as the NAIC and the APCIA, generally use social media for advocacy reasons; however, you do not generally see insurers weighing in on advocacy issues. She said Twitter is a good platform to use when advocating because it is a very news heavy platform. It is important to put position statements on social media platforms when promoting advocacy.

Ms. Pavluk said the APCIA also uses social media for industry and talent promotion. She said the APCIA discusses talent recruitment and retention issues via social media. The APCIA is promoting the insurance industry as an exciting place to work, and insurers are involved in this space. Insurers promote the benefits of being a part of their organizations. Ms. Pavluk said the APCIA is currently running a campaign called “Insurance Keeping Us Connected.” She said this campaign discusses how to stay connected in the new virtual environment, as well as how to get to know your coworkers.

Ms. Pavluk said diversity and inclusion has been a priority for the insurance industry for a long time, but due to the current social environment, the APCIA and insurers are stepping up and speaking out regarding this topic. She said she believes the insurance industry will make strides in this area over the upcoming months. She said earlier this year, the APCIA hosted a “Women & Diversity” conference. She said overall, she believes insurers are making positive strides in this area.
Ms. Pavluk said societal good and philanthropy is the area where the APCIA sees some thought leadership from the insurance industry. She said Hartford’s chief executive officer (CEO) is holding conversations around things such as addiction and ways to combat the opioid epidemic. This conversation started around openness and a discussion around its own staff and their families who might be struggling. Ms. Pavluk said the CSAA Insurance Group held conversations regarding mental health during mental health awareness month. These conversations were started to help reduce the stigma regarding mental health. Ms. Pavluk said there are many stories regarding how insurance companies have given back during the COVID-19 pandemic. Social media is becoming the place for insurance companies to make these types of statements and hold these conversations.

Ms. Pavluk said the DOIs are doing a great job putting content together for consumers. She said the content is well put together and tailored to the state doing the education. She said she believes the challenge is that consumers are not actively seeking this information on a day to day basis. She said if a consumer is looking to see what their policy covers, it is due to experiencing some type of loss. She said there are ways to be creative to get these messages in front of consumers. For example, she said she might be more receptive to receiving safety tips if she is already on a website like Angie’s List looking for a contractor to waterproof her basement. She said the APCIA is getting ready to launch a wildfire preparedness campaign with Nextdoor, which is a neighborhood app that separates people by zip code. She said they will be able to target precise zip codes. Ms. Pavluk said you do have to advertise on Nextdoor; however, it is much less expensive to advertise on the app than the costs for other types of advertising. She said it is also inexpensive to advertise on Facebook.

Ms. Pavluk said the APCIA would like to collaborate more with other entities. She said if your social media channels look the same at the end of March as they did in January and you are not addressing COVID-19 and the new reality that people find themselves in today, then you should be rethinking your strategy. She said younger consumers are looking for organizations to take a stand on social issues and acknowledge the events people are experiencing.

2. **Heard a Presentation from the NAIC Communications Department**

Laura Kane (NAIC) said the NAIC Communications Department uses an integrated approach when building a communications campaign. This enables the Communications Department to leverage its assets and build an audience. Ms. Kane said the Communications Department also partners with like-minded organizations to help the NAIC broaden its reach, and it is a cost-effective way to gain greater visibility for its messages. Partnering with like-minded organizations also expands the NAIC’s media coverage, reinforces the key messages, and improves the search results. NAIC staff will be sending an example of an NAIC Communications Department toolkit following the call.

Ms. Kane said the elements of the NAIC “Your Risk is Real” campaign included infographics, social media posts, Twitter chats, videos, story ideas, draft public service announcement (PSA) audio/news releases, consumer insights, satellite media tours, and web pages. The Communications Department created some interactive items for consumers to use. One item it created was a quiz for consumers called “What the Flood.” This interactive piece includes education regarding flood followed by quiz questions with explanations about the answers.

Ms. Kane said another interactive piece created by the Communications Department includes putting together a “go bag.” This interactive piece allows the consumer to drop items into a bag that they believe they would need to take with them if they needed to evacuate their home due to a disaster. The website reminds the consumer about the NAIC Home Inventory App for consumers to use to inventory their home prior to a disaster. The web page includes a link to the app. Ms. Kane said the NAIC is in the process of updating this app to improve the look and feel.

Ms. Kane said the Communications Department created a set of key messages, as well as sub-messages, to fit into each of the key message categories. Many people still believe that their homeowners insurance policy will cover a flood event, which is a misnomer. Ms. Kane said a survey the Communications Department conducted revealed that approximately 50% of the consumers surveyed believed their homeowners policy covered a flood event. She said when a person is insured, they will recover faster than a person that is not insured.

Ms. Kane said the Communications Department sent out a toolkit to the DOIs to let them know when various events are going to occur and when it is going to send out press releases. She said the Communications Department created information both graphically and photographically. She said people need to see a message at least seven times before they notice the message. She said it may need to even be more than seven times with social media; repetition is a strong learning tool. She said consumers need to see messages on multiple platforms.
Ms. Kane said the Communications Division also uses Twitter chats as part of the way it communicates. The NAIC conducted these Twitter chats in conjunction with other groups, such as the Federal Emergency Management Agency (FEMA), the Insurance Institute for Business & Home Safety (IBHS), Nextdoor, and the APCIA. This helps to increase the number of NAIC Twitter followers.

Ms. Kane said the Communications Division released written press releases, as well as audio news releases. It also organized two satellite media tours. Superintendent Eric A. Cioppa (ME) participated in one of the satellite media tours, and Director Raymond G. Farmer (SC) participated in the other satellite media tour. The reach on these satellite media tours was in the neighborhood of 10,000,000 people. The “Risk is Real” campaign has also brought new reporters to the NAIC asking for information.

David Dunston (NAIC) demonstrated some of the tools created by the Communications Division. He also demonstrated where the NAIC website houses the flood information. Currently, the Communications Division is working on a campaign regarding health insurance education. Mr. Dunston also outlined the current health care campaign the Communications Division is working on.

3. Heard a Presentation from Brenda J. Cude

Brenda J. Cude (University of Georgia) asked the Working Group members to realize that it is a normal human reaction to rationalize decisions, as well as believe these decisions are good. She said she calls this smoothing out our deficiencies, as no one wants to say they have made a poor decision.

Ms. Cude said there are certainly people who do believe that their homeowners insurance covers a flood event. However, it is useful to also consider why someone might think their homeowners insurance covers such an event. She said it is important to think about things people have heard that might reinforce false beliefs regarding what their homeowners policy covers.

Ms. Cude said some homeowners made insurance decisions years ago and do not remember the thought process behind their decisions, while others may just not believe that their home is ever going to flood. She said if a person has never experienced a flood, it might be difficult to imagine that one would ever occur. She said managing the risk of flood is another topic the Working Group might want to consider conveying to homeowners or renters.

Ms. Cude said another category of consumers may hold the belief that the federal government will bail them out in the event of a flood. Consumers often hear about government programs, and they may assume that these programs will take care of the damage they might experience due to flooding. Ms. Cude said this might justify educating the consumer regarding the true economic fallout they would experience in the case that they do not have flood insurance coverage.

Ms. Cude said other homeowners may have thought about purchasing flood insurance, but thought it was too expensive to purchase even if they are unaware of the cost. She suggested that it might be important to educate consumers regarding some information around the cost of flood insurance.

Ms. Cude said many times when people are making insurance decisions, they are also making many other decisions. She said in this case, flood insurance may not get the person’s attention. She said there may also be those homeowners that know they may need flood insurance but decide to take the risk and not purchase flood insurance.

Ms. Cude suggested an app that hits the high points of distinct types of insurance decisions consumers are making that would be beneficial. For example, she said when purchasing a home, a consumer might be thinking of more than one type of insurance (TOI) purchase during that time, so an opportunity for education exists.

Karrol Kitt (Consumer Advocates) said she and Ms. Cude gave a report last summer during the NAIC/Consumer Liaison Committee meeting last summer. She said it is important to do consumer testing for materials that are written for consumers; however, the drawback is the cost of such testing. She said she and Ms. Cude realize that informal testing, where consumers provide their thoughts about materials that are developed by state DOIs, can also be a valuable resource.

Ms. Kitt said the report focused on 20 members of the NAIC. Each of the members were asked to comment on how they engaged consumers when designing their consumer educational and disclosure materials. There were five states in the western
zone, five states in the southern zone, five states in the midwestern zone, and five states in the northeastern zone. Ms. Kitt said 17 of the 20 states provided information.

Ms. Kitt said some of these states directly involved consumers in the design of consumer educational and disclosure materials. She said other states indirectly involved consumers or have plans to involve consumers in the future. She said she and Ms. Cude learned that the states are getting some direct feedback, but not necessarily from individual consumers. Some of those they received feedback from were experts in an area or groups the states partner with on various projects. Ms. Kitt said the states also had some testing done regarding the usefulness and usability of their websites. She said the states learned about consumer attitudes, what consumers are interested in learning about, various organizations’ styles, and the content itself. She said it is important for the states to use informal testing when they do not have the resources to perform formal testing.

Ken Klein (California Western School of Law) said he would encourage state insurance regulators to consider another issue with flood insurance. He said the National Flood Insurance Program (NFIP) coverage is capped at a level that is significantly below the actual reconstruction cost of many homes. For homeowners who do not have access to enough money to cover the shortfall, flood insurance will look like a bad buy. This in turn, will drive up the percentage of people in the insurance pool who only buy flood insurance because they are required by their mortgage to do so. This will make the pricing function like high risk pools; therefore, it all becomes a rigorous cycle.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.
The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met via conference call June 16, 2020. The following Working Group members participated: Joy Hatchette, Chair (MD); Bobbie Baca (CO); George Bradner (CT); Angela King (DC); Heather Droge and Tate Flott (KS); Ron Henderson (LA); Jeana Thomas (MO); Kathy Shortt (NC); Chris Aufenthie (ND); Landon Hubbart, Ron Kreiter and Cuc Nguyen (OK); Tricia Goldsmith (OR); Marianne Baker (TX); and Dena Wildman (WV). Also participating were: Kate Kixmiller (IN); Renee Campbell (MI); Troy Smith (MT); Tynesia Dorsey and Jana Jarrett (OH); Manabu Mizushima (WA); and Jody Ullman (WI).

1. Discussed Creating Social Media Content and the Best Formats to Use to Communicate with Consumers

Ms. Hatchette said there is a need to help consumers better understand their insurance policies and the things that affect the insurance policy. The latest project the Working Group completed is the NAIC Consumer Claims Guide. Some of the state departments of insurance (DOIs) have already used this claims guide following a disaster. Ms. Hatchette said the claims guide helps answer some of the day-to-day questions that consumers have following a disaster. She said the Working Group will want to discuss other avenues to distribute the information contained in the consumer claims guide to the consumer.

Ms. Hatchette said the consumer claims guide is available to DOIs in both portable document format (PDF) file and Microsoft Word format. State DOIs may want to make some changes in the consumer claims guide to meet the needs in their state and can do so easily using the Microsoft Word version of the document.

Ms. Hatchette said one of the items discussed regarding the consumer claims guide was that many consumers, especially younger consumers, are using social media more and more to obtain information. She said one of the Working Group’s previous discussions included considering ways to take the information presented in the consumer claims guide and using chunks of the information to create social media posts.

Ms. Thomas said if the Working Group took this approach, their communications team would post this information on their social media communications.

Ms. Baca said Colorado would take advantage of this opportunity, as well.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said the APCIA would also be willing to post this information on its social media pages too. She said she would also suggest encouraging insurers to use any information the Working Group created in their social media campaigns. She said this would increase the outreach to consumers, as many of them might follow their insurer on social media.

Mr. Bradner said the Working Group needs to consider discussing how to reach younger consumers, as well as identifying the various vehicles for reaching that audience. He said it is unlikely that younger consumers are looking at a DOI’s social media communication.

Ms. Baker said the Texas Department of Insurance (TDI) is using social media and YouTube videos to inform consumers and believes it would be beneficial to explore these vehicles as well, as there will likely be a number of vehicles that state DOIs will need to use to reach the largest number of consumers.

Ken Klein (California Western School of Law) said the vehicle used today may change tomorrow. He said once the Working Group creates the social media snippets, the DOI can use whatever platform is applicable at the time. He said the state DOIs need to track where their audience goes to obtain information at any one moment in time.

Ms. Hatchette asked the Working Group if it is the will of the group to discuss and explore social media platforms before working on putting the information into a format to be used on social media. The Working Group agreed.
Mr. Bradner said once the Working Group determines the platforms that need to be used and the audience the DOIs want to reach, then the Working Group can look at the message the Working Group wants to get out and make it interesting for the audience.

Lisa Groshong (NAIC Center for Insurance Policy and Research—CIPR) said the CIPR is interested in being more involved in this Working Group. She said she would like to know more about the priorities of the Working Group and to help with various projects.

Ms. Hatchette asked NAIC staff to see if the NAIC Communications Division would be willing to join the next Working Group conference call to discuss options regarding messaging. She said she would also be interested in hearing the insurers’ viewpoints regarding the communications strategies they have found to be successful.

Ms. Brown said she would be happy to reach out to the APCIA’s members and present some information to the Working Group during the next conference call. She said many of its members are active on social media and reach a significant percentage of their policyholders through social media.

Ms. Shortt said one of the things North Carolina does is to “like” the Facebook pages of other sources, such as the towns they visit and the fire departments they visit, and then “tag” them in their posts so it will show up on all of the pages they “like” too. She said this allows them to build partnerships with others.

Mr. Henderson said Louisiana’s communications team is active with social media. He said Louisiana also has a high school-based program and a college-based program, so its DOI has a lot of younger people following the DOI. He said these people are interested in insurance as a career path or wanting the DOI to speak at a school. He said the DOI also has a newsletter that it sends out monthly.

Karrol Kitt (University of Texas at Austin) reminded the Working Group that she and Brenda J. Cude (University of Georgia) presented at the NAIC/Consumer Liaison Committee at the 2019 Summer National Meeting regarding a research study they did about what states do engage consumers when designing consumer information education and disclosure. She said they would be willing to send the Working Group presentations for distribution by NAIC staff.

Ms. Cude said it is important to keep in mind the teachable moment when communicating to consumers. She said, for example, people want to know about flood insurance during and after a flood event, which we know is not the right time, but a reality. It is important to think about other times when it might be possible to get people’s interest about flood insurance.

Ms. Hatchette asked NAIC staff to line up some presentations for the next conference call to present the Working Group with information regarding social media outlets and to help the Working Group determine the types of outreach the Working Group should consider. Once the Working Group has decided on the types of outreach, it will begin working on the message.

Ms. King said the District of Columbia does some podcasting, which has been working to reach consumers. She added that a podcast can be inserted into a document.

Ms. Hatchette said it is up to individual states to choose what works for their respective jurisdiction.

2. Discussed Flood Insurance Disclosures

Ms. Hatchette said the Property and Casualty Insurance (C) Committee asked the Working Group to consider creating a disclosure regarding flood insurance. She asked the Working Group for its thoughts, as there are consumers who still believe their homeowners insurance policy will cover a flood event. Even if the consumer does know about flood insurance, he or she may still have questions regarding the limitations of the flood insurance product.

Ms. Bach said the private flood insurance market has been developing relatively slowly, but there is some private flood insurance available. She suggested the Working Group consider taking on the task of preparing a comparison between a National Flood Insurance Program (NFIP) flood policy and a private flood insurance policy.
Mr. Bradner said he would caution the Working Group on taking on too much right now, as the Federal Emergency Management Agency (FEMA) is in the process of working on Risk Rating 2.0. This means there are going to be some changes regarding flood insurance policies. He said he is under the impression that FEMA will also possibly be making significant changes to the flood insurance contract and may possibly include coverage for loss of use, items in finished basements, etc. He said if the Working Group wants to take on this project, it might be a good idea to do so in parallel with changes put into place by FEMA.

Ms. Vollucci said FEMA has deferred Risk Rating 2.0 until October 2021.

The Working Group discussed the idea of creating a disclosure for a policyholder’s standard homeowners policy stating that the policy does not cover flood events.

Ms. Baker said during the last legislative session in Texas, the legislature adopted a statute requiring homeowners policies that do not include flood insurance to have a disclosure that says, “You may also need to consider the purchase of flood insurance. Your insurance policy does not include coverage for damage resulting from a flood, even if hurricane winds and rain cause the flood to occur. Without separate flood insurance coverage, you may have uncovered losses covered by a flood. Please discuss the need to purchase separate flood insurance coverage with your insurance agent or insurance company or visit www.floodsmart.gov.” She said the legislation requires any residential insurance policy or commercial insurance policy that does not include flood insurance to include this disclosure.

Mr. Bradner said that while he thinks the disclosure is a great one, one of the problems regarding disclosures is that many people receive their insurance policy in the mail and never even open the mail or read disclosures. He said after every flood event, a certain number of consumers continue to voice that they did not realize flood insurance is not covered by their homeowners insurance policy. He said this is a frustrating experience for state insurance regulators.

Ms. Brown said she agrees that many consumers do not read their insurance policies. She said that one of the APCIA’s members received kudos from state insurance regulators years ago for putting a piece of paper in the policy’s envelope that would fall out; it read something like, “Water, water everywhere and you are not covered.” She said she believes that for this particular issue, the message is going to have to be extremely simple and that is readily noticeable; otherwise, consumers are not going to be truly aware.

Ms. Hatchette asked Ms. Brown if she believes using the social media the Working Group will gain from its next discussion will aid in consumer understanding.

Ms. Brown said she believes it is a great start and suggested the state DOIs follow local news apps and social media and tag them in posts, as well. She said simple posts, such as, “By the way, did you know your homeowners insurance does not cover you for flood risk, regardless of the cause of your flood?” and tagging the various outlets will spread the message to more consumers. Ms. Brown said if regulators are considering a disclosure from an insurer, she would not suggest putting this disclosure on a declarations page or somewhere in the insurance policy, because consumers oftentimes do not read their policy.

Ms. Cude said consumers are more likely to read their billing information than their insurance policy. She said messages sent to a consumer need to be put on all communications they receive. She said consumers also tend to believe that if they incur damage and do not have insurance, government funds will bail them out. She said this is not true and regulators need to be sure consumers receive this message.

Peter Kochenburger (University of Connecticut School of Law) agreed and said the Working Group needs to find ways to make the disclosures more obvious.

Ms. Brown said the Working Group will also need to consider how to get information to consumers that receive all of their communications regarding their insurance policy digitally. She suggested something on the payment page.

Mr. Bradner said it would also be an innovative idea if a policyholder had an idea how much flood insurance would cost if he or she were to want to consider purchasing flood insurance. If insurers were able to provide this information, it might help consumers make the decision to purchase flood insurance. He said the statement could say, “Your insurance policy does not cover flood damage, but if you were to purchase flood insurance, it might cost $X per year. Contact your agent.”
Ms. Brown said even if an insurer is not a write-your-own (WYO) company, it could provide a link to more information.

Ms. King said District of Columbia received some complaints from consumers who thought they had coverage for sewer backup and overflow. She said this might also need addressing at some point. Ms. King also said in terms of reaching the consumer, there are some avenues the Working Group could consider for first-time homebuyers. She said there are real estate companies and groups that hold home-buying classes. This information could possibly be emphasized and disseminated in these classes.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.

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Workers’ Compensation Policy and the Changing Workforce

ABSTRACT

This paper explores how changes in work and the evolving landscape of legal employment are shifting responsibility for coverage and benefits for occupational injuries, illnesses, and fatalities. Policymakers and regulators need to understand how these changes may create gaps in coverage for workers and leave employers vulnerable to uncertain liability for injuries and deaths on the job. The paper also explores alternative policy solutions to ensure workers have access to benefits if they suffer workplace injury.

INTRODUCTION

Today’s workforce and workplace look very different from the workforce and workplace when the first workers’ compensation laws were passed. The cumulative impact of these changes has made it important to consider the role public policy plays in protecting workers from the health and economic consequences of an occupational injury, illness, or fatality. For most of the past century, a significant portion of workers in the U.S. labor force were protected against economic strain and physical harm through state workers’ compensation laws. As work relationships have grown increasingly complex, there is uncertainty in workers’ compensation protections for some in the labor force. The changes and discussions in this paper are a part of broader discussions on how employment benefits and protections might be revised, redesigned, or reimagined to reflect the contemporary work environment more accurately.

The twenty-first century workforce is more diverse, more de-centralized and more mobile than ever before. This is often at odds with employment classification laws, which were adopted when workers were predominately male and work was conducted in centralized facilities with a rigidly defined management hierarchy. Increasing work fluidity and the application of often conflicting state and federal law are resulting in business uncertainty and legislative proposals across the country. This paper presents an overview of the existing employment classification models and describes the latest legislation aimed at clarifying employment status.

Finally, the paper raises important policy questions that must be considered in light of the new work environment. Policymakers, in addition to business and labor leaders, will also appreciate the description of models and pilot programs that seek to deliver health and economic benefits to injured workers beyond the traditional workers’ compensation system. Discussion and development of solutions is essential for continued economic prosperity and social stability.
Part I: Changing Relationships with Work

Background

An individual’s connection to work shapes his or her life in visible and invisible ways – from lifestyle habits to self-esteem to social benefits. Throughout the last two centuries, those connections to work have become more formal and enshrined in local, state, and federal law. This work, or employment relationship, is important to individuals and their families as benefits and social protections are frequently gained through employment.¹

The first workers’ compensation laws in the United States arose out of changes in the nature and connection to work. The Industrial Revolution saw workers move from farms and villages to cities, transitioning from farm and community-based work to manufacturing and industrial jobs. These changes resulted in more workers in employee/employer relationships with defined wages, hours, and job requirements.

Workers’ compensation insurance prevents employees from taking legal action against their employers for workplace injuries, illnesses and deaths. In return, employees get defined benefits for covered injuries, illnesses and deaths regardless of fault or liability.²

Industrial work was dangerous, and work injuries and fatalities rose, reaching more than 61,000 deaths at work in the U.S. in 1914.³ Recognizing the economic and social cost of these injuries and deaths, state policymakers successfully passed workers’ compensation laws in the majority of states by 1920. Workers’ compensation was no-fault, providing guaranteed wage replacement and medical benefits for employees injured or killed at work.

A Century of Change

The past century has witnessed a transformation across the workforce and the workplace. The number of women in the labor force has steadily increased since 1948. Women represented 57.1% of the U.S. labor force in 2018.⁴ The labor force has increased in ethnic diversity. Hispanics represented 17% of the U.S. labor force in 2016 and all minorities (African-Americans, Asian-Americans, Hispanics/Latinos, and Native Americans) are projected to make up 37% of the working-age population by 2020.⁵ The labor force is steadily getting older. Workers 55 and older are projected to be close to 25% of the labor force by 2024. Union participation has been in decline; 10.7% of wage and salary workers were union members in 2017 (Figure 1).⁶ Higher education has also played a part in the labor force. Between 1992 and 2016, workers with college degrees, including advanced degrees, has increased steadily.⁷

¹ Employment benefits can include health, disability, and/or life insurance, retirement contributions, paid time off, flexible spending accounts, and/or tuition reimbursement. Social protections can include unemployment, workers’ compensation, accommodations, equal opportunity, etc.
⁴ The National Center for Public Policy and Higher Education, figure 1. See: https://www.google.com/url?sa=i&source=images&cd=&ved=2ahUKEwi7Ijymw9JAhWQop4K1cyCDgUQFjAQoAYBgewIBw&usg=AOvVaw3uOJbMnZKdRIm1CfoRP
⁵ Union Rates: https://www.bls.gov/news.release/union2.nr0.htm
⁶ Higher education has also played a part in the labor force. Between 1992 and 2016, workers with college degrees, including advanced degrees, has increased steadily.⁷
The workplace is physically different. Offices that had rows of desks with telephones and typewriters have been replaced by flex workstations and collaboration rooms. It is estimated that 4.3 million employees, close to 3% of the U.S. labor force, worked at home at least half the time in 2016. Additionally, regular work-at-home by employees have grown 140% over the last decade.8 Manufacturing facilities have moved from manually operated heavy equipment to technology-run, highly automated processing. https://globalworkplaceanalytics.com/telecommuting-statistics


The kind of work is changing. The last century saw steady decline in agricultural work, manufacturing has remained steady, and service work has dramatically increased. The U.S. Bureau of Labor Statistics (BLS) projects that nine out of 10 new jobs in the next decade will be in the service-providing sector.9 Healthcare, personal care, community and social services, and computer and mathematical employment are some of the expected fastest-growing occupations.

These changes have dramatically impacted the way people work and live across the U.S. The cumulative impact of these changes is an expansion of the U.S. economy. Real gross domestic product (GDP) has grown from approximately $3 trillion in 1957 to $19 trillion in 2019.10 Labor productivity was 3.8 times higher in 2016 than in 1950 (Figure 2).11

8 Work at home: http://globalworkplaceanalytics.com/telecommuting-statistics
10 Data source found at: https://research.stlouisfed.org/publications/economic-synopses/2016/08/12/labor-compensation-and-labor-productivity-recent-recoveries-and-the-long-term-trend/
11 Data source found at: https://research.stlouisfed.org/publications/economic-synopses/2016/08/12/labor-compensation-and-labor-productivity-recent-recoveries-and-the-long-term-trend/
Over the century, work has also gotten safer. Workplace injuries and fatalities have declined dramatically. The workplace fatality rate was 3.5 workers per 100,000 in 2018 compared to 61 workers per 100,000 in 1914. The rate of injuries/illnesses requiring time away from work was 2.8 per 100 workers in 2018 compared to five per 100 workers in 1914.

The decrease in occupational injuries, illnesses, and fatalities is especially good for workers’ compensation. These declines are keeping more employees engaged in the labor force and making it more affordable for businesses to obtain coverage. However, demographic and work changes have raised other challenges for the workers’ compensation system. The kinds of injuries and illnesses are different, compensability questions are different, and treatment options are different. These, taken with the evolving employment relationship landscape, raise important questions about the central principles of workers’ compensation and if and how they should evolve in the future.

Connections to Work

Another significant change happening within the U.S. labor force is how individuals are connected to work. From the legal perspective, there are two classifications of workers - employees and independent contractors. The common picture of an independent contractor is a person with specialized skills, talents, or expertise who works on a project basis. Independent contractors would typically have multiple clients and conduct their work with a fair degree of autonomy. Businesses would use independent contractors to supplement knowledge or experience of their existing workforce on a temporary basis to meet demand or deadlines.

Employee or Independent Contractor

Workers’ compensation is generally compulsory for employers, and each state has rules that define employees for the purpose of workers’ compensation coverage. Securing workers’ compensation coverage for each of its employees is a direct business cost. In contrast, independent contractors are generally not required to have workers’ compensation coverage.

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15 All states, except Texas and South Dakota, have compulsory workers’ compensation requirements for employers. Exclusions for certain employers or kinds of employees exist in most states. The IAIABC/WCRI Inventory of Workers’ Compensation laws describes coverage exclusions for each of the states.
Defining an employee or independent contractor has been a challenge within state workers’ compensation systems, but classification has become more difficult as employment relationships have increased in complexity. These changes have important implications for workers’ compensation, including which workers should be covered under workers’ compensation and who should bear the costs of coverage. Additionally, policymakers are needed to explore how coverage requirements align incentives for businesses and workers.

While many businesses use independent contractors for highly specialized or project-based work, many organizations have made contract labor a more permanent part of their workforce. July 2018 headlines noted that the number of contractors now exceeds the number of employees at Google.16 Countless large businesses, including Apple, Facebook, and Amazon, have noted the same trend. Contract labor is used by businesses for everything from security and food service to coding and sales.

The decision by a business in how to classify its workers is significant as many protections and benefits for workers are tied to employment, including workers’ compensation coverage requirements. Businesses weigh many factors when considering utilizing employees or independent contractors, but the direct cost to businesses for employees is estimated at 20-30% higher than independent contractors.

### Table 1. Employee vs. Independent Contractor Status

<table>
<thead>
<tr>
<th></th>
<th>Business Considerations</th>
<th>Worker Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>• Control over how, when, and where work is conducted.</td>
<td>• Employer contributions to Medicare, SS, UI, WC, other payroll contributions</td>
</tr>
<tr>
<td></td>
<td>• Less turnover</td>
<td>• Employment protections (ADA, minimum wage, FMLA, anti-discrimination, etc.)</td>
</tr>
<tr>
<td></td>
<td>• Reduced litigation from employment classification disputes</td>
<td>• Stability and security</td>
</tr>
<tr>
<td>Independent Contractors</td>
<td>• Reduced cost (on-demand labor)</td>
<td>• Diminished flexibility in how, when, and where work is conducted</td>
</tr>
<tr>
<td></td>
<td>• More flexibility (on-demand labor)</td>
<td>• Limited ability to work for multiple businesses</td>
</tr>
<tr>
<td></td>
<td>• Gain specialized skills or experience</td>
<td>• Increased turnover</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Consequences</th>
<th>Pros</th>
<th>Consequences</th>
<th>Pros</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>• Higher cost (contributions to Medicare, SS, UI, WC, other payroll contributions)</td>
<td>• Employer contributions to Medicare, SS, UI, WC, other payroll contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Compliance and enforcement with employment protections (ADA, minimum wage, FMLA, anti-discrimination, etc.)</td>
<td>• Employment protections (ADA, minimum wage, FMLA, anti-discrimination, etc.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Alternative Work Arrangements

Whether a worker benefits from the protection of a workers’ compensation policy depends on whether he or she is classified as an employee or an independent contractor. However, several alternative work relationships exist that fall along the spectrum of employee and independent contractor. These alternative work relationships create additional complexity in determining employment classification. The following alternative work arrangements are defined and tracked by the BLS:

- **Independent contractors:** Workers identified as independent contractors, independent consultants, or freelance workers, regardless of whether they are self-employed or wage and salary workers.
- **On-call workers:** Workers called to work only as needed, although they can be scheduled to work for several days or weeks in a row.
- **Temporary help agency workers:** Workers paid by a temporary help agency, whether or not their job is temporary.
- **Workers provided by contract firms:** Workers employed by a company that provides them or their services to others under contract, are usually assigned to only one customer, and usually work at the customer’s work site.

For the purposes of this paper, alternative work arrangements refer to any work performed by anyone not legally defined as an “employee.” Alternative work arrangements raise important questions about coverage for injuries, illnesses, or fatalities occurred while working.

**Platform Work**

Alternative work arrangements are not new; however, expanded internet connectivity has created new ways to connect to work. Companies allowing workers or service providers to connect to clients or customers via the internet are often described as online platforms. Online platforms have created additional complexity in defining the legal work relationship. The rise of online platforms is often seen as being synonymous with the sharing or “gig” economy; however, these platforms reflect an example of a way to facilitate an alternative work arrangement.

Some platform workers may use this type of work as supplemental income while having a full-time job. Others work for multiple platforms at one time, piecing together a living wage.17 Platform work has expanded broadly across industries, with many types of work and services offered.

**Table 2. Examples of Online Platforms**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Companies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Intelligence Tasks</td>
<td>Amazon Mechanical Turk</td>
</tr>
<tr>
<td>Service (cleaning, installation, etc.)</td>
<td>Taskrabbit, Handy, Shiftgig</td>
</tr>
<tr>
<td>Transportation</td>
<td>Uber, Lyft, Sidecar</td>
</tr>
<tr>
<td>Shipping/Logistics</td>
<td>Postmates, Airmule</td>
</tr>
<tr>
<td>Legal</td>
<td>Up Counsel, PowerUp Legal,</td>
</tr>
<tr>
<td>Design/Communications</td>
<td>Upwork, 99designs, freelancer</td>
</tr>
</tbody>
</table>

**By the Numbers**

Quantifying the number of individuals within these various work arrangements is important in understanding how many workers are not covered if they have an occupational injury, illness or fatality. A rising number of individuals in alternative work arrangements could necessitate the need for new private or public solutions to address coverage gaps. Design and implementation of new programs will be influenced by who and how many workers they will serve.

Numerous public and private research efforts have attempted to quantify individuals in various work arrangements. Estimates range from less than 3% to more than 40% of the workforce. There are many

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17 It is estimated that 40% of platform workers work for multiple platforms at one time. 2015 1099 Economy Report by Requests for Startups published May 2015.
reasons for the significant difference in estimates, including data sources, survey methodology, definitions of work arrangements, and counting primary or supplemental income.\(^{18}\)

### Estimates of Alternative Work Arrangements

<table>
<thead>
<tr>
<th>Date</th>
<th>Publication</th>
<th>Description</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2018</td>
<td>BLS Contingent Worker Supplement</td>
<td>Published by the Bureau of Labor Statistics, the supplement measures workers in contingent (short-term or temporary) or alternative arrangements (independent contractors, temporary, on-call, or contract) as their primary source of income.</td>
<td>10.1% workforce in alternative arrangements for “primary income source”</td>
</tr>
<tr>
<td>May 2018</td>
<td>Report on Economic Well-Being of U.S. Households in 2017</td>
<td>Released by the Federal Reserve System, the survey measures adults engaged in “gig work” including both offline and online services and sales.(^\text{19})</td>
<td>31% adults engaged in “gig work”</td>
</tr>
<tr>
<td>2018</td>
<td>State of Independence in America 2018</td>
<td>Longitudinal study by MBO Income that quantifies workers with independent work arrangements, including consultants, freelancers, contractors, temporary and on-call workers.</td>
<td>26.9% of employed population in independent work</td>
</tr>
<tr>
<td>October 2017</td>
<td>Freelancing in America, 2017</td>
<td>Published by the Freelancers Union and Upwork, the publication estimates the number of workers in supplemental, temporary, project or contract-based work.</td>
<td>36% of the workforce in alternative work</td>
</tr>
</tbody>
</table>

This broad range and lack of research consensus has resulted in inconsistent focus and no clear mandate for policy change.

Beyond measuring the number of individuals in different types of work arrangements, it is also useful to examine multi-year trends. Besides the 2017 BLS Contingent Workforce Supplement, most studies have charted an increase over the last decade in the percentage of individuals engaged in independent or alternative work for primary or supplemental income. If this trend continues it may have important implications for labor and employment policy, including workers’ compensation programs.

### Impact of Change

These changes and continued technological advancement will influence the U.S. workforce and workplace in the years to come.

Some of these changes have a direct impact on workers’ compensation systems. The long-term trend of declining injuries and illnesses has translated to stable or reduced premiums for employers and robust private insurance markets in most states. Other changes have influenced how care is delivered and return-to-work opportunities for those displaced from work.

Other changes, including labor force demographics and new work environments, could influence workers’ compensation both directly and indirectly. Demographic changes are influencing who, how, and where individuals are connecting to work. The differing needs (flexibility, portability, supplemental income, debt repayment, etc.) of these diverse workers may result in accelerating growth in alternative work arrangements. The ability to engage and perform services in new ways, virtual and remote, blurs lines between control and the direction of work.

Taken in whole, these changes are increasing the need to examine existing labor law and how social benefits and protections are delivered in the future. The workers’ compensation system does not exist in a vacuum. Coverage for an occupational injury, illness, or fatality must be considered in the context of the large-scale changes within the

\(^{18}\) Cornell University’s School of Industrial and Labor Relations and the Aspen Institute’s Future of Work Initiative maintain the Gig Economy Data Hub which catalogues public and private research efforts to quantify various alternative work arrangements.

\(^{19}\) Offline services could include caregiving or house-cleaning and offline sales could include flea markets or thrift sales; online services could include platform or app work and online sales could include selling items online.
economy. At the heart of this discussion is how workers are connecting to work and who will bear responsibility for any occupational injury, illness, or fatality that occurs.

**Part II: Determining Employment Status**

Employment status is essential for understanding the benefits and protections to which a worker is entitled and the financial obligations a business must pay. The rules for this determination are found in federal and state statute. This is a complex and nuanced area of the law, with determinations of employment status dependent on the application of various tests and characteristics.\(^{20}\) There is no coordination of employment determination between federal and state law.

**Federal Standard**

Federal statutes define “employee” in many different ways. Employment related tests are considered by the Internal Revenue Service (IRS), U.S. Social Security system, Federal Insurance Contributions Act (FICA), federal Fair Labor Standards Act (FLSA), federal Civil Rights Act, federal Age Discrimination in Employment Act (ADEA), Americans with Disabilities Act (ADA), Federal Unemployment Tax Act (FUTA), and many others.

Three tests have been used in employment determination under federal law. Depending on the law, test used, and case-specific facts, a worker could be considered an employee under one law and an independent contractor under another. Employee determination under federal law does not influence workers’ compensation coverage obligations under state law. However, there are similarities in the many characteristics considered at the state and federal level. In addition, continued changes in how workers connect to work may result in pressure to clarify and/or align employment under various areas of the law.

**Tests for Employment Determination under Federal Law\(^{21}\)**

- **Common law (control):** The common law test hinges on control of the means and methods of work. This can include a variety of different factors including direction and supervision of work activities, tools and materials, payment, and intent of the relationship. The IRS uses the common law test and advises three broad categories of consideration: 1) behavioral control; 2) financial control; and 3) relationship of the parties.\(^{22}\)
- **Economic realities:** The economic realities test looks at the financial dependence of a worker on services performed for a specific business. This can include a variety of different factors, including the level of financial risk, whether services are integral to the business operation, and investment in facilities and equipment. The economic realities test is commonly applied under the FLSA which governs minimum wage and overtime requirements. The economic realities test is broader than the control test and generally favors employee status.
- **Hybrid:** The hybrid test looks at both economic and common law factors. Under the hybrid test, economic realities are more heavily weighted than common law characteristics. The hybrid test has been applied in employment determinations under Title VII of the Civil Rights Act. (see https://www.bls.gov/opub/mnl/2002/01/art1full.pdf)

Numerous cases have tested the interpretation of federal law in determining employment status. A series of FedEx cases across 20 states\(^{23}\) found the company improperly classified ground delivery drivers as independent contractors. The decisions hinged largely on the direction and control of drivers. Factors considered included requirements by FedEx drivers to wear uniforms, adhere to appearance standards, drive approved vehicles, and deliver packages on specific days and within certain times.

Decisions of the National Labor Relations Board (NLRB) have also been influential in the interpretation of federal law in this area. Most recently, a January 2019 ruling overturned a 2014 decision\(^{24}\) in favor of employee status based on the application of factors related to entrepreneurial opportunity. The NLRB decision in SuperShuttle DFW noted the independence of drivers in setting hours, ownership/lease of vans, and control of payment methods results in

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\(^{20}\) Even the courts have expressed frustration in the lack of clarity in employment determinations. The Supreme Court, for example, has referred to the definition of an employee under the Americans with Disabilities Act as a “mere ‘nominal definition,'” Clackamas Gastroenterology Assocs. v. Wells, 538 U.S. 440, 444 (2003), and has stated that the definition of an employee under the Employee Retirement Income Security Act is “completely circular and explains nothing,” Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318, 323 (1992).


\(^{22}\) See IRS at https://www.irs.gov/newsroom/understanding-employee-vs-contractor-designation

\(^{23}\) Numerous lawsuits against FedEx were filed beginning in 2004. Two class action lawsuits were heard and decided by the Seventh Circuit Court of Appeals and the Ninth Circuit Court. The decisions resulted in mediated settlements with FedEx of more than $400 million.

\(^{24}\) NLRB in a 2014 FedEx case found in favor of employee status for drivers based on application of the common law test emphasizing direction and control.
significant entrepreneurial opportunity. The greater the entrepreneurial opportunity the more likely it is an independent business which would favor independent contractor status. (see SuperShuttle DFW, Inc. and Amalgamated Transit Union Local 1338.)

This decision was influential in shaping the NLRB Advice Memorandum related to Uber and Uber drivers’ ability to unionize. The memo finds drivers for Uber are independent contractors based on the factors discussed in SuperShuttle DFW, with significance placed on control over manner and means and how the driver is compensated. Both decisions cite entrepreneurial independence as a key consideration in independent contractor status.

The NLRB notes, “Whether to take advantage of these opportunities were among the many entrepreneurial judgments UberX drivers made due to their freedom to set their work schedules, choose log-in locations, and pursue earnings opportunities outside the Uber system.” The ability to work for competitors beyond Uber outweighed other factors of control asserted by the platform, including baseline fares, inability to subcontract work or repeated rejection of trips. Additionally, they noted that minimum service standards and driver ratings had little impact on the driver’s earning potential. (see Uber Technologies, Inc. Cases 13-CA-163062, 14-CA-158833, and 29-CA-177483).

In considering platform workers, the U.S. Department of Labor (DOL) issued an opinion letter in April 2019 which designated service providers of one platform as independent contractors under the FLSA. In applying the “economic realities” test, the U.S. DOL considered six factors of service providers who secured jobs through the virtual platform. The opinion letter described the platform as a referral service not an employer.

These recent opinions have been interpreted by many as a signal of the current administration’s leaning toward liberal application of independent contractor status. It is noted again these interpretations have no bearing in employment classification status under state workers’ compensation laws. It remains to be seen if state courts will evaluate control or economic realities tests in similar ways.

State Standards

In 2017, more than 140 million U.S. jobs were covered under state workers’ compensation systems (NASI, Workers’ Compensation Benefits, Cost, and Coverage, 2019). State law defines workers’ compensation coverage requirements across the U.S. In all states but Texas and South Dakota, coverage is compulsory for employers. However, coverage exemptions are common. Many states do not require that workers’ compensation coverage be purchased for domestic and agricultural workers and small employers.

The general trend over the past century has been expansion of coverage to increase the number of workers protected under the workers’ compensation system. The rise of alternative employment relationships may signal a reversal of this trend. The more workers that find themselves in alternative work arrangements, the more likely they will fall outside the protection of workers’ compensation.

Much like federal law, there may be multiple definitions of “employee” within a state that apply to different areas of the law. This can include intra-state variation across the department of revenue, unemployment insurance, and/or workers’ compensation.

In an effort to simplify and reduce confusion from differing “employment” determinations across state agencies, some states have sought to develop a statewide definition of “employee.” One such effort was in Maine, when the governor created a cross-agency task force compromised of the Maine DOL, Maine Workers’ Compensation Board, and the Maine Attorney General’s Office, to develop a single definition of “employee.” The result was the following:

> Services performed by an individual for remuneration are considered to be employment subject to this chapter unless it is shown to the satisfaction of the bureau, that the individual is free from the essential direction and control of the employing unit, both under the individual's contract of service and in fact, the employing unit proves that the individual meets all of the criteria in Number 1 and three (3) of the criteria in Number 2 as listed below. (See [https://www.maine.gov/labor/misclass/employment_standard.shtml](https://www.maine.gov/labor/misclass/employment_standard.shtml))

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25 The six factors included control; permanency of relation; investment in facilities, equipment, and helpers; skill, initiative, judgment, or foresight required; opportunity for profit and loss; and integrality.

26 Workers’ compensation is voluntary in both Texas and South Dakota. In both states, employers lose the right to the exclusive remedy if they fail to purchase coverage.

27 Recently, exemptions for agricultural workers have been challenged. The New Mexico Supreme Court ruled in 2016 that the agricultural exemption was unconstitutional.

28 A list of state-by-state exemptions can be found in Table 2 of the WCRI/IAIABC Workers’ Compensation Laws as of January 1, 2019.
A similar effort is underway in Alaska, which is in response to the adoption of a new eight-part independent contractor test passed in 2018. (See HB 79).

**State Employment Classification**

Classification of a worker as an employee or independent contractor is essential for the workers’ compensation system as it determines the coverage obligation. From the legal perspective, states are varied in their approach to employment classification. In general, states fall into the following categories:

- **“Employee” Presumption:** Twenty-five states presume a worker is an employee unless they meet the requirements of an independent contractor. A worker may be found to be an independent contractor by meeting certain criteria as defined by law (i.e. they meet all nine provisions set forth in statute) or as determined by an opinion of a judicial body (i.e., determination by a commissioner or judge based on case specific facts).

- **“Independent Contractor” Presumption:** Two states presume independent contractor status for those workers who have completed necessary requirements before beginning work. These requirements generally include a written contract/form filed with the state confirming independent contractor status. The presumption of independent contractor status can be overcome.

- **Silent:** Twenty-three states have no presumption of status for a worker. The criteria for determining employment status may be described but are applied to cases individually.

Appendix A compiles the state standards used to determine employment classification status for purposes of workers’ compensation coverage.

**State Employment Tests**

Similar to federal law, states have developed a variety of tests and/or criteria that are used in the decision of employment status. There are numerous factors considered in state law but generally states evaluate based on:

- **Control of the means, manner, and methods of work:** Rooted in common-law, decisions about what work must be accomplished and how it should be done are central to considering control in the employment relationship. Factors of control vary across states but include who sets days/hours of work, manner in how work is conducted, service standards, appearance requirements, quality specifications or other factors interpreted as giving direction to a worker.

- **Relative nature of work:** Considers the type of work and how it relates to core business functions. Examines how fundamental the work is to what the business does or how it operates.

- **Hybrid:** Weighs factors of both control and the relative nature of work.

Each state has a body of case law that interprets statutes and rules based on case-specific facts. A single decision may be precedential, resulting in more or less workers considered employees for purposes of workers’ compensation coverage. The opinion of the California Supreme Court in Dynamex demonstrates the time, cost, complexities and impact a case can have with respect to employment classification.

In 2004, Dynamex converted its delivery drivers to independent contractors. The company was sued, and the final ruling was issued in 2018, which found the delivery drivers were in fact employees of the company. In the decision, the California Supreme Court applied the ABC test, which requires all three factors be met to be considered an independent contractor. The three factors include:

1. Freedom from control or direction in the performance of work under the contract or engagement.
2. Work is outside the work of the hiring entities normal business.
3. Worker is engaged in an independently established trade, occupation or business of which they are performing the work.

Many have interpreted the application of the ABC test as significantly expanding those workers considered employees in California.

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29 Employment status may also affect the funding mechanism of state worker’ compensation agencies. In many states, the agency is funded through a maintenance tax or surcharge of gross workers’ compensation insurance premiums. Typically, workers’ compensation premium is calculated based on an employer’s payroll. The lower the payroll, the lower the premium, which results in less maintenance tax collected to support the workers’ compensation system administration in the state.

30 The ABC test standard for employment classification in California took effect on January 1, 2020 as a result of the passage of House Bill 5.
In contrast, courts in other states did not find an employer-employee relationship based on similar factors. In 2018, the New York Appellate Division held there was no employer-employee relationship in Vega vs. Postmates Inc. because couriers failed to provide sufficient proof of Postmates’ control over the way work was performed. Sebago vs. Boston Cab Dispatch in 2015 found that taxicab drivers were independent contractors because they were free from control and direction of the cab companies.

**Marketplace Contractors**

The state-by-state nature of employment law, uncertainty, cost and time to confirm employment status creates a volatile business environment. In the past several years, platform companies have worked to change laws to clarify the status of platform service providers as independent contractors. A new term of art, marketplace contractors, was defined, which applies to service providers who are connecting to work through a virtual platform.

Between 2016 and 2018, eight states successfully passed legislation or rule related to marketplace contractors. The eight states are: Arizona, Florida, Indiana, Iowa, Kentucky, Tennessee, Texas, and Utah. Under these new laws, platform service providers are independent contractors if they meet certain requirements. Common marketplace contractor criteria include:

- Written agreement between the platform and the marketplace contractor that says the marketplace contractor is providing services as an independent contractor and not an employee. Most of the legislation granted retroactive status if these agreements were in place previously.
- The platform must be virtual: a web, mobile application or software program. Some legislative language specifically excludes phone or fax services or prohibits services being carried out in a physical location within the state.
- Payment for services performed must be paid on a contract or rate basis. The marketplace contractor is responsible for all tax obligations.
- The marketplace contractor is responsible for providing their own tools or materials to complete the work.
- The marketplace contractor can set his or her own hours.

Some states may have exclusions include transportation networking companies (TNCs), freight transportation, political subdivisions, religious/charitable/educational organizations, and American Indian tribes.

**Impact of Legal Uncertainty of Employment Classification**

Changes in the workforce noted in Part I raise questions about the application and applicability of current methods of determining employment status, especially as related to control of means and methods of work. Work is being organized and performed in ways that allow both independence and oversight in ways that does not fit neatly within current legal frameworks described in Part II. The continued evolution of workers connecting and performing work in new ways may require revision or a redesigned framework for employment classification.

**Part III: Alternative Coverage Models**

Changes in work relationships raise important public policy questions about the protections and benefits currently linked to employment. A continued increase in alternative work arrangements may necessitate new models and programs for social protections, including wage replacement and medical care for occupational injuries, illnesses and fatalities. New programs might exist within the current workers’ compensation system or outside of it. Regardless, consideration of the human, economic and social costs of injuries, illnesses and fatalities at work is an important element to be included in future policy conversations.

Several ideas have emerged that consider benefits and protections in new forms. The following are strategies considered for protecting workers and businesses from the health and economic costs of a work injury:

**Independent Contractor Coverage**

One way to extend coverage is to amend the state workers’ compensation statute to allow a business to optionally provide workers’ compensation coverage to designated independent contractors. Elective coverage for an independent contractor would extend exclusive remedy for the business and be considered

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31 The Texas Workforce Commission adopted a rule (40 T.A.C. § 815.134) which defines a “Marketplace Contractor” as an independent contractor and makes those individuals ineligible for unemployment benefits. Since workers’ compensation is optional in Texas it has no impact on workers’ compensation coverage.

32 There have been discussion papers on alternative options for employment classification. Some have argued for dependent contractor and others have lobbied for independent workers. Any new direction would clearly need to identify which benefits and protections, including workers’ compensation, would be conferred by that status.
a benefit for the contractor. If properly structured, this would not affect the individual’s independent contractor status for unemployment insurance and wage purposes. Texas allows this option for hiring contractors in Texas Labor Code, Section 406.144.

Black Car Fund

The Black Car Fund is a mechanism that provides workers’ compensation coverage for more than 70,000 black car drivers in New York. The Fund was created in 1999 and is funded by a surcharge paid by the customer on each ride provided by an eligible driver.33 Drivers obtain coverage through their dispatch organizations, which are members of the Fund. The unique statutory nature of the Black Car Fund designates drivers as “employees,” so they are eligible for workers’ compensation benefits under New York state law. They retain independent contractor status for all other purposes.

More generically, this concept could be considered a “guild model” where workers providing services in a specific industry (transportation, hairdressing, engineering, etc.) could access workers’ compensation coverage collectively. This could be an attractive alternative for platform companies because the statutory nature of the fund gets around paying “benefits” that could be interpreted as “employee status.”

Occupational Accident Insurance

The private insurance market offers occupational accident insurance policies for those workers not eligible for workers’ compensation. These policies are often associated with high-risk industries with a significant number of independent operators/contractors (i.e. long-haul trucking). An occupational accident insurance policy offers defined coverage for a work-related injury or fatality by the policyholder. Coverage can be purchased directly by an operator/independent contractor or offered by a platform/contracting company.

As a general matter, occupational accident insurance typically includes coverages and benefits associated with workers’ compensation insurance including medical, wage replacement and death benefits. However, there are important differences in a workers’ compensation policy and an occupational accident policy. Occupational accident policies generally have a total benefits cap: a cap on medical benefits, and a cap on wage replacement. In addition, there may be no compensation for permanent impairment or consideration of vocational rehabilitation. There are often exclusions for kinds of injuries/illnesses covered, and abbreviated injury or claim reporting requirements. While there is limited access to an external dispute resolution system, occupational accident insurance is subject to the standard insurance claim dispute processes (e.g., a claimant is permitted to file a complaint with his/her state insurance department, and the insurer is subject to fair claims handling and bad faith laws).

One example is the driver injury protection policy offered to Uber drivers by Aon and Atlantic Specialty Insurance. Uber drivers pay $0.03 per mile, and coverage includes medical benefits, wage replacement benefits and death benefits if they suffer a covered injury while on the app is on. Likewise, as of June 2019, DoorDash now maintains occupational accident insurance on behalf of all U.S. “Dashers” while on a delivery.

Occupational accident insurance is regulated under a different line of insurance than workers’ compensation. This may create a disconnect or confusion for both businesses and workers regarding benefits across the two types of coverage.

Disability Insurance

Another mechanism for providing coverage is expanded use of disability insurance. Disability insurance provides wage replacement benefits for an individual who suffers a sickness or injury. Disability insurance has both private and public insurance options, and five states34 have mandatory disability insurance programs.

There are key differences between disability insurance and workers’ compensation: Disability insurance does not pay medical benefits, wage replacement is capped, and there is no consideration of either permanent partial or total disability or fatalities.

33 The current surcharge is 2.5%, https://www.nybcf.org/faqs
34 California, Hawaii, New Jersey, New York, and Rhode Island
Portable Benefits

Portable Benefit accounts de-couple social protections from the employer and offer coverages to an individual worker. An account is funded and can then be used to obtain various coverages including healthcare, disability or occupational accident insurance, and/or workers’ compensation. Funding of the account could be designed in many ways but could include contributions from an employer(s), platform(s), contract organization(s), client(s), and/or the worker.

Portable benefit accounts have been conceptually supported by policymakers, businesses, labor leaders, and think tank organizations but have not been widely piloted. Important policy, design, and administrative questions must be defined in order to understand if portable accounts would be effective in deliver benefits for work-related injuries, illnesses, and fatalities.

Each of these mechanisms could serve as a model for extending work-related injury, illness and fatality coverage for workers in alternative work arrangements.

Policy Questions and Considerations

Exclusive remedy: One of the central principles of workers’ compensation is exclusive remedy. Employees who have a work-related injury, illness or fatality receive the medical and wage replacement benefits afforded to them by state law. Once those have been received, employers have no further liabilities. If alternative coverage mechanisms are developed, should exclusive remedy be afforded to those businesses? What provisions or standards must be met to have exclusive remedy?

Universal coverage: Workers’ compensation started off as a voluntary program but trended toward universal coverage (with some exceptions). Coverage had clear benefit for both employers and employees. If universal coverage is desirable, you must decouple the mandate from the employment relationship (i.e., employee only) and determine how coverage can be delivered in different environments (i.e., Do independent contractors have to purchase a workers’ compensation policy?).

Standard benefits: Workers’ compensation benefits (wage replacement and medical) are defined in state statute and applied in the same way for all employees in a state. The advantage of a statutory benefit scheme is that it creates equity across all employees/employers and promotes societal stability (given adequacy of benefits). The disadvantage of this scheme is that benefits may not always be “fair” (i.e., account for pain/suffering; maximums penalize high income earners, etc.).

Funding/Delivery: Workers’ compensation policies are funded by employers who pay premiums or self-fund. In nonstandard work arrangements, the financial responsibility for an occupational injury is ambiguous and, therefore, who funds coverage bears discussion. Is it the contracting firm’s responsibility (i.e. for all workers regardless of employment status), or is there a cost-sharing obligation by classification or work type?

Market Access: Workers’ compensation has developed market solutions for businesses who are unable to purchase coverage in the voluntary market (residual market or insurer of last resort). Is a solution like this required or desired for workers in alternative work arrangements? Should the cost of coverage be a consideration in developing or determining solutions (i.e., if you are making $1,000 a year in additional income should you have to buy a policy that costs you some fraction of that?)?

Safe Harbor: Safe harbor provisions exist for businesses who purchase or offer some coverages (health, workers’ compensations, etc.) to ensure they are not interpreted as employment status? What provisions would need to be met for safe harbor? What liabilities would the business and worker face in these situations?
Conclusions

Workers’ compensation is an essential element of the protections and benefits businesses and workers have had in the last century. Employers gain certainty and limit their liability to injuries, illnesses, or fatalities that occur at work. Employees receive healthcare and wage replacement to heal and recover with lessened financial burden. This fragile balance has resulted in sustained stability and equity for most American businesses and their workers.

The employee-employer framework on which the U.S. workers’ compensation system is built has become increasingly complex. Businesses are relying more and more on a labor force that does not neatly fit within legally defined employees and independent contractors. These external changes have the potential for significantly changing employment related protections and benefits.

This presents real questions for the workers’ compensation system. Policymakers, labor, management, and other system stakeholders need to begin considering and preparing for these impacts. 100 years ago, workers’ compensation was adopted after countless lives were lost or seriously damaged by a work injury. Proactively addressing new changes in work and the workplace are the key to responding without more lives lost by American workers.
## Appendix A: State Standards Used to Determine Independent Contractor Status (2019)

<table>
<thead>
<tr>
<th>State</th>
<th>Presumption of Employee Status</th>
<th>Special Rules Specific Occupations</th>
<th>General Description of Criteria</th>
</tr>
</thead>
</table>
| AL    | No provision                  | ALA. CODE § 25-5-50 (2017)        | If the employer’s right of control over the individual extends no further than directing what is to be ultimately accomplished, the individual is an independent contractor. The employer must not retain the right to dictate the manner of operation or how the work should be done. The factors to be considered in determining whether an individual or an entity has retained the right of control include:  
  1. Direct evidence demonstrating a right or an exercise of control.  
  2. The method of payment for services.  
  3. Whether equipment is furnished.  
  4. Whether the other party has the right to terminate the employment.  
| AK    | No Alaska Pulp Corp. v. United Paperworkers Int’l Union, 791 P.2d 1008 (Alaska 1990) | ALASKA STAT. § 23.30.230 (2017) | The Alaska Supreme Court has adopted the “relative nature of the work” test for distinguishing between employees and independent contractors. The test first considers the character of the individual’s work or business, which is determined by considering three factors:  
  1. The degree of skill involved.  
  2. Whether the individual holds himself out to the public as a separate business.  
  3. Whether the individual bears the accident burden.  
  The test then considers the relationship of the individual’s work or business to the purported employer’s business, which is also broken into three factors:  
  1. The extent to which the individual’s work is a regular part of the employer’s regular work.  
  2. Whether the individual’s work is continuous or intermittent.  
  3. Whether the duration of the work is such that it amounts to hiring of continuous services rather than a contract for a specific job.  

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And person performing the services entered into either a written or oral contract, the employment status the parties believed they were creating in the contract will be given deference. However, the contract will be construed in view of the circumstances under which it was made and the conduct of the parties while the job is being performed.

(2) Is a regular part of the employer’s business or service. If it is a regular part of the employer’s business, there is an inference of employee status.

(3) Can be expected to carry its own accident burden. This element is more important than factors (4)-(6). If the person performing the services is unlikely to be able to meet the costs of industrial accidents out of the payment for the services, there is a strong inference of employee status.

(4) Involves little or no skill or experience. If so, there is an inference of employee status.

(5) Is sufficient to amount to the hiring of continuous services, as distinguished from contracting for the completion of a particular job. If the work amounts to hiring of continuous services, there is an inference of employee status.

(6) Is intermittent, as opposed to continuous. If the work is intermittent, there is a weak inference of no employee status.


AZ Rebuttable presumption of independent contractor status created upon the execution of a written agreement compliant with ARIZ. REV. STAT. ANN. § 23-902 (2017).

An independent contractor is a person engaged in work for a business who is:

(1) Independent of that business in the execution of the work and not subject to the rule or control of the business for which the work is done.

(2) Engaged only in the performance of a definite job or piece of work.

(3) Subordinate to that business only in effecting a result in accordance with that business design.

As for the first element, Arizona courts have adopted the “right to control” test, which examines the following factors:

(1) The duration of the employment.

(2) The method of payment.

(3) Who furnishes necessary equipment.

(4) The right to hire and fire.

(5) The extent to which the employer may exercise control over the details of the work.

(6) Whether the work was performed in the usual and regular course of the employer’s business.


A business or independent contractor may prove the existence of an independent contractor relationship by executing a written agreement stating that the business:

(1) Does not require the independent contractor to perform work exclusively for the business.

(2) Does not provide the independent contractor with any business registrations or licenses required to perform the specific services set forth in the contract.

(3) Does not pay the independent contractor a salary or hourly rate instead of an amount fixed by contract.

(4) Will not terminate the independent contractor before the expiration of the contract period, unless the independent contractor breaches the contract or violates the Arizona law.

(5) Does not provide tools for the independent contractor.

(6) Does not dictate the time of performance.

(7) Pays the independent contractor in the name appearing on the written agreement.

(8) Will not combine business operations with the person performing the services rather than maintaining these operations separately.

<table>
<thead>
<tr>
<th>AR</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Various factors are considered to determine the status of a worker:</td>
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<td>(1) The right to control the means and the method by which the work is done.</td>
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<td>(2) The right to terminate the employment without liability.</td>
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<td>(3) The method of payment.</td>
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<td>(4) The furnishing, or the obligation to furnish, the necessary tools, equipment, and materials.</td>
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<td>(5) Whether the person employed is engaged in a distinct occupation or business.</td>
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<td>(6) The skill required in a particular occupation.</td>
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<td>(7) Whether the employer is a business.</td>
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<td>(8) Whether the work is an integral part of the regular business of the employer.</td>
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<tr>
<td>(9) The length of time for which the person is employed.</td>
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<tr>
<td>However, the “right to control” test is usually sufficient to decide most disputes. The ultimate question in these cases is whether the employer has the right to control over the doing of the work, not whether the employer actually exercises such control.</td>
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<tr>
<th>CA</th>
<th>Yes</th>
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<tr>
<td><strong>CAL. LAB. CODE § 2750.5 (2017)</strong></td>
<td><strong>CAL. LAB. CODE § 3352 (2017)</strong></td>
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<tr>
<td>This bill addresses employment status when a hiring entity claims that the person it hired is an independent contractor. AB 5 requires the application of the “ABC test” to determine if workers are employees or independent contractors.</td>
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<td>Under the ABC test, a worker is considered an employee and not an independent contractor, unless the hiring entity satisfies all three of the following conditions:</td>
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<td>(1) The worker is free from the control and direction of the hiring entity in connection with the performance of the work, both under the contract for the performance of the work and in fact.</td>
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<td>(2) The worker performs work that is outside the usual course of the hiring entity’s business.</td>
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<tr>
<td>(3) The worker is customarily engaged in an independently established trade, occupation or business of the same nature as that involved in the work performed.</td>
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<tr>
<td>Cal. Labor Code § 2750.3 (West 2019)</td>
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<th>CO</th>
<th>Yes</th>
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<tr>
<td>Colorado courts have adopted both the “control” test and the “relative nature of the work” test for purposes of determining a worker’s status. If either test is met, the worker is considered an employee for workers’ compensation purposes.</td>
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<tr>
<td>The “control” test primarily considers whether the alleged employer exercises control over the means and methods of accomplishing the contracted service. Other factors include:</td>
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<td>(1) Whether compensation is measured by time or lump sum.</td>
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<td>(2) Which party furnishes the necessary tools and equipment to perform the work.</td>
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<tr>
<td>The “relative nature of the work” test considers the following factors:</td>
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<tr>
<td>(1) The character of the individual’s work.</td>
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<td>(2) The relationship of the individual’s work to the alleged employer’s business.</td>
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<tr>
<td>State</td>
<td>No provision</td>
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<tr>
<td>CT</td>
<td>CONN. GEN. STAT. § 31-275 (2017)</td>
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| DE    | DEL. CODE. ANN. tit. 19, §§ 2301; 2307; 2308; 2316 (2017) | Delaware courts have adopted § 220 of the Restatement (Second) of Agency in determining a worker’s status. The Restatement requires consideration of the following factors:  
1. The extent of control, which, by the agreement, the master may exercise over the details of the work.  
2. Whether or not the one employed is engaged in a distinct occupation or business.  
3. The kind of occupation, with reference to whether, in the locality, the work is usually done under the discretion of the employer or by a specialist without supervision.  
4. The skill required in the particular occupation.  
5. Whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work.  
6. The length of time for which the person is employed.  
7. The method of payment, whether by the time or by the job.  
8. Whether or not the work is a part of the regular business of the employer.  
9. Whether or not the parties believe they are creating the relation of master and servant.  
10. Whether the principal is or is not in business.  
| DC    | D.C. CODE § 32-1501 (2017) | The Department of Employment Services (DOES) applies the “relative nature of the work” test to determine a worker’s status, which focuses on whether the individual is hired to do work in which the company specializes. There are two prongs to the test. First, the nature and character of the individual’s work or business is considered by analyzing three factors:  
1. The degree of skill involved.  
2. The degree to which it is a separate calling or business.  
3. The extent to which it can be expected to carry its own accident burden.  
The second prong analyzes the relationship of the individual’s work to the purported employer’s business. 3 factors are considered:  
1. The extent to which the individual’s work is a regular part of the employer’s regular work.  
2. Whether individual’s work is continuous or intermittent.  
3. Whether the duration is sufficient to amount to the hiring of continuous services, as distinguished from contracting for the completion of a particular job.  
| FL    | FLA. STAT. § 440.02 (2017) | A worker is considered an independent contractor provided at least 4 of the following criteria are met:  
1. The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations.  
2. The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal regulations.  
3. The independent contractor receives compensation for services rendered or work performed, and such compensation is paid to a business rather than to an individual. |
(4) The independent contractor holds one or more bank accounts in the name of the business entity for purposes of paying business expenses or other expenses related to services rendered or work performed for compensation.

(5) The independent contractor performs work or is able to perform work for any entity in addition to or besides the employer at his or her own election without the necessity of completing an employment application or process.

(6) The independent contractor receives compensation for work or services rendered on a competitive-bid basis or completion of a task or a set of tasks as defined by a contractual agreement, unless such contractual agreement expressly states that an employment relationship exists.

If four of the criteria above do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions:

(1) The independent contractor performs or agrees to perform specific services or work for a specific amount of money and controls the means of performing the services or work.

(2) The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.

(3) The independent contractor is responsible for the satisfactory completion of the work or services that he or she performs or agrees to perform.

(4) The independent contractor receives compensation for work or services performed for a commission or on a per-job basis and not on any other basis.

(5) The independent contractor may realize a profit or suffer a loss in connection with performing work or services.

(6) The independent contractor has continuing or recurring business liabilities or obligations.

(7) The success or failure of the independent contractor’s business depends on the relationship of business receipts to expenditures.

**FLA. STAT. § 440.02 (2017).**

| GA | No provision | GA. CODE ANN. § 34-9-2 (2017) | An individual is an independent contractor if such person meets all of the following criteria:

(1) Is a party to a contract which intends to create an independent contractor relationship.

(2) Has the right to exercise control over the time, manner, and method of the work to be performed.

(3) Is paid on a set price per job or a per unit basis, rather than on a salary or hourly basis. |

**GA. CODE ANN. § 34-9-2 (2017).**

| HI | No provision | HAW. REV. STAT. § 386-1 (2017) | Both the “control” and “relative nature of the work” tests are used to determine an individual’s status.

Under the “control” test, an employment relationship exists when the person in whose behalf the work is done has the power to dictate the means and methods by which the work is to be accomplished. Conversely, “[o]ne who contracts with another to do a specific piece of work for him [or her], and who furnishes and has the absolute control of his [or her] assistants, and who executes the work entirely in accord with his [or her] ideas, or with a plan previously given him [or her] by the person for whom the work is done, without being subject to the latter's orders in respect of the details of the work, with absolute control thereof…is an independent contractor.”

The “relative nature of the work test” involves a balancing of factors regarding the general relationships which the employee has with regard to the work performed for each of his employers. Relevant factors include:

(1) Whether the work done is an integral part of the employer’s regular business.

(2) Whether the worker, in relation to the employer's business, is in a business or profession of his own. |
<table>
<thead>
<tr>
<th>State</th>
<th>Provision</th>
<th>Code Section</th>
<th>Test</th>
<th>Details</th>
</tr>
</thead>
</table>
| ID    | Yes       | IDAHO CODE §§ 72-102; 72-212 (2017) | The test to determine an individual’s status is whether the contract gives, or the employer assumes, the right to control the time, manner and method of executing the work, as distinguished from the right merely to require certain definite results. The Idaho courts use a four-factor test to determine an individual’s status:  
1. There must be evidence of the employer’s right to control the employee.  
2. The method of payment.  
3. Whether the employer or individual furnishes major items of equipment.  
4. Whether either party has the right to terminate the relationship at will, or whether one is liable to the other in the event of a preemptory termination. |
| IL    | No provision | 820 ILL. COMP. STAT. 305/1 (2017) | A number of factors are considered in determining an individual’s status. The most important factor is whether the purported employer has a right to control the actions of the individual, followed by the nature of the work performed by the individual in relation to the general business of the employer. Additional relevant, albeit less important, factors include:  
1. The method of payment.  
2. The right to discharge.  
3. The skill the work requires.  
4. Which party provides the needed instrumentalities.  
5. Whether income tax has been withheld.  
6. The label the parties place upon their relationship. |
| IN    | Yes       | IND. CODE §§ 22-3-2-9; 22-3-6-1 (2017) | The Indiana Supreme Court has adopted the test articulated in § 220 of the Restatement (Second) of Agency in determining a worker’s status. The Restatement requires consideration of the following factors:  
1. The extent of control which, by the agreement, the master may exercise over the details of the work.  
2. Whether or not the one employed is engaged in a distinct occupation or business.  
3. The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision.  
4. The skill required in the particular occupation.  
5. Whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work.  
6. The length of time for which the person is employed.  
7. The method of payment, whether by the time or by the job.  
8. Whether the work is a part of the regular business of the employer.  
9. Whether the parties believe they are creating the relation of master and servant.  
10. Whether the principal is or is not in business. |
| IA    | Yes       | IOWA CODE § 85.61 (2016) | Iowa courts have adopted two tests for determining a worker’s status. First, in determining the existence of an employer-employee relationship, the courts analyze the following five factors:  
1. The right of selection, or to employ at will.  
2. Responsibility for payment of wages by the employer.  
3. The right to discharge or terminate the relationship.  
4. The right to control the work.  
5. The identity of the employer as the authority in charge of the work or for whose benefit it is performed. Second, in determining whether a worker qualifies as an independent contractor, the courts consider the following eight factors: |
<table>
<thead>
<tr>
<th>State</th>
<th>Status</th>
<th>Statute/Code</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| KS    | No provision | KAN. STAT. ANN. § 44-508 (2014) | Kansas courts have adopted the Restatement factors in determining a worker’s status. However, the single most important factor is whether the employer controls, or has the right to control, the manner and methods of the worker in doing the particular task. Additional considerations include:  
1. Whether or not the one employed is engaged in a distinct occupation or business.  
2. The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision.  
3. The skill required in the particular occupation.  
4. Whether the employer or the workman supplies the instrumentalities, tools and the place of work for the person doing the work.  
5. The length of time for which the person is employed.  
6. The method of payment, whether by the time or by the job.  
7. Whether the work is part of the regular business of the employer.  
8. Whether the parties believe they are creating the relation of master and servant.  
9. Whether the principal is or is not in business.  
| KY    | Yes    | KY. REV. STAT. ANN. § 342.640 (2014) | Kentucky courts analyze four predominant factors to determine a worker’s status:  
1. The alleged employer’s right to control the details of the work.  
2. The nature of the work as related to the business generally carried on by the alleged employer.  
3. The professional skill of the individual.  
4. The true intent of the parties.  
The “right to control” factor is the most important in the analysis, which is determined by analyzing the following factors:  
1. Method of payment.  
2. Which party furnishes the equipment.  
3. Whether the alleged employer has the right to discharge the individual performing the work.  
| LA    | Yes    | LA. REV. STAT. ANN. § 23:1021 (2013) | Louisiana courts consider the following factors in determining a worker’s status:  
1. Whether there is a valid contract between the parties.  
2. Whether the work being done is of an independent nature such that the individual may employ non-exclusive means in accomplishing it.  
3. Whether the contract calls for specific piecework as a unit to be done according to the individual’s own methods without being subject to the control and direction of the principal, except as to the result of the services to be rendered.  
4. Whether there is a specific price for the overall undertaking. |
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<thead>
<tr>
<th>State</th>
<th>Yes</th>
<th>Statute/Code References</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| ME    | Yes | ME. REV. STAT. tit. 39-A, § 102 (2013) | An individual is presumed to be an employee unless the employing unit proves that the person is free from the essential direction and control of the employing unit. In order for an individual to be an independent contractor, the following criteria must be met:  
(1) The person has the essential right to control the means and progress of the work except as to final results.  
(2) The person is customarily engaged in an independently established trade, occupation, profession or business.  
(3) The person has the opportunity for profit and loss as a result of the services being performed for the other individual or entity.  
(4) The person hires and pays the person’s assistants, if any, and, to the extent such assistants are employees, supervise the details of the assistants’ work.  
(5) The person makes the person’s services available to some client or customer community even if the person’s right to do so is voluntary not exercised or is temporarily restricted.  
Additionally, at least three of the following criteria must be met:  
(1) The person has a substantive investment in the facilities, tools, instruments, materials and knowledge used by the person to complete the work.  
(2) The person is not required to work exclusively for the other individual or entity.  
(3) The person is responsible for satisfactory completion of the work and may be held contractually responsible for failure to complete the work.  
(4) The parties have a contract that defines the relationship and gives contractual rights in the event the contract is terminated by the other individual or entity prior to completion of the work.  
(5) Payment to the person is based on factors directly related to the work performed and not solely on the amount of time expended by the person.  
(6) The work is outside the usual course of business for which the service is performed.  
(7) The person has been determined to be an independent contractor by the federal Internal Revenue Service (IRS). |
| MD    | Yes | MD. CODE ANN. LAB. & EMP. §§ 9-203 to 9-236 (2009) | Maryland courts consider five criteria in determining a worker’s status. The decisive consideration is the “control” test: whether the employer has the right to control and direct the employee in the performance of the work and in the manner in which the work is done. The following factors are also relevant:  
(1) The power to select and hire the employee.  
(2) The payment of wages.  
(3) The power to discharge.  
(4) Whether the work is part of the regular business of the employer. |
| MA    | Yes | MASS. GEN. LAWS ch. 152, § 1 (2011) | The standard in determining a worker’s status is the same as the common law agency standard, the primary factor being the right to control. Massachusetts courts consider the factors set out in the Restatement (Second) of Agency, which are as follows:  
(1) The extent of control which, by the agreement, the master may exercise over the details of the work.  
(2) Whether or not the one employed is engaged in a distinct occupation or business.  
(3) The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision.  
(4) The skill required in the particular occupation. |
Whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work.
(6) The length of time for which the person is employed.
(7) The method of payment, whether by the time or by the job.
(8) Whether or not the work is part of the regular business of the employer.
(9) Whether the parties believe they are creating the relation of master and servant.
(10) Whether the principal is or is not in business.


| MI | No provision | MICH. COMP. LAWS §§ 418.115 to 418.120; 418.161 (2017) | In order for a worker to be considered an employee, three criteria must be met. The worker must not:

1. Maintain a separate business.
2. Hold himself or herself out to and render service to the public.
3. Be an employer subject to the worker’s compensation act.


| MN | No provision | Minnesota regulations set forth criteria for 34 specific occupations. Minn. R. 5224.0010 to 5224.0340 (2017). | Minnesota courts have adopted a five-factor test to determine the status of workers not specifically engaged in the occupations enumerated in MINN. R. 5224.0010 to 5224.0340 (2017):

1. The right to control the means and manner of performance.
2. The mode of payment.
3. The furnishing of tools and materials.
4. Control over the premises where the work was done.
5. The right of discharge.

Of the factors, the right to control is the most important. A number of considerations are used to determine whether the employer possesses such a right to control, including:

1. Employer’s authority over the individual’s assistants.
2. The individual’s compliance with instructions.
3. Whether oral or written reports are required to be submitted to the employer.
4. Whether the work is performed on the employer’s premises.
5. Whether services must be personally rendered to the employer.
6. Whether there is a continuing relationship between the parties.
7. Whether the employee has set hours of work.
8. Whether the individual has been trained by the employer.
9. Whether the individual has simultaneous contracts with different firms.
10. Whether tools and materials have been furnished by the employer.
11. Whether the individual’s expenses are reimbursed.
12. Whether the individual’s compensation is dependent on the number of hours worked.
13. Whether the employer is required to enforce standards or restrictions imposed by regulatory and licensing agencies.

Guhlke v. Roberts Truck Lines, 128 N.W.2d 324 (Minn. 1964); Hunter v. Crawford Door Sales, 501 N.W.2d 623 (Minn. 1993); MINN. R. 5224.0330 (2017); Minn. Dept. of Lab. And Indus., Workers’ Compensation – Determining Independent Contractor or Employee Status, https://www.dli.mn.gov/business/workers-compensation/work-comp-independent-contractor-or-employee |

| MS | No provision | MISS. CODE ANN. §§ 71-3-3; 71-3-5 (West 2017) | Mississippi courts have adopted the “right to control” test to determine a worker’s status. The test consists of the following factors:

1. Direct evidence of right or exercise of control.
2. The method of payment.
3. The furnishing of equipment.
4. The employer’s right to fire.

Se. Auto Brokers v. Graves, 210 So.3d 1012 (Miss. Ct. App. 2015); MISS. CODE ANN. § 71-3-3 (West 2011). |

| MO | No | MO. REV. STAT. § 287.020 (2017) | The primary test to determine a worker’s status is the right to control. If an employer has the right to control the means and manner of a worker’s service, the |
worker is an employee rather than an independent contractor. A number of factors are considered in this analysis:

1. The extent of control.
2. The actual exercise of control.
3. The duration of the employment.
4. The right to discharge.
5. The method of payment.
6. The degree to which the alleged employer furnished equipment.
7. The extent to which the work is the regular business of the employer.
8. The employment contract.

Where the control analysis does not settle the issue, the “relative nature of the work” test is also applied. This test analyzes the economic and functional relationship between the nature of the work and a business’ operation. The following factors are considered:

1. The amount of skill the worker’s job requires.
2. The degree to which the work is a separate calling or enterprise.
3. The extent to which the job might be expected to carry its own accident burden.
4. The relation of the job to the employer’s business.
5. Whether the job being performed is continuous or intermittent.
6. Whether the job’s duration amounts to the hiring of continuous services rather than a contract for the completion of a particular job.

Missouri law allows some independent contractors to recover under worker’s compensation law. Individuals having work done under contract on or about their premises that is an operation of the usual business that they carry are considered an employer and are liable to all workers, regardless of status, for worker’s compensation.


MT Yes


In determining whether an individual is an independent contractor, the court will consider the following factors:

1. Direct evidence of right or exercise of control.
2. Method of payment.
3. Furnishing of equipment.
4. Right of employer to fire.

Under MONT. CODE ANN. § 39-71-417 (2011), a worker can apply for an “Independent Contractor Certification” if, among other things, the worker swears to and acknowledges:

1. That the applicant has been and will continue to be free from control or direction over the performance of the person’s own services, both under contract and in fact.
2. That the applicant is engaged in an independently established trade, occupation, profession or business and will provide sufficient documentation of that fact to the department.


NE Yes

| NEB. REV. STAT. §§ 48-106 (2010) |

Nebraska’s workers’ compensation law and case law suggest there is no single test for determining whether one is an employee or independent contractor, but instead the following factors will be considered in the determination of status:

1. The extent of control that the employer may exercise over the details of the work.
2. Whether the one employed is engaged in a distinct occupation or business.
3. The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision.
4. The skill required in the particular occupation.
5. Whether the employer or the one employed supplies the instrumentalities, tools, and the place of work for the person doing the work.
6. The length of time for which the one employed is engaged.
7. The method of payment, whether by time or by the job.
<table>
<thead>
<tr>
<th>State</th>
<th>Approved</th>
<th>Reference</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| NV    | No       | NEV. REV. STAT. §§ 616A.105 to 616A.360 (2013) | Nevada’s worker’s compensation law defines an independent contractor as any person who renders service for a specified recompense for a specified result, under the control of the person’s principal as to the result of the person’s work only and not as to the means as to which the result is accomplished. Under Nevada’s Industrial Insurance Act, if a worker meets three or more of the following criteria, there is a presumption that the worker is an independent contractor:

1. The person has control and discretion over the means and manner of the performance of any work and the result of the work, rather than the means or manner by which the work is performed, and is the primary item bargained for by the principal in the contract.
2. The person generally has control over the time the work is performed.
3. The person is not required to work exclusively for one principal unless a law, regulation or ordinance otherwise prohibits the person from providing services to more than one principal or the person has entered into a written contract to provide services to only one principal.
4. The person is free to hire employees to assist with the work.
5. The person contributes a substantial investment of capital in the business of the person, including without limitation:
   a. Purchase or lease of ordinary tools, material and equipment.
   b. Obtaining of a license or other permission from the principal to access any work space of the principal to perform the work.
   c. Lease of any work space from the principal required to perform the work for which the person was engaged.

The fact that a person does not satisfy three or more of the listed criteria does not automatically create a presumption that the person is an employee. |
| NH    | Yes      | N.H. REV. STAT. ANN. § 281-A:2 (2017) | Under New Hampshire’s worker’s compensation law, the presumption of employee status can be rebutted if a person meets all of the following criteria:

1. The person possesses or has applied for a federal employer identification number or a social security number, or in the alternative, has agreed in writing to carry out the responsibility imposed on employers under this chapter.
2. The person has control and discretion over the means and manner of performance of the work, in that the result of the work, rather than the means or manner by which the work is performed, is the primary element bargained for by the employer.
3. The person has control over the time when the work is performed, and the time of performance is not dictated by the employer, although the employer may still prescribe a completion schedule, range of work hours and maximum number of work hours to be provided by the person.
4. The person hires and pays the person’s assistants, if any, and to the extent such assistants are employees, supervises the details of the assistants’ work.
5. The person holds himself or herself out to be in business for himself or herself or is registered with the state as a business and the person has continuing or recurring business liabilities or obligations.
6. The person is responsible for satisfactory completion of work and may be held contractually responsible for failure to complete the work.
7. The person is not required to work exclusively for the employer. |

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<tr>
<th>State</th>
<th>Yes/No</th>
<th>Statute</th>
<th>Test or Factors</th>
</tr>
</thead>
</table>
| NJ    | Yes    | N.J. STAT. ANN. § 43:21-19 (2010) | Under New Jersey’s unemployment law, services provided for remuneration shall be deemed to be under an employment relationship unless it is shown that:  
 1. An individual has been and will continue to be free from control or direction over the performance of such service, both under his contract of service and in fact.  
 2. Such service is either outside the usual course of the business for which such service is performed, or that such service is performed outside of all the places of business of the enterprise for which such service is performed.  
 3. Such individual is customarily engaged in an independently established trade, occupation, profession or business.  
The New Jersey Supreme Court in Hargrove v. Sleepy’s, LLC, 106 A.3d 449 (2015) adopted the above test for worker’s compensation purposes and stated that for determining whether an individual is an employee or an independent contractor, the courts must consider twelve factors:  
 1. The employer’s right to control the means and manner of the worker’s performance.  
 2. The kind of occupation and whether the work is supervised or unsupervised.  
 3. The amount of skill involved.  
 4. Who furnishes the equipment and workplace.  
 5. The length of time in which the individual has worked.  
 6. The method of payment.  
 7. The manner of termination of the work relationship.  
 8. Whether there is annual leave.  
 9. Whether the work is an integral part of the business of the employer.  
10. Whether the worker accrues retirement benefits.  
11. Whether the employer pays social security taxes.  
12. The intention of the parties.  
| NM    | Yes    | No provision | New Mexico courts will first employ a “right-to-control” test to determine whether a worker is an employee or independent contractor. If the right-to-control test points to independence, the court will then apply a “relative-nature of the work” test.  
Factors that may be considered in determining existence of employment relationship include:  
1. Direct evidence of exercise of control.  
2. The right to terminate employment relationship at will by either party without liability  
3. The right to delegate work or to hire and fire assistants.  
4. The method of payment whether by time or by job.  
5. Whether the party employed engages in distinct operation or business.  
6. Whether the work is part of employer’s regular business.  
7. Skill required in particular occupation.  
8. Whether the employer supplies instrumentalities, tools or place of work.  
9. Duration of person’s employment.  
10. Whether the person works full-time or part-time of control by one and submission to control by the other.  
| NY    | Yes    | Presumption for employment for construction workers unless the worker is a “separate business entity” § 861-c; N.Y. WORKER’S | An independent contractor is one who is:  
1. Free from control and direction in performing the job, both under his contract and in fact.  
2. The service is performed outside the usual course of business for which the service is performed.  
3. The individual is customarily engaged in an independently established trade, occupation, profession or business that is similar to the service at issue.  
When making a determination of whether an employer-employee relationship exists, the New York courts will consider factors such as the right to control the |
<table>
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<tr>
<th>Region</th>
<th>Code</th>
<th>Note</th>
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<tbody>
<tr>
<td>NC</td>
<td>Yes</td>
<td>§ 97-5.1 (2013) Presumption that taxicab drivers are independent contractors</td>
</tr>
<tr>
<td>ND</td>
<td>Yes</td>
<td>N.D. CENT. CODE § 65-01-03</td>
</tr>
</tbody>
</table>

North Carolina courts define “independent contractor” as one who exercises an independent employment and contracts to do certain work according to his own judgment and method, without being subject to his employer except as to the result of his work.

The determinative factor in North Carolina courts as to whether a person is an employee or independent contractor for purposes of workers’ compensation is control. North Carolina courts will use the “right to control” when determining whether a person is an employee or an independent contractor for purposes of the Workers’ Compensation Act. Generally, where an employer has the right to control over the means and the methods of an employee’s work, there will be an employer-employee relationship. The requirement of control is sufficiently met where its extent is commensurate with that degree of supervision that is necessary and appropriate considering the type of work to be done and the capabilities of the person doing it.

The North Carolina courts will also look at eight factors which indicate classification as independent contractor, including:

1. The worker is engaged in independent business, calling, or occupation.
2. The worker has independent use of his or her special skill, knowledge, or training in execution of work.
3. The worker is doing specified piece of work at fixed price or for lump sum or upon quantitative basis.
4. The worker is not subject to discharge because he adopts one method of doing work rather than another.
5. The worker is not in regular employ of other contracting party.
6. The worker is free to use such assistants as he or she may think proper.
7. The worker has full control over such assistants.
8. The worker is able to select his or her own time.


North Dakota courts consider 20 factors when determining whether a worker is an independent contractor or an employee:

1. The amount of instructions given to the employee by the employer.
2. The amount of training given to the employee.
3. The amount of integration of a person’s services into the business operations.
4. Services rendered personally. If the services must be rendered personally, the person whom the services are performed for are interested in the methods used, which goes towards employer-employee relationship.
5. The ability to hire, supervise, and pay assistants.
6. The continuing relationship between the person and person(s) for whom the services are performed.
7. Set hours of work.
8. Whether full-time is required. An independent contractor is one who is free to work when and for whom he or she chooses. Full-time required suggests an employer-employee relationship.
9. Where the work is performed.
10. The order or sequence set the work must be performed.
11. Whether there is a requirement for regular oral or written reports.
12. How the worker is paid.
13. Whether there is payment of business or traveling expenses, or both.
14. Who is responsible for furnishing of tools and materials.
15. Whether there is significant investment in facilities used by the workman.
16. Realization of profit or loss: A person who may realize a profit or suffer a loss as a result of the person’s services (in addition to the profit or loss ordinarily realized by employees) is generally an independent contractor, but the person who cannot is an employee.
<table>
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<tr>
<th>OH</th>
<th>No provision</th>
<th>OHIO REV. CODE ANN. § 4123.01 (2015)</th>
<th>OHIO REV. CODE ANN. § 4123.01 (2015) states that a person who meets at least 10 of the following criteria are excluded from the definition of employee:</th>
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<tr>
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<td>(1) The worker is required to comply with instructions from the other contracting party regarding the manner or methods of performing services.</td>
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<td>(2) The person is required by the other contracting party to have particular training.</td>
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<td>(3) The person’s services are integrated into the regular functioning of the other contracting party.</td>
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<td>(4) The person is required to perform the work personally.</td>
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<td>(5) The person is hired, supervised, or paid by the other contracting party.</td>
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<td>(6) A continuing relationship exists between the person and the other contracting party that contemplates continuing or recurring work even if the work is not full time.</td>
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<td>(7) The person’s hours of work are established by the other contracting party.</td>
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<td>(8) The person is required to devote full time to the business of the other contracting party.</td>
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<td>(9) The person is required to perform the work on the premises of the other contracting party.</td>
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<td>(10) The person is required to follow the order of work set by the other contracting party.</td>
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<td>(11) The person is required to make oral or written reports of progress to the other contracting party.</td>
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<td>(12) The person is paid for services on a regular basis such as hourly, weekly, or monthly.</td>
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<td>(13) The person’s expenses are paid for by the other contracting party.</td>
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<td>(14) The person’s tools and materials are furnished by the other contracting party.</td>
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<td>(15) The person is provided with the facilities used to perform services.</td>
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<td>(16) The person does not realize a profit or suffer a loss as a result of the services provided.</td>
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<td>(17) The person is not performing services for a number of employers at the same time.</td>
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<td>(18) The person does not make the same services available to the general public.</td>
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<td>(19) The other contracting party has a right to discharge the person.</td>
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<td>(20) The person has the right to end the relationship with the other contracting party without incurring liability pursuant to an employment contract or agreement.</td>
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The general test for determining independent contractor status considers the following factors: who has the right to direct what shall be done and when and how it shall be done; the existence of a contract for the performance by a person of a certain piece or kind of work at a fixed price; the independent nature of the worker’s business; the worker’s employment of assistants with the right to supervise their activities; his or her obligation to furnish the necessary tools, supplies, and materials; his or her right to control the progress of the work except as to final results; the time for which the workman is employed; the method of payment, whether by time or by job; and whether the work is part of the regular business of the employer.

Gillum v. Ind. Com’n, 141 Ohio St. 373 (1943).
<table>
<thead>
<tr>
<th>OK</th>
<th>No provision</th>
<th>Okla. Admin. Code § 380:30-1-2 (2012)</th>
<th>Oklahoma’s case law and the DOL set out several factors to be considered when determining whether an employee/employer relationship exists, including:</th>
</tr>
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|     |              | Department of Labor excludes business owners, volunteers, co-partners, and joint venturers from the definition of “employee” | (1) The nature of the contract between the parties.  
(2) The degree of control the employer may exercise on the details of the work.  
(3) Whether the one employed is engaged in a distinct occupation or business for others.  
(4) The kind of occupation with reference to whether in the locality the work is usually done under the direction of the employer.  
(5) The skill required in the particular occupation.  
(6) Whether the employer or the workman supplies the instrumentalities, tools and the place of work for the person doing the work.  
(7) The length of time for which the person is employed.  
(8) The method of payment.  
(9) Whether the work is part of the regular business of the employer.  
(10) Whether the parties believe they are creating the relationship of master and servant.  
(11) The right of either to terminate the relationship without liability.  

No one factor is controlling, and the court will look into the set of particular facts of each case.  
|     |              | Certain holders of professional licenses | (1) Free from direction and control over the means and manner of providing the services, subject only to the right of the person for whom the services are provided to specify the desired results.  
(2) Except as provided in subsection (4) of this section, is customarily engaged in an independently established business.  
(3) Is licensed under Oregon Revised Statutes Chp. 671 or 701 if the person provides services for which a licensed is required under those chapters.  
(4) Is responsible for obtaining other licenses or certificates necessary to provide services.  

This definition of independent contractor has been adopted into the worker’s compensation statute. Or. Rev. Stat. § 656.005 (2017)  
Oregon case law states that in determining whether a person is an independent contractor, the right to control is decisive. The principal factors in determining independent contractor status are:  
(1) The evidence of the right to or actual exercise of control.  
(2) The method of payment.  
(3) The furnishing of equipment.  
(4) The right to fire.  

<table>
<thead>
<tr>
<th>PA</th>
<th>Yes</th>
<th>Domestic Service, Real Estate, Construction Workers 77 P.S. § 676; 43 P.S. § 933.3</th>
</tr>
</thead>
<tbody>
<tr>
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<td>In determining employee or independent contractor status, the following factors should be considered, but all do not need to be present:</td>
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<td></td>
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<td>(1) Control of the manner in which work is to be done.</td>
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<td>(2) Responsibility for result only.</td>
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<td>(3) Terms of agreement between the parties.</td>
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<td>(4) Nature of the work or occupation.</td>
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<td>(5) Skill required for performance.</td>
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<td>(6) Whether one employed is engaged in distinct occupation or business.</td>
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<td>(7) Who supplies the party tools.</td>
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<td>(8) Whether payment is by time or by job.</td>
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<td>(9) Whether work is part of regular business or alleged employer.</td>
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<td>(10) Whether alleged employer had right to terminate employment at any time.</td>
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<td>Control over the work to be completed and the manner in which it is to be performed are the primary factors in determining employee status for purposes of the worker’s compensation act. 77 P.S. § 22; Hammermill Paper Company v. Rust Engineering Company, 243 A.2d 389 (Pa. 1968); Johnson v. W.C.A.B. (Dubois Courier Exp.), 631 A.2d 693 (Pa. 1993).</td>
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<tr>
<th>RI</th>
<th>No provision</th>
<th>28 R.I. GEN. LAWS. ANN. §§ 28-29-2; 28-29-7 to 28-29-7.2; 28-29-15 Certain industries have special status or are exempted</th>
</tr>
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<td>Under Rhode Island’s workers’ compensation law, an independent contractor is a person who has filed a notice of designation as independent contractor with the director pursuant to or as otherwise found by the workers’ compensation court. In determining whether a worker is an employee or independent contractor, the status depends on the employer’s right or power to exercise control over methods and means of performing the work and not the exercise of actual control. Whether an injured worker is an employee or independent contractor must be decided by the employment contract in the particular case and the surrounding particular circumstances. 28 R.I. GEN. LAWS. ANN. §§ 28-29-2; 28-29-17.1 (1956) Pasetti v. Brusa, 98 A.2d 833 (1953); Henry v. Mondillo, 142 A. 230 (1928).</td>
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<td>Case law establishes the criteria for distinguishing between employee and independent contractor under South Carolina’s worker’s compensation law. Determination of whether a worker’s compensation claimant is an employee or independent contractor focuses on the issue of control. In determining whether an employer had a right to control a workers’ compensation claimant in performance of his or her work, there are four factors the court will look at:</td>
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<td>(1) Direct evidence of the right or exercise of control.</td>
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<td>(2) Furnishing of equipment.</td>
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<td>(3) Method of payment.</td>
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<td>(4) Right to fire.</td>
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<td>It is not actual control exercised, but whether there exists a right and authority to control and direct the particular work or undertake as to the manner or means of its accomplishment. S.C. CODE ANN. § 42-1-130 (1976); Nelson v. Yellow Cab Co., 343 S.C. 102, 538 S.E.2d 276 (S.C.App. 2000); Shatto v. McLeod Regional Medical Center, 406 S.C. 470 (2013).</td>
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<tr>
<th>SD</th>
<th>No provision</th>
<th>S.D. CODIFIED LAWS §§ 62-1-4 to 62-1-5.1 Certain industry exceptions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>There are three primary factors South Dakota courts look at to determine whether one is employee or independent contractor include:</td>
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<td>(1) Whether individual has been and will continue to be free from control or direction over performance of services.</td>
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<td>(2) Both under contract of service and in fact.</td>
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<td>(3) Whether the individual is customarily engaged in independent established trade, occupation, profession or business. Specifically, courts will employ a “right of control” test is used to determine independent contractor status, which includes consideration of the following factors:</td>
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<tr>
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<td>(1) Direct evidence of rate of control.</td>
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<td>(2) Method of payment.</td>
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<tr>
<td>State</td>
<td>Employment Status</td>
<td>Exclusion/Inclusion Details</td>
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<tr>
<td>TN</td>
<td>Yes</td>
<td>Construction workers are exempt from the statutory classification test if requirements of TENN. CODE. ANN. § 50-6-102(10) are met. Tennessee’s workers’ compensation law states that to determine whether an individual is an employee or independent contractor, the following factors will be considered: (1) The right to control the conduct of the work. (2) The right of termination. (3) The method of payment. (4) The freedom to select and hire helpers. (5) The furnishing of tools and equipment. (6) Self-scheduling of working hours. (7) The freedom to offer services to other entities. For purposes of determining whether employee’s relationship is employee or independent contractor, courts consider whether work being performed by contractor is same type of work usually performed by the company that hired the contractor and whether the company has right to control employees of contractor. TENN. CODE ANN. § 50-6-102 (2017); Barber v. Ralston Purina, 825 S.W.2d 96 (1991).</td>
</tr>
<tr>
<td>TX</td>
<td>No provision</td>
<td>TEX. INS. CODE ANN. §§ 406.091 to 406.098; 406.141 to 406.146; 406.161 to 406.165. Special coverage to members of certain industries, construction workers and farm and ranch employees. Texas’ workers’ compensation act defines an independent contractor as a person who contracts to perform work or provide a service for the benefit of another and who ordinarily: (1) Acts as the employer of any employee of the contractor by paying wages, directing activities, and performing other similar functions characteristic of an employer-employee relationship; (2) Is free to determine the manner in which the work or service is performed, including the hours of labor of or method of payment to any employee; (3) Is required to furnish or to have employees, if any, furnish necessary tools, supplies, or materials to perform the work or service. (4) Possesses the skills required for the specific work or service. The Texas courts will also consider the following factors when considering whether one is an independent contractor: the independent nature of the worker’s business; the worker’s obligation to furnish necessary tools, supplies and material to perform the job; the worker’s right to control progress of work; except as to final results; the time for which (s)he is employed; and method of payment, whether by time or by job. TEX. INS. CODE ANN. § 406.121 (1993); Industrial Indem. Exchange v. Southard, 138 Tex. 531 (1942); INA of Texas v. Torres, 808 S.W.2d 291 (1991).</td>
</tr>
<tr>
<td>UT</td>
<td>Yes</td>
<td>UTAH CODE ANN. § 34A-2-104 (2017). Utah’s workers’ compensation law defines an independent contractor as any person engaged in the performance of any work for another who, while so engaged, is: (1) Independent of the employer in all that pertains to the execution of the work. (2) Not subject to the routine rule or control of the employer. (3) Engaged only in the performance of a definite job or piece of work. (4) Subordinate to the employer only in effecting a result in accordance with the employer’s design. The Utah court will consider whatever agreements exist concerning the right of control, as well as the actual dealings between the parties and the control that was in fact asserted. Determination of status of individual as an employee or an independent contractor is based on various factors, and of primary concern is the control, direction, supervision, or the right to control, direct or supervise on behalf of the employer. UTAH CODE ANN. § 34A-2-103 (2017); Utah Home Fire Ins. Co. V. Manning, 985 P.2d 243 (1999); Ruster Lodge v. Industrial Commission, 562 P.2d 227 (1977).</td>
</tr>
<tr>
<td>State</td>
<td>Provision</td>
<td>Legal Reference</td>
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<tr>
<td>VT</td>
<td>No</td>
<td>No provision</td>
</tr>
<tr>
<td>VA</td>
<td>Yes</td>
<td>VA CODE ANN. §§ 65.2-101- to 65.2-104</td>
</tr>
<tr>
<td>WA</td>
<td>No</td>
<td>WASH. REV. CODE ANN. §§ 51.12.010 to 51.12.185 (1996)</td>
</tr>
</tbody>
</table>
| State | Yes | Code | Under West Virginia’s worker’s compensation law, the burden of proving that an individual is an independent contractor is on the party asserting independent contractor status. The following factors are dispositive of whether a worker is an independent contractor:

1. Whether the individual holds himself or herself out to be in business for himself or herself, including whether he or she possesses a license, permit or other certification required to engage in the type of work the worker is performing; whether the individual enters into verbal or written contracts with the persons and/or entities for whom the work is being performed; and whether the individual has the right to regularly solicit business from different persons or entities to perform for compensation the type of work that is being performed.

2. Whether the individual has control over the time when the work is being performed.

3. The individual has control and discretion over the means and manner of the work being performed and in achieving the result of the work.

4. Unless expressly required by law, the individual is not required to work exclusively for the person or entity for whom the work is being performed.

5. If the use of equipment is required to perform the work, the individual provides most significant equipment required to perform the job.

The West Virginia courts will look at the following factors to determine if a worker is an employee or independent contractor: the right or lack of right to supervise work, the method of payment, who owns substantial equipment to be used on the job, who determines what hours are worked, and the nature and terms of the employment contract.


| State | Yes | No provision |

Wisconsin’s worker’s compensation law lists nine criteria, all of which must be met to be considered an independent contractor:

1. Maintains a separate business with his or her own office, equipment, materials and other facilities.

2. Holds or has applied for a federal employer identification number with the IRS or has filed business or self-employment income tax returns with the IRS based on that work or service in the previous year.

3. Operates under contracts to perform specific services or work for specific amounts of money and under which the independent contractor controls the means of performing the services or work.

4. Incurs the main expenses related to the service or work that he or she performs under contract.

5. Is responsible for the satisfactory completion of work or services that he or she contracts to perform and is liable for a failure to complete the work or service.

6. Receives compensation for work or service performed under a contract on a commission or per job or competitive-bid basis and not on any other basis.

7. May realize a profit or suffer a loss under contracts to perform work or service.

8. Has continuing or recurring business liabilities or obligations.

9. The success or failure of the independent contractor’s business depends on the relationship of business receipts to expenditures.

The presumption that a person injured while performing service for another is an employee rather than an independent contractor is rebuttable and ceases to have force or effect when evidence to the contrary is adduced.

WIS. STAT. ANN. § 102.07 (2016); J. Romberger Co. v. Industrial Commission, 234 Wis. 226, 229 (Wis. 1940).
<table>
<thead>
<tr>
<th>WY</th>
<th>No provision</th>
</tr>
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</table>

Wyoming’s workers’ compensation law defines independent contractor as “an individual who performs services for another individual or entity” and:

1. Is free from control or direction over the details of the performance of services by contract and by fact.
2. Represents his services to the public as a self-employed individual or an independent contractor.
3. May substitute another person to perform his services.

The Wyoming Supreme Court has defined an independent contractor as “one who, exercising an independent employment, contracts to do a piece of work according to his or her own methods and without being subject to the control of his or her employer except as to the result of the work.” An express contract between the parties is not conclusive on whether a worker is an independent contractor. However, it is an important factor in defining the relationship between the employer and the worker. The Wyoming Supreme Court stated other factors that are important to the determination, including:

1. The method of payment.
2. The right to determine the relationship without incurring liability.
3. The furnishing of tools and equipment.
4. The scope of the work.
5. The control of the premises where the work is to be done; and whether the worker devotes all of his or her efforts to the position or if he or she also performs work for others.

[Agency Name]

INSURANCE DISASTER RESPONSE PLAN

[Date]
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Financial & Administration Section Chief..........................................................................................

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Finance and Administration Section Team Leads .................................................................
Logistics Section Chief .........................................................................................................
Operations Section Chief ....................................................................................................
Operation Section Team Leads .............................................................................................
Planning Section Chief ........................................................................................................
Deputy .................................................................................................................................
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Introduction

In the event of a disaster that requires an extraordinary response, the [state insurance regulatory entity] has adopted the following disaster response plan.

What this document provides

Following a disaster, this document provides a template for departments of insurance (DOIs) to use when assisting consumers. In advance of a disaster, this document also provides guidance to insurers and other licensees.

This document details how a DOI can work with other agencies to assist consumers, including:

- Federal agencies
- State or local agencies
- The NAIC
- Other state DOIs

This document does not provide information regarding a Continuity of Operations Plan (COOP). Check to see if your department has a COOP that provides detailed information regarding how it is to be implemented.

The purpose of the disaster response plan

The purpose of the disaster response plan is to:

- Provide states with information regarding quick and effective responses to meet the insurance information needs of its citizens.
- Provide information regarding the coordination of resources with other state agencies to mitigate the effects of a disaster.

The disaster response plan will be activated by the commissioner, director or superintendent. It will be implemented by the disaster or incident management team.
Information the disaster response plan provides
This disaster response plan template provides information to assist state insurance departments in responding to disasters. This disaster response plan is scalable to respond to disasters affecting:

- Limited areas within the state.
- Several locations throughout the state.
- The entire state.

NAIC Disaster Assistance Program
The NAIC Disaster Assistance Program is a series of services provided by the NAIC to any member jurisdiction experiencing the aftermath of a disaster where additional support is needed.

The NAIC can provide the following services following a disaster:

- Disaster Relief Call Center
- Disaster Recovery Center (DRC) Insurance Regulator Staff
- Communications Services
- NAIC Coordinated Data Call

Services are provided once a formal request is made by an NAIC member (a jurisdiction’s appointed/elected insurance commissioner) to the NAIC officers, asking them to direct NAIC senior management to allocate budgeted funds and resources toward their need for disaster relief assistance. The day-to-day project is then overseen by the NAIC Director of Member Services who coordinates a variety of NAIC department staff overseeing operations and volunteers throughout the length of services needed.

Ways a jurisdiction can prepare to receive NAIC assistance
Jurisdictions can prepare information that will better facilitate NAIC assistance after a catastrophic event. These items may be incorporated as part of your jurisdiction’s Business Continuity Plan. Jurisdictions need to consider how they want calls and complaints tracked by NAIC volunteers and provide templates, if appropriate.

The following are some high-level action items to do prior to contacting the NAIC:

- Identify your critical staff and who will be coordinating with the NAIC.
- Assess the level of impact to your staff. This level of impact may determine the support you need from the NAIC.
- Assess the functionality of your systems and facilities—i.e., phone, internet, other communications and office—after the event.
- Assess access to power and your critical infrastructure.
- Assess business impact analysis; i.e., the minimum you need to function.
- If possible, consider the type of assistance you may need: call center overflow, onsite regulatory staff support, website, or remote office. However, the NAIC is also prepared to consider new services to meet your unique needs.
- Document how a trusted third party may access your communications systems: phone and internet.
• Prepare and provide talking points for the NAIC, frequently asked questions (FAQ), jurisdiction guidelines—i.e., emergency adjuster licensing rules—which can be shared with call center staff and onsite DRC volunteers.
• Share jurisdiction-issued bulletins and how we are to handle them.

**NAIC services set-up time after approval of assistance**

The NAIC is ready to help at any time after a member has requested assistance.

• Call center: within 24–48 hours after contact.
• DRC volunteers may be available within 48–72 hours after contact.
• Communications services are available within 24–48 hours after contact and member approval of information.
• NAIC Coordinated Data Call within 24–48 hours after contact.

**Additional information**

Where possible, the NAIC may reach out to a member jurisdiction prior to an imminent disaster to offer information about our program or answer any questions they may have about systems that may be affected in the event of a disaster.

NAIC Research and Government Relations departments are able to participate in briefings with the Financial and Banking Information Infrastructure Committee (FBIIC), the Federal Emergency Management Agency (FEMA), and Homeland Security to share information from, and to, NAIC jurisdictions.

The National Insurance Producer Registry (NIPR) and/or the Interstate Insurance Product Regulation Commission (Compact) are able to assist affected jurisdictions who may need emergency adjuster licenses and/or help processing product filings.

**Disaster relief call center**

The NAIC works with your department’s technical team to connect a 1-800 NAIC telephone line and/or computer system—State Based Systems (SBS)—with your jurisdiction’s consumer phone line and/or complaint tracking system.

• Call center is staffed with experienced insurance department regulator volunteers capable of answering consumer concerns.
• Call center is flexible enough to handle your entire call volume, allowing your staff to assist people in the field.
• Call center may also be set to roll-over to state insurance regulator volunteers whenever you experience call overflow.

**Cost:**

• There is no cost to your jurisdiction for this service.
• The NAIC covers the cost for the 1-800 phone line; call center equipment, facilities and coordination; and the travel/lodging reservations and expense for state insurance regulator volunteers.
• Your fellow members/commissioners provide their state insurance regulator staff as volunteers.
DRC insurance regulator staff

The NAIC facilitates and coordinates insurance department regulator volunteers to staff your designated DRC location(s).

- Volunteers cover one to two week shift rotations to man the daily operation of the DRC.
- The NAIC will arrange travel and lodging for the assigned state insurance regulator volunteers.
- If needed, the NAIC can help provide loaner laptops or cell phones for state insurance regulator volunteer use at a DRC location.

Cost:
- There is no cost to your jurisdiction for this service.
- The NAIC covers the cost of the loaner equipment and travel/lodging expenses for the state insurance regulator volunteers.
- Your fellow members/commissioners proffer their state insurance regulator staff as volunteers.

To deploy this service, an insurance department staff/disaster coordinator contacts Trish Schoettger, NAIC Director of Member Services at tschoettger@naic.org or 816.783.8506. She will coordinate a call with the member/commissioner, NAIC President, and NAIC Chief Executive Officer (CEO) or Chief Operating Officer (COO) to utilize these services.

NAIC-hosted insurance department website

In the case where the affected jurisdiction has lost the use of its facility or their website becomes inoperable, the NAIC can act as an interim host for the jurisdiction’s insurance department website. If needed, the NAIC can also serve as a resource to communicate your updated status to other jurisdictions and/or agencies or change information.

Cost:
- There is no cost to your jurisdiction for this service.
- The NAIC covers the cost of hosting the site.

NAIC-coordinated data call

The NAIC assists states with data calls related to the collection of claims data following disasters. Data calls are typically conducted weekly immediately after a disaster and then biweekly or monthly as a higher percentage of claims close.
Preparation

The steps to preparation

A DOI needs to promptly and efficiently respond to a disaster. Effective response to a disaster requires preparation and planning, including:

- Identifying appropriate staff to perform necessary activities.
- Training appropriate staff.
- Identifying available resources.
- Identifying any resource shortfalls and how these might be addressed.

Important planning considerations

Preparedness for disasters requires identifying resources and expertise in advance and planning how these can be used in a disaster. Planning considerations include:

- Putting procedures in place for internal tracking and reimbursement costs expended by the DOI in response to a disaster.
- Designating a team of individuals and assigning responsibilities to ensure that everyone on the team understands their roles and responsibilities during a disaster situation.
- Updating plans and procedures based upon post-mortem evaluation of the DOI’s performance in prior disaster response efforts.

Available training

As a part of efforts to prepare for response to disasters, state DOIs and agencies participate with local jurisdictions and private entities in exercises and training. Staff should be periodically trained on how to assist consumers during a disaster.

Training regarding information on FEMA assistance programs and the National Flood Insurance Program (NFIP) is recommended.

FEMA has free courses available to emergency management teams. These courses can be found by using the following link: https://training.fema.gov/is/.

The NFIP has developed a reference guide on flood-related issues for state insurance regulators and other officials. This document can be found using the following link: https://www.fema.gov/media-library-data/1525272377818-3cb0cf795a73c135c8543d2459e12c80/NFIPDeskReferencev18_508_V4.1.pdf.
Insurance contact information that a DOI should regularly collect

It is important for a DOI to maintain current insurance company contacts for insurers licensed to do business in the state, including non-admitted surplus lines insurers. Some states may maintain contact information in SBS, another database, or through a Microsoft Outlook contact list obtained by an annual request.

Partnerships with private volunteer organizations can also be useful in coordinating response after a disaster. [State Insurance Department] should identify consumer or non-profit organizations that would be open to a partnership.

Insurance company contacts:
Following a disaster, a DOI will likely need to contact insurers. The contact information should include:

- Insurers doing business in a state.
- A primary contact and a secondary contact (both would likely be a member of the insurer’s disaster response team).
- High-level senior management to respond to questions or issues promptly.

Requirements of insurance company contacts
After a disaster, state insurance regulators will need to be able to contact insurers for information. Contacts should:

- Be able to provide coverage data and loss statistics, by county or region, according to a standardized format developed by the DOI.
- Be knowledgeable regarding their internal information systems and sources and authorized to access such systems so that applicable and timely information can be provided upon the request of the DOI.
- Be able to respond to requests for information from legislators, the governor’s office, FEMA officials, or press inquiries.

Other necessary contacts
DOIs will need contacts for local, state and federal officials (these should be maintained and updated).

Contacts will report other disaster information to the DOI, including lists of company claim offices and phone numbers, adjuster information, and company toll-free numbers, etc.
Types of information that should be ready for dissemination in the event of a disaster

Following a disaster, a DOI will be responsible for helping consumers regarding claims. Some of the items a DOI will want to have on hand to provide to consumers include:

- Consumer brochures.
- Consumer alerts.
- Insurer contacts for consumers.
- Other forms of information relating to preparation and response to all types of disasters (this information should be updated prior to a disaster).

The NAIC’s Transparency and Readability of Consumer Information (C) Working Group created a document to help guide consumers through a claim following a disaster. This document can be passed out following a disaster: https://content.naic.org/sites/default/files/inline-files/Claim%20Disaster%20Guide%20-%20Generic%20FINAL%207%2023%202019.pdf.

Types of data a DOI should collect regarding disasters

A DOI should define the appropriate area in their department responsible for creating and maintaining a database that holds coverage data and loss statistics collected from insurers. If a DOI does not have the resources to maintain a database, the NAIC can provide this service.

Information to be collected (generally collected by ZIP code) includes such items as the:

- Number of claims reported
- Number of claims closed with and without payment
- Paid losses
- Incurred losses

Data collection tools the NAIC can provide

The NAIC can provide the data template adopted by the NAIC Property and Casualty (C) Committee and Executive (EX) Committee and Plenary if the DOI does not have its own data call template. This template can be found on the Catastrophe Insurance (C) Working Group’s webpage under the Related Documents tab. The link to the webpage is: https://www.naic.org/cmte_c_catastrophe.htm.

The NAIC coordinated data call

The NAIC assists states with data calls related to the collection of claims data following disasters. Data calls are typically conducted weekly immediately after a disaster and then biweekly or monthly as a higher percentage of claims close. The length of time that data is collected is usually dependent upon the severity of the event. For example, a minor hurricane, like Irma, will not necessitate weekly reporting, even in the beginning. Having the NAIC assist with a data call could require a confidentiality agreement if the state does not already have one that would encompass the data call.
Types of information a DOI, in coordination with Public Affairs, should maintain, update, post on the state’s website, and distribute via social media

- https://www.insureuonline.org/disaster_prep_wildfires.pdf
- https://www.naic.org/documents/consumer_alert_flood_insurance_understanding_risk.htm

Resources required for emergency response

The availability and capability of resources needs to be determined and includes the following:

- People
- Facilities
- Materials and supplies
- Funding
- Information regarding threats or hazards

Periodically review resources dedicated to the Disaster Response Team to make certain that there are enough cell phones, laptops, and other equipment and materials available for staff.

Disaster Recovery Team Personnel within the DOI should be identified to act as first responders if the DOI is required to respond to an emergency.

DOI employees are divided into those who will work outside of the office and those who will work at the DOI in an onsite or offsite call center.

Contact information for members of the team should be maintained.

Employees should receive periodic training and updates on procedures for assisting consumers in the event of a disaster.

The DOI shall maintain Disaster Recovery supplies and information for use by the Team.
Brief description of the Major Incident Management Functions
(See org chart template - Appendix 1)

COMMAND
Sets the incident objectives, strategies and priorities. Has overall responsibility for the incident.

OPERATIONS
Conducts operations to reach the incident objectives. Establishes tactics and directs all operational resources.

PLANNING
Supports the incident action planning process by tracking resources, collecting/analyzing information, and maintaining documentation.

LOGISTICS
Arranges for resources and needed services to support achievement of the incident objectives.

FINANCE AND ADMINISTRATION
Monitors costs related to the incident. Provides accounting, procurement, time recording and cost analysis.

Keep in mind, larger states may have more resources available than smaller states. See important note to DOIs.
Disaster Response/Incident Management Team

Response Leadership Team (Your State Emergency Management Agency would call this the Command Support Staff)

The purpose of this team is to:
- Provide direction before, during and after a disaster.
- Ensure periodic review and assessment of the State Disaster Response Plan and hold the incident management team accountable for implementation.
- Test and update the plan on a regular and consistent basis.

Location
This team is located at the [Home office] unless an alternative location is needed.

Duties:
Upon notification of a significant disaster, the commissioner, superintendent or director will notify this team to begin implementation of the Disaster Response Plan.

Identify which other disaster response units should be activated.

Members:
The response leadership team should include the following:
- Incident Commander (IC) (commissioner, director, superintendent, chief deputy or their designee).
- Public Information Officer (PIO) (the person that handles media and communication requests).
- Safety Officer (SO) (this person is the human resources (HR) chief manager).
- Finance /Administration Section Chief.
- Legal Counsel (LC).
- Emergency Operations Center (EOC) Liaison Officer (ELO) (this could be your lead consumer affairs staff member).
- Any other positions, as required, who report directly to the IC (they may have an assistant or assistants, as needed).

Incident Commander (IC) – (may be the Agency Head or their designee)
The IC is responsible for all incident action plans (IAPs) and activities to sustain critical functions and services. These tasks include:
- Developing strategies and tactics before the execution of action plans in the event of a disaster.
- Ordering and releasing resources.
- Conducting incident operations.

The IC is responsible for:
- Managing all incident operations.
- Ensuring overall incident safety.
• Assessing the situation and notifying internal teams and departments.
• Appointing others.
• Carrying out all ICS management functions until they delegate a function.
• Providing information services to internal and external stakeholders.
• Managing all operations at the disaster site.

It is possible for the IC to accomplish all management functions during the aftermath of a small event. The IC only creates the sections that are needed. If a section is not staffed, the IC will personally manage those functions.

Public Information Officer (PIO)
The PIO is responsible for interfacing with the public, industry, media, and/or other agencies with incident-related information requirements.

The PIO is responsible for:
• Drafting and issuing all public announcements.
• Making all press releases.
• Establishing an event-specific webpage (if needed).
• Sending event-specific updates out via social media and posting them online.
• Giving all interviews with the communications media relative to the incident and the Agency’s action plan to address the situation. The PIO establishes communications with PIOs in other State Agencies and the Governor’s Media Office to convey situation status, progress toward resolving the incident, and any actions needed in support of or to address the situation.

The PIO works directly with the IC and Agency Head on all sensitive communications and may seek advice and counsel from other members of the Command Support Staff on legal or personnel matters and from the Section Chiefs on background relating to the situation and the actions the Agency are taking.
Safety Officer (SO)
The SO monitors incident operations and advises the IC on all matters relating to operational safety, including the health and safety of agency personnel.

The SO is responsible for:
- Monitoring conditions and developing measures for assuring safety of personnel.
- Advising the IC about incident safety issues.
- Conducting risk analyses.
- Implementing safety measures.
- Monitoring building accessibility.
- Communicating with the IC and staff.

Legal Counsel (LC)
The LC is the member of the Incident Command Support Team who provides legal counsel to the IC.

Examples of support would include:
- Providing advice relative to Agency jurisdiction and contractual obligations.
- Completing other tasks as assigned by the IC.

The LC may also be asked to:
- Review any public statements to be issued by the PIO.
- Provide opinion and guidance on employee relations-based issues.
- Provide opinion and guidance on issues that relate to the Agency mission and the public.

Emergency Liaison Officer (ELO)
The ELO is the point of contact for representatives of other governmental agencies, nongovernmental organizations, and the private sector.

The ELO provides a liaison between the DOI and the state’s Department of Emergency Management and Homeland Security (DEMHS), especially when the DEMHS has elected to activate its EOC.

A close working relationship between the Agency and the EOC is required for timely communication and action appropriate to directives received. The ELO will represent the Agency at the EOC and establish ongoing communications and scheduled status reviews with the Agency Incident Command.
Roles and Responsibilities

Financial & Administration Section Chief

The Financial and Administration Section Chief is a member of the Incident Command General Staff. This person is also the leader of the Administration Section. In the context of the COOP, the Financial and Administration Section Chief is responsible for the internal processes within the Agency, including financial and human resource functions, which are necessary to enable the critical functions being addressed by the Operations Section.

The Administration Section Chief sustains or recovers processes to maintain the fiscal integrity of the Agency and ensure that essential human resource processes are sustained. The Administration Section Chief works closely with the Operations and Logistics Sections to identify requirements and assess available options.

The Finance/Administration Section Chief is responsible for:
- Analyzing all financial, administrative and cost aspects of an incident.
- Maintaining daily contact with agency administrative headquarters on finance and administration matters.
- Meeting with assisting and cooperating agency representatives.
- Advising the IC on financial and administrative matters.
- Developing the operating plan for the Finance/Administrative Section.
- Coordinating finances at the local level.
- Establishing or transitioning into an existing Finance/Administrative Section.
- Supervising and configuring section with units to support, as necessary.
- Negotiating and monitoring contracts.
- Timekeeping.
- Analyzing cost.
- Compensating for injury or damage to property.
- Documenting reimbursement (e.g., under mutual aid agreements and assistance agreements).

The Finance/Administration Section is set up for any incident that requires incident-specific financial management.

The Time, Compensation/Claims, Cost and Procurement Units may be established within this section.
Finance and Administration Section Team Leads

The Finance and Administration Section Team Leads should be a qualified member of the Incident Command General Staff. This person reports to the Administration Section Chief.

Finance and Administration Section Team Leads are responsible for:

- The coordination of the initial action plan execution and recovery efforts for one of the Administration Section Teams.
- Business continuity interruption preparedness.
- Response coordination.
- Post-interruption corrective action based on lessons learned for the functions that are part of the normal operational responsibilities of the work group.

In the National Incident Management System (NIMS) these Team Leads often head branches or divisions. Section Chiefs will determine the organization appropriate under respective sections.

Logistics Section Chief

This Logistics Section Chief is a member of the Incident Command General Staff and the leader of the Logistics Section.

The Logistics Section Chief is responsible for:

- Overseeing the resources and processes needed to sustain or recreate the work environment for Operations and Administration Section functions (in the context of the COOP), including facility, technology, equipment and supplies.
- Addressing plant, tool, technology and information security (including the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) requirements for the Incident Command.
- Working closely with the Operations and Administration Sections to identify requirements and assess available options.

The Logistics Section is responsible for all services and support needs, including:

- Ordering, obtaining, maintaining and accounting for essential personnel, equipment and supplies.
- Providing communication planning and resources.
- Setting up food services for responders.
- Setting up and maintaining incident facilities.
- Providing support transportation.
- Providing medical services to incident personnel.
Operations Section Chief

Typically, the Operations Section Chief is the person with the greatest tactical expertise in dealing with the problem at hand. The Operations Section Chief is a member of the Incident Command General Staff and the leader of the Operations Section. This person is responsible for the sustenance or recovery of the functions within the agency that serve the citizens of the state. The Operations Section Chief may have one or more Deputies who are qualified to fill this position.

The Operations Section Chief is responsible for:
- Directly managing all incident tactical activities.
- Implementing the IAP.
- Developing and implementing strategies and tactics to carry out the incident objectives.
- Organizing, assigning and supervising the tactical response resources.
- Having one or more Deputies who are qualified to assume these responsibilities. (This is recommended where multiple shifts are needed, as well as for succession planning).

Operation Section Team Leads

An Operation Section Team Lead is a qualified member of the Incident Command General Staff who reports to the Operation Section Chief. This individual is responsible for the coordination of the initial action plan and recovery effort of the Operation Section Teams.

Operation Section Team Leads are responsible for:
- Pre-incident preparedness.
- IAP coordination.
- Post-incident corrective action based on lessons learned for the functions that are part of the normal operational responsibilities of the work group.

Planning Section Chief

The Planning Section Chief is a member of the Incident Command General Staff and leader of the Planning Section. This individual is responsible for the development of the Business Continuity Plan and COOP document and works closely with the IC, General Staff (other Section Chiefs), and Command Support Staff to ensure that critical functions and their resource requirements are identified and that preparatory actions are taken. The Planning Section Chief ensures that communications information needed to execute the COOP has been captured.

In the continuity plan action period, the Planning Section Chief is responsible for:
- Serving as a coach to Incident Command.
- Ensuring that regular crisis action plan review sessions are held.
- Ensuring that outstanding issues are identified.
- Ensuring that appropriate alternatives are considered.
- Ensuring that action assignments are clearly distributed.
The Planning Section Chief may have one or more Deputies who are qualified to assume these responsibilities. This is recommended where multiple shifts are needed, as well as for succession planning.

The major activities of the Planning Section may include:

- Collecting, evaluating and displaying incident intelligence and information.
- Preparing and documenting IAPs.
- Tracking resources assigned to the incident.
- Maintaining incident documentation.
- Developing plans for demobilization.

Deputy

The Deputy is a fully qualified individual who, in the absence of a superior, can be delegated the authority to manage a functional operation or perform a specific task. In some cases, the Deputy acts as relief for a superior; therefore, the Deputy must be fully qualified in the position.

Deputies can be assigned to the IC, Command Support Staff, and the Section Chief positions.

Statistics Operational Network Task Group

The purpose of this group is to facilitate an analysis of a catastrophe with insurance companies and the [agency name] whenever a catastrophic event occurs.

The Statistics Operational Network Task Group will be located [insert location of home office or other designated location] unless otherwise chosen due to necessity.

The Statistics Operational Network Task Group is charged with the responsibility of creating a “contact list” of insurance community liaisons. This contact list will allow for prompt contact of people within the insurance industry who should be able to provide coverage data and loss statistics, by region, according to any standardized format developed by [agency].

The Team Lead should be knowledgeable of company internal information systems and sources authorized to access such systems so that applicable and timely information can be provided to [agency] or emergency response agencies upon request.

Members of this Task Group should include divisions that perform data collection/analysis, market conduct, and financial regulation.
**Consumer Operational Team Lead**

The Consumer Operational Team Lead works with the PIO to provide consumers with the information needed to contact their insurance companies and the fundamentals to file a claim and convey necessary information to the Emergency Response Team.

A Consumer Information Task Group will be located [insert location of home office or other designated location] unless otherwise selected by the Disaster Executive Committee due to necessity.

If a disaster is declared, a consumer hotline should be immediately activated, but consideration may be needed to relocate it. The hotline:

- Should be able to ramp up to provide a 24-hour service.¹
- Should operate utilizing four six-hour shifts.

---

*Branch offices might initially be made operational through the use of cell phones until other landlines are established.*

---

Hotline staff should:

- Have a list of 800 numbers of the major property/casualty (P/C) insurers in the state.
- Have the list of Emergency Response Task Group key personnel.
- Have other emergency agency numbers to be used in the event of a disaster.
- Be provided with a communications kit, which will be used to tell consumers about claim procedures.

Members should include:

- Consumer services unit senior management.
- Internal resource senior management.

**Communications Operations Task Group**

The purpose of this group is to work with the PIO to create a central source for media information relevant to disaster insurance and the disaster plan response activities.

This Group:

- Prepares news releases about the steps to take before, during and after a disaster.
- Produces brochures about preparedness.
- Dispatches speakers to various locations, as needed.
- Maintains contact with all media.

---

¹ It may not be necessary to operate 24 hours a day, but it is likely that the hotline may need to be open for hours longer than the agency is typically open. The agency will need to be prepared for these circumstances.
The Communications Team will be [insert location of home office or other designated location] unless otherwise chosen by the Disaster Executive Committee due to necessity.

The Communications Operations Task Group is responsible for:

- Developing a consistent message to be communicated to consumers.
- Distributing advisories and brochures to units of government throughout the state so that they may reproduce them for local residents. (The NAIC may be contacted for assistance in bulk reproduction).

The Communications Task Group should:

- Be in constant contact with the [State Emergency Management Agency’s Communications Team] to coordinate media announcements.
- Contact news organizations throughout the state with a Media Advisory.
- Notify news agencies that [agency name] is the primary source for obtaining and forwarding information relative to insurance and a disaster.
- Be in constant touch with the Emergency Response Task Group and branch offices to coordinate the information flow.

**Much of the information will be obtained from the designated liaison persons of the Emergency Response Task Group.**

**This system ensures that information being supplied to the media is consistent, accurate, and up-to-the-minute.**

The Communications Task Group is:

- Responsible for ensuring that messaging is consistent.
- Responsible for developing an Outreach Team to operate quickly and efficiently in affected areas to answer questions in town meetings and other informational gatherings.
- Responsible for supplement information provided through the media and other sources about how to quickly and effectively prepare insurance claims information.

Members include:

- Senior media or communications staff.
- Legislative personnel.
- Key agency staff with public speaking experience.
Logistics Task Group

The purpose of this Task Group is:

- To consult with other task groups regarding the DOI’s logistical and technical capabilities, and requirements, to enable the efficient execution of the DOI’s State Disaster Response Plan.
- To coordinate with the Emergency Response Task Group regarding logistical and technical capabilities for Emergency Response Task Group and/or field or temporary offices.
- To coordinate with other areas regarding logistical and technical capabilities for hotline and other consumer communication needs.

The Logistics Task Group will be [insert location of home office or other designated location] unless otherwise chosen by the Disaster Executive Committee due to necessity.

The duties of the Logistics Task Group are:

- To identify resource needs of the other task groups regarding the DOI’s logistical and technical capabilities and requirements to enable the insurance department to respond better and faster to disasters and include these in the implementation plan.
- To coordinate technical requirements for an alternate designated facility to ensure its immediate activation in case the DOI’s home or central office is damaged/destroyed in a disaster and include these in the implementation plan.

Members include:

- Senior staff from internal resource or budget.
- Senior staff from the information technology (IT) unit.
- Senior staff from any branch office locations.

Branch Office(s)

Branch offices will be responsible for addressing and solving problems where possible and overseeing operations in their responsibility area.

While the composition and basic duties will be the same as those of the Emergency Response Task Group, the branch office(s) will deal with the local problems and handle them from a closer vantage point.

Branch offices will be established at the existing location of the branch offices, unless the Emergency Response Task Group indicates a more appropriate location.

The branch office will be responsible for:

- Channeling information within the zone for which the branch office is responsible.
- Forwarding requests for speakers and press contacts to the Communications Task Group.
- Obtaining general insurance information and all written material explaining how to prepare claims from the Consumer Services Task Group.
• Routinely reporting to the Emergency Response Task Group about daily activities.
• Sending all problems that cannot be worked out locally to the Emergency Response Task Group for review.
• Obtaining DOI brochures.

Members include senior staff from branch office location(s).

Where serious disputes or problems arise, the branch office will forward these back to the Emergency Response Task Group; otherwise, the branch office will manage its own operation and report only.

It is imperative that senior staff remain at the Branch Office Operations center for command purposes.

These centers fall under the direction of the Emergency Response Task Group.
Appendix 1
Business Continuity Org Chart
Appendix 2
Response Levels and Definitions
## RESPONSE LEVELS AND DEFINITIONS

<table>
<thead>
<tr>
<th></th>
<th>Disaster Level 1</th>
<th>Disaster Level 2</th>
<th>Disaster Level 3</th>
<th>Disaster Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insured Losses</strong></td>
<td>Less than $100 Million</td>
<td>Between $100 Million and $1 Billion</td>
<td>Between $1 Billion and $10 Billion</td>
<td>Greater than $10 Billion</td>
</tr>
<tr>
<td><strong>Types of Events</strong></td>
<td>Rural Tornadoes, Rural Hailstorms, Rural Windstorms, Local Flash Floods</td>
<td>Town-leveling tornadoes, Suburban Hail and/or windstorms, Area-wide ice storms, Area-wide flash floods, Rural &amp; Residential Forest/Wildfires</td>
<td>Region-wide, Region-wide ice storms, Urban Tornadoes, Major outbreak, multiple tornadoes, Urban Floods, Urban/Suburban Fires, Significant Blizzards, Moderate earthquakes</td>
<td>Significant Earthquakes, A major New Madrid EQ, Significant record-breaking floods, Major influenza outbreak</td>
</tr>
<tr>
<td><strong>Geographical Extent</strong></td>
<td>Localized</td>
<td>Localized to disbursed</td>
<td>Localized to widespread</td>
<td>Disbursed to widespread</td>
</tr>
<tr>
<td><strong>Affected Population</strong></td>
<td>Small</td>
<td>Small to Moderate</td>
<td>Small to Large</td>
<td>Moderate to Large</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td>Hoisington, Kansas F4 Tornado (April 21, 2001) $43 Billion in Damages</td>
<td>La Plata, Maryland F4 Tornado (April 28, 2002) $100M in Damage</td>
<td>Nashville Flood (May 1, 2010) $1.5 Billion in Damages</td>
<td>Great Flood of 1993 (Missouri &amp; Mississippi Rivers) $15–20 Billion in Damages</td>
</tr>
<tr>
<td></td>
<td>Haysville/Wichita, Kansas F4 Tornado (May 3, 1999) $150 Million in Damage</td>
<td>Oakland/Berkeley Firestorm (October 19, 1991) $1.54 Billion in Damages</td>
<td>Northridge Earthquake (January 17, 1994) (Mag. 6.7 Mom. Mag.) $15 Billion in Damages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Greensburg, Kansas EF5 Tornado (May 4, 2007) $153 million in Damage (Approx. 2,000 claims)</td>
<td>Tornado Outbreak in KC, Okla. City (May 2005) F3s &amp; F4s $3.2 Billion</td>
<td>FEMA Estimate for a Mag. 7.7 Earthquake in Missouri: $30+ Billion in Damages</td>
<td></td>
</tr>
</tbody>
</table>
# DIRECTOR’S CONTACTS
## TOP 20 P/C INDUSTRY CONTACT LIST

<table>
<thead>
<tr>
<th>Carrier Name</th>
<th>Director’s Contact Name</th>
<th>Director’s Contact Title</th>
<th>Director’s Contact Address</th>
<th>Director’s Contact E-mail</th>
<th>Director’s Contact Cell Phone #</th>
<th>Director’s Contact Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

## DIRECTOR’S CONTACTS
## TOP 20 COMMERCIAL/ALLIED LINES CONTACT LIST

<table>
<thead>
<tr>
<th>Carrier Name</th>
<th>Director’s Contact Name</th>
<th>Director’s Contact Title</th>
<th>Director’s Contact Address</th>
<th>Director’s Contact E-mail</th>
<th>Director’s Contact Cell Phone #</th>
<th>Director’s Contact Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3
Sample Contact Lists
INSURANCE TRADE ASSOCIATION and KEY INDUSTRY GROUPS
CONTACT LIST

STATE INSURANCE TRADE ASSOCIATION (SITA)
Address 1
Address 2
Executive Director:
Phone:
Fax:
E-mail Address:
Internet Address:

STATE INSURANCE AGENT ASSOCIATION
Address 1
Address 2
Executive Director:
Phone:
Fax:
E-mail Address:
Internet Address:

NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES (NAMIC)
3601 Vincennes Rd
Indianapolis, IN 46268
Key Executive: Charles Chamness, CFO
Phone: 317-875-5250
Fax: 317-879-8408
E-mail Address: lforrester@namic.org or cchamness@namic.org
Internet Address: www.namic.org
INSURANCE SERVICES OFFICE (ISO)
2828 E. Trinity Mills Road, Suite 315
Carrolton, TX 75006
Assistant Regional Manager:
Phone
Fax:
E-mail Address:
Internet Address: www.iso.com

AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION (APCIA)
Address:
City, State, Zip:
Contact:
Phone:
Fax:
E-mail Address:
Internet Address:

INSURANCE INFORMATION INSTITUTE (III)
110 William Street
New York, NY 10038
Key Executive:
Phone:
Fax:
E-mail Address
Internet Address: www.iii.org
STATE INSURANCE GUARANTY ASSOCIATIONS
Address 1
Address 2
Contact:
Phone:
Fax:
E-mail Address:
Internet Address:

NATIONAL ASSOCIATION OF INSURANCE AND FINANCIAL ADVISORS (NAIFA)
Address 1
Address 2
Contact:
Phone:
Fax:
E-mail Address:
Internet Address:

NATIONAL COUNCIL ON COMPENSATION INSURANCE (NCCI)
Address 1
Address 2
Contact:
Phone:
Mobile:
Fax:
E-mail Address:
Internet Address:
STATE PROPERTY RESIDUAL MARKET OR FAIR PLAN

Address 1
Address 2
Manager:
Phone:
Fax:
E-mail Address:
Internet Address:
MEDIA CONTACTS (EXAMPLE FROM MISSOURI Department of Insurance)

<table>
<thead>
<tr>
<th>Newspapers</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Springs Examiner</td>
<td><a href="mailto:dbrendel@examiner.net">dbrendel@examiner.net</a></td>
<td>(816) 229-9161</td>
</tr>
<tr>
<td>Boonville Daily News, The</td>
<td><a href="mailto:news@boonvillenews.com">news@boonvillenews.com</a></td>
<td>(660) 882-5335</td>
</tr>
<tr>
<td>Branson Daily News, The</td>
<td><a href="mailto:bdn@tri-lakes.ent">bdn@tri-lakes.ent</a></td>
<td>(417) 334-3161</td>
</tr>
<tr>
<td>Carthage Press, The</td>
<td><a href="mailto:carpress@ipa.net">carpress@ipa.net</a></td>
<td>(417) 358-2191</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Broadcast</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Associated Press</td>
<td><a href="mailto:pstevens@ap.org">pstevens@ap.org</a></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Television Stations</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>KCTV</td>
<td><a href="mailto:kctv@kctv.com">kctv@kctv.com</a></td>
<td>913-677-5555</td>
</tr>
<tr>
<td>KETC</td>
<td><a href="mailto:letters@ketc.pbs.org">letters@ketc.pbs.org</a></td>
<td>800-729-9966</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radio Stations</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>KAAN</td>
<td><a href="mailto:rodneyh@netins.net">rodneyh@netins.net</a></td>
<td>660-425-7575</td>
</tr>
<tr>
<td>KAHR</td>
<td><a href="mailto:kool967@semo.net">kool967@semo.net</a></td>
<td>866-917-9797</td>
</tr>
<tr>
<td>KALM -</td>
<td><a href="mailto:mail@kkountry.com">mail@kkountry.com</a></td>
<td>417-264-7211</td>
</tr>
<tr>
<td>KAOL</td>
<td><a href="mailto:KMZU@carolnet.com">KMZU@carolnet.com</a></td>
<td>660-542-0404</td>
</tr>
<tr>
<td>KBDZ</td>
<td><a href="mailto:news@suntimesnews.com">news@suntimesnews.com</a></td>
<td>573-547-2980</td>
</tr>
</tbody>
</table>
Proposal from the Center for Economic Justice

To the NAIC Property Casualty (C) Committee

Revision to Financial Statements to Allow Timely Calculation of Average Premium for Private Passenger Auto and Homeowners Insurance

August 12, 2020

The measurement and reporting of average premium for private passenger auto and homeowners insurance is of great interest to consumers, policymakers and regulators. Towards this end, the NAIC publishes two reports – one for private passenger auto and one for homeowners insurance – that report these values.

The usefulness of these average premium metrics is crushed because the data are old and not timely. The auto average premiums are presented in the Auto Insurance Database report. The current database, published in January 2020, provides average auto insurance premium data through 2017 – over two years after the end of the reporting period and nearly three years after the first quarter of 2017. The homeowners average premium is reported in the “Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report,” which suffers from the same lack of timeliness. The 2017 data were published at the end of November 2019.

The lack of timeliness of the average premium values means that these data have very limited or no use for either financial or market analysis. The lack of timeliness also means that the data are no use in informing public policy debates about personal lines insurance costs. In addition, the severe time lag between actual experience and reporting fails to inform the public or policymakers of recent trends or outcomes and can, consequently, mislead the public and policymakers.

CEJ proposes modification of the state page of the annual and quarterly financial statements to add two data columns or fields – written exposures and earned exposures – for personal auto and homeowners lines of business. This simple change will enable regulators to monitor changes in average auto premium in a far-timelier manner than the current approach through the Auto Insurance Database or homeowners report.
By adding written and earned exposures to the state pages, regulators can get average premium per vehicle within 3 months after the end of the experience period. And by adding these two columns to the quarterly financial statement, regulators can get changes each quarter in average annual premium at least on a national basis. Attached is a detailed proposal for the committee to present to the Blanks Task Force. It should be noted that this additional reporting will not impose a significant burden on insurers since insurers monitor written and earned exposures and have such data readily available.

The benefits of timelier average premium data are considerable. Timely average premium data would permit financial analysts to utilize changes in average premium as part of financial analysis. Similarly, the more timely average premium data would become a valuable tool for market regulation analysts, including, but not limited to, an added data point for use the Market Conduct Annual Statement. Last, but not least, this proposal would allow the NAIC to calculate and publish average annual premium data for residential property and personal auto insurance by state in a time frame to both make the data meaningful for describing market conditions and to inform individual state regulators and policymakers of actual changes in personal lines average premiums – as opposed to expected changes gleaned from rate filings.
Draft Proposal to NAIC Blanks Working Group to
Add Exposure Data Elements to State Pages of NAIC Financial Statements

Describe Proposal

Add two columns to the property casualty annual statement state page – “Direct Exposures Written” and “Direct Exposures Earned” – to be reported, initially, only for lines 2.5 (Private Flood) 4 (Homeowners), 19.1 (PPA No Fault), 19.2 (PPA Liability) and 21.1 (PPA Physical Damage) Direct Exposures Earned would be placed between current columns 1 (Direct Premiums Written) and 2 (Direct Premiums Earned). Direct Exposures Earned would be placed between current columns 2 (Direct Premiums Earned) and 3 (Dividends Paid).

Below is an illustrative mock-up. .

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>1 Direct Premiums Written</th>
<th>2 Direct Exposures Written</th>
<th>3 Direct Premiums Earned</th>
<th>4 Direct Exposures Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fire</td>
<td>XXXXXXXXXXXX</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Allied Lines</td>
<td>XXXXXXXXXXXX</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. . .</td>
<td>XXXXXXXXXXXX</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 Private Flood</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td>XXXXXXXXXXXX</td>
<td></td>
</tr>
<tr>
<td>. . .</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td>XXXXXXXXXXXX</td>
<td></td>
</tr>
<tr>
<td>4. Homeowners Multi-Peril</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
<td>XXXXXXXXXXXX</td>
</tr>
<tr>
<td>. . .</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.1 PPA No Fault</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.2 PPA Liability</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.3 Comm Auto No Fault</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.4 Comm Auto Liability</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.1 PPA Physical Damage</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. . .</td>
<td>XXXXXXXXXXXX</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Instructions

A Written Exposure for lines 2.5 and 4 is defined as a single residential property for which coverage was written at any time during the calendar reporting period and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

A Written exposure for lines 19.1, 19.2 and 21.1 is defined as single motor vehicle for which coverage was written at any time during the calendar reporting year and remained in force through the end of the calendar reporting year. If the coverage was written and cancelled within the calendar reporting year, the written exposure is the fraction of the year the coverage was in force.

An Earned Exposure for lines 2.5 and 4 is defined as the fraction of the calendar reporting year for which a single residential property had coverage in force.

An Earned Exposure for lines 19.1, 19.2 and 21.2 is defined as the fraction of the calendar reporting year for which a single motor vehicle had coverage in force.

Examples. Assume a homeowners policy is written on July 1 during the reporting year and remains in force through the end of the reporting year. This activity would be reported as one (1.0) written exposure and 0.5 earned exposure.

Assume a private passenger policy with No-Fault, Liability and Physical Damage coverages was written on April 1 and cancelled by the insured on July 1. This activity would be reported as 0.25 written and 0.25 earned exposures.

Purpose and Benefits

The average written and average earned premium per exposure is an important metric for a variety of regulatory and public policy purposes. The NAIC annually produces reports of average personal auto and homeowners premiums, but the data in these reports are old and stale for timely assessment of absolute average premium and changes in average premium over time. Both reports are typically produced 24 months after the end of the experience period – average auto or homeowners premiums for 2017 are published at the beginning of 2020. While there are valid reasons for the length of time needed to produce these reports – primarily because these reports contain information beyond average premium – the average premium numbers lose significant relevance because of their age.

This Blanks proposal would allow the calculation of average written and average earned premium for residential property and personal auto coverages in a far more timely fashion – with three to four months following the reporting year instead of 24 months. The benefits of timelier average premium data are considerable. Timely average premium data would permit financial analysts to utilize changes in average premium as part of financial analysis. Similarly, the more-timely average premium data would become a valuable tool for market regulation analysts, including, but not limited to, an added data point for use the Market Conduct Annual Statement.
Last, but not least, this proposal would allow the NAIC to calculate and publish average annual premium data for residential property and personal auto insurance by state in a time frame to both make the data meaningful for describing market conditions and to inform individual state regulators and policymakers of actual changes in personal lines average premiums – as opposed to expected changes gleaned from rate filings.
CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

Casualty Actuarial and Statistical (C) Task Force Aug. 5, 2020, Minutes..............................................................8-147
Casualty Actuarial and Statistical (C) Task Force July 14, 2020, Minutes (Attachment One).................................8-150
COVID-19 Data Call Proposal (Attachment One-A) .........................................................................................8-152
Casualty Actuarial and Statistical (C) Task Force May 19, 2020, Minutes (Attachment Two).................................8-160
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The Casualty Actuarial and Statistical (C) Task Force met via conference call Aug. 5, 2020. The following Task Force members participated: Steve Kelley, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel J. Davis (AL); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Lynne Wehmueller (CA); Andrew N. Mais represented by George Bradner and Wanchin Chou (CT); Karima M. Woods represented by Monica Dyson (DC); David Altmaier represented by Howard Eagelfeld (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel and Andria Seip (IA); Robert H. Muriel represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers represented by Julie Lederer (MO); Chris Nicolopoulos represented by Christian Citerella (NH); Marlene Caride represented by Carl Somson and Mark McGill (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Jillian Froment represented by Tom Botsko (OH); Glenn Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl and Ying Liu (OR); Jessica K. Altman represented by Michael McKenney (PA); Raymond G. Farmer represented by Will Davis (SC); Kent Sullivan represented by Eric Hintikka (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); and Mike Kreidler represented by Eric Slavich (WA).

Also participating was: Gordon Hay (NE).

1. **Adopted its July 14, 2020; May 19, 2020; Feb. 18, 2020; Jan. 28, 2020; and 2019 Fall National Meeting Minutes**

Mr. Vigliaturo said the Task Force met July 14, May 19, Feb. 18 and Jan. 28. During these meetings, the Task Force took the following action: 1) adopted a recommendation to the Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) Task Force to defer implementation of the CAS/SOA continuing education (CE) log for 2020 and allow appointed actuaries to add a column to their existing CE log, indicating the categorization approved by the Task Force (“Appointed Actuary CE Log Categories”); 2) adopted a response on Project #2019-40 regarding Statement of Statutory Accounting Principles (SSAP) No. 53—Property Casualty Contracts—Premiums to the Statutory Accounting Principles (E) Working Group; 3) adopted a response to the Actuarial Standards Board’s (ASB’s) Request for Input on a Potential P/C Rate Filing ASOP on the Best Practices for Regulatory Review of Predictive Analytics white paper for a public comment period ending Nov. 22.

The Task Force also met June 25, May 14, April 14, and March 17 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.

The Task Force held its Predictive Analytics Book Club conference calls July 28, June 23, May 26, April 28, and Feb. 25. During its July 28 meeting, Chris Gross (Gross Consulting) presented on actuarial case reserves. During its June 23 meeting, Ron Lettofsky (Arity) presented on modeling concepts, hyperparameter tuning, and telematics. During its May 26 meeting, Mathias Millberg Lindholm (Stockholm University) presented on discrimination-free insurance pricing. During its April 28 meeting, Benjamin Williams presented on the Emblem predictive model. During its Feb. 25 meeting, Christopher Holt (self-employed) presented on Python and R.

Mr. Botsko made a motion, seconded by Mr. Chou, to adopt the Task Force’s July 14, 2020 (Attachment One), May 19, 2020 (Attachment Two), Feb. 18, 2020 (Attachment Three), Jan. 28, 2020 (Attachment Four) and Dec. 7, 2019 (see NAIC Proceedings – Summer 2020, Casualty Actuarial and Statistical (C) Task Force) minutes. The motion passed unanimously.

2. **Adopted the Report of the Actuarial Opinion (C) Working Group**

Ms. Krylova said the Working Group met June 11 to discuss exam procedures and other related issues. She said the Working Group discussed review of qualification documentation and will address any related issues in its annual Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion (Regulatory Guidance) document. She said the Working Group will be proposing changes to the Financial Condition Examiners Handbook and the Financial Analysis Handbook and discussing the risk repository later in the year.

Ms. Krylova made a motion, seconded by Mr. Botisko, to adopt the report of the Actuarial Opinion (C) Working Group, including its June 11 minutes (Attachment Five). The motion passed unanimously.
3. **Adopted the Report of the Statistical Data (C) Working Group**

Mr. Sornson said the preliminary data for the *Auto Insurance Database Report* and the *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report) should be ready for review in September.

Mr. Sornson made a motion, seconded by Mr. Piazza, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

4. **Discussed the CAS/SOA Task Force’s Appointed Actuary CE Log**

Mr. Vigliaturo said the Task Force discussed the CAS/SOA CE log for appointed actuaries. During its July 14 conference call, the Task Force adopted a recommendation to the CAS/SOA Task Force to defer the implementation of the CAS/SOA CE log for 2020 and allow appointed actuaries to add a column to their existing CE log indicating the categorization approved by the Task Force (on the adopted document titled “Appointed Actuary CE Log Categories”). He asked for the 2020 implementation plan and what steps, such as exposure, will be taken for development of the 2021 CE log for appointed actuaries.

Ann Weber (SOA) said the CAS and SOA plan to send communication in September to promote awareness of the requirement to appointed actuaries. The log will continue to be refined. She said the functionality of the log has been discussed.

Ms. Lederer requested a public exposure after the initial communication so appointed actuaries can provide comment. She asked whether anyone who attests to having met the specific qualification standards would be required to use the log even if not an appointed actuary.

Ken Williams (CAS) said anyone who might wish to be an appointed actuary for the year should use the log. Ms. Weber said anyone can use the log.

Ms. Lederer said the NAIC’s authority only applies over appointed actuaries.

Mr. Stolyarov strongly cautioned against the use of the CE log for any purpose other than evaluating the competence of appointed actuaries. He also does not want this log, if it is more likely to be audited, to deter actuaries from becoming appointed actuaries.

5. **Discussed Proposal 2019-49 (Retroactive Reinsurance Exception)**

Mr. Vigliaturo said the Statutory Accounting Principles (E) Working Group referred Project #2019-49: Retroactive Reinsurance Exception to the Task Force in January. He said this is the project initialized from a letter presented by the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries (Academy). Three volunteers are working to bring a draft proposal to the Task Force: Mr. Hay, Mr. Botsko and Ms. Fisk.

Mr. Hay said regulators met with COPLFR members to discuss the referral. He said there are risk-based capital (RBC) issues and implications, and potential changes to SSAP No. 62R—Property and Casualty Reinsurance might need to be proposed. He said the volunteer regulators will meet with the Working Group leaders to discuss the referral and related observations after the Summer National Meeting.


The *Regulatory Review of Predictive Models* white paper dated June 12 was exposed for a public comment period ending July 27 (Attachment Six). Nine comment letters were received (Attachment Seven).

Mr. Piazza suggested a drafting group review the final set of comments and propose a white paper for consideration of adoption.

Kay Noonan (NAIC) said interested parties have concerns about the scope of the white paper and its potential to alter the existing legal structure, which states follow for review of rates and rating plans. She suggested the following language to address the concerns: “As discussed further in the body of the White Paper, this document is intended as guidance for regulators as they review predictive models. Nothing in this document is intended to, or could, change the applicable legal and regulatory standards for approval of rating plans. This guidance is intended only to assist regulators as they review models to determine whether modeled rates are compliant with existing state laws and regulation. To the extent these best practices are incorporated
The Product Filing Review Handbook provides that it is intended to ‘add uniformity and consistency of regulatory processes, while maintaining the benefits of the application of unique laws and regulations that address the state-specific needs of the nation’s insurance consumers.’"

The Task Force agreed the wording reflects the Task Force’s intent and expectation that the document is only guidance.

Interested parties highlighted some of the written comments. Some Task Force members expressed the white paper is close to being finalized.

7. **Heard Reports from Professional Actuarial Organizations**

The Task Force heard reports from the Academy regarding its COPLFR and Casualty Practice Council activities; reports from the Academy, the Actuarial Board for Counseling and Discipline (ABCD) and the Actuarial Standards Board (ASB) on professionalism; and reports from the CAS and SOA on property/casualty (P/C) actuarial research (Attachment Eight).

8. **Heard a Report on a Proposed COVID-19 Data Call**

During its May 19 and July 14 calls, the Task Force discussed a potential NAIC data call on COVID-19 for multiple lines of insurance, including commercial lines and workers’ compensation. Mr. Vigliaturo said the data call differed from the Property and Casualty Insurance (C) Committee data call, which focused on the business interruption coverage. He said the Committee has started considering a second phase of COVID-19 data calls, creating potential for overlap with the Task Force’s work. He said the Task Force will no longer be working on that project but has forwarded information about its prior work to the Committee.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force met via conference call July 14, 2020. The following Task Force members participated: Steve Kelley, Chair, represented by Phil Vigliaturo and Connor Meyer (MN); James J. Donelon, Vice Chair, represented by Warren Byrd, Rich Piazza and Larry Steinitz (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis (AL); Christina Corieri represented by Vanessa Darrah, Vincent Gosz and Tom Zuppan (AZ); Ricardo Lara represented by Mitra Sanandajifar (CA); Michael Conway represented by Mitchell Bronson, Eric Unger and Sydney Sloan (CO); Andrew N. Mais represented by Susan Andrews, Wanchin Chou and Qing He (CT); Karima M. Woods represented by David Cristhifil (DC); David Altmair represented by Robert X. Lee (FL); Doug Ommer represented by Travis Grassel (IA); Robert H. Muriel represented by Reid McClintock and Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd and Heather Droge (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindsey-Myers represented by Cynthia Amann, LeAnn Cox, Kendra Fox and Julie Lederer (MO); Mike Causey represented by Arthur Schwartz (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Mark McGill (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Jillian Froment represented by Maureen Motter (OH); Glen Mulready represented by Landon Hubbart, Andrew Schallhorn and Shelly Scott (OK); Jessica K. Altman represented by Kevin Clark, James DiSanto, Michael McKenna and Bethany Sims (TX); Michael S. Piectak represented by Rosemary Raszka (VT); and Mike Kreidler represented by Eric Slavich (WA). Also participating were: Kevin Dyke (MI); Gordon Hay (NE); and Tomasz Serbinowski (UT).

1. **Adopted the Report of the Actuarial Opinion (C) Working Group**


2. **Discussed a COVID-19 Proposed Data Call**

Mr. Schwartz proposed an NAIC data call on COVID-19 for multiple lines of insurance, including commercial lines and workers’ compensation, on the Task Force’s May 19 call. Mr. Schwartz said the public and legislators would be interested in this data, and the data could be used in a lot of ways in the future. He said he would create templates for a data call. Mr. Schwartz explained his attached proposal (Attachment One-A). He said the data would allow actuaries to look at changes to frequency, severity and premium distribution by month by state and compare those to the same period a year ago. He said the Insurance Services Office (ISO) has a presentation on data aspects of COVID-19, but it did not provide actual data.

Mr. Schwartz proposed that the data call be completed immediately and quarterly thereafter. Data would need to be reviewed for reasonability, and companies may need to be contacted and questioned about their data; only aggregate data would be available publicly. Mr. Schwartz said the data would be useful to project premium taxes. He said the data would be useful to consumers, media, state insurance regulators, and legislators, and it could help the industry.

The following issues were discussed: 1) frequency can be calculated in different ways using the proposed data; 2) this data call potentially overlaps with work being done by the Property and Casualty Insurance (C) Committee and the Market Regulation and Consumer Affairs (D) Committee; 3) the proposed monthly breakdown is needed because each month is affected differently; 4) the 2019 distribution might not be a typical distribution for comparison to 2020; 5) 2020 data is also affected by non-COVID-19 factors; 6) accident year data would be better than calendar year data for this type of analysis; 7) the data call should be limited to lines of business severely affected; 8) a financial solvency data call might be more important; 9) the data call would be burdensome to the industry; 10) advisory organizations might be able to collect and share data; 11) data definitions are needed; and 12) projected values will be difficult to estimate.
Mr. McKenney said some accident year claim, loss, and exposure data for the lines of business affected would be useful. He said some companies are filing rate changes based on 2019 data with no analysis of the pandemic. Mr. Davis said a company filed for an auto insurance rate increase in Alabama. He questioned how the company would know that claim frequency will return to pre-COVID-19 levels. Mr. Steinert said a company provided a COVID-19 analysis in which there are drivers increasing costs, such as people driving faster, a low supply of auto parts, and recessionary influences.

Birny Birnbaum (Center for Economic Justice—CEJ) recommended that the Task Force review a data call proposed by the Consumer Federation of America (CFA), and the CEJ proposed a data call. He said: 1) new claims received would be a useful data element; 2) data should be granular and on a weekly basis; 3) new claims received could be compared to new claims received in months or a year prior; 4) COVID-19 is the dominant factor on changes to frequency and severity; 5) traditional data elements have problems from timing (e.g., paid claims include claims initiated in prior periods, and premium would be affected by refunds or rebates; 6) the key items are exposures in force; 7) the data call format should be one table rather than multiple Excel worksheets; and 8) the data should all be made public.

Angela Gleason (American Property Casualty Insurance Association—APCIA) said the Property and Casualty Insurance (C) Committee and the Market Regulation and Consumer Affairs (D) Committee data call has focused on business interruption, but there is consideration to expand to more lines. She said the proposal is for a lot of data, and companies are right in the middle managing the crisis. She said the data call could divert important resources from helping consumers. Peter Kochenburger (University of Connecticut School of Law) said companies are likely collecting the data for their own purposes, so there would be work to put the data in the regulatory requested format, but he said it would seem like there would not be much additional work.

Mr. Vigliaturo said the proposal appears to need to be refined. He suggested that ideas be sent to Kris DeFrain (NAIC), and some volunteers could then refine the proposal.

### 3. Discussed the Continued Competence Charge and the CAS/ SOA Task Force’s Appointed Actuary CE Log

Mr. Vigliaturo said the Task Force discussed the Casualty Actuarial Society/Society of Actuaries (CAS/ SOA) continuing education (CE) log for appointed actuaries on its May 19 call. One proposal was to consider allowing an actuary to add a column to the actuary’s own CE log rather than use the proposed template. It was noted that data compilation would not be as easy with this methodology, but actuaries have never been required to use a specific template. Some members expressed concern that the data output might not be very actionable by state insurance regulators, given the potential for actuaries to code different categories for the same presentation. Mr. Vigliaturo said he remains concerned with the timing, given that actuaries have used their own log for six months in 2020.

Ann Weber (SOA) said there is a new version of the log, and the aim is to finalize the log as soon as possible. She said both organizations need to get information out to membership soon. Ms. Lederer said even with the updated version of the log, her concerns expressed on the May 19 call still apply. She suggested that the CAS and SOA expose the log for comment from its current appointed actuaries and any actuary who might be an appointed actuary in the future. Mr. Dyke said the log is required via the Annual Statement instructions, and the form of the log was referred to the CAS/ SOA Task Force to decide. He said the categories of CE are posted on the Task Force’s website in a document titled, “Appointed Actuary CE Log Categories.”

Ms. Lederer made a motion, seconded by Mr. Davis, to recommend that the CAS/ SOA Task Force defer the implementation of the CAS/SOA CE log for 2020 and allow appointed actuaries to add a column to their existing CE log indicating the categorization approved by the Task Force (“Appointed Actuary CE Log Categories”).

### 4. Discussed Project #2019-49: Retroactive Reinsurance Exception

Mr. Vigliaturo said the Statutory Accounting Principles (E) Working Group referred Project #2019-49: Retroactive Reinsurance Exception to the Task Force. He said this is the project initialized from a letter presented by the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries (Academy). Mr. Hay said he would work with George Levine (Academy) to develop a proposal.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
### Typical distribution of direct written premium

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Line of Business
Fire
Allied lines
Multiple peril crop
Federal flood
Private crop
Private flood
Farmowners multiple peril
Homeowners multiple peril
Commercial multiple peril (non-liability portion)
Commercial multiple peril (liability portion)
Mortgage guaranty
Ocean marine
Inland marine
Financial guaranty
Medical professional liability
Earthquake
Group accident and health
Credit A&H (group and individual)
Collectively renewable A&H
Non-cancelable A&H
Guaranteed renewable A&H
Non-renewable for stated reasons only
Other accident only
Medicare Title XVIII exempt from state taxes or fees
All other A&H
Federal employees health benefits plan premium
Workers' compensation
Other liability - occurrence
Other liability - claims-made
Excess workers' compensation
Products liability
Private passenger auto no-fault (personal injury protection)
Other private passenger auto liability
Commercial auto no-fault (personal injury protection)
Other commercial auto liability
Private passenger auto physical damage
Commercial auto physical damage
Aircraft (all perils)
Fidelity
Surety
Burglary and theft
Boiler and machinery
Credit
Warranty
Aggregate write-ins for other lines of business

Grand Total for P&C Lines of Business

Title

Life
Ordinary Life (Total Life and Annuity Considerations)
Credit Life (Total Life and Annuity Considerations)
Group Life (Total Life and Annuity Considerations)
Industrial Life (Total Life and Annuity Considerations)
Group A&H
Federal Employee Health Benefit Program
Credit A&H
Collectively Renewable A&H

2019 Annual Statement Premium
Projected 2020 Annual Statement Premium
2019 Annual Statement Policyholder Dividends
2020 Annual Statement Policyholder Dividends
Policies in force as of December 31, 2019
Policies in force as of December 31, 2020

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Non-cancelable A&H
Guaranteed Renewable A&H
Non-renewable A&H
Other Accident
All Other A&H

Grand Total for L&H Lines of Business

Health
Line of Business
Individual Comprehensive
Group Comprehensive
Medicare Supplement
Vision Only
Dental Only
Federal Employees Health
Title XVIII Medicare
Title XIX Medicaid
Other

Grand Total for Health Lines of Business
### Typical distribution of direct losses paid

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**Grand Total for P&C Lines of Business**

**Title**

**Life**

- Ordinary Life (Total Life and Annuity Considerations)
- Credit Life (Total Life and Annuity Considerations)
- Group Life (Total Life and Annuity Considerations)
- Industrial Life (Total Life and Annuity Considerations)
- Group A&H
- Federal Employee Health Benefit Program
- Credit A&H
- Collectively Renewable A&H
- Non-cancelable A&H
- Guaranteed Renewable A&H
- Non-renewable A&H
- Other Accident
- All Other A&H

**Grand Total for L&H Lines of Business**

**Health**

- Line of Business
- Individual Comprehensive
- Group Comprehensive
- Medicare Supplement
- Vision Only
- Dental Only
- Federal Employees Health
- Title XVIII Medicare
- Title XIX Medicaid
- Other

**Grand Total for Health Lines of Business**

© 2020 National Association of Insurance Commissioners
### Actual distribution of direct losses paid

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### Grand Total for Life and Health Lines of Business

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### Grand Total for Health Lines of Business

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Non-renewable A&H
Other Accident
All Other A&H

Grand Total for L&H Lines of Business

Health
Line of Business
Individual Comprehensive
Group Comprehensive
Medicare Supplement
Vision Only
Dental Only
Federal Employees Health
Title XVIII Medicare
Title XIX Medicaid
Other

Grand Total for Health Lines of Business
Casualty Actuarial and Statistical (C) Task Force
Conference Call
May 19, 2020

The Casualty Actuarial and Statistical (C) Task Force met via conference call May 19, 2020. The following Task Force members participated: Steve Kelley, Chair, represented by Phil Viggliaturo and Connor Meyer (MN); James J. Donelon, Vice Chair, represented by Rich Piazza and Larry Steinert (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis and Jerry Workman (AL); Christina Corieri represented by Vanessa Darrah and Tom Zuppan (AZ); Ricardo Lara represented by Annie Chao and Lynne Wehmueller (CA); Michael Conway represented by Sydney Sloan and Eric Unger (CO); Andrew N. Mais represented by Susan Andrews, Wanchin Chou, Qing He and Doris Schirmacher (CT); Karima M. Woods represented by David Christhilf and Monica Dyson (DC); David Altmaier represented by Jie (Peggy) Cheng, Howard Eagelfeld, and Robert X. Lee (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen, Kim Cross and Andria Seip (IA); Robert H. Muriel represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers represented by LeAnn Cox and Julie Lederer (MO); Mike Causey represented by Kevin Conley and Arthur Schwartz (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Mark McGill (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Jillian Froment represented by Tom Botsko (OH); Glen Mulready represented by Cuc Nguyen and Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl and Ying Liu (OR); Jessica K. Altman represented by Kevin Clark, James DiSanto, Michael McKenney and Bojan Zorkic (PA); Raymond G. Farmer represented by Will Davis and Michael Wise (SC); Kent Sullivan represented by J’ne Byckovski, Brock Childs, Nicole Elliott, Miriam Fisk, Eric Hintikka, Brian Ryder and Bethany Sims (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); and James A. Dodrill represented by Tonya Gillespie and Juanita Wimmer (WV).

1. **Adopted the Report of the Actuarial Opinion (C) Working Group**

Ms. Krylova said the Actuarial Opinion (C) Working Group has not met recently, but it formed a drafting group to prepare a draft of potential changes to the *Financial Analysis Handbook* and the *Financial Condition Examiners Handbook*.

2. **Discussed the Regulatory Review of Predictive Models White Paper**

Mr. Piazza said the drafting group revised the *Regulatory Review of Predictive Models* white paper based on Oct. 15, 2019, comments. He said the revised paper was not exposed earlier to allow all parties to focus on the coronavirus pandemic and related work. He said the documentation is the same as used for previous exposures. An Excel file showing how submitted comments were addressed and/or reasons why no change was made; a Word files was also presented.

Mr. Piazza said some of the significant changes are: 1) the information elements were moved to an appendix and include cross-references to the best practices; 2) some items found to be outside of the Task Force’s charges that are not contributing to the purpose of the paper were moved to the “Other Consideration” section; and 3) the “Other Consideration” section was revised to be a bulleted topics list. Once changes are made to the paper to reflect the final ad hoc group call, the chair will expose the paper for a 45-day public comment period.

Birny Birnbaum (Center for Economic Justice—CEJ) asked questions regarding: 1) whether state insurance regulators use the phrase “justify rates” in reference to the state rating law that says rates shall not be excessive, inadequate or unfairly discriminatory; and 2) the meaning of the Task Force’s charge to issue guidance.

Mr. Piazza responded that the phrase “justifying rates” must be in line with all the state laws; and the Task Force’s guidance to the states is intended to help state insurance regulators review rate filings.

Mr. Birnbaum asked if generalized linear models (GLMs) are used for overall rate determination or classification rating plans.

Mr. Piazza said classification rating plans, but state insurance regulators must evaluate that the rates are in line with state law.
3. Discussed the Continued Competence Charge and the CAS/SOA Task Force’s Appointed Actuary CE Log

Mr. Vigliaturo discussed the history and timeline for the continued competence charge. He said the work started when the continued competence charge was adopted Oct. 24, 2017, by the Executive (EX) Committee. The Task Force adopted proposals made by the Casualty Actuarial Society/Society of Actuaries (CAS/ SOA) Appointed Actuary Continuing Education Task Force (CAS/SOA CE Task Force) to address the framework of and some details about the project. During its Jan. 28 conference call, the Task Force adopted a proposal to the Blanks (E) Working Group to modify 2020 annual financial statement instructions to outline the framework for this project. The Task Force’s proposal was exposed for comment to the Blanks (E) Working Group; it received some comments from the American Academy of Actuaries (Academy), and it will be considered for adoption during the Blanks (E) Working Group’s May 28 conference call. No modifications to the Task Force’s original proposal were proposed by the Working Group.

With the instructions in place, Mr. Vigliaturo said the Task Force needs to discuss the proposed CE log. He said the CAS/SOA CE Task Force exposed the CE log for comment and then made some changes to the proposed CE log based on submitted comments.

Ken Williams (CAS) said changes were made to make the log easier to use.

Ms. Lederer submitted a comment letter for the Task Force call (Attachment Two-A). She said several changes were made to align with her assessment in February, and she referred to recommendations in her letter. She would prefer to ask actuaries to add a column to the individual actuary’s own CE log. While the data compilation will not be as easy, she prefers that method rather than promulgating a template for the log. She said the data output will not be actionable by state insurance regulators.

Mr. Vigliaturo said he is concerned about whether: 1) the CE log can be ready for the 2020 log, given that half of the year is already gone; and 2) there will be meaningful results when one presentation can fit into multiple categories.

Kathleen C. Odomirok (Academy) said the information will not be valuable in the proposed format, and she suggested that the CE log be re-exposed.

Ralph S. Blanchard III (Travelers) supported Ms. Lederer’s proposal to add a CE column to an actuary’s own log.

Ms. Darby asked whether the Task Force might consider taking the current proposed log and improving it for future use.

Ms. Lederer said her preference is not to use the template; however, if the Task Force wants to use the template, then she offered suggestions in her comment letter. The Task Force will continue discussion on its next call.

4. Discussed COVID-19 Issues

Mr. Vigliaturo said there are numerous ratemaking and coverage issues arising from COVID-19. The Property and Casualty Insurance (C) Committee recently adopted a data call proposal to collect business interruption insurance data. He said many insurers have issued refunds or dividends to reflect significant changes in claims experience arising from more people self-quarantining. He asked state insurance regulators to discuss related state activities.

Mr. Stolyarov described activity in Nevada, such as the following: 1) private passenger auto insurers offered premium relief from 15% to 25% as a refund/credit/dividend; 2) some commercial auto insurers offered premium relief; 3) workers’ compensation insurers were asked to make changes in payroll calculations and re-classify employees who are being paid but not working; 4) the state requested a moratorium on adverse credit-based insurance scoring to the extent arisen from COVID-19; and 5) the states are focused on preventing inadvertent adverse impacts on future renewal business.

Mr. Citarella said some states might wish to require that credit-based scoring not be modified in the given situation for new business, in addition to renewals.

David F. Snyder (American Property Casualty Insurance Association—APCIA) said many states already have laws in place regarding exceptions for adverse actions in credit scores.
Mr. Birnbaum said those current laws are not effective because consumers do not know how to use them.

Mr. Zuppan said some states are waiving exclusions in personal lines policies for transporting goods and medicine. He said state insurance regulators will need to evaluate the ratemaking data to make sure such losses are excluded when they no longer waive such exclusions.

Ms. Darby said she is documenting what each company is doing so she can evaluate such actions in future filings.

Mr. Schwartz asked for consideration of an NAIC data call on COVID-19 for multiple lines of insurance, including commercial lines and workers’ compensation. He said the public and legislators would be interested in this data, and the data could be used in a lot of ways in the future. He considered proposing a state data call, but he believes the right action would be for the NAIC to do so. He said he expects little claim activity in business interruption insurance because of pandemic exclusions. He said he would create templates for a data call.

Mr. Schwartz said he annually compiles data to predict premium taxes by line of business. He said taxes vary by entity, and some have tax breaks. He said this year, this is a real issue with expectations that many will not be able to pay premiums. Individuals are out of jobs, and some businesses are going out of business.

Mr. Vigliaturo said the idea is interesting. He said the Task Force will need to discuss it with the Property and Casualty Insurance (C) Committee before proceeding.

J. Robert Hunter (Consumer Federation of America—CFA) presented issues documented in his May 7 joint comment letter with the CEJ (Attachment Two-B). He said auto rates are excessive, even after the insurers make premium relief payments. He said state insurance regulators should take action.

Mr. Snyder said the state insurance regulators are using a thoughtful approach under difficult circumstances. He said any solution needs to be evaluated company by company; there is no “one-size-fits-all” solution.

Mr. Birnbaum said the APCIA has mischaracterized the CFA/CEJ proposal; it is a data-driven approach and not a one-size-fits-all solution. All auto rates immediately became excessive when past claim history no longer represented the current situation. He said the state insurance regulators need data to assess what types of actions are needed.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
Good evening,

I reviewed the revised CE log (attached) in light of my 2-28-20 letter (also attached) on the previous draft. I believe there have been some significant improvement to the log, and I appreciate the effort of those working on this project. Below, I list continuing concerns, improvements from the prior draft, and additional comments.

Continuing concerns, as first noted in my comment letter dated 2-28-20:

1. Though the log has improved from the prior draft, I still believe it would be preferable to ask actuaries to add a column to their existing CE log to indicate the NAIC-sanctioned category, as opposed to promulgating a required log format.
2. The dropdown menus that don’t allow free text make the categorization columns inflexible and reduce the value of aggregated data collected from these logs.
3. I recommend that actuaries not be required to use this spreadsheet to track their CE until 2021 since we are well into 2020. (In contrast, cell C9 of the INSTRUCTIONS tab suggests that this form will be used to log CE performed in 2020.)
4. My comment on general versus specific CE has been partially addressed, since the actuary completing the log can now indicate if the session is used to meet general or specific CE. But it would be helpful if the cells in columns 13-17 were grayed or locked if the actuary selected “no” in column 12.
5. As described in my letter, both the CAS and the SOA’s CE policies recommend a “brief description” of the CE activity. There is still no column for this in the log. The actuary could describe the activity in column 18, “additional notes,” but it would be preferable to add a distinct column.
6. The form sometimes refers to CE (e.g., cell C27 of the INSTRUCTIONS tab) and sometimes CPD (e.g., cell C20 of the INSTRUCTIONS tab). I recommend using CE since that aligns with the Statement of Actuarial Opinion instructions’ reference to continuing education. Regardless, the form creators should choose one acronym and stay consistent.
7. Some minor typos remain (e.g., in cells C9, C27, A36, and A37 of the INSTRUCTIONS tab).

Positive changes from the 9-26-19 to the 5-15-20 log that reflect suggestions I made in my 2-28-20 letter:

1. The categorization of CE in the log has been simplified, with some columns collapsed.
2. The log has more mechanisms in place to reduce category-related input error (specifically, in column 15, which depends on the input in column 14).
3. The distinction between the categories in USQS section 3.1.1.2 and the NAIC categories is now clear.
4. The log now calculates the total CE credits.
   a. One issue: The log should calculate credits by attestation year in column 2, but the formula in cell H88 is just a simple sum.
b. One suggestion: As I noted in my letter, it would be helpful if the log calculated additional subtotals by attestation year: specific, organized, professionalism, and general business.

Additional comments on 5-15-20 log:

1. Column 2, “attestation year,” is new with the revised log. I recommend clarifying this column, perhaps with more wording and some examples on the INSTRUCTIONS tab. (We in Missouri experienced confusion from an appointed actuary this year in regards to the attestation year. He attested to meeting the requirements for 2019 on the CAS’s website since he did his CE in 2019, whereas he should have attested for 2020.)

2. I recommend changing the wording in the peach shaded cells in row 8 from “Only required for appointed actuaries” to something like “Only required for those certifying compliance with the CE requirements of the NAIC P/C Statement of Actuarial Opinion.” I believe anyone who self-certifies compliance for NAIC SAOs on the CAS or SOA website will be subject to audit, regardless of appointed actuary status.

3. I believe actuaries may be confused about what to put in column 3 (“continuing education description”) and column 6 (“event name”). Based on the column titles, I would put a brief description of the activity in column 3 and the title of the activity in column 6; this is not what the log’s creators intend, per the INSTRUCTIONS tab.
   a. In addition, in contrast to the red shading and the text that says “required,” column 6 is only required in a specific situation per the INSTRUCTIONS tab. So this should probably be shaded peach, with the “required” label removed.

4. Column 4 (“event type”) is a dropdown menu, and the user is not allowed to enter freeform text. But some event types mentioned in the USQS (e.g., committee work and courses) aren’t included in the menu.

5. Columns 9 and 10 need editing.
   a. First, the log is incorrect in assuming that the activity isn’t organized if it’s sponsored by one’s employer. USQS Section 2.2.7 says, “Continuing education can be obtained through either ‘organized activities’ that involve interaction with actuaries or other professionals working for different organizations or ‘other activities.’... In-house meetings can satisfy the requirement of interaction with actuaries or professionals working for different organizations by using outside speakers.”
   b. Second, it’s not correct for column 10 to default to “organized” if one selects “no” for column 9. E.g., if a CE activity is self-study, one would answer “no” to column 9 since this wasn’t a presentation by the employer, but it’s not correct for column 10 to then default to “organized.”

6. Why is there a column 16 for the “other” subcategory? Could these subcategories be added to the dependent dropdown list in column 15?

Thank you for considering these comments.

Best regards,

Julie Lederer, FCAS, MAAA
Property and Casualty Actuary
Missouri Department of Commerce and Insurance
February 28, 2020

Ann Weber
Director of Government Affairs
Society of Actuaries
Via email to: aweber@soa.org

RE: Appointed Actuary 2020 CE log

Dear Ann:

I appreciate the efforts of those who developed the exposed CE log. I used my 2019 continuing education to run a pilot test, and my comments below are based on that test. I start with general comments and then offer specific comments.

General comments:

The log may have several possible goals:

1. Assist appointed actuaries in ensuring they’ve met the CE requirements
2. Allow appointed actuaries to completely and accurately describe the CE topics they covered during the year
3. Make the review of the logs by the CAS and SOA more streamlined
4. Facilitate data compilation

It seems that the exposed log may favor goals 3 and 4 over 1 and 2.

- The categorization of CE (in columns K through R of the “2019 ATTESTATION FORM” tab) is complicated, which doesn’t further goal 1.
- In contrast to goal 2, the dropdown menus in the category columns make the form inflexible. I attended several CE opportunities in 2019 that cross multiple categories (e.g., a webinar that touched on analytics, programming, and emerging issues). The form does not allow the user to enter any free-form text in a cell with a dropdown menu, so the form doesn’t appropriately reflect the variety of topics covered in those CE opportunities.

I recommend that the CAS and SOA turn away from the idea of a standardized log and simply request that appointed actuaries add a column to their existing CE log to indicate the NAIC-sanctioned category (or categories) for the 15 hours of specific CE. This would further goals 1 and 2. It would also give appointed actuaries freedom to record CE in the format of their choosing, while providing the CAS and SOA the requested information on the categorization of specific CE. Note that, while neither the CAS CE Policy nor the USQS nor the SOA CPD Requirement mandates a particular format, each does specify the type of information that the log should contain. Appointed actuaries should, of course, continue complying with these requirements as they add a new column for the specific CE category.

It’s true that my recommendation could make it harder to achieve goal 4. But, as I noted in two 2019 comment letters and on CASTF’s 1/28/20 teleconference, I question the value of the summarized data anyway. In addition, when I was filling out the exposed log with my 2019 CE, I frequently had to make a subjective decision on which category to choose. This made me realize that the summarized data on CE categories may not be very reliable.

Furthermore, my understanding is that those who meet the specific qualification standards only have to classify their CE according to the NAIC-approved categories for the 15 hours of specific CE, not for the
entire 30 hours. This spreadsheet does not permit the user to make a clear distinction between CE used to meet the general requirement and CE used to meet the specific requirement. Asking actuaries to add a “category” column to their existing CE log would allow them to enter something like “N/A” in the column for any learning opportunities that they’re not using to fulfill the specific CE requirements.

Specific comments:

If you decide to promulgate a standardized template and go forward with the exposed log (or something similar):

1. What is the planned implementation date? I recommend that actuaries not be required to use this spreadsheet to track their CE until 2021 (for work performed in 2022) since we are well into 2020. It took me awhile to figure out the attestation form and move my CE for 2019 into the form, even though my 2019 CE was fully documented in a similar Excel spreadsheet.

2. Is the intent for appointed actuaries to use this log to record both general and specific CE? If so, as noted above, the log is not set up to smoothly accommodate general CE, but there are a few simple changes that could help: The log could have a column in which the actuary indicates whether the learning opportunity is used to meet the specific CE requirements (see the sample form in Appendix 5 of the USQS); if not, then the actuary would not need to complete the category entries in columns K through R.

3. It seems like the workbook attempts to blend the topics in USQS 3.1.1.2 with the categories approved for use by the CASTF and, in so doing, mischaracterizes the USQS.
   a. For example, the categories in columns L through P of the “2019 ATTESTATION FORM” tab are not all from section 3.1.1.2 of the USQS, despite the column headers in row 13.
      i. For example, column P is labeled “Section 3.1.1.2 Requirements & Practice Notes Categorization (Secondary).” But section 3.1.1.2 of the USQS does not mention “requirements and practice notes”; rather, this is one of the NAIC-sanctioned categories.
   b. I don’t think USQS 3.1.1.2 even needs to be referenced on this attestation form, since appointed actuaries will need to classify their specific CE according to the NAIC-sanctioned categories, not the categories in USQS 3.1.1.2. If you agree, then changes need to be made to several tabs (“INSTRUCTIONS,” “USQS Section 2.3, 3.1.1.2, 3.3,” “Topic selection flow chart,” and “2019 ATTESTATION FORM”).

4. I’m not clear on column Q (“Does this meet Section 3.3 by meeting an OTHER CPD category?”). I’m not sure why section 3.3 of the USQS is referenced here; section 3.3 says nothing about the “other” categories. Rather, the “other” category referenced is category #7 of the NAIC-sanctioned categories (per https://content.naic.org/sites/default/files/inline-files/Appointed%20Actuary%20CE%20Categories.docx). So why would this category be treated differently than the other categories in columns L through P? It seems that columns Q and R could be collapsed into one column and, if an actuary got CE in one of the “other” subcategories, he or she could mark “yes” in column K and “Other” in column L, then select the subcategory (“accounting other than statutory,” “analytics,” etc.) in the combined column Q/R.

5. As noted above, the category columns are difficult to figure out. In addition, the log has few mechanisms in place to reduce category-related input error, which further reduces the value of any summarized data gathered from these logs. This is another argument for doing away with
the category columns and allowing the actuary to simply add a category column to his or her existing CE log.

a. For instance, a user is allowed to enter “no” in column K yet still select a category from the dropdown menu in column L. Ideally, the log would make it impossible to do that, perhaps by locking column L if the user selects “no” in column K.

b. Since there’s nothing prohibiting it, I assume that some actuaries will select multiple categories in columns M through R. For example, if an actuary attends a seminar session on predictive modeling in workers’ compensation reserving, he might select “Reserves” in column “L,” “Reserving Analysis” in column O, and “Modeling” in column R. Per the “Topic selection flow chart” tab of the workbook, I understand that this is not what the log’s creators are hoping for and that a user should only enter a category in one of columns M, N, O, P, or R. Regardless, this type of (technically incorrect) log entry reflects the reality of continuing education, since most sessions touch on multiple disciplines.

c. Would it be possible to use dependent dropdown menus to make the workbook more user-friendly and reduce the risk of entry error? There could be a dropdown menu in column M that depends on the primary category the user selects in column L. For example, if the user selected “Policy form/coverage” in column L, the options in the column M dropdown menu would be “Form coverage,” etc. If the user selected “Reinsurance” in column L, the options in the column M dropdown menu would be “Reinsurance collateral,” etc. This would also have the benefit of making the form more printer-friendly by reducing the number of columns.

6. Cell C24 of the “INSTRUCTIONS” tab suggests that the minutes entered by the user will be used to calculate credit hours. I don’t see where this is done. In addition, no total is calculated on the “2019 ATTESTATION FORM” tab. It would be helpful, both for the users and the reviewers, for the form to calculate various totals:

a. Total CE credits (actuaries should earn a minimum of 30, per USQS 2.2.2). (This assumes that the log is designed to be used to track both general and specific CE.)

b. Total specific CE credits (minimum of 15, per USQS 3.3)

c. Organized specific CE credits (minimum of 6, per USQS 3.3)

d. Professionalism credits (minimum of 3, per USQS 2.2.2)

e. General business credits (maximum of 3, per USQS 2.2.9)

7. Both the SOA’s CPD Requirement (Section D.1.b.i) and the CAS CE Policy (Section A.3) say that the CE log should include “a brief description” of the CE activity. My informal conversations with members of the CAS’s Continuing Education Compliance Committee have suggested that the committee members find a brief description helpful when they’re reviewing an actuary’s CE log. (I certainly found the descriptions in my 2019 log helpful when trying to determine which category to select in the exposed log.) Should there be an additional column in the log to reflect this requirement and assist the reviewers?

8. (This is more of a question on the categories, as presented in https://content.naic.org/sites/default/files/inline-files/Appointed%20Actuary%20CE%20Categories.docx, rather than on the log itself, though it’s reflected in column R of the “2019 ATTESTATION FORM” tab.) What is the difference between “7. Other” and “OTHER CE that should be tracked (may be INSIDE or OUTSIDE the specific requirements of 3.1.1.2, U.S. Qualification Standards (ASB))”? The subcategories (e.g., analytics and modeling) are the same in both categories.
9. (This is more of a comment for the CAS and SOA's reviewers rather than a comment on the log itself, but it presented itself during my pilot test of the log.) I frequently attend CE sessions on industry trends (the status of the workers' compensation residual market, historical reserve development by line of business, trends in the commercial auto segment, etc). It seems like this type of session should be eligible for specific CE, but it wasn’t clear to me how I should categorize it. One could argue that these learning opportunities are “directly relevant to” (to use the language of USQS Section 3.3) a variety of categories: form/coverage, reserving data, reserving analysis, emerging issues, etc. I bring this up because this type of CE session is so common that I assume others besides me will face the same conundrum in determining the most appropriate category.

10. CAS members may not be familiar with the term “CPD.” It’s not used in the 2019 Property/Casualty Annual Statement Instructions or in the sample CE log in Appendix 5 of the USQS. (The term is used in the CAS CE Policy but only in reference to other organizations' CE requirements.)

11. I noted some minor typos (e.g., in cell C9 of the “INSTRUCTIONS” tab).

Thank you for allowing me to comment on the exposed log.

Sincerely,

Julie Lederer, FCAS, MAAA, CPCU
Missouri Department of Commerce and Insurance
May 7, 2020

Auto Insurance Premiums are Excessive in Your State

Dear Commissioner,

Consumer Federation of America and the Center for Economic Justice just released a major report detailing the current situation in auto insurance in America and the fact that, throughout every state in the country, consumers are still paying excessive premiums even after the recent voluntary relief granted by most auto insurance companies. The report is attached.

Our report demonstrates that motor vehicle accident data indicate that a minimum average 30% premium relief payment to policyholders to account for COVID-19 impacts is needed starting March 18, 2020 through May 2020, even after accounting for offsetting factors that raise insurer costs during this time. While many insurers should be applauded for their actions taken to date to help policyholders, most insurers’ auto insurance premium relief has not been sufficient. Additionally, future driving – miles driven and vehicles on the road – will not snap back to pre-COVID-19 levels anytime soon, if ever. Gradual relaxing of shelter-in-place restrictions, slow economic recovery, and permanent changes in work-related travel demonstrate the need for on-going auto insurance premium relief and a different regulatory approach until a new normal develops.

While we recognize the extraordinary challenges and demands faced by state Departments during this unprecedented time, in most states not enough attention has been paid to the need for further immediate and ongoing auto insurance premium relief. Perhaps not surprisingly, most regulatory systems have proven to be unprepared for the effects of this unprecedented pandemic. Nevertheless, statutory responsibilities – ensuring insurance rates are not excessive and not unfairly discriminatory and protecting consumers – requires your action to ensure fair treatment of consumers and prevention of windfall profits for insurers.

Below are several actions that your department can and should take to ensure that auto insurance premiums are not excessive or unfair today and throughout the COVID-19 pandemic:
1. Review the paybacks and credits insurers have implemented for the March to May 2020 period to assure adequate relief is being granted.

This step requires review of the current paybacks and credits both in terms of the amount of the action and in terms of the duration. As our new report shows, the most common plan implemented by insurers, 15% for April and May, is significantly inadequate relief for consumers. Relief should be at least in the 30% range and the time covered should be from mid-March until May 31, 2020.

2. Freeze auto insurance rates at the March 1, 2020 level to act as the base for future discount/credit action to keep rates from being excessive after May 31, 2020.

The rates in effect as of March 1, 2020, the “pre-pandemic rates,” will be the basis for pricing auto insurance going forward until more normal actuarial methods can be applied. Prospective ratemaking using normal actuarial methods is impossible at least during the tenure of the pandemic and its near-term effects. Using recent data for 1 to 5 years of experience is largely irrelevant to the conditions that will prevail starting June 1, 2020 and stretching out for an unknown period of at least months.

3. Implement an immediate, easy to apply, plan to determine discounts and credits to apply to premiums to be charged on and after June 1, 2020.

Departments can undertake simple data collection, such as new claims counts, to be used initially until a more sophisticated approach is developed. These data are accurate enough to produce reasonable discounts and credits to apply to the pre-pandemic rates now in effect. The method to be applied is a retrospective adjustment in the form of a return of premiums, which should be based on new claims for the month as compared to new claims from the pre-COVID-19 base premiums. For example, new claims filed in June 2020 will be used to calculate the discount for June to apply to the actual collected premiums for the month to calculate the payback. The payback of premiums thus determined will be made by no later than the end of July. This method will be applied, month by month, until data collection sufficient to implement a new approach is available.

4. Begin development of a more sophisticated approach as a glide path from the continued effects of the COVID-19 pandemic toward the day when enough data are available to allow normal actuarial techniques to be used again to produce prospective auto insurance rates.
Data collection of possible, more sophisticated retrospective adjustments, will be
developed and implemented as such data become available. Actuaries from
Departments of Insurance, the National Association of Insurance Commissioners,
consumer groups, and insurers should be called upon to propose and review ideas for
such data collection and methodology for returning excessive premiums, month by
month. Particular care must be taken here to develop methods not reliant on current
reserves, which are subjective and subject to manipulation.

5. After data including the COVID-19 era becomes available, department and other
actuaries (including the NAIC) should work together to determine if and when such
data might be useful and appropriate to use in prospective ratemaking.

This step will be tricky since the data during the pandemic will be affected by many
factors. Some reliance on pre-Covid-19 experience may be appropriate to consider.
The “new normal,” a post-COVID-19 era, will likely not resemble the pre-COVID-19
era and significant downward adjustments in miles driven are almost sure to be
ingrained in the society and must be recognized in ratemaking.

6. Return to normal prospective ratemaking once all the COVID-19 data are collected
and a determination that such ratemaking is possible and appropriate.

Thank you for your consideration, and please let us know if you have any questions.

Sincerely,

J. Robert Hunter, FCAS, MAAA
Director of Insurance
Consumer Federation of America
CFA@ConsumerFed.org
The Casualty Actuarial and Statistical (C) Task Force met via conference call Feb. 18, 2020. The following Task Force members participated: Steve Kelley, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza and Larry Steinert (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis (AL); Christina Corieri represented by Vincent Gosz (AZ); Ricardo Lara represented by Lynne Wehmueller and Mitra Sanandajifar (CA); Michael Conway represented by Mitchell Bronson, Rolf Kaumann, Sydney Sloan and Eric Unger (CO); Andrew N. Mais represented by Susan Andrews and Qing He (CT); David Altmairer represented by Howard Eagellfield (FL); Colin M. Hayashida represented by Randy Jacobsen (HI); Doug Ommen represented by Travis Grassel (IA); Robert H. Muriel represented by Reid McClintock (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers represented by Julie Lederer (MO); Alexander K. Feldvebel represented by Christian Citarella (NH); Marlene Caride represented by Mark McGill and Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Jillian Froment represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl and Ying Liu (OR); Jessica K. Altman represented by Kevin Clark and Michael McKenney (PA); Raymond G. Farmer represented by Michael Wise (SC); Kent Sullivan represented by J’ne Byckovski, Brock Childs, Miriam Fisk, Eric Hintikka, and Bethany Sims (TX); Michael S. Pieciak represented by Pat Murray (VT); Mike Kreidler represented by Eric Slavich (WA); and James A. Dodrill represented by Juanita Wimmer (WV). Also participating was: Gordon Hay (NE).

1. **Adopted the Report of the Actuarial Opinion (C) Working Group**

Ms. Krylova said the Actuarial Opinion (C) Working Group met in regulator-to-regulator session to discuss changes in the regulatory review procedures based on revisions to the qualified actuary definitions. The Working Group plans to review the financial examination and analysis handbooks and hold a monthly regulator-to-regulator call to discuss financial examination procedures and issues. Ms. Krylova made a motion, seconded by Ms. Lederer, to adopt the Working Group’s report. The motion passed unanimously.

2. **Discussed the CAS/SOA Task Force’s Appointed Actuary CE Log**

Mr. Vigliaturo said the blanks proposal to modify 2020 instructions for the Statement of Actuarial Opinion (SAO) was adopted during the Task Force’s Jan. 28 conference call.

Mr. Vigliaturo said the proposed continuing education (CE) log was received from the Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) Appointed Actuary Continuing Education Task Force. Ralph Blanchard (Travelers) said he questions what can be done with the information, and there will be discrepancies in reporting. He said one discrepancy is that the U.S. qualification standards talk about CE “relevant to” topics, and the log says CE “in” a topic. Mr. Hay said the intention seems to be for the CAS/SOA compliance groups to gather summaries from appointed actuary submissions, thereby informing the Task Force of a profile of what the appointed actuaries are reporting for CE. Ms. Lederer volunteered to beta test the electronic version of the log. Comments are due to the CAS and SOA by March 10.


On Jan. 7, Mr. Vigliaturo received a notice from Robin Marcotte (NAIC) about the Statutory Accounting Principles (E) Working Group’s creation of Project #2019-40, and he was told that the project could affect the loss ratios and information reported in Schedule P. The Working Group requested the Task Force’s opinion about the proposed change in wording.

Mr. McKenney and Mr. Citarella drafted a response to the referral. Mr. McKenney said a few insurers are reporting significant risk-related fees and other charges as “other income” rather than as premium, thereby avoiding premium tax. He said there is a very narrow exception in a Statement of Statutory Accounting Principles (SSAP) No. 53—Property Casualty Contracts—Premiums footnote stating that installment fees can be reported to other income, but some have applied that more broadly to risk-related fees and charges. The proposal is to change the footnote on SSAP No. 53 to explain that the narrow exception is meant for non-risk-related fees and expenses. Any risk-related premium would be reported as premium and not “other income.” He said there are fees related to installment fees, but they would be postage and immaterial expenses, so they did not discuss...
expenses in the footnote. Mr. Steinert asked if motor vehicle reports (MVRs) or inspections of homes would be premium or not. Mr. McKenney said the reports would be related to the transfer of risk; and to the extent that the insurer is charging for it, the charges would be reported as premium. Mr. Jacobson said those kinds of charges to insureds are considered premium in Hawaii statutes. Mr. Eagelfeld said in Florida, if the amount is required in order for the policy to be written, it is premium. He said installment fees are not; inspection fees of a third party are. Mr. McKenney said a difference is if the insured is charging for it.

Investment income being similar to the use of premium financing companies was discussed. Mr. McKenney said the letter quotes the SSAP, and the Task Force is not opining on that.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that the Task Force recommend the narrow exception be closed and installment fees be included in premium. He said installment fees are related to the cost of investment income, and that is related to the transfer of risk. He said any loopholes will be exploited. He added that managing general agent (MGA) fees are included in the transfer of risk, so the installment fees should be treated similarly. Mr. Steinert said premium is known up front; installment fees emerge through the life of the policy and could change. Mr. Birnbaum says accounting shows past experience. Mr. McKenney said the proposal is to narrow the exception; he would caution trying to close it altogether, as that could lead to some insurers not offering installment plans. He said the exception says that if a policy would be canceled for nonpayment of installment fees, then the installment fees are premium. Mr. Stolyarov said premium taxes in Nevada would be on all installment fees, but this proposal is only for accounting purposes.

Mr. Citarella made a motion, seconded by Mr. McKenney, to adopt the letter to the Statutory Accounting Principles (E) Working Group (Attachment Three-A). The motion passed unanimously.


The Statutory Accounting Principles (E) Working Group asked the Task Force to assist with Project #2019-49: Retroactive Reinsurance Exception. This is the project initialized from a letter presented by the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries (Academy). The aim is to provide more guidance to address diversity in practice regarding the accounting for retroactive reinsurance contracts which meet the exception to be accounted for prospectively. Mr. Vigliaturo asked for volunteers on this project. He said the Working Group received some comments about inconsistent and missing information included in the COPLFR letter, and it will provide answers to the Task Force before asking the Task Force to proceed.

5. Adopted a Response to the ASB’s Request for Input on a Potential P/C Rate Filing ASOP

During the Nov. 12, 2019, conference call and the 2019 Fall National Meeting, the Task Force discussed the Actuarial Standards Board’s (ASB’s) request for input on a potential property/casualty (P/C) rate filing Actuarial Standard of Practice (ASOP). During the Jan. 28 call, the Task Force discussed compiled state insurance regulators’ responses to the ASB’s questions and how to proceed. Mr. Vigliaturo said the comment deadline is Feb. 28, and he noted that individual state insurance regulators can submit comments to the ASB also.

Mr. Stolyarov said the staff-drafted letter represents state insurance regulators’ comments and views. Mr. Eagelfeld agreed and said ASOPs can and are being used as safe harbors. He said state insurance regulators should oppose such actions.

Mr. Birnbaum said the Task Force should oppose the proposed ASOP. The letter said there are divergent views, and it does not indicate that there is opposition. Providing a letter appears to provide support unless the Task Force says it is not in favor. Mr. Vigliaturo said some state insurance regulators previously said the ASOP could provide some benefit, and others opposed. He said the letter does not support the ASOP, but there is diverse opinion.

Mr. Dahl made a motion, seconded by Ms. Darby, to adopt the response to the ASB (Attachment Three-B). The motion passed unanimously.


Mr. Piazza said the drafting group has revised the Regulatory Review of Predictive Models white paper and a mapping of submitted comments to a proposed resolution. He said the plan is to submit the new draft to the Task Force in the next two weeks. He said the drafting group plans to provide a mapping of best practices and information items to put into the paper
for the Spring National Meeting. The national meeting agenda will include time for interested party comments and discussion of the paper. Mr. Piazza said he expects to recommend a short exposure period, some edits to the paper based on submitted comments, and then consideration for adoption. He said the process for adoption involves consideration by the Task Force, its parent committee, and the Executive (EX) Committee and Plenary.

7. Reported on SOA Letters About the States’ Statutes for Qualified Actuaries

Mr. Vigliaturo said some states have received letters from the SOA about the definition of qualified actuary in state law. He said it might be helpful for the Task Force to discuss the term for other actuarial job duties beyond that needed for the annual statement instructions. The annual statement instructions define a qualified actuary for appointed actuaries who issue the SAO. Mr. Vigliaturo said state law often defines qualified actuary for other actuarial roles, such as self-insured certifications and rate filings. He asked whether the Task Force would like to recommend a definition for other roles.

Ann Weber (SOA) said the tracked changes included in the SOA’s letters to Alabama, Florida, Louisiana, Maine, Maryland and South Carolina show insertion of the SOA Fellow of the Society of Actuaries (FSA) into statutes. She said that was planned to be a placeholder and not a proposal for exact wording. Proposals beyond the financial statement duties (e.g., pricing for workers’ compensation, self-insurance, and commercial auto groups) are on hold at the SOA.

Mr. Slavich said Washington is initiating rulemaking to make qualified actuary definitions more in line with the NAIC definition.

Mr. Blanchard said COPLFR discovered that self-insured workers’ compensation was not a line of business under the California insurance department, and that is similar to other states. He said the issue of the definitions is a state matter and not an NAIC matter. Mr. Vigliaturo said if the justification for the SOA to use the credential for the law is based on something the NAIC has done, it is probably appropriate for the NAIC to respond to questions about the review and whether the NAIC definition is appropriate for other uses.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

W:\National Meetings\2020\Spring\TF\CasAct\2-18 CASTF min.docx
TO: Dale Bruggeman, Chair  
Statutory Accounting Principles (E) Working Group

FROM: Phillip Vigliaturo, Chair  
Casualty Actuarial and Statistical (C) Task Force

DATE: February 18, 2020

SUBJECT: Comments on the Statutory Accounting Principles (E) Working Group Ref# 2019-40  
Exposure Draft of Footnote 1 to SSAP No. 53 - Property Casualty Contracts–Premiums

Thank you for the opportunity to comment on the Statutory Accounting Principles (E) Working Group’s (“SAPWG”) exposure draft of changes proposed to Footnote 1 of SSAP No. 53 - Property Casualty Contracts–Premiums.

As you know, the Casualty Actuarial and Statistical (C) Task Force (“CASTF”) exists under the National Association of Insurance Commissioner (NAIC) Property and Casualty Insurance (C) Committee. The Task Force’s mission is to identify, investigate and develop solutions to actuarial problems and statistical issues in the property and casualty industry. Our members include the state insurance regulators tasked with reviewing property and casualty insurance rates in accordance with state laws, actuarial principles and actuarial standards of practice. As such, we have great interest in the SAPWG’s proposed changes to Footnote 1 of SSAP No. 53 - Property Casualty Contracts–Premiums.

In considering the treatment of various types of fees and service charges for purposes of reporting them on NAIC financial statements, we are guided by the Casualty Actuarial Society’s Statement of Principles Regarding Property and Casualty Insurance Ratemaking (https://www.casact.org/professionalism/standards/princip/sppcrate.pdf). These principles are as follows:

- Principle 1: A rate is an estimate of the expected value of future costs.
- Principle 2: A rate provides for all costs associated with the transfer of risk.
- Principle 3: A rate provides for the costs associated with an individual risk transfer.
- Principle 4: A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer.

As noted in Footnote 1 of SSAP No. 53, an installment fee “has no relationship to the amount of insurance coverage provided, the period of coverage, or the lost investment income associated with receiving the premium over a period of time rather than in a lump sum” and “there is no underwriting risk” associated with an installment fee. As such, an installment fee is not related to the transfer of risk and should not be reported as premium. However, insurance companies use many other charges and fees that are related to the transfer of risk and that should be reported as premium. As actuaries, actuarial students and rate review analysts, the members of CASTF support clarification that ensures fees and charges associated with the transfer of risk are reported as premium and that fees and charges not associated with the transfer of risk will not be reported as premium. This will help ensure that actuarial analyses that make use of written and earned premium, as reported on NAIC financial statements, are consistent with the Casualty Actuarial Society’s Statement of Principles Regarding Property and Casualty Insurance Ratemaking.

For these reasons, the members of CASTF support the revisions proposed to Footnote 1 of SSAP No. 53 as detailed in SAPWG’s Ref# 2019-40.

For the same reasons, the members of CASTF would opine that, theoretically, there should be a reporting location for insurance company expenses incurred as a result of administering installment plans that is separate and distinct from underwriting and/or other expenses. However, we also understand that insurance companies are under no obligation to offer installment plans and we wouldn’t want to place additional reporting burdens on the industry that could cause some insurers to cease offering installment plans, especially when the expenses associated with their administration is of questionable materiality.

W:\National Meetings\2020\Summer\TF\CasAct\CASTF Comments to SAPWG - SSAP 53 v2020-02-07

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February 18, 2020

Property/Casualty Rate Filing ASOP
Actuarial Standards Board
1850 M Street, NW, Suite 300
Washington, DC 20036-4601

RE: ASB COMMENTS: Property/Casualty Rate Filing Request for Input

The Casualty Actuarial and Statistical (C) Task Force is responding to the Actuarial Standards Board (ASB) request for input concerning the development of an actuarial standard of practice (ASOP) on property/casualty (p/c) rate filings. As noted in the ASB request, the ASOP would be expected to provide guidance to actuaries on the actuarial aspects of the selection of final rates and p/c rate filings to state insurance departments. The potential standard would be guidance regarding the actuarial aspects of a rate filing for the filing actuary, the regulatory actuary, and the reviewing actuary.

The Task Force members have divergent views as to whether a rate filing ASOP is appropriate. While not offering a single consensus opinion, the attachment contains compiled state insurance regulators’ answers to your questions and some additional comments.

The Task Force appreciates this opportunity to provide comments to the ASB. If you have any questions about our comments, please contact Kris DeFrain, at kdefrain@naic.org.

Sincerely,

Phil Vigliaturo, ACAS, MAAA
Chair, Casualty Actuarial and Statistical (C) Task Force

Attachment
The Casualty Actuarial and Statistical (C) Task Force met via conference call Jan. 28, 2020. The following Task Force members participated: Steve Kelley, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Rich Piazza and Larry Steinert (LA); Lori K. Wing-Heier represented by Michael Ricker (AK); Jim L. Ridling represented by Daniel Davis (AL); Ricardo Lara represented by Giovanni Muzzarelli and Mitra Sanandajifar (CA); Michael Conway represented by Mitchell Bronson, Rolf Kaumann, Sydney Sloan and Eric Unger (CO); Andrew N. Mais represented by Susan Andrews, George Bradner, Wanchin Chou and Qing He (CT); Karima M. Woods represented by David Christhilf and Sharon Shipp (DC); David Altmairer represented by Howard Egelfield and Robert X. Lee (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Robert H. Muriel represented by Reid McClintock and Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd and Heather Droge (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chloë Lindley-Myers represented by Cynthia Amann, LeAnn Cox, Kendra Fox, Julie Lederer and Anthony Senevey (MO); Mike Causey represented by Richard Kohan and Arthur Schwartz (NC); Alexander K. Feldvebel represented by Christian Citarella (NH); Marlene Caride represented by Mark McGill and Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Jillian Froment represented by Tom Botsko and Laura Miller (OH); Glen Mulready represented by Ron Kreitter, Joel Sander and Andy Schallhorn (OK); Andrew R. Stolfi represented by Karl Bitzky, Will Davis and Michael Wise (SC); Kent Sullivan represented by J’ne Byckovski, Brock Childs, Miriam Fisk, Eric Hintikka, Elizabeth Howland and Brian Ryder (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); and Mike Kreidler represented by Eric Slavich (WA). Also participating was: Kevin Dyke (MI).

1. **Announced Chair and Vice Chair Appointments**

Mr. Vigliaturo announced he appointed Mr. Sornson to continue to chair the Statistical Data (C) Working Group, as well as Ms. Krylova to chair and Ms. Fisk to vice chair the Actuarial Opinion (C) Working Group.

2. **Adopted the Report of the Statistical Data (C) Working Group**

Mr. Sornson said the *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report), the *Report on Profitability by Line by State* (Profitability Report) and the *Competition Database Report* have all been released. The *Auto Insurance Database Report* was distributed to the Task Force for review. Mr. Sornson said he is working to resolve a few follow-up questions with statistical agents.

Mr. Sornson made a motion, seconded by Mr. Piazza, to adopt the Working Group’s report. The motion passed unanimously.

3. **Discussed the Regulatory Review of Predictive Models White Paper**

Mr. Piazza said the third draft of the *Regulatory Review of Predictive Models* white paper was exposed during the Task Force’s Oct. 15, 2019, conference call for a 38-day public comment period ending Nov. 22, 2019. The Task Force received 11 comment letters and offered an opportunity for an oral presentation of those comments at the 2019 Fall National Meeting. He said the drafting group is working through the comments using the same process it has for prior exposures, mapping the comments to specific sections of the paper and providing commentary as to how the comments might be addressed in the white paper. Mr. Piazza said he expects to have a revised white paper prior to the Task Force’s Feb. 18 conference call and suggested a final exposure of the paper for comments.

4. **Received Notices from the Statutory Accounting Principles (E) Working Group**

Mr. Vigliaturo said the American Academy of Actuaries (Academy) Committee on Property and Liability Financial Reporting (COPLFR) wrote a letter to the Task Force and the Statutory Accounting Principles (E) Working Group last year pointing out ambiguities in guidance for reporting portfolio retroactive reinsurance or loss portfolio transfer. COPLFR offered several suggestions for clarifying the relevant instructions. The Task Force decided the Working Group would take the lead on this project.
Mr. Vigliaturo said that on Jan. 7, the Task Force received a notice from Robin Marcotte (NAIC) regarding the Working Group’s creation of two projects (Attachment Four-A). He said he would seek a couple of volunteers to help.

Mr. Vigliaturo said the first project is called Project #2019-49: Retroactive Reinsurance Exception. This item requests comments and volunteers to address a request from COPLFR to provide more guidance to address diversity in practice regarding the accounting for retroactive reinsurance contracts that meet the exception to be accounted for prospectively.

Mr. Vigliaturo said the second project is called Project #2019-40: Reporting of Installment Fees and Expenses. This proposal could affect the loss ratios and information reported in Schedule P, so the Working Group is seeking the Task Force’s reaction to the proposed change in wording. He requested a couple of volunteers to develop a proposed response for the Task Force’s consideration. Mr. Citarella and Mr. McKenney volunteered after the conference call.

5. **Adopted the 2020 Annual Statement Instruction Changes**

Mr. Dyke said he participates on the Casualty Actuarial Society (CAS) and Society of Actuaries (SOA) Appointed Actuary Continuing Education (CE) Task Force (CAS/ SOA CE Task Force). He said the Task Force has been discussing the CAS/ SOA CE Task Force’s Appointed Actuary CE Verification Process for more than a year. At the 2019 Fall National Meeting, the Task Force exposed the revised 2020 annual statement instructions, which codify the process. He said one comment letter was received from Missouri. Ms. Lederer made suggestions via the comment letter and some additional wording changes. The Task Force discussed the proposed changes.

Ms. Lederer made a motion, seconded by Ms. Mottar, to adopt the 2020 annual statement instruction changes as revised on the conference call and refer the proposal to the Blanks (E) Working Group (Attachment Four-B). The motion passed unanimously.

Mr. Vigliaturo said the CE log proposed by the CAS and SOA was distributed. Ann Weber (SOA) requested comments from the Task Force. She said there will be a pilot test of the log. Ralph Blanchard (The Travelers Companies) requested the CAS and SOA expose the document publicly. He requested a comment period beyond March 1. Mr. Dyke said the document is not a Task Force item to adopt; the Task Force empowered the CAS and SOA to adopt a log. Kris DeFrain (NAIC) said she will post the proposed document on the Task Force’s website and direct comments to Ms. Weber.

6. **Discussed the ASB’s Request for Input on Potential P/C Rate Filing ASOP**

Mr. Vigliaturo said the Actuarial Standards Board (ASB) has requested input on a potential property/casualty (P/C) rate filing Actuarial Standard of Practice (ASOP). Numerous state insurance regulators and two interested parties submitted answers to the ASB questions and other comments to the Task Force (Attachment Four-C). Mr. Vigliaturo asked whether the Task Force wants to respond as a group or whether it wants to leave commenting to individual states. Mr. Smith suggested a compilation of comments be sent because he believes the Task Force should not be silent on the topic. Mr. Botsko said the letter should say there is diversity of opinion and that it is not an easy decision to make. Mr. Vigliaturo asked NAIC staff to draft a letter based on submitted comments, reflecting diversity of opinions, and present it during the Task Force’s Feb. 18 conference call.

7. **Reported on SOA Letters About States’ Statutes for Qualified Actuaries**

Mr. Vigliaturo said some states have received letters from the SOA about states’ statutes defining “qualified actuary.” Ms. Weber said there are some places in states’ statutes where a “qualified actuary” is defined in relation to the NAIC P/C Statements of Actuarial Opinion and other places where the definition relates to other actuarial work. She said one example is to look at different fund reserves, so the focus is broader than the NAIC project. She said the SOA recognizes states might not be able to make changes this year and that this is a long-term project. She said letters have been sent to Alabama, Florida, Louisiana, Maine and South Carolina. More states will receive letters in the future.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
From: Marcotte, Robin <RMarcotte@naic.org>
Sent: Tuesday, January 7, 2020 11:03 AM
To: Vigliaturo, Phillip <Phil.Vigliaturo@state.mn.us>; Botsko, Thomas <thomas.botsko@insurance.ohio.gov>
Cc: Gann, Julie <JGann@naic.org>; Marcotte, Robin <RMarcotte@naic.org>; Sediqzad, Fatima <fsediqzad@naic.org>; Stultz, Jake <jstultz@naic.org>; Pinegar, Jim <jpinegar@naic.org>; DeFrain, Kris <kdefrain@naic.org>; Yeung, Eva K. <EYeung@naic.org>; Barr, Jane <JBarr@naic.org>; Bruggeman, Dale <dale.bruggeman@insurance.ohio.gov>
Subject: Notice of exposure/ request for volunteers

To the chairs of the Casualty Actuarial and Statistical (C) Task Force and Property and Casualty Risk Based Capital Working Group

Attached are notices of two items that were exposed by the Statutory Accounting Principles (E) Working Group at the Fall National Meeting.

- 2019-40: Reporting of Installment Fees and Expenses  this item includes a request for comments on questions including on whether to develop guidance to allow reporting of installment fee expenses outside of underwriting expenses.
- 2019-49: Retroactive Reinsurance Exception  This item is a requests comments and volunteers to address a request from the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries Working Group to provide more guidance to address diversity in practice regarding the accounting for retroactive reinsurance contracts which meet the exception to be accounted for prospectively.

Both items have the potential to affect schedule P reporting and risk based capital calculations.

Please contact NAIC staff with any questions or volunteers!

Robin Marcotte | Senior Manager Accounting Policy | NAIC | ☎: 816 783 8124 | Fax 816 460 7571  rmarcotte@naic.org

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Kris DeFrain</th>
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<tbody>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8229</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:kdefrain@naic.org">kdefrain@naic.org</a></td>
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<tr>
<td>ON BEHALF OF:</td>
<td>Phil Vigliaturo, Chair, Casualty Actuarial and Statistical (C) Task Force</td>
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<tr>
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<td>Director, Research and Actuarial Dept.</td>
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FOR NAIC USE ONLY

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Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

The proposal will require appointed actuaries to attest to meeting Continuing Education (CE) requirements and participate in the CAS/SOA CE review procedures, if requested. These proposed changes were adopted by the Task Force on Jan. 28, 2020.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

As charged by the Property and Casualty Insurance (C) Committee to ensure continued competence of appointed actuaries, the revisions would implement the CAS and SOA P/C Appointed Actuary Continuing Education Verification Process.
Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018

** ACTUARIAL OPINION **

1. There is to be included with or attached to Page 1 of the Annual Statement the statement of the Appointed Actuary, entitled “Statement of Actuarial Opinion” (Actuarial Opinion), setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required Exhibits, shall be in the format of and contain the information required by this section of the Annual Statement Instructions – Property and Casualty.

Upon initial engagement, the Appointed Actuary must be appointed by the Board of Directors by Dec. 31 of the calendar year for which the opinion is rendered. The Company shall notify the domiciliary commissioner within five business days of the initial appointment with the following information:

a. Name and title (and, in the case of a consulting actuary, the name of the firm).

b. Manner of appointment of the Appointed Actuary (e.g., who made the appointment and when).

c. A statement that the person meets the requirements of a Qualified Actuary (or was approved by the domiciliary commissioner) and that documentation was provided to the Board of Directors.

Once this notification is furnished, no further notice is required with respect to this person unless the Board of Directors takes action to no longer appoint or retain the actuary or the actuary no longer meets the requirements of a Qualified Actuary.

If subject to the U.S. Qualification Standards, the Appointed Actuary shall annually attest to having met the continuing education requirements under Section 3 of the U.S. Qualification Standards for issuing Actuarial Opinions. As agreed with the actuarial organizations, the Casualty Actuarial Society (CAS) and Society of Actuaries (SOA) will determine the process for receiving the attestations for their respective members and make available the attestations to the public. An Appointed Actuary subject to the U.S. Qualification Standards and not a member of the CAS or SOA shall select one of the above organizations to submit their attestation.

In accordance with the CAS and SOA’s continuing education review procedures, an Appointed Actuary who is subject to the U.S. Qualification Standards and selected for review shall submit a log of their continuing education in a form determined by the CAS and SOA. The log shall include categorization of continuing education approved for use by the Casualty Actuarial and Statistical Task Force. As agreed with the actuarial organizations, the CAS and SOA will provide an annual consolidated report to the NAIC identifying the types and subject matter of continuing education being obtained by Appointed Actuaries. An Appointed Actuary subject to the U.S. Qualification Standards and not a member of the CAS or SOA shall follow the review procedures for the organization in which they submitted their attestation.
## Individual State Regulators’ Responses to the
Actuarial Standards Board’s (ASB) Request for Input on a Potential
Property/Casualty (P/C) Rate Filing Actuarial Standard of Practice (ASOP)

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<tr>
<th>State</th>
<th>1. What are the existing or current actuarial responsibilities in determining the final proposed rates?</th>
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| CA    | a. Ensuring that the final proposed rates are loss cost-based, and the rating variables themselves reflect a substantial relationship to the risk of loss.  
     b. Ensuring that the rates or rating relativities, at minimum, move directionally and substantially toward their indicated values, where those indicated values consider only the relationship between the rating variable and the risk of loss.  
     c. Under California regulation, there is no room for consideration of non-loss cost based factors such as an individual’s willingness to pay a higher premium, retention/lifetime value in the development of the expense premium, or competitive position. Exception: Competitive position may be a consideration if used for the development of a new product, or rating variable, for which the insurer has no data upon which to base its rates. |
<p>| CO    | Colorado currently reviews rate filings for validation of earned premium, losses, expenses, return on investment and underwriting profit utilized in determining the loss ratio and resultant premiums. We further perform reasonableness tests for factor and trend selections. Lastly, we review any predictive models for goodness of fit and compliance of variables as well as compliance with the rate capping bulletin B-5.32 and/or the price optimization bulletin B-5.36. This involves reviewing rating variables to ensure that they comply both in nature and application. |
| MN    | Must fit the legal standards of not excessive, inadequate or unfairly discriminatory and follow the unfair trade practices statute in our state. |
| NE    | “Actuarial responsibility” is an interesting concept. Responsibility or accountability for P&amp;L is typically delegated to an actuary only through his/her role in Line Management. Some actuaries are good candidates for Line Management, and may find actuarial skills helpful in those jobs, but only they can say whether they are still providing actuarial services to their superiors, themselves or subordinates when making (and selling) Line decisions. I would look for providers of actuarial services in Staff positions. The Line at tactical levels can be directed to implement recommendations from a staff actuary with or without exceptions, but upper Line Management can also permit or guide subordinates to entirely ignore the actuary. Actuarial recommendations or indications probably gain value when sensitive to, but independent of Line Management. Whether that works depends on culture, leadership, organization and execution. Assume that’s achieved for a moment. Who determined the final proposed rates? I say Line Management from Board of Directors. |</p>
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<th>State</th>
<th>Response</th>
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<tr>
<td>PA</td>
<td>I believe the insurance company’s management is responsible for determining the final proposed rates. Often these decisions are based on actuarial analyses, but this is not always the case. PA law, to my knowledge, does not require that an actuary be involved with the setting of final proposed rates. In fact, in my experience, many small companies do not use actuaries in many of their rate filings. When actuaries are involved, I believe ASOPs 12, 13, 23, 25, 29, 30, 38, 39, 41, 43 and 53 apply. However, they apply to the actuarial work and not to management’s decision to deviate from the actuarial analyses.</td>
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<td>WV</td>
<td>The rate analyst determines the need for an actuarial review or performs the review using the skills and knowledge they’ve received through years of training or experience as a rate analyst. The rate analyst does have the final approval/disapproval capability of a rate filing. Note: WV does not employ in-house actuaries and all actuarial reviews are performed by a contracted actuarial firm.</td>
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| CA    | a. Ensuring that the data underlying the rate or rate relativity indications is accurate, reconciles to external reports, and is internally (between exhibits in the current rate filing) and time-wise (between current and prior filings) consistent.  
b. Ensuring the data provided in support of the proposed rate or rate relativities is appropriate for the product to which the filing applies.  
c. Ensuring that appropriate actuarial assumptions (e.g., trend, development, etc.) were made to project premiums, losses and DCCE for the rate effective period, and are compliant with regulations.  
d. Ensuring appropriate use of credibility, including determining the appropriate standard for full credibility, the rule for partial credibility and the complement of credibility, in the absence of regulations that prescribe those values.  
e. Ensuring proper adherence to regulations in the development of rates, even in those cases where regulations may deviate from actuarial principles or standards of practice. |
| CO    | We do not prepare rate filings as we are regulators. |
| MN    | It seems companies try to provide as little information as what they can get away with. What makes it even more difficult for the regulator to review is the filer only files what is changed, meaning there could be quite a bit of unsupported and perhaps not up to standards parts of the rating plan that does not get reviewed. This is a problem for our department due to staffing issues. |
| NE    | I’m now a regulatory actuary, but in my early years making rate filings, the company funded no actuaries, with pride. If “actuarial” or “actuarial-looking” documents were required, I was among the non-actuaries who created them. A decade or so later, an
An actuarial unit managed by an ACAS or FCAS would routinely deliver supporting documents to a state filings counterparty, but at levels well below ACAS. So managers were both credentialed actuaries (bound by the ASOP’s) and internally accountable, but employees actually creating and delivering the filing support were un-credentialed. The ACAS or FCAS was effectively anonymous in rate filings, unless the state required a credentialed actuary’s signature, or objections (e.g. litigation) caused a credentialed actuary to be named. The insurer made rate filings, but generally didn’t have to identify an actuary or even delegate work it to an actuary.

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<th>PA</th>
<th>Same answer as #1</th>
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<td>WV</td>
<td>WV requires an actuarial certification for rate filings. All rate filings must be fully supported by actuarial data and must be adequate and fair.</td>
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3. Are there aspects of rate filings that you consider actuarial in nature? What aspects do you consider not actuarial in nature?

| CA  | a. Reconciliation of data underlying the rate filing, loss and premium trend, on-leveling of premiums, loss and DCCE development, catastrophe adjustment, modeling, credibility adjustment, expense loads, reinsurance, including any deviations (variances) to prescribed methods for handling these aspects, where applicable, are considered actuarial in nature.  
   b. To the extent that filed changes to underwriting guidelines and forms do not have an impact on rates, these changes are not actuarial in nature, but are still subject to regulatory review. |
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<tr>
<td>CO</td>
<td>We consider any rules that affect rate or premium to be actuarial in nature as well as any calculations involving rate development including trends, factors and relativities. Remaining rules and filing procedures are considered non-actuarial.</td>
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<tr>
<td>MN</td>
<td>If it is a rate filing all aspects of the filing would be actuarial in nature. However, filers often include information in the filing that are not actuarial in nature. Due to staffing issues, we have to filter which filings we review. Things like rate pages we have the non-technical staff spot check.</td>
</tr>
<tr>
<td>NE</td>
<td>Obviously, actuaries have developed widely accepted techniques to argue that proposed rates are not excessive or inadequate. Showing that proposed rates are not unfairly discriminatory is perhaps multi-disciplinary rather than actuarial, even in the absence of any public policy decisions. The legal standards that rates must meet are not inherently actuarial.</td>
</tr>
<tr>
<td>PA</td>
<td>It depends on the filing. Some filings are based on actuarial analyses. Some are not. Some include actuarial analyses and then deviate from the analyses based on non-actuarial decisions. I think it is typically pretty easy to identify the aspects of the filing that are actuarial in nature and the aspects that are not.</td>
</tr>
<tr>
<td>WV</td>
<td>The trending and justification is actuarial. Policy count, position in the market, marketing, etc. is not considered actuarial.</td>
</tr>
</tbody>
</table>

4. What aspects of a rate filing frequently cause issues during regulatory review?
|   | a. Do these issues cover actuarial content that should adhere to ASOP guidance?  
| b. If so, what makes these issues actuarial content in your opinion?  
| c. If not considered as actuarial content, why not?  
|   |   |
| CA | • There are frequently data issues, where the data underlying the rate filing exhibits doesn’t match to external reports, or to other exhibits within the rate filing.  
|   | • Filers may omit some of the required documentation, in the hope that the reviewer will not request it.  
|   | • Given that California is a prior approval state, actuarial support for all rate changes is required. Often, industry actuaries responsible for California filings bypass this step. There is often a lack of documentation and support for requested rate changes, especially at the segmentation level. When support is provided, it can be shoddily prepared or incomplete, or lack clarity as to assumptions and methods.  
|   | • When justifying numerical results, industry actuaries often fail to provide their calculations in Excel format, with working formulas.  
|   | • Industry actuaries tend to provide simplistic “vanilla” responses to regulator questions requesting clarification of insurer actions or assumptions, often resulting in the need for additional follow-up questions and further delay in the review of the filing. Example, a very common response to the Department’s request for justification of a trend period is “to ensure a balance between stability and responsiveness,” without any discussion of the drivers of the trends, mix shifts or why other allowable trend fits were not suitable.  
|   | • Many of the actuarial assumptions that insurers are allowed to use in personal lines are prescribed by California regulation. In other lines, there is considerable flexibility in how an industry actuary supports its rate action. The filer should provide more detailed actuarial documentation, not less, as is often the case, for these lines of business in support of their rate changes.  
| a. | Many of these issues are related to actuarial content and actuarial communication, and are already appropriately covered by existing ASOPs. Perhaps it’s only necessary to revise the ASOP on Actuarial Communication to include more emphasis on communications to regulators.  
| b. | These issues reflect concerns with the support, data and assumptions underlying the requested rate actions. The Department requires that sufficient information be provided to be able to understand what the insurer is doing with the rates, if it is actuarially appropriate and if it is allowed by regulation. Effective review of the rates cannot be accomplished in the absence of appropriate actuarial support and documentation of the assumptions and methods underlying the rate change analysis.  
| c. | --  
| CO | Review of rules for compliance, incomplete filing submissions, review of predictive models and rate transition plans for compliance.  

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<tbody>
<tr>
<td>a.</td>
<td>Yes, rate development is directed by guidelines for compliance and with the advent of GLM's in rating it has become increasingly difficult to determine if an insurer's rating model adheres to actuarial principles.</td>
</tr>
<tr>
<td>b.</td>
<td>Ratemaking and data use compliance are actuarial in nature.</td>
</tr>
<tr>
<td>c.</td>
<td>It would be considered filing procedures specific to State guidelines.</td>
</tr>
<tr>
<td>MN</td>
<td>Complex models including glms, capping, affinity groups, discounts, car scores telemetrics.</td>
</tr>
<tr>
<td></td>
<td>a. Some will, but some are based upon our state's interpretation of statutes and regulations.</td>
</tr>
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<td></td>
<td>b. If they are not state statute or regulation, then actuarial principals apply.</td>
</tr>
<tr>
<td></td>
<td>c. Some of the statutory provisions and rules override actuarial principles.</td>
</tr>
<tr>
<td>NE</td>
<td>Incomplete or missing explanations. Exhibits missing, poorly labeled or not self-explanatory. Non-adherence to or ignorance of published requirements. Content not organized to make completeness of the filing easy to assess. Factors must be objective rather than subjective in my state. I sometimes see loss costs adopted using some variant of the standard NAIC form, without rate adequacy support for Loss Cost Modification Factors not equal to 1.000, and/or unsupported variations in proposed LCMF's.</td>
</tr>
<tr>
<td></td>
<td>a. No.</td>
</tr>
<tr>
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<td>b/c: These issues are like a bunch of smart high school kids testing whether the teacher is reading, and being entertained when the teacher gets overwhelmed. If the delinquents are actuaries, maybe the actuarial solution would be to deprive the actuaries of the anonymity that currently renders all of the ASOP's inapplicable.</td>
</tr>
<tr>
<td>PA</td>
<td>• Erroneous data. This can take many forms, but as one example, basic ratemaking data (e.g. car-years, earned premium, incurred losses, etc.) underlying traditional actuarial analyses is often inaccurate and may not even not reconcile throughout a filing’s supporting documentation.</td>
</tr>
<tr>
<td></td>
<td>• Filings that propose rate changes but do not include any supporting documentation.</td>
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<td>• Filings that include some supporting documentation but not at the same level as the proposed changes (e.g. an overall rate level indication is provided but support for the various rating variable changes that are proposed is not provided).</td>
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<td>• Filings that propose rates which deviate from the actuarial indications without any additional information for the deviations.</td>
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<td></td>
<td>• Simple mathematical errors. In particular, the inability to correctly multiply the LCM by the loss cost.</td>
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<td>• The lack of a filing contact that can speak technically about the filing.</td>
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<td></td>
<td>• Rates and rules that do not comply with state law.</td>
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<td>• Attempts to get around actually filing the rates that will be used.</td>
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<td></td>
<td>• Insurers not responding to objection letters in a timely manner.</td>
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<tr>
<td></td>
<td>a. Some do (erroneous data, documentation of the actuarial work, actuarial communications)</td>
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<tr>
<td>State</td>
<td>Comment</td>
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<tr>
<td>b.</td>
<td>I think it is generally pretty easy to decipher when filing issues are actuarial in nature and when they are not.</td>
</tr>
<tr>
<td>c.</td>
<td>Many rate filings and much content of rate filings do not use or require any actuarial knowledge. I think it is generally pretty easy to decipher when filing issues are actuarial in nature and when they are not.</td>
</tr>
<tr>
<td>WV</td>
<td>Nearly all companies are using modeling for most actuarial data. It’s often hard to determine if data is correct as we only receive aggregate results of trending and cannot confirm each factor calculation or if the model is appropriately used. Our sole assurance that the data is accurate is the actuarial certification which is often signed by a company representative and not an actuary.</td>
</tr>
<tr>
<td></td>
<td>5. Given that many rate filings contain the results of large computer modeling, does the proposed ASOP on Modeling (<a href="http://www.actuarialstandardsboard.org/asops/modeling-fourth-exposure-draft/">http://www.actuarialstandardsboard.org/asops/modeling-fourth-exposure-draft/</a>) sufficiently address your concerns with regard to rate filings?</td>
</tr>
<tr>
<td>CA</td>
<td>The NAIC’s draft white paper on “Regulatory Review of Predictive Models” may offer more guidance in this area, at least for certain lines and types of models.</td>
</tr>
<tr>
<td>CO</td>
<td>The proposed ASOP provides sufficient guidance on review of predictive models including evaluation of the data, user input and model output.</td>
</tr>
<tr>
<td>MN</td>
<td>No. I don’t think CASTF would be writing a white paper if it did.</td>
</tr>
</tbody>
</table>
| NE | No.  
1 First, the Modeling ASOP has been in development since December 2012, so I count eight years and we’re waiting for comments on the fourth exposure draft. Meanwhile, modeling practice continues to evolve. I’d like to see an argument that says the ASOP process is keeping up.  
2 Second, ASOP guidance is binding on credentialed actuaries only. Of people involved in making and reviewing rate filings, the vast majority are not bound by the ASOP’s, and those who are bound by them can enjoy anonymity. While ASOP’s have educational value for those not bound by them, I would not assume that the non-credentialed audience will understand or respect the Modeling ASOP, or a Rate Filings ASOP, well enough for the public to benefit.  
3 Third, I have taken another look at the Modeling 4th exposure draft, and find it rather abstract and distant compared to the relatively concrete multivariate pricing problem. I see a need to update ASOP 12 (Risk Classification) adopted in 2005, which says “The actuary should consider the interdependence of risk characteristics. To the extent the actuary expects the interdependence to have a material impact on the operation of the risk classification system, the actuary should make appropriate adjustments.” The update should try to specify the changing meaning of “appropriate adjustments” after a few decades’ trend in the power of hardware platforms and statistical software. |
<p>| PA | While modeling is common, many rate filings and much content of rate filings do not use models. |
| WV | WV is continuing the review of the fourth draft. |</p>
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<thead>
<tr>
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<th>6. What actuarial aspects need further guidance to actuaries in the rate determination process beyond the guidance already contained in existing ASOPs?</th>
</tr>
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<tbody>
<tr>
<td>CA</td>
<td>None. Most actuarial topics that would be relevant to supporting the development of rates in California already have ASOPs. Additionally, ASOPs tend to be high level and general, and rate filing requirements vary by each state’s regulatory filing law, making the development of a single overriding guidance for all jurisdictions difficult.</td>
</tr>
<tr>
<td>CO</td>
<td>We do not prepare rate filings as we are regulators.</td>
</tr>
<tr>
<td>MN</td>
<td>The biggest problem from a regulator’s point of view is that the actuaries do not make the filing and as a result, much of the actuarial support does not exist in the filing. As a result, as a regulator, we have to track down the actuary (if there is one) who has provided the support. It is not always true that this person is an actuary and most state statutes do not require credentialed actuaries to produce rate filings.</td>
</tr>
<tr>
<td>NE</td>
<td>See above. I have not agreed that any aspect of determining final rates is inherently actuarial.</td>
</tr>
<tr>
<td>PA</td>
<td>Beyond that which already exists in ASOPs 12, 13, 23, 25, 29, 30, 38, 39, 41, 43 and 53, I might offer the actuary’s reliance upon third party reports could use further guidance. There seems to be a lot of uncertainty regarding the accuracy of third party reports and the amount of information they include and exclude. Is it okay for the actuary to recommend rating values for “unknown” or “report not ordered”, etc? Is it okay for these rating values to be non-unity? Can two risks of the same class and essentially the same hazard be charged different rates only because a third party had come across data for one of the risks and not the other?</td>
</tr>
<tr>
<td>WV</td>
<td>N/A</td>
</tr>
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<th>7. What actuarial aspects need further guidance to actuaries in the rate filing process beyond the guidance already contained in existing ASOPs?</th>
</tr>
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<tbody>
<tr>
<td>CA</td>
<td>In light of the fact that many industry actuaries argue actuarial concepts even when regulations clearly require different treatment in the development of rates, it may be worthwhile to shore up language in existing ASOPs to emphasize, even more than is done currently, that in the event of a conflict between regulation/statute and actuarial principle, regulation/statute take precedence.</td>
</tr>
<tr>
<td>CO</td>
<td>Evaluating the predictive model for discriminatory, duplicative or prohibited variables.</td>
</tr>
<tr>
<td>MN</td>
<td>If company actuaries (and their consultants) followed ASOP 41, then disclosure would not be an issue.</td>
</tr>
<tr>
<td>NE</td>
<td>See above. I have not agreed that any aspect of determining final rates is inherently actuarial.</td>
</tr>
<tr>
<td>PA</td>
<td>Same answer as #6</td>
</tr>
<tr>
<td>WV</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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<th>8. Is guidance to actuaries needed for all rate filings?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>All lines of insurance?</td>
</tr>
<tr>
<td>b.</td>
<td>All types of rate regulation laws (prior approval, file and use, use and file, etc.)?</td>
</tr>
<tr>
<td>State</td>
<td>Response</td>
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<tr>
<td>CA</td>
<td>In the event an ASOP is developed for rate filings...&lt;br&gt;a. Yes. There is no reason why guidance from an ASOP shouldn’t apply to all lines, if it is deemed to be necessary at all.&lt;br&gt;b. Again, while prior approval states generally have stricter regulations and prescribe the requirements with regard to rate filings, there is no reason why guidance from an ASOP shouldn’t apply to all rate regulation filing laws, if it is deemed to be necessary at all.&lt;br&gt;c. --</td>
</tr>
<tr>
<td>CO</td>
<td>Yes, guidance to actuaries is need for all rate filings in P&amp;C.&lt;br&gt;a. Within P&amp;C, yes.&lt;br&gt;b. Yes, within reason.&lt;br&gt;c. N/A</td>
</tr>
<tr>
<td>MN</td>
<td>Well it should be. This answer applies to 8a, 8b and 8c is n/a.</td>
</tr>
<tr>
<td>NE</td>
<td>Those who actually submit filings need to guide those who provide rates and/or evidence.</td>
</tr>
<tr>
<td>PA</td>
<td>I’m not sure further guidance is needed than that which already exists in ASOPs 12, 13, 23, 25, 29, 30, 38, 39, 41, 43 and 53 with the possible exception of the actuary’s reliance upon third party reports.&lt;br&gt;a. Same answer&lt;br&gt;b. Same answer. I don’t think the applicable filing review standard affects the actuarial work.&lt;br&gt;c. Same answer.</td>
</tr>
<tr>
<td>WV</td>
<td>No, often rate filings contain a single factor change that does not affect the overall rate. Those filings require very little actuarial data and no actuarial certification.&lt;br&gt;a. No, often rate filings contain a single factor change that does not affect the overall rate. Those filings require very little actuarial data and no actuarial certification.&lt;br&gt;b. No, often rate filings contain a single factor change that does not affect the overall rate. Those filings require very little actuarial data and no actuarial certification.&lt;br&gt;c. I believe it would be on a case by case basis based on various requirements noted by the State.</td>
</tr>
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9. Should the scope of this standard be confined to filings that require an actuarial certification?

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<tr>
<th>State</th>
<th>Response</th>
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<tbody>
<tr>
<td>CA</td>
<td>If an actuary, or any individual performing actuarial work, is responsible for the submission of a rate filing in a particular jurisdiction, that actuary/individual should be guided by the same ASOP, whether or not actuarial certification is required.</td>
</tr>
<tr>
<td>CO</td>
<td>No</td>
</tr>
<tr>
<td>MN</td>
<td>I see no good reason why it should be limited to just filings requiring certifications.</td>
</tr>
<tr>
<td>NE</td>
<td>No. ASOP’s should be developed for more general circumstances. Confining an ASOP’s scope this way would waste valuable volunteer hours, and if ASOP guidance happened to differ from or conflict with a state’s certification requirement would trigger a routine but gratuitous disclosure. If this became a proposed model actuarial certification requirement for P&amp;C rate filings, can the NAIC (CASTF) consider who would be an appropriate author?</td>
</tr>
<tr>
<td>PA</td>
<td>I’m not sure that this ASOP is needed, but if it is, then it should apply to the actuarial work regardless of the inclusion / exclusion of any certification.</td>
</tr>
<tr>
<td>WV</td>
<td>I believe it would be on a case by case basis but the actuarial certification should definitely require the standards be applied.</td>
</tr>
</tbody>
</table>

### Information about position and role in the rate filing process

| CA | These comments are being submitted by regulatory actuaries who work in the Rate Regulation Branch of the California Department of Insurance: Lynne Wehmueller, FCAS, MAAA
Chief Actuary – Rate Regulation Branch
California Department of Insurance

Mitra Sanandajifar, FCAS, MAAA
Senior Casualty Actuary – Rate Regulation Branch
California Department of Insurance

Edward Cimini, ACAS, MAAA
Senior Casualty Actuary – Rate Regulation Branch
California Department of Insurance

Our role as regulatory actuaries is to review rate filings on behalf of the California Insurance Department. |
| CO | I am a regulator
Review rate filings on behalf of insurance department(s) |
| MN | A regulator
Review rate filings on behalf of insurance department(s) |
| NE | I am currently a regulatory actuary, and a member of the Casualty Committee of the Actuarial Standards Board.
I review rate filings on behalf of the Nebraska insurance department, but only those referred on an exception basis for actuarial review.

My resume’ shows several decades experience beginning as an agent, then personal lines underwriter, and state filings analyst in a corporate legal context. My first actuarial job was in an IT context, where I spent a decade designing, implementing and refining automated actuarial systems including rate level indications, rating factors experience, trend data and analyses, loss development data and reserving analyses. The rate level indications, including selected trends and LDF’s, wer available for decision support “on the shelf” throughout the company, and routinely used
I spent another two decades in actuarial pricing management for personal and commercial lines. From about 1990 to 2011, as rating system development became increasingly GLM-dependent, I had various combinations of hands-on versus oversight involvement, with each project concluding with documentation, explanation, internal selling and finally rate filing deliverables. Since 2011, as the Property & Casualty Actuary at the Nebraska Department, my primary responsibilities are in the Examination Division. When the Property & Casualty Division occasionally refers rate filings to me, the typical reason is either the rating system’s dependency on a complex model, or a market segments perceived trend into rate inadequacy.

PA  --

WV  A regulator (non-actuary)
Review rate filings on behalf of insurance department(s)

Additional Comments

NV  I write these comments to express categorical opposition to the development of any Actuarial Standard of Practice (ASOP) on Property/Casualty (P/C) insurance rate filings, for the following reasons. I will be happy to discuss my reasons for opposition further during subsequent conference calls of the Casualty Actuarial and Statistical Task Force (CASTF) and in any other contexts that may be considered beneficial. However, in prior conversations with other States’ regulatory actuaries, it has become apparent to me that significant differences of opinion exist on this subject, and thus a single combined comment from the CASTF to the American Academy of Actuaries’ Actuarial Standards Board (ASB) would not be practical or reflective of the broad spectrum of regulatory actuaries’ views and preferences. Accordingly, I am of the view that comments submitted to the ASB on this subject should be sent by individual regulatory actuaries on their own behalf.

The views expressed herein are my own and not necessarily a reflection of the views of any organization in which I am a member or participant.

1. Requirements for rate filings are prescribed pursuant to State law, and an ASOP would not add any rigor those requirements or ensure any beneficial outcomes that State requirements do not already produce. Indeed, State law and regulatory guidance takes precedence over ASOPs, as the text of many ASOPs already acknowledges.

2. However, an ASOP may serve to dilute the efficacy of State-based insurance regulation by reducing the diversity of State-specific requirements – some of which facilitate cutting-edge awareness of insurers’ predictive models and other filing innovations and the evaluation of the consumer impacts of such proposals – to the lowest common denominator. ASOPs are by nature broad and general and could not be a substitute for the detailed set of filing-related statutes, regulations, guidelines, and precedents that individual States have developed. Especially in prior-approval
jurisdictions, it would be difficult to imagine an ASOP adding any useful aspects that
the State had not already considered, but it would be easy to imagine a filer referring
to the ASOP as perceived justification for creating a filing that falls significantly short
of State-specific requirements.

3. Indeed, as has been observed with other ASOPs related to elements of ratemaking
and risk classification in the past, some insurers and insurer-aligned interested parties
are likely to use the new ASOP as an attempted shield from regulatory scrutiny,
alleging that because certain regulatory inquiries or principles of filing review are not
found in the ASOP, they are therefore illegitimate for the regulator to delve into. This
has been particularly observed with a prevalent industry remark that because ASOP
No. 12 on Risk Classification does not require causation to be demonstrated,
therefore, regulators should not consider questions of causation at all. Many
regulatory actuaries have justifiably pushed back against this interpretation, but a
Rate-Filing ASOP would create many more openings for certain interested parties to
seek to challenge regulatory inquiries instead of appropriately responding to them.
These kinds of challenges often will not prevail, but they could bog down the
conversation on emerging rating treatments in unnecessary retreading of the same
generic territory for many years – time which could have been better spent examining
the substance of specific rating treatments, models, variables, and supporting data.

4. Currently there is no legal requirement, at least in the majority of jurisdictions, for a
credentialed actuary to be involved either in the development of a P/C rate filing or in
its review. Having actuaries involved in both roles is, of course, a benefit given the
extensive additional technical knowledge and subject-specific expertise that actuaries
bring (albeit, not a benefit that is practically achievable in every rate-filing situation).
A Rate-Filing ASOP would bind the actuaries but not the non-actuaries involved in
filing creation and review. This would have an undesirable and unintended effect on
the incentives of the principals on both sides of the process. If it is more burdensome
to utilize the actuaries in rate filings (because they personally would have to comply
with an additional set of requirements to which non-actuaries are not bound), then
why not (per the logic that would tempt such principals) opt to develop and process
the filings using non-actuaries only, especially if this is permitted by law? It is
important to keep in mind that the principals on each side of the rate-filing
interaction are concerned about their own objectives and requirements being met
(the insurer’s business goals and speed to market in a jurisdiction and the regulator’s
responsibility to protect consumers and enforce the law, as well as a desire for
efficiency in processing an often-considerable filing workload) – and would view the
superimposition of another set of requirements by a third interest (that of the
promulgators of the ASOP) as an inconvenience and a complicating factor. The
promulgators of the ASOP are presumably motivated by a desire to strengthen the
actuarial profession, yet the Rate-Filing ASOP would have the opposite effect in
practice by discouraging the utilization of credentialed actuaries in rate-filing
contexts. For the prospects of the members of the actuarial profession to be advanced, it needs to be as easy as possible for both insurers and regulatory agencies to utilize actuaries in developing, reviewing, and corresponding on rate filings.

5. Because the Rate-Filing ASOP, at least per the wording of the ASB’s exposure document, would appear to encompass the roles of “the regulatory actuary” and “the reviewing actuary”, and because the American Academy of Actuaries is composed predominantly of actuaries practicing within the private sector and employed by regulated entities, a serious concern arises that the creation of a Rate-Filing ASOP would invert the regulator-industry relationship, and would effectively create a situation wherein industry members would be “regulating the regulators” – a scenario that could even be termed regulatory capture. This concern could be averted if the proposed ASOP clearly expresses that it only applies to those actuaries submitting the rate filings, not those actuaries who review the filings on behalf of State regulatory agencies. Those who review rate filings should only be bound by the requirements of applicable law and the policies, procedures, precedents, and deliberations of the regulatory agencies whom they represent. All of these aforementioned requirements were developed with the interests of consumers and the general public in mind, whereas there is no guarantee that an ASOP developed predominantly by private-sector actuaries – even persons of the highest integrity – would have this as its primary motivation. Even exceptional good character and good motives on the part of industry decision-makers cannot be a justification for a situation where they come to “regulate the regulators” – for this would be inconsistent with the very reasons for the existence of insurance regulation in the first place.

6. Especially if the Rate-Filing ASOP binds regulatory actuaries, this leaves an opening for a filing company’s actuaries to allege violations of the ASOP on the part of a regulatory actuary who attempts to inquire regarding certain matters within the filing where there is a disagreement between the company and the regulators regarding the appropriateness of certain treatments. It is important to prevent any situation where filers may be able to utilize this kind of tactic to thwart regulatory reviewers from performing their jobs. Currently, more so than in any prior era, it is imperative for regulators to thoroughly review emerging predictive models and ask new and different types of questions to ensure that long-standing objectives of transparency and fair treatment of consumers are maintained. Hence it is vital to preserve an environment in which questioning of new filing methodologies and new types of rating classifications – an activity to which regulatory actuaries are uniquely suited – does not carry with it the potential for personal adverse consequences.

7. Especially given the NAIC’s ongoing efforts to express regulatory predictive-model-review best practices / guidance – as exemplified by the white paper in progress regarding the Regulatory Review of Predictive Models – the proposal for a Rate-Filing ASOP appears to be duplicative and to create parallel and potentially conflicting standards with those expressed in the NAIC guidance. The NAIC guidance explicitly
recognizes the sovereignty of individual States and the ability of individual States to
tailor the NAIC guidance to their own unique contexts. The Rate-Filing ASOP, on the
other hand, is vulnerable to becoming a one-size-fits-all approach. Furthermore, the
simultaneous existence of the NAIC white-paper guidance and the Rate-Filing ASOP
could engender confusion among both filers and regulators.

8. The entire project for a Rate-Filing ASOP appears to expand the domain of ASOPs
beyond the context in which they are useful or beneficial. It is reasonable to have
ASOPs that articulate guidelines for behavior in areas where only private parties are
involved, or areas where the law is straightforward and highly consistent across States
(as is the case, for instance, with regard to annual Statements of Actuarial Opinion
pertaining to loss and loss-adjustment-expense reserves carried on insurers’ NAIC P/C
Annual Statements). However, in areas where the requirements of law and the
guidance of regulators are both highly varied and highly detailed, an ASOP drafted
predominantly by private parties can only undermine the objectives of the regulatory
process. I fully support the concept of a self-regulating actuarial profession – but that
self-regulation must always subordinate itself to the official regulation that States
perform in the course of reviewing and making decisions on insurers’ P/C rate filings.
Where the official regulation has clearly expressed itself, the self-regulation needs to
take a step back and let the regulators regulate as they know best.

9. Existing ASOPs already address such areas relevant to ratemaking as risk
classification (ASOP No. 12), trending (ASOP No. 13), credibility (ASOP No. 25) expense
provisions in ratemaking (ASOP No. 29), profit and contingency provisions and cost of
capital (ASOP No. 30), catastrophe losses (ASOP No. 39) – as well as other areas that
would be applicable in a ratemaking context. I do not see any reason that insurers’
actuaries would need any additional ASOP-style guidance for rate filings in particular
that would not be encompassed by the guidance in the aforementioned concept-
specific ASOPs. Both insurers and regulators who wish to draw upon ASOPs for any
portion of their work product or the justification thereof already have an ample and
extensively developed set of provisions to reference.

For the aforementioned reasons, I recommend that individual regulatory actuaries
oppose the establishment of any manner of ASOP specific to P/C Rate Filings. Again, it
is my view that CASTF as a whole would not be able to express a unified view on this
proposal because of the considerable difference in individual members’ views. I do,
however, respect these differences – an expression of the desirable variety inherent
in State-based insurance regulation – and am open to discussing this topic further
with any CASTF members who express an interest in doing so.

Mr. Gennady Stolyarov II, FSA, ACAS, MAAA, CPCU, ARe, ARC, API, AIS, AIE, AIAF
Lead Actuary, Property and Casualty Insurance, Nevada Division of Insurance

| NE | Those in favor of a P&C Rate Filings ASOP should make their case. |
• If most people involved in rate filings will not be bound by the proposed ASOP (or perhaps more importantly ASOP #41), and if those who are bound by the ASOP’s can choose anonymity, how does the proposed Rate Filings ASOP help? In particular, to attract participation by regulatory actuaries, how should regulators expect to benefit from the proposed Rate Filings ASOP?

• Some have suggested starting with ASOP #8, which addresses Health Rate Filings. After appropriate edits, the P&C guidance appears to depend on references to ASOP #53 on “Estimated Future Costs” adopted in 2018 and ASOP’s 12, 13, 25, 29, 30, 38 and 39 adopted earlier. Is there anything in the Health Rate Filings ASOP that’s applicable to P&C filings but not already adopted for P&C actuaries’ work?

• I have studied the previously accumulated comments, but briefly, instead of reasons in favor I saw assertions regarding scope. Those in favor of a P&C Rate Filings ASOP need to describe the problem(s) they’re perceiving and explain how their envisioned ASOP would help. Unless compelling reasons surface in favor, the ASB should focus elsewhere.

Background (legal context for an actuarial role)

• An assertion that filed rates (or loss costs) are neither excessive nor inadequate can be efficiently supported by actuarial evidence that has evolved into familiar exhibits, ranging in sophistication from a one-page experience exhibit to a rate level indication summary supported by detailed ancillary exhibits and rigorous explanatory narrative. Rate advisory organizations, insurers, state regulators, actuaries and sometimes consumer advocates have given this much attention. For brevity, the current technical regulatory requirements often reflect a hard-won working balance between interested parties, with actuaries facilitating much of the long transition from trial and error toward more of a science that can be memorialized. A series of ASOP’s document evidentiary practices that previously evolved and stabilized among actuaries, regulators and others (e.g. insurers’ managements and occasionally litigators) over decades.

• Evidence for an assertion that filed rates (or loss costs) are not unfairly discriminatory is a more complex problem, with subjective aspects well known long before recent decades’ technological developments. Market leading insurers historically adhered fairly closely to rate advisory organizations’ coverage forms and loss cost relativities. Innovation has accelerated following various tipping points, including a proliferation of increasingly powerful personal computers, internet connectivity, affordable multi-source datasets and easily-accessible software. It is a matter of decades since insurers writing standard or specialty coverages began using statistical models to create increasingly complex independent rating plans for competitive advantage and/or defense. Advisory organization aggregations of competitors’ statistical data are much further removed from final prices for a viable competitor than
the days when advisory organizations filed final rates. Now, insurers commonly develop and implement independent and specialized classification systems for their most populated personal and commercial coverages, and they commonly assert trade secrets deserving of confidentiality for their supporting evidence. So evidence sufficient to justify classification systems and pricing relationships within them is stubbornly unsettled territory. States’ allocated resources seem to vary a lot, but my general impression is that increasingly granular classification systems have progressed far ahead of regulators’ capacity for review and response. Efforts are in their infancy to balance products’ speed-to-market versus consumer protection and market stability. A consensus definition of “not unfairly discriminatory” would be helpful, but we’ve often diverged. A main reason is that statistical evidence alone isn’t probative. Meanwhile, products and rates evolve, and generally, insurance markets function despite lack of agreement.

- All this evidence supporting assertions that rates meet legal standards can come from any source, not necessarily actuarial or a credentialed actuary. A credentialed actuary’s certification or testimony is sometimes legally required, but generally the whole product development cycle can at least theoretically exist without actuaries. Even if we think actuaries or their subordinates should be involved, or know for a fact that they are, it is arguably not in the rate filer’s interest to identify one or more of their most recruitable employees in a public record. The regulatory focus should be on the evidence provided and whether it is sufficient.
The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met via conference call June 11, 2020. The following Working Group members participated: Anna Krylova, Chair (NM); Miriam Fisk, Vice Chair (TX); Susan Andrews and Qing He (CT); David Christhilf (DC); Patrick Hyde, Chantel Long and Judy Mottar (IL); Tom Botsko (OH); Nicolas Lopez (OK); and Kevin Clark and James DiSanto (PA). Also participating were: Michael Ricker (AK); Robert Lee (FL); and Cynthia Amann and Julie Lederer (MO).

1. Discussed the Risk Repository


Miguel Romero (NAIC) described the Technical Group’s processes and reasoning. He said the Technical Group’s membership is mostly accounting types, but they did have some actuaries under contract at the time. The tendency was to only make changes that would affect the character, nature or procedure performed. They did not add anything to the benefit of external auditors because it is believed that the relationship is the external auditors are input into the examination process and not the other way around. He said the document would be exposed for public comment in August or later. He said if there are any proposed changes that the Working Group believes might have been misunderstood, comments are requested.

Ms. Fisk suggested that the Working Group work from a clean version because all the different tracked changes are confusing. The Working Group decided to discuss this again when the Technical Group exposes its proposed document.

Ms. Lederer said she does not have a good feel for the goal of the Technical Group. She said harmonization of the property/casualty (P/C), life and health repositories would have an impact on the acceptance of some of the proposed changes. She said the change in the definition of “qualified actuary” might be an issue to propose again. She said the Working Group can explain why that is needed.

Ms. Lederer said the new risk proposal around P/C long-duration contracts might be helpful to the examiner; therefore, further explanation might be useful. She said some of the new risks proposed could use further commentary to aid examiner understanding of why the new risks were proposed.


Ms. Krylova said volunteers from the Working Group prepared a first draft of a proposal. She said changes focus on the revisions made to the actuarial opinion instructions.

Mr. Lee said an associate of the Casualty Actuarial Society (CAS) would be required to have the advanced reserving exam, and all would be required to have the U.S. statutory examination.

Ms. Krylova said the first mention matches the exhibit in the actuarial opinion, and the wording was modified later on the same page. She said she attempted to not rewrite the instructions and rather just refer to the instructions.

Ms. Lederer said the analysis document is the Statement of Actuarial Opinion (SAO) worksheet. The qualification matches Exhibit B. Now that the definition has been expanded, analysts or actuaries need to use the qualification documentation to evaluate qualification. In Missouri, the qualification documentation would be requested in three situations: 1) there is a new appointed actuary; 2) the company is going under examination; and 3) state insurance regulators have concerns. In review of the qualification documentation, Ms. Lederer made sure that the documentation matches the instructions defining “qualified actuary.”
Ms. Krylova said if the states do not have an actuary, the *Financial Analysis Handbook* might need instructions on how to assist such review.

Mr. Botsko said the actuaries in Ohio do something similar to Missouri, where background information and attestation are gathered to show that the actuary is qualified. He said Ohio has an automated system that fills out the checklist from downloaded documents.

Ms. Andrews said the *Financial Analysis Handbook* needs a paragraph for the states that do not have actuaries.

Ms. Krylova asked members to submit suggestions with expectations to expose the document for comment soon thereafter.

No one suggested changes to the proposal for the *Financial Condition Examiners Handbook*.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.
EXPOSURE NOTE: The drafting group considered comments submitted based on the 10/15/19 draft. Please submit comments on this 6/12/20 draft to Kris DeFrain (kdefrain@naic.org) by Monday, July 27. The plan is to adopt a white paper at the Summer National Meeting, so proposed edits (rather than general comments) are more likely to be considered.

Casualty Actuarial and Statistical (C) Task Force

Regulatory Review of Predictive Models

White Paper

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I. INTRODUCTION

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

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

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

- Draft and propose changes to the Product Filing Review Handbook to include best practices for review of predictive models and analytics filed by insurers to justify rates.
- Draft and propose state guidance (e.g., information, data) for rate filings based on complex predictive models.

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

II. WHAT IS A “BEST PRACTICE?”

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

Key Regulatory Principles

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

1. State insurance regulators will maintain their current rate regulatory authority and autonomy.
2. State insurance regulators will be able to share information to aid companies in getting insurance products to market more quickly across the states.
3. State insurance regulators will share expertise and discuss technical issues regarding predictive models to make the review process in any state more effective and efficient.

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1 In this paper, references to “model” or “predictive model” are the same as “complex predictive model” unless qualified.
4. State insurance regulators will maintain confidentiality, in accordance with state law, regarding predictive models.

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

III. SOME ISSUES IN REVIEWING TODAY’S PREDICTIVE MODELS

The term “predictive model” refers to a set of models that use statistics to predict outcomes4. When applied to insurance, the model is chosen to estimate the probability or expected value of an outcome given a set amount of input data; for example, models can predict the frequency of loss, the severity of loss, or the pure premium. The generalized linear model5 is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan.

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

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

Today, the majority of predictive models used in personal automobile and home insurance rating plans are GLMs.6 According to many in the insurance industry, GLMs introduce significant improvements over univariate-based rating plans by automatically adjusting for correlations among input variables. However, it is not always easy to understand the complex predictive model output’s relationship to cost. This creates a problem for the regulator when model results are difficult to explain to someone with little to no expertise in modeling techniques, e.g., a consumer.

Generalized Linear Models

A GLM consists of three elements7:

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

As can be seen in the description of the three GLM components above, it may take more than a casual introduction to statistics to comprehend the construction of a GLM. As stated earlier, a downside to GLMs is that it is more challenging to interpret the GLMs output than with univariate models.

To further complicate regulatory review of models in the future, modeling methods are evolving rapidly and not limited just to GLMs. As computing power grows exponentially, it is opening up the modeling world to more sophisticated forms of data acquisition and data analysis. Insurance actuaries and data scientists seek increased predictiveness by using even more complex predictive modeling methods. Examples of these methods are predictive models utilizing random forests, decision trees, neural networks, or combinations of available modeling methods (often referred to as ensembles). These

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5 The generalized linear model (GLM) is a flexible family of models that are unified under a single method. Types of GLM include logistic regression, Poisson regression, gamma regression and multinomial regression.
7 Information on model elements can be found in most statistics’ books.
Evolving techniques will make the regulators’ understanding and oversight of filed rating plans incorporating predictive models even more challenging.

In addition to the growing complexity of predictive models, many state insurance departments do not have in-house actuarial support or have limited resources to contract out for support when reviewing rate filings that include use of predictive models. The Big Data (EX) Working Group identified the need to provide states with guidance and assistance when reviewing predictive models underlying filed rating plans. The Working Group circulated a proposal addressing aid to state insurance regulators in the review of predictive models as used in personal automobile and home insurance rate filings. This proposal was circulated to all of the Working Group members and interested parties on December 19, 2017, for a public comment period ending January 12, 2018. The Big Data Working Group effort resulted in the new CASTF charges (see the Introduction section) with identifying best practices that provide guidance to states in the review of predictive models.

Credibility of GLM Output

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

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

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

It might be better to revise the question “Do regulators need best practices to review predictive models?” to “Are best practices in the review of predictive models of value to regulators and insurance companies?” The answer is “yes” to both questions. Regulatory best practices need to be developed that do not unfairly or inordinately create barriers for insurers and ultimately consumers while providing a baseline of analysis for regulators to review the referenced filings. Best practices will aid regulatory reviewers by raising their level of model understanding. Also, with regard to scorecard models and the model algorithm, there is often not sufficient support for relative weight, parameter values, or scores of each variable. Best practices can potentially aid in addressing this problem.

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

- Best practices provide guidance to regulators in their essential and authoritative role over the rating plans in their state.

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9 All comments received by the end of January were posted to the NAIC website March 12 for review.
10 Sometimes insurers do review complements of credibility and further weight the GLM output with those complements. While this may not be a standard practice today, new techniques could result in this becoming more standard in the future.
11 GLMs provide confidence intervals, credibility methods do not. There are techniques such as penalized regression that blend credibility with a GLM and improve a model’s ability to generalize.”
• All states may have a need to review predictive models whether that occurs with approval of rating plans or in a market conduct exam. Best practices help the regulator identify elements of a model that may influence the regulatory review as to whether modeled rates are appropriately justified, compliant with state laws and regulations, and whether to act on that information.

• Best practices provide a framework for states to share knowledge and resources to facilitate the technical review of predictive models.

• Best practices can lead to improved quality in predictive model reviews across states, aiding speed to market and competitiveness of the state marketplace.

• Best practices aid training of new regulators and/or regulators new to reviewing predictive models. (This is especially useful for those regulators who do not actively participate in NAIC discussions related to the subject of predictive models.)

• Each regulator adopting best practices will be better able to identify the resources needed to assist their state in the review of predictive models.

V. SCOPE

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

VI. CONFIDENTIALITY

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

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

VII. BEST PRACTICES FOR REGULATORY REVIEW OF PREDICTIVE MODELS

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

1. Ensure that the selected rating factors, based on the model or other analysis, produce rates that are not excessive, inadequate, or unfairly discriminatory.

See Appendix B.
a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.

b. Determine that individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.

c. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.

d. Review the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as associated selected relativities, to ensure they are compatible with practices allowed in the state and do not reflect prohibited characteristics.

2. Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output.

a. Obtain a clear understanding of how the selected predictive model was built.

b. Determine that the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values and outliers are handled.

c. Determine that any adjustments to the raw data are handled appropriately, including but not limited to, trending, development, capping and removal of catastrophes.

d. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is periodically refreshed, so model output reflects changes to non-static risk characteristics.

3. Evaluate how the model interacts with and improves the rating plan.

a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models).

b. Obtain a clear understanding how the insurer integrates the model into the rating plan and how it improves the rating plan.

c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.

4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.

a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided models are in compliance with state laws, particularly prohibitions on unfair discrimination.

b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.

c. Review predictive models in a timely manner to enable reasonable speed to market.
VIII. PROPOSED CHANGES TO THE PRODUCT FILING REVIEW HANDBOOK

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

CHAPTER THREE
The Basics of Property and Casualty Rate Regulation

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

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

Interaction between Rating Variables (Multivariate Analysis)

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

Approval of Classification Systems

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

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

Rating Tiers – (No change is proposed.)

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

Predictive Modeling

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

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

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

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

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

Generalized Linear Models

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

What is a “Best Practice”? A best practice is a form of program evaluation in public policy. At its most basic level, a practice is a “tangible and visible behavior… [based on] an idea about how the actions…will solve a problem or achieve a goal”¹⁴. Best practices can maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking.¹⁵ Therefore, a best practice represents an effective method of problem solving. The "problem" regulators want to solve is probably better posed as seeking an answer to this question: How can regulators determine that predictive models, as used in rate filings, are compliant with state laws and regulations? However, best practices are not intended to create standards for filings that include predictive models.

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

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

Best Practices for the Regulatory Review of Predictive Models

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

1. Ensure that the selected rating factors, based on the model or other analysis, produce rates that are not excessive, inadequate, or unfairly discriminatory.
   a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.

¹³ Refer to Appendix B in the NAIC’s white paper titled Regulatory Review of Predictive Models found at the NAIC website.
b. Determine that individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.

c. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.

d. Review the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as associated selected relativities, to ensure they are compatible with practices allowed in the state and do not reflect prohibited characteristics.

2. Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output.

a. Obtain a clear understanding of how the selected predictive model was built.

b. Determine that the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values and outliers are handled.

c. Determine that any adjustments to the raw data are handled appropriately, including but not limited to, trending, development, capping and removal of catastrophes.

d. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is periodically refreshed, so model output reflects changes to non-static risk characteristics.

3. Evaluate how the model interacts with and improves the rating plan.

a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models).

b. Obtain a clear understanding how the insurer integrates the model into the rating plan and how it improves the rating plan.

c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.

4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.

a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided models are in compliance with state laws, particularly prohibitions on unfair discrimination.

b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.

c. Review predictive models in a timely manner to enable reasonable speed to market.

Confidentiality

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

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

Advisory Organizations – (No change is proposed.)

Workers’ Compensation Special Rules – (No change is proposed.)

Premium Selection Decisions – (No change is proposed.)

Installment Plans – (No change is proposed.)

Policy Fees – (No change is proposed.)

Potential Questions to Ask Oneself as a Regulator – (No change is proposed.)

Questions to Ask a Company
If you remain unsatisfied that the company has satisfactorily justified the rate change, then consider asking additional questions of the company. Questions should be asked of the company when they have not satisfied statutory or regulatory requirements in the state or when any current justification is inadequate and could have an impact on the rate change approval or the amount of the approval.

If there are additional items of concern, the company can be notified so they will make appropriate modifications in future filings.

The CASTF white paper, *Regulatory Review of Predictive Models*, documents questions that a regulator may want to ask when reviewing a model. These questions are listed as “information elements” in Appendix B of the paper. Note that although Appendix B focuses on GLMs for personal automobile and home insurance, many of the “information elements” and concepts they represent may be transferable to other types of models, other lines of business, and other applications beyond rating.

**Additional Ratemaking Information**

The Casualty Actuarial Society (CAS) and the Society of Actuaries (SOA) have extensive examination syllabi that contain a significant amount of ratemaking information, on both the basic topics covered in this chapter and on advanced ratemaking topics. The CAS and SOA websites contain links to many of the papers included in the syllabi. Recommended reading is the *Foundations of Casualty Actuarial Science*, which contains chapters on ratemaking, risk classification, and individual risk rating.

**Other Reading**

Some additional background reading is recommended:

  - Chapter 1: Introduction
  - Chapter 3: Ratemaking
  - Chapter 6: Risk Classification
  - Chapter 9: Investment Issues in Property-Liability Insurance
  - Chapter 10: Only the section on Regulating an Insurance Company, pp. 777–787
- Casualty Actuarial Society (CAS) Statements of Principles, especially regarding property and casualty ratemaking.
- Association of Insurance Compliance Professionals: “Ratemaking—What the State Filer Needs to Know.”
- Review of filings and approval of insurance company rates.
- NAIC Casualty Actuarial and Statistical (C) Task Force’s white paper: “Regulatory Review of Predictive Models.”

**Summary**

Rate regulation for property/casualty lines of business requires significant knowledge of state rating laws, rating standards, actuarial science, statistical modeling and many data concepts.

- Rating laws vary by state, but the rating laws are usually grouped into prior approval, file and use or use and file (competitive), no file (open competition), and flex rating.
- Rate standards typically included in the state rating laws require that “Rates shall not be inadequate, excessive, or unfairly discriminatory.”
- A company will likely determine their indicated rate change by starting with historical years of underwriting data (earned premiums, incurred loss and loss adjustment expenses, general expenses) and adjusting that data to reflect the anticipated ultimate level of costs for the future time period covered by the policies. Numerous adjustments are made to the data. Common premium adjustments are on-level premium, audit, and trend. Common loss adjustments are trend, loss development, Catastrophe/large loss provisions, and an adjusting and other (A&O) loss adjustment expense provision. A profit/contingency provision is also calculated to determine the indicated rate change.
- Once an overall rate level is determined, the rate change gets allocated to the classifications and other rating factors.
Individual risk rating allows manual rates to be modified by an individual policyholder’s own experience.

Advisory organizations provide the underlying loss costs for companies to be able to add their own expenses and profit provisions (with loss cost multipliers) to calculate their insurance rates.

Casualty Actuarial Society’s Statement of Principles Regarding Property and Casualty Insurance Ratemaking provides guidance and guidelines for the numerous actuarial decisions and standards employed during the development of rates.

NAIC model laws also include special provisions for workers’ compensation business, penalties for not complying with laws, and competitive market analysis to determine whether rates should be subject to prior approval provisions.

Best practices for reviewing predictive models are provided in the CASTF white paper titled Regulatory Review of Predictive Models. The best practices and many of the information elements and underlying concepts may be transferrable to other types of models, other lines of insurance, and applications beyond rating.

While this chapter provides an overview of the rate determination/actuarial process and regulatory review, state statutory or administrative rule may require the examiner to adopt different standards or guidelines than the ones described.

No additional changes are proposed to the Product Filing Review Handbook.

IX. PROPOSED STATE GUIDANCE

This paper acknowledges that different states will apply the guidance within the paper differently, based on variations in the legal environment pertaining to insurance regulation in those states, as well as the extent of available resources, including staff members with actuarial and/or statistical expertise, the workloads of those staff members, and the time that can be reasonably allocated to predictive-model reviews. States with prior-approval authority over personal-lines rate filings often already require answers in connection with many of the information elements expressed in this paper. However, states – including those with and without prior-approval authority – may also use the guidance in this paper to choose which model elements to focus on in their reviews and/or to train new reviewers, as well as to gain an enhanced understanding of how predictive models are developed, supported, and deployed in their markets. Ultimately, the insurance regulators within each state will decide how best to tailor the guidance within this paper to achieve the most effective and successful implementation, subject to the framework of statutes, regulations, precedents, and processes that comprise the insurance regulatory framework in that state.

X. OTHER CONSIDERATIONS

During the development of state guidance for the review of predictive models used in rate filings, important topics that may impact the review arose that were not within the scope of this paper. These topics are listed here without elaboration, not in any order of importance, and is not an exhaustive list but may need to be addressed during the regulator’s review of a predictive model. It may be that one or more of these topics will be addressed by an NAIC committee in the future. These topics are:

- Provide guidance for regulators to identify when a rating variable or rating plan becomes too granular.
- Provide guidance for regulators on the importance of causality vs. correlation when evaluating a rating variable's relationship to risk, in general and in relation to Actuarial Standard of Practice 12 (ASOP 12).
- Provide guidance for regulators on the value and/or concerns of data mining, including how data mining may assist in the model building process, how data mining may conflict with standard scientific principles, how data mining may increase "false positives" during the model building process, and how data mining may result in less accurate models or models that are unfairly discriminatory.
- Provide guidance and/or tools for the regulator to determine how a policy premium is calculated and to identify the most important risk characteristics that underlie the calculated premium.
- Provide guidance for regulators when reviewing consumer-generated data in insurance transactions including disclosure to the consumer, ownership of data, and verification of data procedures.
- Provide guidance, research tools, and techniques for regulators to monitor consumer market outcomes resulting from insurers’ use of data analytics underlying rating plans.
- Provide guidance for regulators to expand the best practices and information elements contained in this white paper to non-GLM models and insurance applications other than for personal automobile and home insurance rating plans.
- Provide guidance for regulators to determine that individual input characteristics to a model or a sub-model, as well as associated relativities, are not unfairly discriminatory or a “proxy for a protected class.”
- Provide guidance for regulators to identify and minimize unfair discrimination manifested as “disparate impact.”
- Provide guidance for regulators that seek a causal or rational explanation why a rating variable is correlated to expected loss or expense, and why that correlation is consistent with the expected direction of the relationship.
APPENDIX A – BEST PRACTICE DEVELOPMENT

Best-practices development is a method for reviewing public policy processes that have been effective in addressing particular issues and could be applied to a current problem. This process relies on the assumptions that top performance is a result of good practices and these practices may be adapted and emulated by others to improve results.\(^{16}\)

The term “best practice” can be a misleading one due to the slippery nature of the word “best”. When proceeding with policy research of this kind, it may be more helpful to frame the project as a way of identifying practices or processes that have worked exceptionally well and the underlying reasons for their success. This allows for a mix-and-match approach for making recommendations that might encompass pieces of many good practices\(^{17}\).

Researchers have found that successful best-practice analysis projects share five common phases:

**Scope**

The focus of an effective analysis is narrow, precise and clearly articulated to stakeholders. A project with a broader focus becomes unwieldy and impractical. Furthermore, Bardach urges the importance of realistic expectations in order to avoid improperly attributing results to a best practice without taking into account internal validity problems.

**Identify Top Performers**

Identify outstanding performers in this area to partner with and learn from. In this phase, it is key to recall that a best practice is a tangible behavior or process designed to solve a problem or achieve a goal (i.e. reviewing predictive models contributes to insurance rates that are not unfairly discriminatory). Therefore, top performers are those who are particularly effective at solving a specific problem or regularly achieve desired results in the area of focus.

**Analyze Best Practices**

Once successful practices are identified, analysts will begin to observe, gather information and identify the distinctive elements that contribute to their superior performance. Bardach suggests it is important at this stage to distill the successful elements of the process down to their most essential idea. This allows for flexibility once the practice is adapted for a new organization or location.

**Adapt**

Analyze and adapt the core elements of the practice for application in a new environment. This may require changing some aspects to account for organizational or environmental differences while retaining the foundational concept or idea. This is also the time to identify potential vulnerabilities of the new practice and build in safeguards to minimize risk.

**Implementation and Evaluation**

The final step is to implement the new process and carefully monitor the results. It may be necessary to make adjustments, so it is likely prudent to allow time and resources for this. Once implementation is complete, continued evaluation is important to ensure the practice remains effective.


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APPENDIX B – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES’ OBJECTIVES (WHEN REVIEWING GLMS)

This appendix identifies the information a regulator may need to review a predictive model used by an insurer to support a personal automobile or home insurance rating plan. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to sufficient information that helps determine if the rating plan meets state specific filing and legal requirements.

Documentation of the design and operational details of the model will ensure business continuity and transparency of models used. Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing need to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be shared with regulators in a timely manner and documented, and IT controls should be in place, such as a record of versions, change control and access to model.18

Many information elements listed below are probably confidential, proprietary or trade secret and should be treated as such according to state law. Regulators should be aware of their state laws on confidentiality when requesting data from insurers that may be proprietary or trade secret. For example, some proprietary models may have contractual terms (with the insurer) that prevent disclosure to the public. Without clear necessity, exposing this data to additional dissemination may compromise the model’s protection.19

Though the list of information is long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate for a regulator (approximately 25%).

The “Level of Importance to the Regulator’s Review” is a ranking of information a regulator may need to review is based on the following level criteria:

**Level 1** - This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

**Level 2** - This information is necessary to continue the review of all but the most basic models; such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

**Level 3** - This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Levels 1 and 2. These data elements address even more detailed aspects of the model. This information does not necessarily need to be included with the initial submission, unless specifically requested in a particular state, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws.

**Level 4** - This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Levels 1, 2, and 3. This most granular level of detail is addressing the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested in a particular state. It is typically requested only if the reviewer has serious concerns that the model may produce rates or rating factors that are excessive, inadequate, or unfairly discriminatory.

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19 There are some models that are made public by the vendor and would not result in a hindrance of the model’s protection.
Lastly, though the best practices presented in this paper will readily be transferrable to review of other predictive models, the information elements presented here might be useful only with deeper adaptations when starting to review different types of predictive models. If the model is not a GLM, some listed items might not apply, for example, not all predictive models generate p-values or F tests. Depending on the model type, other considerations might be important but are not listed here. When information elements presented in this appendix is applied to lines of business other than personal automobile and home insurance or other type of models, unique considerations may arise. Regulators should be aware of the context in which a predictive model is deployed, the uses to which the model is proposed to be put, and the potential consequences the model may have on the insurer, its customers, and its competitors. This paper does not delve into these possible considerations, but regulators should be prepared to address them as they arise.
### A. SELECTING MODEL INPUT

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to the Regulator’s Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Available Data Sources</td>
<td></td>
<td>Request details of all data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal or policy year and when it was last evaluated. For each data source, get a list all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets. Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the Fair Credit Reporting Act. If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete and unbiased in terms of relevant and representative time frame, representative of potential exposures and lacking in obvious correlation to protected classes. Note that reviewing source details should not make a difference when the model is new or refreshed; refreshed models would report the prior version list with the incremental changes due to the refresh.</td>
</tr>
<tr>
<td>A.1.a</td>
<td>Review the details of sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model).</td>
<td>1</td>
<td>Accuracy of insurance data should be reviewed. It is assumed that the data in the insurer's data banks is subject to routine internal company audits and reconciliation. “Aggregated data” is straight from the insurer's data banks without further modification (e.g., not scrubbed or transformed for the purposes of modeling). In other words, the data would not have been specifically modified for the purpose of model building. The company should provide some form of reasonability check that the data makes sense when checked against other audited sources.</td>
</tr>
<tr>
<td>A.1.b</td>
<td>Reconcile aggregated insurance data underlying the model with available external insurance reports.</td>
<td>4</td>
<td>The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing and validation. The company should provide an explanation where the data came from geographically and that it is a good representation for a state, i.e., the distribution by state should not introduce a geographic distribution.</td>
</tr>
<tr>
<td>A.1.c</td>
<td>Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

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### 2. Sub-Models

<table>
<thead>
<tr>
<th>A.2.a</th>
<th>Consider the relevance of (e.g., is there a bias) of overlapping data or variables used in the model and sub-models.</th>
<th>1</th>
<th>Check if the same variables/datasets were used in both the model, a sub-model or as stand-alone rating characteristics. If so, verify there was no double-counting or redundancy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.2.b</td>
<td>Determine if the sub-model was previously approved (or accepted) by the regulatory agency.</td>
<td>1</td>
<td>If the sub-model was previously approved, that may reduce the extent of the sub-model’s review. If approved, verify when and that it was the same model currently under review. However, previous approvals do not necessarily confer a guarantee of ongoing approval, for example when statutes and regulations have changed or if a model’s indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator’s efforts and determine whether or not the prior decision needs to be revisited.</td>
</tr>
<tr>
<td>A.2.c</td>
<td>Determine if sub-model output was used as input to the GLM; obtain the vendor name, and the name and version of the sub-model.</td>
<td>1</td>
<td>To accelerate the review of the filing, get the name and contact information for a representative from the vendor. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The &quot;contact&quot; can be an intermediary at the insurer, e.g., a filing specialist, who can place the regulator in direct contact with a Subject Matter Expert (SME) at the vendor. Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. SMEs on sub-model may need to be brought into the conversation with regulators (whether in-house or 3rd-party sub-models are used).</td>
</tr>
<tr>
<td>A.2.d</td>
<td>If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.</td>
<td>1</td>
<td>For example, it is important to know hurricane model settings for storm surge, demand surge, long/short-term views. To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The &quot;SME&quot; can be an intermediary at the insurer, e.g., a filing specialist, who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor.</td>
</tr>
<tr>
<td>A.2.e</td>
<td>If using catastrophe model output (a sub-model) as input to the GLM under review, verify whether loss associated with the modeled output was removed from the loss experience datasets.</td>
<td>1</td>
<td>If a weather-based sub-model is input to the GLM under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause...</td>
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</table>
distortions in the modeled results by double counting such losses when determining relativities or loss loads in the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model, inclusion of freeze losses when using a winter storm model or including demand surge caused by any catastrophic event.

Note that, the rating plan or indications underlying the rating plan, may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large BI losses, in the case of personal automobile insurance, be capped or excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model's training, test and validation data?

<table>
<thead>
<tr>
<th>A.2.f</th>
<th>If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model's output as input. Depending on the result of item A.2.b, the importance of this item may be decreased.</td>
</tr>
</tbody>
</table>

### 3. Adjustments to Data

<table>
<thead>
<tr>
<th>A.3.a</th>
<th>Determine if premium, exposure, loss or expense data were adjusted (e.g., developed, trended, adjusted for catastrophe experience or capped) and, if so, how? Do the adjustments vary for different segments of the data and, if so, identify the segments and how was the data adjusted?</th>
</tr>
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<tr>
<td>2</td>
<td>The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be capped, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model's training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane or severe convective storm losses for personal automobile comprehensive or home insurance.</td>
</tr>
<tr>
<td>A.3.b</td>
<td>Identify adjustments that were made to aggregated data, e.g., transformations, binning and/or categorizations. If any, identify the name of the characteristic/variable and obtain a description of the adjustment.</td>
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<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>This is most relevant for variables that have been &quot;scrubbed&quot; or adjusted.</td>
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<tr>
<td></td>
<td>Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it.</td>
</tr>
<tr>
<td></td>
<td>It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category were provided. This data can be displayed in either graphical or tabular formats.</td>
</tr>
<tr>
<td>A.3.c</td>
<td>Ask for aggregated data (one data set of pre-adjusted/scrubbed data and one data set of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data.</td>
</tr>
<tr>
<td></td>
<td>This is most relevant for variables that have been &quot;scrubbed&quot; or adjusted.</td>
</tr>
<tr>
<td></td>
<td>Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it.</td>
</tr>
<tr>
<td></td>
<td>It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category were provided. This data can be displayed in either graphical or tabular formats.</td>
</tr>
<tr>
<td>A.3.d</td>
<td>Determine how missing data was handled.</td>
</tr>
<tr>
<td></td>
<td>This is most relevant for variables that have been &quot;scrubbed&quot; or adjusted.</td>
</tr>
<tr>
<td></td>
<td>The regulator should be aware of assumptions the modeler made in handling missing, null or &quot;not available&quot; values in the data. For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or re-coding of values were made, they should be explained.</td>
</tr>
<tr>
<td></td>
<td>It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data were provided. This data can be displayed in either graphical or tabular formats.</td>
</tr>
<tr>
<td>A.3.e</td>
<td>If duplicate records exist, determine how they were handled.</td>
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<tr>
<td></td>
<td>Look for a discussion of how outliers were handled. If necessary, the regulator may want to investigate further by getting a list (with description) of the outliers and determine what adjustments were made to each outlier. To understand the filer's response, the regulator should ask for the filer's materiality standard.</td>
</tr>
<tr>
<td>A.3.f</td>
<td>Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process.</td>
</tr>
<tr>
<td></td>
<td>This should explain how data from separate sources was merged or how subsets of policies, based on selected characteristics, are filtered to be included in the data underlying the model and the rationale for that filtering.</td>
</tr>
</tbody>
</table>

4. Data Organization

A.4.a Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests. | 2 |
<table>
<thead>
<tr>
<th></th>
<th>Obtain documentation on the insurer’s process for reviewing the appropriateness, reasonableness, consistency and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable.</th>
<th></th>
<th>An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make rational sense. For example, if “murder” or “theft” data are used to predict the wind peril, provide support and a rational explanation for their use.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.4.b</td>
<td></td>
<td>2</td>
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</tr>
<tr>
<td>A.4.c</td>
<td>Identify material findings the company had during their data review and obtain an explanation of any potential material limitations, defects, bias or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted.</td>
<td></td>
<td>A response of &quot;none&quot; or &quot;n/a&quot; may be an appropriate response.</td>
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### B. BUILDING THE MODEL

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to Regulator’s Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High-Level Narrative for Building the Model</td>
<td>Identify the type of model underlying the rate filing (e.g. Generalized Linear Model – GLM, decision tree, Bayesian Generalized Linear Model, Gradient-Boosting Machine, neural network, etc.). Understand the model's role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.</td>
<td>1</td>
<td>It is important to understand if the model in question is a GLM, and therefore these information elements are applicable or, if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/coverage. Note, if the model is not a GLM, the information elements in this white paper may not apply in their entirety.</td>
</tr>
<tr>
<td></td>
<td>Identify the software used for model development. Obtain the name of the software vendor/developer, software product and a software version reference used in model development.</td>
<td>3</td>
<td>Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a &quot;contact&quot; in the event the regulator has questions. The &quot;contact&quot; can be an intermediary at the insurer who can place the regulator in direct contact with appropriate SMEs. Open-source software/programs used in model development should be identified by name and version the same as if from a vendor.</td>
</tr>
<tr>
<td></td>
<td>Obtain a description how the available data was divided between model training, test and/or validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, whether the company made any further subdivisions of available data and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation why that came to occur. Obtain a discussion of whether the model was rebuilt using all of the data or if it was only based on the training data.</td>
<td>1</td>
<td>The reviewer should be aware that modelers may break their data into three or just two datasets. Although the term “training” is used with little ambiguity, “test” and “validation” are terms that are sometimes interchanged, or the word “validation” may not be used at all. It would be unexpected if validation and/or test data were used for any purpose other than validation and/or test, prior to the selection of the final model.</td>
</tr>
<tr>
<td></td>
<td>Obtain a brief description of the development process, from initial concept to final model and filed rating plan.</td>
<td>1</td>
<td>The narrative should have the same scope as the filing.</td>
</tr>
<tr>
<td>B.1.e</td>
<td>Obtain a narrative on whether loss ratio, pure premium or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.1.f</td>
<td>Identify the model’s target variable.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.1.g</td>
<td>Obtain a description of the variable selection process.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.1.h</td>
<td>In conjunction with variable selection, obtain a narrative on how the company determine the granularity of the rating variables during model development.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>B.1.i</td>
<td>Determine if model input data was segmented in any way. For example, was modeling performed on a by-coverage, by-peril, or by-form basis? If so, obtain a description of data segmentation and the reasons for data segmentation.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.1.j</td>
<td>If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**2. Medium-Level Narrative for Building the Model**

<p>| B.2.a | At crucial points in model development, if selections were made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections. | 3 |</p>
<table>
<thead>
<tr>
<th>B.2.b</th>
<th>If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments.</th>
<th>2</th>
<th>Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding how these adjustments were done, including any statistical improvement measures relied upon.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.2.c</td>
<td>Obtain a description of the testing that was performed during the model-building process and a discussion of why interaction terms were included (or not included).</td>
<td>3</td>
<td>There should be a description of testing that was performed during the model-building process. Examples of tests that may have been performed include univariate testing and review of a correlation matrix.</td>
</tr>
<tr>
<td>B.2.d</td>
<td>For the GLM, identify the link function used. Identify which distribution was used for the model (e.g., Poisson, Gaussian, log-normal, Tweedie). Obtain an explanation why the link function and distribution were chosen. Obtain the formulas for the distribution and link functions, including specific numerical parameters of the distribution. Obtain a discussion of applicable convergence criterion.</td>
<td>1</td>
<td>Solving the GLM is iterative and the modeler can check to see if fit is improving. At some point convergence occurs, though when it occurs can be subjective or based on threshold criteria. The convergence criterion should be documented with a brief explanation of why it was selected. If the software's default convergence criteria were relied upon, the regulator should look for a description of the default convergence criterion and an explanation of any deviation from it.</td>
</tr>
<tr>
<td>B.2.e</td>
<td>Obtain a narrative on the formula relationship between the data and the model outputs, with a definition of each model input and output. The narrative should include all coefficients necessary to evaluate the predicted pure premium, relativity or other value, for any real or hypothetical set of inputs.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>B.2.f</td>
<td>If there were data situations in which GLM weights were used, obtain an explanation of how and why they were used.</td>
<td>3</td>
<td>Investigate whether identical records were combined to build the model.</td>
</tr>
</tbody>
</table>

### 3. Predictor Variables

<table>
<thead>
<tr>
<th>B.3.a</th>
<th>Obtain a complete data dictionary, including the names, types, definitions and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable and all other variables in the model used on their own or as an interaction with other variables (including sub-models and external models).</th>
<th>1</th>
<th>Types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. For any variable(s) intended to function as a control or offset, obtain an explanation of its purpose and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.3.b</td>
<td>Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.</td>
<td>4</td>
<td>The purpose of this requirement is to identify variables that the company finds to be predictive but ultimately may reject for reasons other than loss-cost considerations (e.g., price optimization). Also, look for variables the company tested and then rejected. This item could help address concerns about data dredging. The reasonableness of including a variable with given significance level could depend greatly on the other variables the company evaluated for inclusion in the model and the criteria for inclusion or omission. For instance, if the company tested 1,000 similar variables...</td>
</tr>
</tbody>
</table>
and selected the one with the lowest p-value of 0.001, this would be a far, far weaker case for statistical significance than if that variable was the only one the company evaluated. Note, context matters.

<table>
<thead>
<tr>
<th>B.3.c</th>
<th>Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>While GLMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer's V). The regulatory reviewer should understand what statistic was used to produce the matrix but should not prescribe the statistic.</td>
<td></td>
</tr>
<tr>
<td>B.3.d</td>
<td>Obtain a rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate. For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable.</td>
<td></td>
</tr>
<tr>
<td>B.3.e</td>
<td>If the modeler made use of one or more dimensionality reduction techniques, such as a Principal Component Analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of linearly uncorrelated variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, and an explanation how the results of the dimensionality reduction technique was used within the model.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>For models that are built using multi-state data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on State-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk. Look for geographic stability measures, e.g., across states or territories within state.</td>
<td></td>
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</tbody>
</table>

4. Adjusting Data, Model Validation and Goodness-of-Fit Measures

<table>
<thead>
<tr>
<th>B.4.a</th>
<th>Obtain a description of the methods used to assess the statistical significance/goodness of the fit of the model to validation data, such as lift charts and statistical tests. Compare the model's projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.</th>
<th>1</th>
</tr>
</thead>
</table>
### B.4.b

For all variables (discrete or continuous), review the appropriate parameter values, confidence intervals, chi-square tests, p-values and any other relevant and material tests. Determine if model development data, validation data, test data or other data was used for these tests.

1. Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model. For example, the threshold might be lower when many candidate variables were evaluated for inclusion in the model.

Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed.

### B.4.c

Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold.

1. The explanation should clearly identify the thresholds for statistical significance used by the modeler. Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model. For example, the threshold might be lower when many candidate variables were evaluated for inclusion in the model.

Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests.
| B.4.d | For overall discrete variables, review type 3 chi-square tests, p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests. | 2 | Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed. |
| B.4.e | Obtain evidence that the model fits the training data well, for individual variables, for any relevant combinations of variables and for, the overall model. | 2 | For a GLM, such evidence may be available using chi-square tests, p-values, F tests and/or other means. The steps taken during modeling to achieve goodness-of-fit are likely to be numerous and laborious to describe, but they contribute much of what is generalized about GLM. We should not assume we know what they did and ask "how?" Instead, we should ask what they did and be prepared to ask follow-up questions. |
| B.4.f | For continuous variables, provide confidence intervals, chi-square tests, p-values and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests. | 2 | Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed. |
| B.4.g | Obtain a description how the model was tested for stability over time. | 2 | Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets).
Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data. The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls will exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model?
The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time. |
| B.4.h | Obtain a narrative on how potential concerns with overfitting were addressed. | 2 | Visual review of plots of actual errors is usually sufficient.
The reviewer should look for a conceptual narrative covering these topics: How does this particular GLM work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices. If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced. |
| B.4.i | Obtain support demonstrating that the GLM assumptions are appropriate. | 3 | |
| B.4.j | Obtain 5-10 sample records with corresponding output from the model for those records. | 4 | |
### 5. “Old Model” Versus “New Model”

| B.5.a | Obtain an explanation why this model is an improvement to the current rating plan. If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model. | 2 | Regulators should expect to see improvement in the new class plan’s predictive ability or other sufficient reason for the change. |
| B.5.b | Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison. | 3 | One example of a comparison might be sufficient. This is relevant when one model is being updated or replaced. Regulators should expect to see improvement in the new class plan’s predictive ability. This information element requests a comparison of Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data. This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph for information on Gini coefficients. |
| B.5.c | Determine if double lift charts were analyzed and obtain a narrative on the conclusion drawn from this analysis. | 2 | One example of a comparison might be sufficient. Note that "not applicable" is an acceptable response. |
| B.5.d | If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model. Obtain an explanation why these variables were dropped from the new model. Obtain a list of all new predictor variables in the new model that were not in the prior old model. | 2 | Useful to differentiate between old and new variables so the regulator can prioritize more time on variables not yet reviewed. |

### 6. Modeler Software

| B.6.a | Request access to SMEs (e.g., modelers) who led the project, compiled the data, built the model, and/or performed peer review. | 3 | The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model. |
C. THE FILED RATING PLAN

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to Regulator's Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Impact of Model on Rating Algorithm</td>
<td>In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (how it was used) in the rating system.</td>
<td>1</td>
<td>The &quot;role of the model&quot; relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model's goal, but rather a description of how specifically the model is used. This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</td>
</tr>
<tr>
<td>C.1.a</td>
<td>Obtain an explanation of how the model was used to adjust the rating algorithm.</td>
<td>1</td>
<td>Models are often used to produce factor-based indications, which are then used as the basis for the selected changes to the rating plan. It is the changes to the rating plan that create impacts. Consider asking for an explanation of how the model was used to adjust the rating algorithm.</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.</td>
<td>1</td>
<td>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</td>
</tr>
</tbody>
</table>
## 2. Relevance of Variables and Relationship to Risk of Loss

| C.2.a | Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss (or expense) for the type of insurance product being priced. | 2 | The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model results should be consistent with the expected direction of the relationship. This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated. |

## 3. Comparison of Model Outputs to Current and Selected Rating Factors

| C.3.a | Compare relativities indicated by the model to both current relativities and the insurer's selected relativities for each risk characteristic/variable in the rating plan. | 1 | “Significant difference” may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical. |

| C.3.b | Obtain documentation and support for all calculations, judgments, or adjustments that connect the model's indicated values to the selected values. | 1 | The documentation should include explanations for the necessity of any such adjustments and explain each significant difference between the model's indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. This information is especially important if differences between model indicated values and selected values are material and/or impact one consumer population more than another. |

| C.3.c | For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures. | 2 | Modeling loss ratio with these characteristics/variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations, e.g., tier placement models often use risk characteristics/variables that are also used elsewhere in the rating plan. One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals. |
### 4. Responses to Data, Credibility and Granularity Issues

<table>
<thead>
<tr>
<th>C.4.a</th>
<th>Determine what, if any, consideration was given to the credibility of the output data.</th>
<th>2</th>
<th>At what level of granularity is credibility applied. If modeling was by-coverage, by-form or by-peril, explain how these were handled when there was not enough credible data by coverage, form or peril to model.</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.4.b</td>
<td>If the rating plan is less granular than the model, obtain an explanation why.</td>
<td>2</td>
<td>This is applicable if the insurer had to combine modeled output in order to reduce the granularity of the rating plan.</td>
</tr>
<tr>
<td>C.4.c</td>
<td>If the rating plan is more granular than the model, obtain an explanation why.</td>
<td>2</td>
<td>A more granular rating plan implies that the insurer had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications.</td>
</tr>
</tbody>
</table>

### 5. Definitions of Rating Variables

| C.5.a | Obtain a narrative on adjustments made to model output, e.g., transformations, binning and/or categorizations. If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment. | 2 | If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation how model output was translated into these rating tiers or intermediate rating categories. |

### 6. Supporting Data

| C.6.a | Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments. | 4 | For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc.? Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference. |
Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the multivariate indicated relativity is 1.25, this is potentially a plausible application of the multivariate techniques. If, however, the univariate indicated relativity is 0.7 and the multivariate indicated relativity is 1.25, a regulator may question whether the attribute in question is negatively correlated with other determinants of risk. Credibility of state data should be considered when state indications differ from modeled results based on a broader data set. However, the relevance of the broader data set to the risks being priced should also be considered. Borderline reversals are not of as much concern.

### 7. Consumer Impacts

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.6.b</td>
<td>Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.</td>
<td>4</td>
</tr>
</tbody>
</table>

These rating variables may represent changes to rating factors, be newly introduced to the rating plan, or have been removed from the rating plan.

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.7.a</td>
<td>Obtain a listing of the top five rating variables that contribute the most to large swings in premium, both as increases and decreases.</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.7.b</td>
<td>Determine if the insurer performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.</td>
<td>3</td>
</tr>
</tbody>
</table>

One way to see sensitivity is to analyze a graph of each risk characteristic’s/variable’s possible relativities. Look for significant variation between adjacent relativities and evaluate if such variation is reasonable and credible.

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.7.c</td>
<td>For the proposed filing, obtain the impacts on expiring policies and describe the process used by management, if any, to mitigate those impacts.</td>
<td>2</td>
</tr>
</tbody>
</table>

Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense, and hence may be viewed as unfairly discriminatory by some states.
<table>
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<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.7.d</td>
<td>Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business), and sufficient information to explain the disruptions to individual consumers.</td>
<td>2</td>
</tr>
<tr>
<td>C.7.e</td>
<td>Obtain exposure distributions for the model's output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business.</td>
<td>3</td>
</tr>
<tr>
<td>C.7.f</td>
<td>Identify policy characteristics, used as input to a model or sub-model, that remain &quot;static&quot; over a policy's lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as &quot;static,&quot; yet change over time.</td>
<td>3</td>
</tr>
</tbody>
</table>

The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan.

While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated.

See Appendix C for an example of a disruption analysis.

See Appendix C for an example of an exposure distribution.

Some examples of "static" policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured's risk profile based on "static" variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured's true and current risk profile.

A few examples of "non-static" policy characteristics are age of driver, driving record and credit information (FCRA related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.
| C.7.g | Obtain a means to calculate the rate charged a consumer. | 3 | The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. Ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. Note that this information may be proprietary. |
| C.7.h | In the filed rating plan, be aware of any non-insurance data used as input to the model (customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors. | 1 | If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, data may need to be documented with an overview of who owns it and the topic of consumer verification may need to be addressed, including how consumers can verify their data and correct errors. |

### 8. Accurate Translation of Model into a Rating Plan

| C.8.a | Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan’s manual, in fact, reflects the model output and any adjustments made to the model output. | 1 | The regulator can review the rating plan's manual to see that modeled output is properly reflected in the manual's rules, rates, factors, etc. |

### 9. Efficient and Effective Review of Rate Filing

<p>| C.9.a | Establish procedures to efficiently review rate filings and models contained therein. | 1 | &quot;Speed to market&quot; is an important competitive concept for insurers. Though regulators need to understand the rate filing before accepting the rate filing, the regulator should not request information which does not increase their understanding of the rate filing. Regulators should review their state's rate filing review process and procedures to ensure that they are fair and efficient. Regulators need to be aware that requesting information that is not necessary for a decision to be made on a rate filing's compliance with state laws and regulations. |
| C.9.b | Be knowledgeable of state laws and regulations in order to determine if the proposed rating plan (and models) are compliant with state law. | 1 | This is a primary duty of regulators. The regulator should be knowledgeable of their state laws and regulations and apply them to a rate filing fairly and efficiently. The regulator should pay special attention to prohibitions of unfair discrimination. |</p>
<table>
<thead>
<tr>
<th>C.9.c</th>
<th>Be knowledgeable of state laws and regulations in order to determine if any information contained in the rate filing (and models) should be treated as confidential.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The regulator should be knowledgeable of their state laws and regulations regarding confidentiality of rate filing information and apply them to a rate filing fairly and efficiently. Confidentiality of proprietary information is key to innovation and competitive markets.</td>
</tr>
</tbody>
</table>
Appendix B (cont.)

Mapping BPs to IEs and IEs to BPs

Table 1 maps the best practices to each GLM information element. Table 2 maps the GLM information elements to each best practice. With this mapping a regulator interested in how to meet the objective of a best practice can consider the information elements associated with the best practice in the table.

<table>
<thead>
<tr>
<th>Information Element</th>
<th>Selected Best Practices Mapped to Info Element</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Selecting Model Input</strong></td>
<td></td>
</tr>
<tr>
<td>A.1. Available Data Sources</td>
<td></td>
</tr>
<tr>
<td>A.1.a</td>
<td>1.b, 1.d, 2.b, 3.a</td>
</tr>
<tr>
<td>A.1.b</td>
<td>2.b, 2.c</td>
</tr>
<tr>
<td>A.1.c</td>
<td>1.b</td>
</tr>
<tr>
<td>A.2. Sub-Models</td>
<td></td>
</tr>
<tr>
<td>A.2.a</td>
<td>1.b, 1.d, 3.a, 3.c</td>
</tr>
<tr>
<td>A.2.b</td>
<td>4.c</td>
</tr>
<tr>
<td>A.2.c</td>
<td>2.a, 2.d, 3.a, 4.c</td>
</tr>
<tr>
<td>A.2.d</td>
<td>2.a, 2.d, 3.a, 4.c</td>
</tr>
<tr>
<td>A.2.e</td>
<td>2.c, 1.d, 2.a, 3.a</td>
</tr>
<tr>
<td>A.2.f</td>
<td>1.b, 1.d, 2.a, 3.a</td>
</tr>
<tr>
<td>A.3. Adjustments to Data</td>
<td></td>
</tr>
<tr>
<td>A.3.a</td>
<td>1.b, 2.a, 2.b, 2.c</td>
</tr>
<tr>
<td>A.3.b</td>
<td>2.a, 2.c</td>
</tr>
<tr>
<td>A.3.c</td>
<td>2.b, 2.c</td>
</tr>
<tr>
<td>A.3.d</td>
<td>2.b, 2.c</td>
</tr>
<tr>
<td>A.3.e</td>
<td>2.b, 2.c</td>
</tr>
<tr>
<td>A.3.f</td>
<td>2.b, 2.c</td>
</tr>
<tr>
<td>A.4. Data Organization</td>
<td></td>
</tr>
<tr>
<td>A.4.a</td>
<td>2.a, 2.b, 2.c, 3.a</td>
</tr>
<tr>
<td>A.4.b</td>
<td>1.b, 1.d, 2.b, 2.c</td>
</tr>
<tr>
<td>A.4.c</td>
<td>1.d, 2.a, 2.b, 2.c</td>
</tr>
<tr>
<td><strong>B. Building the Model</strong></td>
<td></td>
</tr>
<tr>
<td>B.1. High-Level Narrative for Building the Model</td>
<td></td>
</tr>
<tr>
<td>B.1.a</td>
<td>2.a</td>
</tr>
<tr>
<td>B.1.b</td>
<td>2.a</td>
</tr>
<tr>
<td>B.1.c</td>
<td>2.a</td>
</tr>
<tr>
<td>B.1.d</td>
<td>2.a, 3.b</td>
</tr>
<tr>
<td>B.1.e</td>
<td>2.a</td>
</tr>
<tr>
<td>B.1.f</td>
<td>1.b, 2.a</td>
</tr>
<tr>
<td>B.1.g</td>
<td>1.b, 1.d, 2.a, 3.a</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------</td>
</tr>
<tr>
<td>B.1.h</td>
<td>2.a, 2.b</td>
</tr>
<tr>
<td>B.1.i</td>
<td>1.b, 2.a</td>
</tr>
<tr>
<td>B.1.j</td>
<td>2.a, 2.c</td>
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</table>

B.2. Medium-Level Narrative for Building the Model

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>B.2.b</td>
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</tr>
<tr>
<td>B.2.c</td>
<td>2.a, 3.b</td>
</tr>
<tr>
<td>B.2.d</td>
<td>2.a</td>
</tr>
<tr>
<td>B.2.e</td>
<td>2.a, 3.a, 3.b</td>
</tr>
<tr>
<td>B.2.f</td>
<td>2.a, 2.c</td>
</tr>
</tbody>
</table>

B.3. Predictor Variables

<table>
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<td>B.3.b</td>
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</tr>
<tr>
<td>B.3.d</td>
<td>1.b, 1.d, 3.a</td>
</tr>
<tr>
<td>B.3.e</td>
<td>2.a, 3.a</td>
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B.4. Adjusting Data, Model Validation and Goodness-of-Fit Measures

<table>
<thead>
<tr>
<th>B.4.a</th>
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</tr>
</thead>
<tbody>
<tr>
<td>B.4.b</td>
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<tr>
<td>B.4.c</td>
<td>1.b, 2.a</td>
</tr>
<tr>
<td>B.4.d</td>
<td>1.b, 2.a, 2.b, 3.b</td>
</tr>
<tr>
<td>B.4.e</td>
<td>1.b, 2.a</td>
</tr>
<tr>
<td>B.4.f</td>
<td>1.b, 2.a, 3.b</td>
</tr>
<tr>
<td>B.4.g</td>
<td>2.a, 2.d, 3.b</td>
</tr>
<tr>
<td>B.4.h</td>
<td>2.a</td>
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<tr>
<td>B.4.i</td>
<td>1.b, 2.a</td>
</tr>
<tr>
<td>B.4.j</td>
<td>1.d, 2.a, 3.c</td>
</tr>
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</table>

B.5. “Old Model” Versus “New Model”

<table>
<thead>
<tr>
<th>B.5.a</th>
<th>3.b</th>
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<tbody>
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<td>B.5.b</td>
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<tr>
<td>B.5.c</td>
<td>3.b</td>
</tr>
<tr>
<td>B.5.d</td>
<td>2.d, 3.a, 3.b</td>
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</tbody>
</table>

B.6. Modeler Software

| B.6.a | 2.a |

C. The Filed Rating Plan

C.1. General Impact of Model on Rating Algorithm

<table>
<thead>
<tr>
<th>C.1.a</th>
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</tr>
</thead>
<tbody>
<tr>
<td>C.1.b</td>
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</tr>
<tr>
<td>C.1.c</td>
<td>1.b, 1.d, 3.a, 3.c</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
</tr>
<tr>
<td>C.2. Relevance of Variables and Relationship to Risk of Loss</td>
<td></td>
</tr>
<tr>
<td>C.2.a</td>
<td>1.b, 1.d, 3.a</td>
</tr>
<tr>
<td>C.3. Comparison of Model Outputs to Current and Selected Rating Factors</td>
<td></td>
</tr>
<tr>
<td>C.3.a</td>
<td>1.a, 1.c, 3.b</td>
</tr>
<tr>
<td>C.3.b</td>
<td>1.a, 1.c, 3.b</td>
</tr>
<tr>
<td>C.3.c</td>
<td>3.a, 3.b, 3.c</td>
</tr>
<tr>
<td>C.4. Responses to Data, Credibility and Granularity Issues</td>
<td></td>
</tr>
<tr>
<td>C.4.a</td>
<td>3.b</td>
</tr>
<tr>
<td>C.4.b</td>
<td>3.b</td>
</tr>
<tr>
<td>C.4.c</td>
<td>3.b</td>
</tr>
<tr>
<td>C.5. Definitions of Rating Variables</td>
<td></td>
</tr>
<tr>
<td>C.5.a</td>
<td>2.c, 3.b, 3.c</td>
</tr>
<tr>
<td>C.6. Supporting Data</td>
<td></td>
</tr>
<tr>
<td>C.6.a</td>
<td>2.c</td>
</tr>
<tr>
<td>C.6.b</td>
<td>1.b, 3.b</td>
</tr>
<tr>
<td>C.7. Consumer Impacts</td>
<td></td>
</tr>
<tr>
<td>C.7.a</td>
<td>1.a, 1.c</td>
</tr>
<tr>
<td>C.7.b</td>
<td>1.a, 1.c</td>
</tr>
<tr>
<td>C.7.c</td>
<td>1.a, 1.c, 3.b</td>
</tr>
<tr>
<td>C.7.d</td>
<td>1.a, 1.c</td>
</tr>
<tr>
<td>C.7.e</td>
<td>1.a, 1.c</td>
</tr>
<tr>
<td>C.7.f</td>
<td>2.d</td>
</tr>
<tr>
<td>C.7.g</td>
<td>1.c, 3.b</td>
</tr>
<tr>
<td>C.7.h</td>
<td>1.d, 2.b, 2.d, 3.b</td>
</tr>
<tr>
<td>C.8. Accurate Translation of Model into a Rating Plan</td>
<td></td>
</tr>
<tr>
<td>C.8.a</td>
<td>3.b, 3.c</td>
</tr>
<tr>
<td>C.9. Efficient and Effective Review of a Rate Filing</td>
<td></td>
</tr>
<tr>
<td>C.9.a</td>
<td>4.a</td>
</tr>
<tr>
<td>C.9.b</td>
<td>4.a</td>
</tr>
<tr>
<td>C.9.c</td>
<td>4.a, 4.b</td>
</tr>
</tbody>
</table>
# Appendix B: Table 2

## Information Element Mapped to Best Practices

<table>
<thead>
<tr>
<th>Best Practice</th>
<th>Best Practice Code</th>
<th>Information Element (for GLMs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ensure that the factors developed based on the model produce rates that are not excessive, inadequate, or unfairly discriminatory.</td>
<td></td>
<td>C.3.a, C.7.a, C.7.b, C.7.c, C.7.d, C.7.e, C.7.f</td>
</tr>
<tr>
<td>a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.</td>
<td>1.a</td>
<td></td>
</tr>
<tr>
<td>b. Determine that individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.</td>
<td>1.b</td>
<td>A.1.a, A.1.c, A.2.a, A.2.f, A.3.a, A.4.b, B.1.f, B.1.g, B.1.i, B.3.a, B.3.d, B.4.c, B.4.d, B.4.e, B.4.f, B.4.i, C.1.c, C.2.a, C.6.b</td>
</tr>
<tr>
<td>c. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.</td>
<td>1.c</td>
<td>C.3.a, C.3.b, C.7.a, C.7.b, C.7.c, C.7.d, C.7.e, C.7.g</td>
</tr>
<tr>
<td>d. Review the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as, associated selected relativities to ensure they are compatible with practices allowed in the state and do not reflect prohibited characteristics.</td>
<td>1.d</td>
<td>A.1.a, A.2.a, A.2.e, A.2.f, A.4.b, A.4.c, B.1.g, B.3.a, B.3.c, B.3.d, B.4.j, C.1.c, C.2.a, C.7.h</td>
</tr>
</tbody>
</table>

<p>| 2. Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output. | | |
| a. Obtain a clear understanding of how the selected predictive model was built. | 2.a | A.1.a, A.2.c, A.2.d, A.2.e, A.2.f, A.3.a, A.3.b, A.4.a, A.4.c, B.1.a, B.1.b, B.1.c, B.1.d, B.1.e, B.1.f, B.1.g, B.1.h, B.1.i, B.1.j, B.2.a, B.2.b, B.2.c, B.2.d, B.2.e, B.2.f, B.3.a, B.3.b, B.3.c, B.3.e, B.4.a, B.4.b, B.4.c, B.4.d, B.4.e, B.4.f, B.4.g, B.4.h, B.4.i, B.4.j, B.5.b, B.5.c, B.6.a, C.1.a, C.4.b, C.4.c, C.5.a |
| b. Determine that the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values and outliers are handled. | 2.b | A.1.a, A.1.b, A.3.a, A.3.b, A.3.c, A.3.d, A.3.e, A.3.f, A.4.a, A.4.b, A.4.c, B.1.h, B.4.d, C.6.a, C.7.h |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Determine that any adjustments to the raw data are handled appropriately, including but not limited to trending, development, capping, and removal of catastrophes.</td>
<td>2.c</td>
<td>A.1.b, A.2.e, A.3.a, A.3.b, A.3.c, A.3.d, A.3.e, A.3.f, A.4.a, A.4.b, A.4.c, B.1.j, B.2.b, B.2.f, C.5.a, C.6.a</td>
</tr>
<tr>
<td>d. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is periodically refreshed, so model output reflects changes to non-static risk characteristics.</td>
<td>2.d</td>
<td>A.2.c, A.2.d, B.4.g, B.5.d, C.7.f, C.7.h</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evaluate how the model interacts with and improves the rating plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models).</td>
<td>3.a</td>
<td>A.1.a, A.2.a, A.2.c, A.2.d, A.2.e, A.2.f, A.4.a, B.1.g, B.2.e, B.3.a, B.3.c, B.3.d, B.3.e, B.5.d, C.1.c, C.2.a, C.3.c, C.7.h</td>
</tr>
<tr>
<td>b. Obtain a clear understanding how the insurer integrates the model into the rating plan and how it improves the rating plan.</td>
<td>3.b</td>
<td>B.1.d, B.2.c, B.2.e, B.4.a, B.4.b, B.4.d, B.4.f, B.4.g, B.5.a, B.5.b, B.5.c, B.5.d, C.1.a, C.1.b, C.3.a, C.3.b, C.3.c, C.4.a, C.4.b, C.4.c, C.5.a, C.6.b, C.7.c, C.7.g, C.7.h, C.8.a</td>
</tr>
<tr>
<td>c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.</td>
<td>3.c</td>
<td>A.2.a, A.4.j, C.1.b, C.1.c, C.3.c, C.5.a, C.8.a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided they are in compliance with state laws, particularly prohibitions on unfair discrimination.</td>
<td>4.a</td>
<td>C.9.b, C.9.c</td>
</tr>
<tr>
<td>b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.</td>
<td>4.b</td>
<td>C.9.a, C.9.b, C.9.c</td>
</tr>
<tr>
<td>c. Review predictive models in a timely manner to enable reasonable speed to market.</td>
<td>4.c</td>
<td>C.9.a, C.9.b, C.9.c</td>
</tr>
</tbody>
</table>
APPENDIX C – GLOSSARY OF TERMS

Adjusting Data – Adjusting data refers to any changes made when the modeler makes any to the raw data. For example, capping losses, on-leveling, binning, transformation of the data, etc. This includes scrubbing of the data.

Aggregated Data - Data summarized or compiled in a manner that is meaningful to the intended user of the data. Aggregation involves segmenting and combining individual data entries into categories based on common features within the data. For example, aggregated raw data requested for a predictive model would be categorized in the same manner as the categories of variables which receive specific treatments within the model outputs.

Big Data – “Big Data” refers to extremely large data sets analyzed computationally to infer laws (regressions, nonlinear relationships, and causal effects) to reveal relationships and dependencies or to perform predictions of outcomes and behaviors.

Composite Characteristic - A composite characteristic is the combination of two or more individual risk characteristics. Composite characteristics are used to create composite variables.

Composite Score - A composite score is a number derived by combining multiple variables by means of a sequence of mathematical steps - for example, a credit-based insurance scoring model.

Composite Variable - A composite variable is a variable created by incorporating two or more individual risk characteristics of the insured into a single variable.

Continuous Variable - A continuous variable is a numeric variable that represents a measurement on a continuous scale. Examples include age, amount of insurance (in dollars), and population density.

Control Variable - Control variables are variables whose relativities are not used in the final rating algorithm but are included when building the model. They are included in the model so that other correlated variables do not pick up their signal. For example, state and year are frequently included in countrywide models as control variables so that the different experiences and distributions between states and across time do not influence the rating factors used in the final rating algorithm.

Correlation Matrix - A correlation matrix is a table showing correlation coefficients between sets of variables. Each random variable (X_i) in the table is correlated with each of the other variables in the table (X_j). Using the correlation matrix, one can determine which pairs of variables have the highest correlation. Below is a sample correlation matrix showing correlation coefficients for combinations of 5 variables B1:B5. The table shows that variables B2 and B4 have the highest correlation coefficient (0.96) in this example. The diagonal of the table is always set to one, because the correlation coefficient between a variable and itself is always 1. The upper-right triangle would be a mirror image of the lower-left triangle (because correlation between B1 and B2 is the same as between B2 and B1). In other words, a correlation matrix is also a symmetric matrix.

Data Dredging - Data dredging is also referred to as data fishing, data snooping, data butchery, and p-hacking. It is the misuse of data analysis to find patterns in data that can be presented as statistically significant when, in fact, there is no real underlying effect. Data dredging is done by performing many statistical tests on the data and focusing only on those that produce significant results. Data dredging is in conflict with hypothesis testing, which entails performing at most a handful of tests to determine the validity of the hypothesis about an underlying effect.
Data Source - A data source is the original repository of the information used to build the model. For example, information from internal insurance data, an application, a vendor, credit bureaus, government websites, a sub-model, verbal information provided to agents, external sources, consumer information databases, etc.

Discrete Variable - A discrete variable is a variable that can only take on a countable number of values/categories. Examples include number of claims, marital status, and gender.

Discrete Variable Level - Discrete variables are generally referred to as "factors" (not to be confused with rating factors), with values that each factor can take being referred to as "levels." ²⁴

Double-Lift Chart - Double lift charts are similar to simple quantile plots, but rather than sorting based on the predicted loss cost of each model, the double lift chart sorts based on the ratio of the two models’ predicted loss costs. Double lift charts directly compare the results of two models.²⁵

Exponential Family - The exponential family is a class of distributions that share the same general density form and have certain properties that are used in fitting GLMs. It includes many well-known distributions, such as the Normal, Poisson, Gamma, Tweedie, and Binomial, to name a few.²⁶

Fair Credit Reporting Act – The Fair Credit Reporting Act (FCRA), 15 U.S.C. § 1681 (FCRA) is U.S. Federal Government legislation enacted to promote the accuracy, fairness and privacy of consumer information contained in the files of consumer reporting agencies. It was intended to protect consumers from the willful and/or negligent inclusion of inaccurate information in their credit reports. To that end, the FCRA regulates the collection, dissemination and use of consumer information, including consumer credit information.²⁷ Together with the Fair Debt Collection Practices Act (FDCPA), the FCRA forms the foundation of consumer rights law in the United States. It was originally passed in 1970 and is enforced by the US Federal Trade Commission, the Consumer Financial Protection Bureau and private litigants.

Generalized Linear Model - Generalized linear models (GLMs) are a means of modeling the relationship between a variable whose outcome we wish to predict and one or more explanatory variables. The predicted variable is called the target variable and is denoted y. In property/casualty insurance ratemaking applications, the target variable is typically one of the following:

- Claim count (or claims per exposure)
- Claim severity (i.e., dollars of loss per claim or occurrence)
- Pure premium (i.e., dollars of loss per exposure)
- Loss ratio (i.e., dollars of loss per dollar of premium)

For quantitative target variables such as those above, the GLM will produce an estimate of the expected value of the outcome. For other applications, the target variable may be the occurrence or non-occurrence of a certain event. Examples include:

- Whether or not a policyholder will renew his/her policy.
- Whether a submitted claim contains fraud.

For such variables, a GLM can be applied to estimate the probability that the event will occur.

The explanatory variables, or predictors, are denoted x₁, . . . , xₚ, where p is the number of predictors in the model. Potential predictors are typically any policy term or policyholder characteristic that an insurer may wish to include in a rating plan.

Some examples are:

- Type of vehicle, age, or marital status for personal auto insurance.
- Construction type, building age, or amount of insurance (AOI) for home insurance.²⁸

²⁴https://www.casact.org/pubs/dpp/dpp04/04dpp1.pdf
Geodemographic - Geodemographics is the study of the population and its characteristics, divided according to regions on a geographical basis. This involves application of clustering techniques to group statistically similar neighborhoods and areas with the assumption that the differences within any group should be less than the difference between groups. While the main source of data for a geodemographic study is the census data, the use of other sources of relevant data is also prevalent. Geodemographic segmentation is based on two principles:

1. People who live in the same neighborhood are more likely to have similar characteristics than are two people chosen at random.
2. Neighborhoods can be categorized in terms of the characteristics of the population that they contain. Any two neighborhoods can be placed in the same category, i.e., they contain similar types of people, even though they are widely separated.

Granularity of Data - Granularity of data is the level of segmentation at which the data is grouped or summarized. It reflects the level of detail used to slice and dice the data.

For example, a postal address can be recorded, with coarse granularity, as:
- Country

Or, with finer granularity, as multiple fields:
- Country
- State

Or, with much finer granularity, as multiple fields:
- Country
- State
- County
- ZIP Code
- Property Geo Code

Home Insurance - Home insurance covers damage to the property, contents, and outstanding structures (if applicable), as well as loss of use, liability and medical coverage. The perils covered, the amount of insurance provided, and other policy characteristics are detailed in the policy contract.

Insurance Data - Data collected by the insurance company. For example, data obtained from the consumer through communications with an agent or on an insurance application would be "insurance data." However, data obtained from a credit bureau or census would not be considered "insurance data" but would be considered "non-insurance data" instead.

Interaction Term - Two predictor variables are said to interact if the effect of one of the predictors on the target variable depends on the level of the other. Suppose that predictor variables X₁ and X₂ interact. A GLM modeler could account for this interaction by including an interaction term of the form X₁X₂ in the formula for the linear predictor. For instance, rather than defining the linear predictor as \( \eta = \beta_0 + \beta_1X_1 + \beta_2X_2 \), they could set \( \eta = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_1X_2 \).

The following two plots of modeled personal auto bodily injury pure premium by age and gender illustrate this effect. The plots are based on two otherwise identical log-link GLMs, built using the same fictional dataset, with the only difference between the two being that the second model includes the Age-Gender interaction term while the first does not. Notice that the male curve in the first plot is a constant multiple of the female curve, while in the second plot the ratios of the male to female values differ from age to age.

---

29 Granularity (also called graininess), https://en.wikipedia.org/wiki/Granularity#Data_granularity
31 To see that this second definition accounts for the interaction, note that it is equivalent to \( \eta = \beta_0 + \beta_1X_1 + \beta_2X_2 \) and to \( \eta = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_1X_2 \), with \( \beta_1' = \beta_1 + \beta_3X_2 \) and \( \beta_2' = \beta_2 + \beta_3X_1 \). Since \( \beta_1' \) is a function of \( X_2 \) and \( \beta_2' \) is a function of \( X_1 \), these two equivalences say that the effect of \( X_1 \) depends on the level of \( X_2 \) and vice versa.
**Lift Chart** - See definition of quantile plot.

**Linear Predictor** - A linear predictor is the linear combination of explanatory variables ($X_1, X_2, \ldots, X_k$) in the model... e.g.,
$$\hat{\eta} = \beta_0 + \beta_1 X_1 + \beta_2 X_2.$$

**Link Function** - The link function, $g(\mu)$, specifies how the expected value of the response relates to the linear predictor of explanatory variables; e.g., $\eta = g(E(Y_i)) = E(Y_i)$ for linear regression, or $\eta = \logit(\pi)$ for logistic regression.

**Missing data** - Missing data occurs when some records contain blanks or "Not Available" or "Null" where variable values would normally be available.

**Non-Insurance Data** - Non-insurance data is data provided by another party other than the insurance company. For example, data obtained from a credit bureau or census would be considered "non-insurance data." However, data obtained from the consumer through communications with an agent or on an insurance application would not be considered "non-insurance data" but would be "insurance data" instead.

**Offset Variable** – Offset variables (or factors) are model variables with a known or pre-specified coefficient. Their relativities are included in the model and the final rating algorithm, but they are generated from other studies outside the multivariate analysis and are fixed (not allowed to change) in the model when it is run. The model does not estimate any coefficients for the offset variables, and they are included in the model, so that the estimated coefficients for other variables in the model would be optimal in their presence. Examples of offset variables include limit and deductible relativities that are more appropriately derived via loss elimination analysis. The resulting relativities are then included in the multivariate model as offsets. Another example is using an offset factor to account for the exposure in the records; this does not get included in the final rating algorithm.

**Overfitting** – Overfitting is the production of an analysis that corresponds too closely or exactly to a particular set of data and may, therefore, fail to fit additional data or predict future observations reliably.

**PCA Approach (Principal Component Analysis)** – The PCA method creates multiple new variables from correlated groups of predictors. Those new variables exhibit little or no correlation between them—thereby making them potentially more useful in a GLM. A PCA in a filing can be described as “a GLM within a GLM.” One of the more common applications of PCA is geodemographic analysis, where many attributes are used to modify territorial differentials on, for example, a census block level.

**Personal Automobile Insurance** – Personal automobile insurance is insurance for privately owned motor vehicles and trailers for use on public roads not owned or used for commercial purposes. This includes personal auto combinations of private passenger auto, motorcycle, financial responsibility bonds, recreational vehicles and/or other personal auto. Policies

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33 https://online.stat.psu.edu/stat504/node/216
include any combination of coverage such as the following: auto liability, personal injury protection (PIP), medical payments (MP), uninsured/underinsured motorist (UM/UIM); specified causes of loss, comprehensive, and collision.36

**Post-model Adjustment** - Post-model adjustment is any adjustment made to the output of the model including but not limited to adjusting rating factors or removal of variables.

**Probability Distribution** – A probability distribution is a statistical function that describes all the possible values and likelihoods that a random variable can take within a given range. The chosen probability distribution is supposed to best represent the likely outcomes.

**Proxy Variable** - A proxy variable is any variable that indirectly captures the characteristics of another variable, whether or not that other variable is used in the insurer’s rating plan.

**Quantile Plot** - A quantile plot is a visual representation of a model’s ability to accurately differentiate between the best and the worst risks. Data is sorted by predicted value from smallest to largest, and the data is then bucketed into quantiles with the same volume of exposures. Within each bucket the average predicted value and the average actual value are calculated and for each quantile the actual and the predicted values are plotted. The first quantile contains the risks that the model predicts have the best experience and the last quantile contains the risks predicted to have the worst experience. The plot shows two things: how well the model predicts actual values by quantile, and the lift of the model, the difference between the first and last quantile, which is a reflection of the model's ability to distinguish between the best and worst risks. By definition, the average predicted values would be monotonically increasing, but the average actual values may show reversals.37 An example follows:

![Quantile Plot](image)

**Rating Algorithm** – A rating algorithm is the mathematical or computational component of the rating plan used to calculate an insured’s premium.

**Rating Category** - A rating category is the same as a rating characteristic and can be quantitative or qualitative.

**Rating Characteristic** - A rating characteristic is a specific risk criterion of the insured used to define the level of the rating variable that applies to the insured. Ex. Rating variable- Driver age, Rating characteristic- Age 42

**Rating Factor** – A rating factor is the numerical component included in the rate pages of the rating plan's manual. Rating factors are used together with the rating algorithm to calculate the insured’s premium.

**Rating Plan** – The rating plan describes in detail how to combine the various components in the rules and rate pages to calculate the overall premium charged for any risk. The rating plan is very specific and includes explicit instructions, such as:
- the order in which rating variables should be considered,
- how the effect of rating variables is applied in the calculation of premium (e.g., multiplicative, additive, or some unique mathematical expression),

36 NAIC, [https://content.naic.org/cipr_topics/topic_auto_insurance.htm](https://content.naic.org/cipr_topics/topic_auto_insurance.htm)
the existence of maximum and minimum premiums (or in some cases the maximum discount or surcharge that can be applied), and
specifics associated with any rounding that takes place.
If the insurance product contains multiple coverages, then separate rating plans by coverage may apply.38

Rating System - The rating system is the insurance company's IT infrastructure that produces the rates derived from the rating algorithm.

Rating Tier - A rating tier is rating based on a combination of rating characteristics rather than a single rating characteristic resulting in a separation of groups of insureds into different rate levels within the same or separate companies. Often, rating tiers are used to differentiate quality of risk, e.g., substandard, standard, or preferred.

Rating Treatment - Rating treatment is the manner in which an aspect of the rating affects an insured’s premium.

Rating Variable - A rating variable is a risk criterion of the insured used to modify the base rate in a rating algorithm.39

Rational Explanation – A “rational explanation” refers to a plausible narrative connecting the variable and/or treatment in question with real-world circumstances or behaviors that contribute to the risk of insurance loss in a manner that is readily understandable to a consumer or other educated layperson. A “rational explanation” does not require strict proof of causality but should establish a sufficient degree of confidence that the variable and/or treatment selected are not obscure, irrelevant, or arbitrary.

A “rational explanation” can assist the regulator in explaining an approved rating treatment if challenged by a consumer, legislator, or the media. Furthermore, a “rational explanation” can increase the regulator’s confidence that a statistical correlation identified by the insurer is not spurious, temporary, or limited to the specific data sets analyzed by the insurer.

Raw Data - Data originating straight from the insurer's data banks without modification (e.g., not scrubbed, transformed). Raw data may occur with or without aggregation. Aggregated raw datasets are those summarized or compiled prior to data selection and model building.

Sample Record - A sample record is one line of data from a data source including all variables. For example:

<table>
<thead>
<tr>
<th>Record</th>
<th>ZIP</th>
<th>Coverage Type</th>
<th>Lot Size</th>
<th>Roof</th>
<th>Age</th>
<th>Replacement Cost</th>
<th>Heating</th>
<th>Living Area</th>
<th>Num Stories</th>
<th>Num Bathrooms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>04254</td>
<td>garage, basement</td>
<td>25700</td>
<td>asphalt shingle</td>
<td>1680</td>
<td>213000</td>
<td>FORCED HOT WATER</td>
<td>1680</td>
<td>1</td>
<td>Ranch</td>
</tr>
</tbody>
</table>

Scrubbed Data - Scrubbed data is data reviewed for errors, where "N/A" has been replaced with a value, and where most transformations have been performed. Data that has been "scrubbed" is now in a useable format to begin building the model.

Scrubbing Data - Scrubbing is the process of editing, amending, or removing data in a dataset that is incorrect, incomplete, improperly formatted, or duplicated.

SME - Subject Matter Expert.

Sub-Model - A sub-model is any model that provides input into another model.

Variable Transformation - A variable transformation is a change to a variable by taking a function of that variable, for example, when age's value is replaced by the value (age)^2. The result is called a transformation variable.

Voluntarily Reported Data - Voluntarily reported data is data directly obtained by a company from a consumer. Examples would be data taken directly from an application for insurance or obtained verbally by a company representative.

Univariate Model – A univariate model is a model that only has one independent variable.

APPENDIX D – SAMPLE RATE-DISRUPTION TEMPLATE

- First, fill in the boxes for minimum and maximum individual impacts, shaded in light blue. Default values in the cells are examples only.
- The appropriate percent-change ranges will then be generated based on the maximum/minimum changes.
- For every box shaded in light green, replace “ENTER VALUE” with the number of affected insureds within the corresponding change range.
- Once all values are filled in, use the “Charts” feature in Excel to generate a histogram to visually display the spread of impacts.

**NOTE:** Values of Minimum % Change, Maximum % Change, and Total Number of Insureds must reconcile to the Rate/Rule Schedule in SERFF.

<table>
<thead>
<tr>
<th>Minimum % Change</th>
<th>Uncapped</th>
<th>Capped (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-30.00%</td>
<td></td>
<td>-15.00%</td>
</tr>
<tr>
<td>30.00%</td>
<td></td>
<td>15.00%</td>
</tr>
<tr>
<td>Total Number of Insureds (Auto-Calculated)</td>
<td>1994</td>
<td>1994</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent-Change Range</th>
<th>Number of Insureds in Range</th>
<th>Percent-Change Range</th>
<th>Number of Insureds in Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>-30% to &lt;-25%</td>
<td>2</td>
<td>-15% to &lt;-10%</td>
<td>452</td>
</tr>
<tr>
<td>-25% to &lt;-20%</td>
<td>90</td>
<td>-10% to &lt;-5%</td>
<td>340</td>
</tr>
<tr>
<td>-20% to &lt;-15%</td>
<td>130</td>
<td>-5% to &lt;0%</td>
<td>245</td>
</tr>
<tr>
<td>-15% to &lt;-10%</td>
<td>230</td>
<td>Exactly 0%</td>
<td>12</td>
</tr>
<tr>
<td>-10% to &lt;-5%</td>
<td>340</td>
<td>&gt;0% to &lt;5%</td>
<td>150</td>
</tr>
<tr>
<td>-5% to &lt;0%</td>
<td>245</td>
<td>5% to &lt;10%</td>
<td>160</td>
</tr>
<tr>
<td>Exactly 0%</td>
<td>12</td>
<td>10% to &lt;15%</td>
<td>401</td>
</tr>
<tr>
<td>&gt;0% to &lt;5%</td>
<td>150</td>
<td>15% to &lt;20%</td>
<td>234</td>
</tr>
<tr>
<td>5% to &lt;10%</td>
<td>160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10% to &lt;15%</td>
<td>401</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15% to &lt;20%</td>
<td>201</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% to &lt;25%</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25% to &lt;30%</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30% to &lt;35%</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXAMPLE Uncapped Rate Disruption**

![Graph showing number of insureds in range](image)

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EXAMPLE Capped Rate Disruption

State Division of Insurance - EXAMPLE for Largest Percentage Increase

- Fill in fields highlighted in light green. Fields highlighted in red are imported from the Template for Rate Disruption.

<table>
<thead>
<tr>
<th>Largest Percentage Increase</th>
<th>Corresponding Dollar Increase (for Insured Receiving Largest Percentage Increase)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncapped Change</td>
<td>30.00</td>
</tr>
<tr>
<td>Uncapped Dollar Change</td>
<td>$165.00</td>
</tr>
<tr>
<td>Capped Change (if applicable)</td>
<td>15.00</td>
</tr>
<tr>
<td>Capped Dollar Change (if applicable)</td>
<td>$82.50</td>
</tr>
</tbody>
</table>

Characteristics of Policy (Fill in Below)

- For Auto Insurance: At minimum, identify the age and gender of each named insured, limits by coverage, territory, make / model of vehicle(s), prior accident / violation history, and any other key attributes whose treatments are affected by this filing.

- For Home Insurance: At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

Automobile policy: Three insureds - Male (Age 54), Female (Age 49), and Male (Age 25). Territory: Las Vegas, ZIP Code 89105.

<table>
<thead>
<tr>
<th>Vehicle:</th>
<th>BI Limits:</th>
<th>PD Limits:</th>
<th>UM/UIM Limits:</th>
<th>MED Limits:</th>
<th>COMP Deductible:</th>
<th>COLL Deductible:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009 Ford Focus</td>
<td>$50,000 / $100,000</td>
<td>$25,000</td>
<td>$50,000 / $100,000</td>
<td>$5,000</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>2003 Honda Accord</td>
<td>$25,000 / $50,000</td>
<td>$10,000</td>
<td>$25,000 / $50,000</td>
<td>$1,000</td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

No prior accidents, 1 prior speeding conviction for 25-year-old male. Policy receives EFT discount and loyalty discount.

Primary impacts are the increases to the relativities for the age of insured, ZIP Code 89105, COLL Deductible of $1,000, and symbol for 2003 Honda Accord.

Most Significant Impacts to This Policy (Identify attributes - e.g., base-rate change or changes to individual rating variables)

- For Auto Insurance: At minimum, identify the age and gender of each named insured, limits by coverage, territory, make / model of vehicle(s), prior accident / violation history, and any other key attributes whose treatments are affected by this filing.

- For Home Insurance: At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

<table>
<thead>
<tr>
<th>Attribute</th>
<th>% Impact (Uncapped)</th>
<th>Dollar Impact (Uncapped)</th>
<th>What lengths of policy terms does the insurer offer in this book of business?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Age (M/25)</td>
<td>12.00%</td>
<td>$66.00</td>
<td>Check all options that apply below.</td>
</tr>
<tr>
<td>COLL Deductible ($1,000)</td>
<td>10.00%</td>
<td>$61.60</td>
<td>☑ 12-Month Policies</td>
</tr>
<tr>
<td>Territory (89105)</td>
<td>4.00%</td>
<td>$27.10</td>
<td>☑ 6-Month Policies</td>
</tr>
<tr>
<td>Vehicle Symbol (2003 Honda Accord)</td>
<td>1.46%</td>
<td>$10.29</td>
<td>☑ 3-Month Policies</td>
</tr>
<tr>
<td>Effect of Capping</td>
<td>-11.54%</td>
<td>-$82.50</td>
<td>☐ Other (SPECIFY)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15.00%</td>
<td>$82.50</td>
<td></td>
</tr>
</tbody>
</table>

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Attachment Six

Casualty Actuarial and Statistical (C) Task Force

8/5/20
### State Division of Insurance - EXAMPLE for Largest Dollar Increase

<table>
<thead>
<tr>
<th>Largest Dollar Increase</th>
<th>Current Premium</th>
<th>Uncapped Percent Change</th>
<th>Corresponding Percentage Increase (for Insured Receiving Largest Dollar Increase)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncapped Change</td>
<td>$306.60</td>
<td></td>
<td>12.00%</td>
</tr>
<tr>
<td>Capped Change</td>
<td>$306.60</td>
<td></td>
<td>12.00%</td>
</tr>
</tbody>
</table>

#### Characteristics of Policy (Fill in Below)

- **For Auto Insurance:** At minimum, identify the age and gender of each named insured, limits by coverage, territory, make / model of vehicle(s), prior accident / violation history, and any other key attributes whose treatments are affected by this filing.
- **For Home Insurance:** At minimum, identify age and gender of each named insured, amount of insurance, territory, construction type, protection class, any prior loss history, and any other key attributes whose treatments are affected by this filing.

#### Automobile policy: Two insureds - Male (Age 33), Female (Age 32). Territory: Reno, ZIP Code 89504.

<table>
<thead>
<tr>
<th>Vehicle:</th>
<th>BI Limits:</th>
<th>PD Limits:</th>
<th>UM/UIM Limits:</th>
<th>MED Limits:</th>
<th>COMP Deductible:</th>
<th>COLL Deductible:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Tesla Model S</td>
<td>$200,000 / $600,000</td>
<td>$50,000</td>
<td>$200,000 / $600,000</td>
<td>$10,000</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>2015 Mercedes-Benz C-Class</td>
<td>$200,000 / $600,000</td>
<td>$50,000</td>
<td>$200,000 / $600,000</td>
<td>$10,000</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

1 prior at-fault accident for 32-year-old female. Policy receives EFT discount and loyalty discount.

Primary impacts are the increases to the relativities for the age of insured, symbol for 2015 Mercedes-Benz C-Class, and increased-limit factors for Property Damage and Medical Payments coverages.

#### Most Significant Impacts to This Policy

(Identify attributes - e.g., base-rate change or changes to individual rating variables)

**NOTE:** If capping is proposed to apply for this policy, include the impact of capping at the end, after displaying uncapped impacts by attribute. Add rows as needed. Total percent and dollar impacts should reconcile to the values presented above in this exhibit.

<table>
<thead>
<tr>
<th>Attribute</th>
<th>% Impact (Uncapped)</th>
<th>Dollar Impact (Uncapped)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Age (M/33)</td>
<td>3.15%</td>
<td>$80.48</td>
</tr>
<tr>
<td>Insured Age (F/32)</td>
<td>3.23%</td>
<td>$85.13</td>
</tr>
<tr>
<td>Vehicle Symbol (2015 Mercedes-Benz C-Class)</td>
<td>2.45%</td>
<td>$66.65</td>
</tr>
<tr>
<td>Increased-Limit Factor for PD</td>
<td>1.55%</td>
<td>$43.20</td>
</tr>
<tr>
<td>Increased-Limit Factor for MED</td>
<td>1.10%</td>
<td>$31.14</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12.00%</td>
<td>$306.60</td>
</tr>
</tbody>
</table>
Kris DeFrain, FCAS, MAAA, CPCU
Director of Research and Actuarial Services
National Association of Insurance Commissioners

Sent via email


Dear Kris:

I appreciate this opportunity to comment on the Casualty Actuarial and Statistical Task Force (CASTF)’s June 12, 2020, exposure draft containing potential best practices for the Regulatory Review of Predictive Models (RRPM). I note that it appears that the CASTF is working to bring the review process of its white paper to a close. Clearly this is a topic of interest for the Academy’s membership. As in our prior two letters,1,2 we would like to offer just some brief comments.

I would like to revisit a point from my prior letter. Specifically, in Section VII there is a discussion of regulatory best practices. Item 1.b. discusses the need to determine that individual input characteristics and resulting rating factors are related to the expected loss or expense differences in risk. Later in the document, Appendix B, *Information Elements A.4.b and B.3.d* seeks to obtain information as to the rational relationship or rational explanation that predictive data or predictor variables have to the predicted variable. Predictive data or predictor variables that are related to risk of loss (as demonstrated by analysis of historical insurance loss or expense data across the predictors) are key rational relationships. As we consider this, actuaries are guided by Actuarial Standard of Practice (ASOP) No. 12, *Risk Classification*. Within that ASOP, there are several key considerations to guide both regulators and modelers.

The RRPM White Paper provides considerable latitude in its scope. Perhaps this is in keeping with the range of possibilities that new data sources coupled with broad computing power brings to the predictive modeling field. Insurance underwriting has, for decades, been moved in the direction of greater granularity in its use of data and underwriter judgment. All the while, these efforts have facilitated better pricing accuracy and broader availability of insurance products.

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short, model innovation has many potential benefits to the insurance market. At the same time, there is the potential for modeling to be stretched too far through such innovations. One would hope that application of the RRPM White Paper best practices, used effectively, finds a balance between innovation and control.

New data sources are ever changing, and especially when considered in the context of technological improvements possible for the insurance industry, pose interesting challenges and opportunities. Properly used, these new tools and access to data should lead to expense reductions that ultimately yield lower costs in the insurance system. That said, new data sources require considerable due diligence as they are assimilated into the modeling process. ASOP No. 23, *Data Quality,* is available to guide actuaries as they consider new information sources. We would again hope that a RRPM process will work collaboratively with ASOP No. 23 around new data sources.

Finally, as CASTF moves toward finalizing its recommendations for the RRPM process and thus toward implementation across the various states, I think that it is important to understand the workload challenges that will perhaps result from the new RRPM requirements. Specifically, will the state regulators have the necessary staffing and/or resources to move toward effective implementation?

Thanks once again for allowing this input. The Academy remains available to assist as CASTF moves forward with this.

Sincerely,

Richard Gibson, MAAA, FCAS
Senior Casualty Fellow
American Academy of Actuaries
The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to provide comment on the NAIC Casualty Actuarial and Statistical Task Force (CASTF) exposure draft, dated June 12, 2020, regarding the Regulatory Review of Predictive Models.

APCIA is committed to working collaboratively with the NAIC in support of innovation and the effort to leverage the advancements in technology and data analytics to effectively respond to the changing risks and needs of insurance consumers. APCIA appreciates some changes have been made by the drafting group, such as mapping the best practices with the information elements. In reviewing the document as a whole, however, APCIA’s conclusion remains that the information collected in Appendix B will lead to significant increase in the length of time and costs for filing approval with limited regulatory benefit. Importantly, several of these information elements are redundant, highly prescriptive, and overly detailed. Approval time is going to be significantly extended and our ability to respond to the needs of the insurance consumer negatively delayed.

Finally, the Key Regulatory Principles identify principles that the best practices are based on to promote a comprehensive and coordinated review of predictive models across states. Principle two indicates that “State regulators will be able to share information to aid companies in getting insurance products to market more quickly across the states.” APCIA recognizes that this is not necessarily new for this version of the White Paper but inquires if CASTF could explain what is meant by that particular principle.

We have included a red-line version of Appendix B for your consideration. A description of the APCIA reasoning for each recommended change is provided in the final column of the chart.

Thank you for your consideration of these comments and APCIA is happy to answer any questions that you may have.

Respectfully submitted,

Angela Gleason
APENDIX B – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES’ OBJECTIVES (WHEN REVIEWING GLMS)

This appendix identifies the information a regulator may need to review a predictive model used by an insurer to support a personal automobile or home insurance rating plan. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to sufficient information that helps determine if the rating plan meets state specific filing and legal requirements.

Documentation of the design and operational details of the model will ensure business continuity and transparency of models used. Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing need to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be shared with regulators in a timely manner and documented, and IT controls should be in place, such as a record of versions, change control and access to model. APCIA Comment for Consideration: This paragraph describes documentation that needs to be kept on the model, but also adds to the IT controls for model revisions. Since the majority of the models within the review are the pricing models, which need to be filed with the department of insurance, the IT controls are on the rating plans and not necessarily the model version. Additionally, companies are already subject to robust IT controls. It is also unclear on what is meant by the following sentence: “Major changes to the model need to be shared with regulators in a timely manner . . .” If a company refreshes the model and notices an indication changed for a particular attribute, won’t the appropriate mechanism for sharing that information be part of a filing to adjust the rating plan? This sentence could be read to suggest a different type of information being necessary.

Many information elements listed below are probably confidential, proprietary or trade secret and should be treated as such according to state law. Regulators should be aware of their state laws on confidentiality when requesting data from insurers that may be proprietary or trade secret. For example, some proprietary models may have contractual terms (with the insurer) that prevent disclosure to the public. Without clear necessity, exposing this data to additional dissemination may compromise the model's protection. Though the list of information is long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate for a regulator (approximately 25%).

The “Level of Importance to the Regulator’s Review” is a ranking of information a regulator may need to review is based on the following level criteria:

- **Level 1** - This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

- **Level 2** - This information is necessary to continue the review of all but the most basic models; such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

- **Level 3** - This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Levels 1 and 2. These data elements address even more detailed aspects of the model. This information does not necessarily need to be included with the initial submission, unless specifically requested in a particular state, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws.

- **Level 4** - This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Levels 1, 2, and 3. This most granular level of detail is addressing the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested in a particular state. It is typically requested only if the reviewer has serious concerns that the model may produce rates or rating factors that are excessive, inadequate, or unfairly discriminatory.

Lastly, though the best practices presented in this paper will readily be transferrable to review of other predictive models, the information elements presented here might be useful only with deeper adaptations when starting to review different types of predictive models. If the model is not a GLM, some listed items might not apply, for example, not all predictive models generate p-values or F tests. Depending

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2 There are some models that are made public by the vendor and would not result in a hindrance of the model's protection.
on the model type, other considerations might be important but are not listed here. When information elements presented in this appendix is applied to lines of business other than personal automobile and home insurance or other type of models, unique considerations may arise, in particular data volume and credibility may be lower for other lines of business. Regulators should be aware of the context in which a predictive model is deployed, the uses to which the model is proposed to be put, and the potential consequences the model may have on the insurer, its customers, and its competitors. This paper does not delve into these possible considerations, but regulators should be prepared to address them as they arise.

**A. SELECTING MODEL INPUT**

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to the Regulator’s</th>
<th>Comments</th>
<th>APCIA Comments</th>
</tr>
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<tbody>
<tr>
<td>1. Available Data Sources</td>
<td>Review the details of sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model).</td>
<td>1</td>
<td>Request details of all data sources, with a proportionate impact on rates, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source recognizing the need for exceptions for the proprietary components when sufficient confidentiality and trade secret protections are not available. For insurance data, get a list all companies whose data is included in the datasets. Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the Fair Credit Reporting Act. If the data is from an outside source, find out what steps the insurer has taken to verify the outside source has processes and procedures in place to assess the data’s accuracy, completeness and unbiased characteristics in terms of relevant and representative time frame, representative of potential exposures and lacking in obvious correlation to protected classes. Note that reviewing source details should not make a difference when the model is new or refreshed—refreshed models would report the prior version list with the incremental changes due to the refresh.</td>
<td>Not all</td>
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<tr>
<td></td>
<td>A.1.a</td>
<td></td>
<td>Requesting a contributing company list is an unnecessary overreach and, in some cases, will be unknown due to aggregation and anonymization. In addition, there could be contractual restrictions for sharing this information. APCIA respectfully believes that the remaining data elements should be sufficient. At the very least this should not be considered essential level 1 data. Insurance companies can take some verification steps, but most of the work will have to be completed by the third-party. The suggestion for refreshed models infers that a company needs to document changes in data source on a refresh and that is not a requirement. There may need to be some clarification around what is considered “insurance” and non-insurance data. Also, consideration should be given to the application of CAS ASOP 12.</td>
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<tr>
<td>A.1.b</td>
<td>Reconcile aggregated insurance data underlying the model with available external insurance reports.</td>
<td>4</td>
<td>Accuracy of insurance data should be reviewed. It is assumed that the data in the insurer's data banks is subject to routine internal company audits and reconciliation. “Aggregated data” is straight from the insurer's data banks without further modification (e.g., not scrubbed or transformed for the purposes of modeling). In other words, the data would not have been specifically modified for the purpose of model building. The company should provide some form of reasonability check that the data makes sense when checked against other audited sources.</td>
<td></td>
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<tr>
<td>A.1.c</td>
<td>Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.</td>
<td>2</td>
<td>The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing and validation. The company should provide an explanation where the data came from geographically and that it is a good representation for a state, i.e., the distribution by state should not introduce a geographic bias. For example, there could be a bias by peril or wind-resistant building codes. Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur.</td>
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### 2. Sub-Models -

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<tbody>
<tr>
<td>A.2.a</td>
<td>Consider the relevance of (e.g., is there a bias) of overlapping data or variables used in the model and sub-models.</td>
<td>1</td>
<td>Check if the same variables/datasets were used in both the model, a sub-model or as stand-alone rating characteristics. If so, verify the insurance company has processes and procedures in place to assess and address there was no double-counting or redundancy.</td>
</tr>
<tr>
<td>A.2.b</td>
<td>Determine if the sub-model was previously approved (or accepted) by the regulatory agency.</td>
<td>1</td>
<td>If the sub-model was previously approved, that may reduce the extent of the sub-model’s review. If approved, obtain the SERFF number and verify when and that it was the same model currently under review. However, previous approvals do not necessarily confer a guarantee of ongoing approval, for example when statutes and regulations have changed or if a model's indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator's efforts and determine whether or not the prior decision needs to be revisited.</td>
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Many models are developed using a countrywide or a regional dataset, rarely is a model built for a specific state. This review must balance the question of relevance with potential scarcity of data for a particular state. Confidentiality and competitiveness issues may arise when disclosing vendor information. Since this is an element for expediting review, it is reasonable to make sure the insurance company consents to the vendor identification and dialogue. In addition, the insurer may not have the right to disclose if a sub-model is purchased. Extending the regulator’s review to the underlying sub-model in the same breadth and depth as the insurer’s filed model seems very impractical.
| A.2.c | Determine if sub-model output was used as input to the GLM; obtain the vendor name, and the name and version of the sub-model. | 1 | To accelerate the review of the filing, and consented to by the company, get the name and contact information for a representative from the vendor. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The "contact" can be an intermediary at the insurer, e.g., a filing specialist, who can place the regulator in direct contact with a Subject Matter Expert (SME) at the vendor. Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. SMEs on sub-model may need to be brought into the conversation with regulators (whether in-house or 3rd-party sub-models are used). |
| A.2.d | If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run. | 1 | For example, it is important to know hurricane model settings for storm surge, demand surge, long/short-term views. To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The "SME" can be an intermediary at the insurer, e.g., a filing specialist, who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor. |
| A.2.e | If using catastrophe model output (a sub-model) as input to the GLM under review, verify whether loss associated with the modeled output was removed from the loss experience datasets. Obtain an explanation of how catastrophic models are integrated into the model to ensure no double-counting. | 1 | If a weather-based sub-model is input to the GLM under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double counting such losses when determining relativities or loss loads in the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model, inclusion of freeze losses when using a winter storm model or including demand surge caused by any catastrophic event. Note that, the rating plan or indications underlying the rating plan, may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should In addition to the recommended changes in the comments, they should clarify that this element is directed at vendor contact information and not the accuracy of the vendor data. If it is vendor data accuracy, then the burden of that question, as noted elsewhere in these comments, will be on the vendor, not the insurer. This note is not discussing catastrophe model outputs but rather a general statement about large losses and should be removed from the Sub-Model section and moved into the Data section or at the very least the weight of this observation should be lowered. |
A.2.f If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.

1 Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model’s output as input. Depending on the result of item A.2.b, the importance of this item may be decreased.

If the scoring algorithm is purchased, an insurer may not have the right to disclose this information. It would be much more efficient to instead point to filing of sub-models. Additionally, similar to the comment above, given the numerous sub-models common in the industry, extending the regulator’s review to the underlying model, in the same breadth and depth as the insurer’s filed model, seems impractical.

Finally, there should be clarity as to the difference between a “scoring model” and a “sub-model.”

### 3. Adjustments to Data

A.3.a Determine if premium, exposure, loss or expense data were adjusted (e.g., developed, trended, adjusted for catastrophe experience or capped) and, if so, how? Do the adjustments vary for different segments of the data and, if so, identify the segments and how was the data adjusted?

2 The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model’s training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane or severe convective storm losses for personal automobile comprehensive or home insurance.

The way that an insurer adjusts premium could be trade secret and APCIA is concerned about confidentiality. Further, insurers may be willing to describe the process at a high level, but getting into each transformation to each variable, is extensive.
| A.3.b | Identify adjustments that were made to aggregated data, e.g., transformations, binning and/or categorizations. If any, identify the name of the characteristic/variable and obtain a description of the adjustment. | 1 | Previous sections will detail the adjustments made, so providing a comparison is not necessary. |
| A.3.c | Ask for aggregated data (one data set of pre-adjusted/scrubbed data and one data set of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data. | 4 | If a regulator may never ask for the aggregated information, as pointed out in the note, what is the purpose of including it? |
| A.3.d | Determine how missing data was handled. | 1 | |
| A.3.e | If duplicate records exist, determine how they were handled. | 1 | |
| A.3.f | Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process. | 3 | Drafters should make it clear that this section is looking for a description of the type of outliers and the treatment and not a listing. |

4. Data Organization
| A.4.a | Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests. | 2 | This should explain how data from separate sources was merged or how subsets of policies, based on selected characteristics, are filtered to be included in the data underlying the model and the rationale for that filtering. | We are unclear as to the value of documenting the procedure to merge data as such the value of the information is disproportionate to the work needed to provide this information. At the very least this question should not be asked often and should be a level 3 or 4, instead of a 2. |
| A.4.b | Obtain documentation on the insurer’s process for reviewing the appropriateness, reasonableness, consistency and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable. | 2 | An example is when by-peril or by-coverage modeling is performed, the documentation should be for each peril/coverage and make rational sense. For example, if “murder” or “theft” data are used to predict the wind peril, provide support and a rational explanation for their use. | This question gets into the debate on correlation versus causation. Is actuarial justification sufficient or does this imply a logical argument is required? Insurers can provide information related to accuracy, consistency, and comprehensiveness, but have concerns with expanding the inquiry into causational questions. Further, the Information Element and Comment do not match. The information element is talking more about data as a whole, while the comment is going to specific variables, which is something better suited for “Building the Model.” The comment does not reflect what the perceived intent of the information element is. |
| A.4.c | Identify material findings the company had during their data review and obtain an explanation of any potential material limitations, defects, bias or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted. | 1 | A response of “none” or “n/a” may be an appropriate response. | What is the justification for this request? Is the request for the final elements or for the exploratory dataset? Bias in data is almost impossible to know without a full dataset to compare to – we can only make assumptions or inferences. The question does not necessarily speak to the appropriateness of the model. For example, where a new data element is only available on 40% of the exposure – how does this impact the model or output? |
B. BUILDING THE MODEL

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to Regulator’s Review</th>
<th>Comments</th>
<th>APCIA comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1.a</td>
<td>Identify the type of model underlying the rate filing (e.g. Generalized Linear Model – GLM, decision tree, Bayesian Generalized Linear Model, Gradient-Boosting Machine, neural network, etc.). Understand the model’s role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.</td>
<td>1</td>
<td>It is important to understand if the model in question is a GLM, and therefore these information elements are applicable or, if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/coverage. Note, if the model is not a GLM, the information elements in this white paper may not apply in their entirety.</td>
<td>APCIA suggests that there should be additional clarity, if not deleted, as to the expectation for asking for an explanation of why the model is appropriate for the line of business. Different techniques may be suitable depending on the intended application of the model, however this is not specifically related to the line of business.</td>
</tr>
<tr>
<td>B.1.b</td>
<td>Identify the software used for model development. Obtain the name of the software vendor/developer, software product and software version reference used in model development.</td>
<td>3</td>
<td>Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a “contact” in the event the regulator has questions. The “contact” can be an intermediary at the insurer who can place the regulator in direct contact with appropriate SMEs. Open-source software/programs used in model development should be identified by name and version the same as if from a vendor.</td>
<td>What is the purpose for this information? It is unclear how the software used for building the model is relevant to the review and B.1.a already asks for information about the type of model. Without reviewing the code, which is impractical, it is unclear what the regulator will do with the version information. APCIA is uncertain as to how this applies to whether or not the model and output are appropriate. Also, if the insurer has developed their own internal tools, how will this be disclosed since those tools are proprietary. Ultimately, we feel this section should be deleted in its entirety. Otherwise, we offer a few suggested edits for your consideration.</td>
</tr>
<tr>
<td>B.1.c</td>
<td>Obtain a description how the available data was divided between model training, test and/or validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, whether the company made any further subdivisions of available data and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation why that came to occur. Obtain a discussion of whether the model was rebuilt using all of the data or if it was only based on the training data.</td>
<td>1</td>
<td>The reviewer should be aware that modelers may break their data into three or just two datasets. Although the term “training” is used with little ambiguity, “test” and “validation” are terms that are sometimes interchanged, or the word “validation” may not be used at all. It would be unexpected if validation and/or test data were used for any purpose other than validation and/or test, prior to the selection of the final model.</td>
<td>Cross validation is commonly used when there is limited data available. Cross validation should be listed as an option in this section.</td>
</tr>
<tr>
<td>B.1.d</td>
<td>Obtain a brief description of the development process, from initial concept to final model and filed rating plan.</td>
<td>1</td>
<td>The narrative should have the same scope as the filing.</td>
<td></td>
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<tr>
<td>B.1.e</td>
<td>Obtain a narrative on whether loss ratio, pure premium or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.</td>
<td>1</td>
<td>There should be an option for “deviation from current rate” in this list as well.</td>
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<tr>
<td>B.1.f</td>
<td>Identify the model’s target variable.</td>
<td>1</td>
<td>A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the “raw” data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.</td>
<td>It is unnecessary to comment on the data mining, because the general model validation should cover this.</td>
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<tr>
<td>B.1.g</td>
<td>Obtain a description of the variable selection process.</td>
<td>1</td>
<td>The narrative regarding the variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making the decisions regarding variable selection.</td>
<td>The modeler should comment if any form of data mining to identify selected variables was performed and explain how the modeler...</td>
</tr>
<tr>
<td>B.1.h</td>
<td>In conjunction with variable selection, obtain a narrative on how the company determine the granularity of the rating variables during model development.</td>
<td>3</td>
<td>This discussion should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected.</td>
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<td>B.1.i</td>
<td>Determine if model input data was segmented in any way. For example, was modeling performed on a by-coverage, by-peril, or by-form basis? If so, obtain a description of data segmentation and the reasons for data segmentation.</td>
<td>4</td>
<td>The regulator would use this to follow the logic of the modeling process. This information is duplicative of B.1.a</td>
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<tr>
<td>B.1.j</td>
<td>If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied.</td>
<td>2</td>
<td>Adjustments may be needed given models do not explicitly consider the credibility of the input data or the model’s resulting output; models take input data at face value and assume 100% credibility when producing modeled output. The use of “credibility” seems to be referring to the actuarial concept of credibility. It is not clear what the relevance is of that concept in modeling. Rather, the question should focus on approach and philosophy to feature engineering in model statistics to determine the appropriateness of features and levels. The comments should clarify that this refers to model credibility, not actuarial. If this information element is trying to address credibility as it relates to adjustments made to model factors/results post model building, then this information may be more relevant in the filed rating plan section where selections are made to the factors due to credibility concerns.</td>
<td></td>
</tr>
</tbody>
</table>

2. Medium-Level Narrative for Building the Model

<p>| B.2.a | At crucial points in model development, if selections were made among alternatives regarding model assumptions or techniques, obtain a narrative on the judgment used to make those selections. | 3 | 4 | This should be a level 4 instead of a 3. If a state has serious concerns with a model, this does not seem like an item that would come up. |</p>
<table>
<thead>
<tr>
<th>B.2.b</th>
<th>If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments.</th>
<th>2</th>
<th>Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding how those adjustments were done, including any statistical improvement measures relied upon. This is duplicative of B.1.d, so long as there is no clarity in when the “beginning” and “end” of a modeling exercise. APCIA does not believe this information is relevant if focused on the iterations of model building. As an example, is a model refresh considered a new modeling exercise or a continuation/update to an open modeling exercise?</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.2.c</td>
<td>Obtain a description of the testing that was performed during the model-building process and a discussion of why interaction terms were included (or not included).</td>
<td>3</td>
<td>There should be a description of testing that was performed during the model-building process. Examples of tests that may have been performed include univariate testing and review of a correlation matrix. The interaction element is irrelevant unless a regulator has concerns around the interaction that was recommended to be included.</td>
</tr>
<tr>
<td>B.2.d</td>
<td>For the GLM, identify the link function used. Identify which distribution was used for the model (e.g., Poisson, Gaussian, log-normal, Tweedie). Obtain an explanation why the link function and distribution were chosen. Obtain the formulas for the distribution and link functions, including specific numerical parameters of the distribution. Obtain a discussion of applicable convergence criterion.</td>
<td>1</td>
<td>Solving the GLM is iterative and the modeler can check to see if fit is improving. At some point convergence occurs, though when it occurs can be subjective or based on threshold criteria. The convergence criterion should be documented with a brief explanation of why it was selected. If the software's default convergence criteria were relied upon, the regulator should look for a description of the default convergence criterion and an explanation of any deviation from it. The request for formulas for the distribution and link functions seems like unnecessary “textbook” information. Additionally, obtaining a description of convergence criterion does not provide any valuable information and should be deleted.</td>
</tr>
<tr>
<td>B.2.e</td>
<td>Obtain a narrative on the formula relationship between the data and the model outputs, with a definition of each model input and output. The narrative should include all coefficients necessary to evaluate the predicted pure premium, relativity or other value, for any real or hypothetical set of inputs.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>B.2.f</td>
<td>If there were data situations in which GLM weights were used, obtain an explanation of how and why they were used.</td>
<td>3</td>
<td>Investigate whether identical records were combined to build the model. Are there level 1 or level 2 Information elements that could get to this information?</td>
</tr>
<tr>
<td>3. Predictor Variables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.3.a</td>
<td>Obtain a complete data dictionary, including the names, types, definitions and uses of each predictor variable, offset variable, control variable, proxy variable, geographic variable, geodemographic variable and all other variables in the model used on their own or as an interaction with other variables (including sub-models and external models).</td>
<td>1</td>
<td>Types of variables might be continuous, discrete, Boolean, etc. Definitions should not use programming language or code. For any variable(s) intended to function as a control or offset, obtain an explanation of its purpose and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact. Certainly, key variables must be clearly explained, but such a comprehensive and formal dictionary is not necessary. Including “uses” also raises confidentiality concerns.</td>
</tr>
<tr>
<td>B.3.b</td>
<td>Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.</td>
<td>4</td>
<td>The purpose of this requirement is to identify variables that the company finds to be predictive but ultimately may reject for reasons other than loss cost considerations (e.g., price optimization). Also, look for variables the company tested and then rejected. This item could help address concerns about data dredging. The reasonableness of including a variable with given significance level could depend greatly on the other variables the company evaluated for inclusion in the model and the criteria for inclusion or omission. For instance, if the company tested 1,000 similar variables and selected the one with the lowest p-value of 0.001, this would be a far, far weaker case for statistical significance than if that variable was the only one the company evaluated. Note, context matters. APCIA appreciates the intent behind this but there may be an extensive list of variables not considered, which could significantly detract from the primary focus of the regulator’s review, which is to assess the model presented including the variables that were ultimately selected. Additionally, going through this list of variables that will have no impact on a customer’s premium in the final rating plan is extensive and not relevant. The fact that an insurer looked at a variable that was later deemed to be rejected for some reason, should not have a bearing on the validity and approval of the model within the filing.</td>
</tr>
<tr>
<td>B.3.c</td>
<td>Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).</td>
<td>3</td>
<td>While GLMs accommodate collinearity, the correlation matrix provides more information about the magnitude of correlation between variables. The company should indicate what statistic was used (e.g., Pearson, Cramer's V). The regulatory reviewer should understand what statistic was used to produce the matrix but should not prescribe the statistic.</td>
</tr>
<tr>
<td>B.3.d</td>
<td>Obtain a rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.</td>
<td>3</td>
<td>The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate. For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable. This Information element is vague. Most of the rational explanations will relate to the correlation. Since causation cannot be proven it potentially can come with biases or misunderstanding of the characteristics. For example, the data can suggest as a predictor increases so does the loss cost and thus the predicted factors, however, to opine on potential reasonings for this may not be appropriate. We should let the data drive the discussion. However, a welcomed discussion on how the data aligns is appropriate. To ask if there is a frequency or severity component, how a variable interacts with those variables (for example, limit), or is there are large losses that drive the results are appropriate. This demonstrates that the modeler spent time to understand the data and what is driving the results that they see.</td>
</tr>
<tr>
<td>B.3.e</td>
<td>If the modeler made use of one or more dimensionality reduction techniques, such as a Principal Component Analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of linearly uncorrelated variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, and an explanation how the results of the dimensionality reduction technique was used within the model.</td>
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<tr>
<td>2</td>
<td>This element is textbook “rules based” and redundant.</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Adjusting Data, Model Validation and Goodness-of-Fit Measures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B.4.a</td>
<td>Obtain a description of the methods used to assess the statistical significance/goodness of the fit of the model to validation data, such as lift charts and statistical tests. Compare the model's projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.</td>
</tr>
<tr>
<td>1</td>
<td>For models that are built using multi-state data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on State-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk. Look for geographic stability measures, e.g., across states or territories within state.</td>
</tr>
<tr>
<td>1</td>
<td>It is excessive to have the statement about geographic stability measures when the 1st paragraph talks about state level data being potentially low credibility.</td>
</tr>
<tr>
<td>B.4.b</td>
<td>For all variables (discrete or continuous), review the appropriate parameter values, confidence intervals, chi-square tests, p-values, and any other relevant and material tests. Determine if model development data, validation data, test data or other data was used for these tests.</td>
</tr>
<tr>
<td>4</td>
<td>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model. For example, the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around</td>
</tr>
<tr>
<td>4</td>
<td>This is overly prescriptive and could include trade secret information. The information can be sufficiently gleaned elsewhere without this amount of detail.</td>
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</table>
the modeled parameters; for example, confidence intervals around each level of an AQL curve might be more than what is needed.

B.4.c Identify the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold.

The explanation should clearly identify the thresholds for statistical significance used by the modeler. Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model. For example, the threshold might be lower when many candidate variables were evaluated for inclusion in the model.

Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests.

This is overly prescriptive and could include trade secret information. The information can be sufficiently gleaned elsewhere without this amount of detail. Additionally, the information element is focused very specifically on p-values, yet in prior discussions it was mentioned that other tests may be leveraged as p-values may not be appropriate.
<p>| | |</p>
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<tr>
<td><strong>B.4.d</strong></td>
<td>For overall discrete variables, review type 3 chi-square tests, p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests.</td>
</tr>
<tr>
<td></td>
<td>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed. This is overly prescriptive and could include trade secret information. The information can be sufficiently gleaned elsewhere without this amount of detail.</td>
</tr>
<tr>
<td><strong>B.4.e</strong></td>
<td>Obtain evidence that the model fits the training data well, for individual variables, for any relevant combinations of variables and for the overall model.</td>
</tr>
<tr>
<td></td>
<td>For a GLM, such evidence may be available using chi-square tests, p-values, F-tests and/or other means. The steps taken during modeling to achieve goodness-of-fit are likely to be numerous and laborious to describe, but they contribute much of what is generalized about GLM. We should not assume we know what they did and ask &quot;how?&quot; Instead, we should ask what they did and be prepared to ask follow-up questions. This is overly prescriptive and could include trade secret information. The information can be sufficiently gleaned elsewhere without this amount of detail.</td>
</tr>
<tr>
<td>B.4.f</td>
<td>2</td>
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<tr>
<td>For continuous variables, provide confidence intervals, chi-square tests, p-values and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests.</td>
<td></td>
</tr>
<tr>
<td>Typical p-values greater than 5% are large and should be questioned. Reasonable business judgment can sometimes provide legitimate support for high p-values. Reasonableness of the p-value threshold could also vary depending on the context of the model, e.g., the threshold might be lower when many candidate variables were evaluated for inclusion in the model. Overall lift charts and/or statistical tests using validation data may not provide enough of the picture. If there is concern about one or more individual variables, the reviewer may obtain, for each discrete variable level, the parameter value, confidence intervals, chi-square tests, p-values and any other relevant and material tests. For variables that are modeled continuously, it may be sufficient to obtain statistics around the modeled parameters; for example, confidence intervals around each level of an AOI curve might be more than what is needed. This is overly prescriptive and could include trade secret information. The information can be sufficiently gleaned elsewhere without this amount of detail.</td>
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<table>
<thead>
<tr>
<th>B.4.g</th>
<th>2</th>
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<tbody>
<tr>
<td>Obtain a description how the model was tested for stability over time.</td>
<td></td>
</tr>
<tr>
<td>Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets). Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data. The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls will exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model? The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim</td>
<td></td>
</tr>
<tr>
<td>B.4.b</td>
<td>Obtain a narrative on how potential concerns with overfitting were addressed.</td>
</tr>
<tr>
<td>B.4.i</td>
<td>Obtain support demonstrating that the GLM assumptions are appropriate.</td>
</tr>
<tr>
<td>B.4.j</td>
<td>Obtain 5-10 sample records with corresponding output from the model for those records.</td>
</tr>
</tbody>
</table>
### 5. “Old Model” Versus “New Model”

| B.5.a | Obtain an explanation why this model is an improvement to the current rating plan. If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model. | 2 | Regulators should expect to see improvement in the new class plan’s predictive ability or other sufficient reason for the change. |
| B.5.b | Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison. | 2 | One example of a comparison might be sufficient. This is relevant when one model is being updated or replaced. Regulators should expect to see improvement in the new class plan’s predictive ability. This information element requests a comparison of Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data. This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph for information on Gini coefficients. This is too prescriptive and should be eliminated. |
| B.5.c | Determine if double lift charts were analyzed and obtain a narrative on the conclusion drawn from this analysis. | 2 | One example of a comparison might be sufficient. Note that “not applicable” is an acceptable response. This is too prescriptive and should be deleted. |
| B.5.d | If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model. Obtain an explanation why these variables were dropped from the new model. Obtain a list of all new predictor variables in the new model that were not in the prior old model. | 2 | Useful to differentiate between old and new variables so the regulator can prioritize more time on variables not yet reviewed. |

### 6. Modeler Software

| B.6.a | Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the model, and/or performed peer review. | 2 4 | The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model. This should be a level 4 as opposed to a 3. At a level 3 requesting access to the modelers appears excessive. Also requesting access to the SMEs that performed a peer review is quite excessive and |
would require companies to think about how to ensure the peer reviewer is prepared for discussions.

### C. THE FILED RATING PLAN

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Impact of Model on Rating Algorithm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.1.a</td>
<td>In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (how it was used) in the rating system.</td>
<td>1</td>
<td>The &quot;role of the model&quot; relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model's goal, but rather a description of how specifically the model is used. This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</td>
</tr>
<tr>
<td>C.1.b</td>
<td>Obtain an explanation of how the model was used to adjust the rating algorithm.</td>
<td>4</td>
<td>Models are often used to produce factor-based indications, which are then used as the basis for the selected changes to the rating plan. It is the changes to the rating plan that create impacts. Consider asking for an explanation of how the model was used to adjust the rating algorithm. This information is already addressed in section B.</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain text).</td>
<td>1</td>
<td>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</td>
</tr>
</tbody>
</table>
### 2. Relevance of Variables and Relationship to Risk of Loss

<table>
<thead>
<tr>
<th>C.2.a</th>
<th>Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss (or expense) for the type of insurance product being priced.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model results should be consistent with the expected direction of the relationship. This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.</td>
</tr>
</tbody>
</table>

The narrative is going to be subjective, instead the data should just speak for itself.

### 3. Comparison of Model Outputs to Current and Selected Rating Factors

<table>
<thead>
<tr>
<th>C.3.a</th>
<th>Compare relativities indicated by the model to both current relativities and the insurer's selected relativities for each risk characteristic/variable in the rating plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“Significant difference” may vary based on the risk characteristic/variable and context. However, the movement of a selected relativity should be in the direction of the indicated relativity; if not, an explanation is necessary as to why the movement is logical.</td>
</tr>
</tbody>
</table>

Insurers are willing to provide a high-level explanation of the selection, but not the factors due to confidentiality concerns. This Information Element may be more relevant on model refresh/updates to indications.

<table>
<thead>
<tr>
<th>C.3.b</th>
<th>Obtain documentation and support for all calculations, judgments, or adjustments that connect the model's indicated values to the selected values.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The documentation should include explanations for the necessity of any such adjustments and explain each significant difference between the model's indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. This information is especially important if differences between model indicated values and selected values are material and/or impact one consumer population more than another.</td>
</tr>
</tbody>
</table>

This Information Element is duplicative of C.3.a.
For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures.

Modeling loss ratio with these characteristics/variables as control variables would account for possible overlap. The insurer should address this possibility or other considerations, e.g., tier placement models often use risk characteristics/variables that are also used elsewhere in the rating plan.

One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals.

### 4. Responses to Data, Credibility and Granularity Issues

<table>
<thead>
<tr>
<th>C.4.a</th>
<th>Determine what, if any, consideration was given to the credibility of the output data.</th>
<th>2</th>
<th>At what level of granularity is credibility applied. If modeling was by-coverage, by-form or by-peril, explain how these were handled when there was not enough credible data by coverage, form or peril to model.</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.4.b</td>
<td>If the rating plan is less granular than the model, obtain an explanation why.</td>
<td>2</td>
<td>This is applicable if the insurer had to combine modeled output in order to reduce the granularity of the rating plan. Consider combining this C.4.b and C.4.c.</td>
</tr>
<tr>
<td>C.4.c</td>
<td>If the rating plan is more granular than the model, obtain an explanation why.</td>
<td>2</td>
<td>A more granular rating plan may imply that the insurer had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications. However, it may be necessary to extrapolate due to data availability or other considerations. APCIA believes the comment for this information element is presumptive and needs to be balanced out with recognition that there could be other explanations.</td>
</tr>
</tbody>
</table>

### 5. Definitions of Rating Variables

| C.5.a | Obtain a narrative on adjustments made to model output, e.g., transformations, binning and/or categorizations. If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment. | 2 | If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation how model output was translated into these rating tiers or intermediate rating categories. This is too detailed and it is not clear how this provides value to the review. It also could be trade secret. There is a risk of exposing intellectual property without serving any benefit. This is simply more documentation and does not help in the review. |

### 6. Supporting Data

| C.6.a | Obtain aggregated state-specific, book of business-specific, univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation whether it is raw or adjusted and, if the latter, obtain a detailed | 4 | For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc.? Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference. Caution must be exercised whenever drilling down on actual results, including by year, as these may volatile and in and of themselves not reflective of the model’s predictive power. This variability should be visible and contemplated through appropriate statistical metrics and testing. Additionally, there are confidentiality considerations. While this does not have individual record consumer information, with enough of these data cuts a competitor could back into |

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### C.6.b
Obtain an explanation of any material (especially directional) differences between model indications and state-specific univariate indications.

<table>
<thead>
<tr>
<th>Explanation for the adjustments</th>
<th>Multivariate indications may be reasonable as refinements to univariate indications, but possibly not for bringing about significant reversals of those indications. For instance, if the univariate indicated relativity for an attribute is 1.5 and the multivariate indicated relativity is 1.25, this is potentially a plausible application of the multivariate techniques. If, however, the univariate indicated relativity is 0.7 and the multivariate indicated relativity is 1.25, a regulator may question whether the attribute in question is negatively correlated with other determinants of risk. Credibility of state data should be considered when state indications differ from modeled results based on a broader data set. However, the relevance of the broader data set to the risks being priced should also be considered. Borderline reversals are not of as much concern. Consider adding a comment that if the multivariate performs well against the state level data, then this should suffice. However, credibility considerations need to be made as state level segmentation comparisons generally do not have enough credibility.</th>
</tr>
</thead>
</table>

### C.7.a
Obtain a listing of the top five rating variables that contribute the most to large swings in premium, both as increases and decreases.

| These rating variables may represent changes to rating factors, be newly introduced to the rating plan, or have been removed from the rating plan. |
| This is complicated to answer. A company would need additional objective information before they could answer this. For example, does a large swing refer to a renewal or difference between two customers? |

### C.7.b
Determine if the insurer performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.

| One way to see sensitivity is to analyze a graph of each risk characteristic's/variable's possible relativities. Look for significant variation between adjacent relativities and evaluate if such variation is reasonable and credible. |
| This is also complicated to answer and not all transition testing can be done and requires a lot of simulations. Not all companies will have this capability. |

### C.7.c
For the proposed filing, obtain the impacts on expiring policies and describe the process used by management, if any, to mitigate those impacts.

| Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense, and hence may be viewed as unfairly discriminatory by some states. |

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7. Consumer Impacts – This is an important consideration for implementing a plan. However, this is not a statistical concept and reliance upon this may actually lead to rates that are not cost based. Rather than an obstacle to approval we suggest consumer impacts must be clearly understood, and the regulator and the company must work together to develop an implementation plan that addresses any concerns. However, these should not be the basis for evaluating the predictive model itself. Additionally, there should be more clarity as to what is meant by “consumer.”
| C.7.d | Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business), and sufficient information to explain the disruptions to individual consumers. | The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan. While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated. See Appendix C for an example of a disruption analysis. |
| C.7.e | Obtain exposure distributions for the model's output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business. | See Appendix C for an example of an exposure distribution. | Item C.7.d should suffice for this. The impacts shown here are combined with all changes occurring, not just those related to variables in the model. |
| C.7.f | Identify policy characteristics, used as input to a model or sub-model, that remain "static" over a policy's lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as "static," yet change over time. | Some examples of "static" policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured’s risk profile based on "static" variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured’s true and current risk profile. A few examples of "non-static" policy characteristics are age of driver, driving record and credit information (FCRA related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company. |
| C.7.g | Obtain a means to calculate the rate charged a consumer. | The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. Ability to calculate the rate charged would allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. Note that this information may be proprietary. This is logistically challenging for companies to execute and it is more a market conduct item than a filing review item. Additionally, the rate order of calculation rule around ration policy should suffice here. |
| C.7.h | In the filed rating plan, be aware of any non insurance data used as input to the model (customer provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors. | If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, data may need to be documented with an overview of who owns it and the topic of consumer verification may need to be addressed, including how consumers can verify their data and correct errors. If this information element is concerning the non-insurance (3rd party data) that is used in the development of the model, then other Section A would already have discussed this item. If this information element is concerning the non-insurance (3rd party data) that is used to rate a policy, then we would request replacing “as input to the model” with “as variables in the rating of a policy” for clarity. |

### 8. Accurate Translation of Model into a Rating Plan

| C.8.a | Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan's manual in fact, reflects the model output and any adjustments made to the model output. | The regulator can review the rating plan's manual to see that modeled output is properly reflected in the manual's rules, rates, factors, etc. Is this information element asking for a new piece of documentation or is it just recommending that the regulator should seek to understand this information? |

### 9. Efficient and Effective Review of Rate Filing

<p>| C.9.a | Establish procedures to efficiently review rate filings and models contained therein. | &quot;Speed to market&quot; is an important competitive concept for insurers. Though regulators need to understand the rate filing before accepting the rate filing, the regulator should not request information which does not increase their understanding of the rate filing. Regulators should review their state's rate filing review process and procedures to ensure that they are fair and efficient. Regulators need to be aware that requesting information that is not necessary for a decision to be made on a rate filing's compliance with state laws and regulations. The last sentence in the second paragraph of the comment is incomplete. |
| C.9.b | Be knowledgeable of state laws and regulations in order to determine if the proposed rating plan (and models) are compliant with state law. | This is a primary duty of regulators. The regulator should be knowledgeable of their state laws and regulations and apply them to a rate filing fairly and efficiently. The regulator should pay special attention to prohibitions of unfair discrimination. |</p>
<table>
<thead>
<tr>
<th>C.9.c</th>
<th>Be knowledgeable of state laws and regulations in order to determine if any information contained in the rate filing (and models) should be treated as confidential.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The regulator should be knowledgeable of their state laws and regulations regarding confidentiality of rate filing information and apply them to a rate filing fairly and efficiently. Confidentiality of proprietary information is key to innovation and competitive markets.</td>
</tr>
</tbody>
</table>
Dear Ms. DeFrain,

I write you as director of finance, insurance and trade policy at the R Street Institute, a nonprofit, nonpartisan public policy research organization (“think tank”). We appreciate the opportunity afforded by the Casualty Actuarial and Statistical Task Force to offer input on the revised draft of the Regulatory Review of Predictive Models White Paper.

We commend the Task Force for its work and are heartened by several updates in the revised paper. For example, in the section on relevance of variables and relationship to risk of loss, we welcome the revised paper’s substitution that a rate-filing narrative ought to explain a variable’s “rational” relationship to cost, rather than original “logical and intuitive.” Actuarially credible and statistically significant variables may, in fact, prove to be counter-intuitive.

However, we remain concerned that the paper exceeds the scope of its stated purpose and that it could be interpreted to recommend more stringent reviews of existing models that have served consumers well for decades. In response to earlier comments we filed, the Ad Hoc Team asserted “the fact that predictive models have been reviewed in depth by regulators for many years under the current confidentiality provisions...is prima facie evidence that the negative impacts that R Street is alleging will not arise.” However, the team elsewhere notes that it “would be unfortunate if a model is withdrawn from the market because the modeler is unwilling to share information with regulators.”

Our position is that it would be not just unfortunate, but disruptive, and threatens to reverse progress made over three decades toward more competitive insurance markets that better serve consumers. We will continue to recommend that regulators exercise to avoid such market disruption.

Sincerely,

R.J. Lehmann
Director of Finance, Insurance and Trade Policy
R Street Institute
Honorable Steve Kelley  
Commissioner, Minnesota Department of Commerce  
Chairman, NAIC Casualty Actuarial and Statistical Task Force  
Minnesota Department of Commerce  
85 7th Place East, Suite 280  
Saint Paul, MN 55101

Honorable James J. Donelon  
Commissioner, Louisiana Department of Insurance  
Vice-Chairman, NAIC Casualty Actuarial and Statistical Task Force  
1702 N. Third Street; P.O. Box 94214  
Baton Rouge, LA 70802

Submitted Electronically to kdefrain@naic.org


Dear Chairman Kelley and Vice Chair Donelon:

I write on behalf of the Consumer Data Industry Association (CDIA) to comment on the exposure draft concerning best practices when reviewing predictive models and analytics. This draft was released by your Casualty Actuarial and Statistical Task Force (“Task Force”) on June 12, 2020. Thank you for allowing CDIA another chance to offer comments on behalf of our consumer reporting agency (“CRA”) members. We offer comments on section VI in the body of the whitepaper and sections A, B and C in the modeling guide.

The Consumer Data Industry Association is the voice of the consumer reporting industry, representing consumer reporting agencies including the nationwide credit bureaus, regional and specialized credit bureaus, background check and residential screening companies, and others. Founded in 1906, CDIA promotes the responsible use of consumer data to help consumers achieve their financial goals, and to help businesses, governments and volunteer organizations avoid fraud and manage risk. Through data and analytics, CDIA members empower economic opportunity all over the world, helping ensure fair and safe transactions for consumers, facilitating competition and expanding consumers’ access to financial and other products suited to their unique needs.

Section VI, 1. c (p. 5) addresses a “Review [of] the individual input characteristics to and output factors from the predictive model (and its sub-models), as well as, associated selected relativities to ensure they are not unfairly discriminatory”. We appreciate your feedback on our initial comments expressing concerns related to including “sub-models” like Credit-Based Insurance Scores (“CBIS”) into the regulatory
review process. However, we do respectfully believe this will increase the burden of regulatory compliance for CRAs, slowdown the speed to market and impede the relationship between insurers and consumers. These new burdens can inject unnecessary friction into consumers who seek quick decisions and competitive prices from their insurers.

We respectfully believe these are “new, proposed obligations”. The review of CBIS models has been established and ongoing in many States for close to two decades like you highlight, but those occur in other forms of insurance and not under the forms the Casualty Actuarial and Statistical (C) Task Force is seeking to add to its handbook and make an industry wide practice. The current reviews may include the same CBIS models, but if they are not currently being reviewed then we would argue these are in fact new obligations on CRAs.

Many States have provided certain confidentiality protections from the general public for CBIS models in accordance with their State law, but many is not all states. CDIA members spend significant amounts of time and resources developing their models and complying with current regulations. only takes one employee in one state to make one mistake and decades of hard work, investment and research is available for anyone to view, replicate, deceive or use to commit fraud. We are encouraged by the inclusion of new confidentiality language in Section VII of the Whitepaper, pertaining state confidential, proprietary, or trade secret state laws and relevant contractual provisions, and request inclusion of the language as a proposed change to the Product Filing Review Handbook. Even with the new language, the lack of a national exemption from public records remains a concern because information that has never previously been requested could be subject to the myriad of public disclosure laws around the country. There is no surety to how all states will respond to public records requests.

New language in Section V of the Whitepaper suggests that reliance on state confidentiality authority, regulations, and rules may not govern if the NAIC or another third party becomes involved in the review process on behalf of the states. NAIC or third-party participation in the review process causes significant trade secret and proprietary information protection concerns. It is not clear from the new language what protections, law, or authority would apply in such a case. We request clarifying language be added that, as a floor, the confidential, proprietary, and trade secret protections of the state on behalf of which a review is being performed apply.

We understand no information should be confidential from the regulators themselves. However, if the CBIS models are reviewed and accepted elsewhere, it would seem that a repetitive and costly process is occurring for not much if any added value to the final product for the consumers. The credit reporting system is a consistent nationwide process. Exposing individual characteristics of scoring models to public record requests allows competitors access to information that they can use to gain an unfair advantage over another company. It also reduces the incentive to continue to
create new solutions, reducing a competitive environment, which ultimately hurts consumers. Regulators should be able to know whether scoring models are in compliance with the law, but this information should not be accessible as a public record.

The potential for confidentiality concerns is not only with the CRAs, but the companies they work with (date furnishers and lenders) in the credit reporting system and their consumers. We are not convinced that including CBIS in this type of review is mission critical. Yet, if this review needs to be in the process, CDIA recommends the establishment of highly specific rules to protect confidentiality and proprietary information. Additionally, a separate review process of sub-models as an optional request with defined valid concerns would help in addressing concerns.

Credit-based insurance scores do not unfairly discriminatory towards any race, religion, gender, ethnicity, or other established suspect classes and there are studies that show the lack of illegal discrimination. A myth of illegal discrimination pervades many media accounts and public policy debates, but in truth, credit-based insurance scores do not promote redlining or other illegal insurance practices.

Section VI 3.a. (p. 6) addresses how to “[e]valuate how the model interacts with and improves the rating plan” and how to “[o]btain a clear understanding of the characteristics that are input to a predictive model (and its sub-models), their relationship to each other and their relationship to non-modeled characteristics/variables used to calculate a risk’s premium.” We recognize the goal of the regulator in seeking to understand how the individual components of the rating plan interrelate to produce a consumer’s premium, but we feel the NAIC’s comment to CDIA comments on this add further confusion to our members. The white paper only mentions “characteristics”, but your comment refers to “information that the ‘CRAs use to create CBIS’ is essential to understanding the structure of the CBIS models, the variables used, and their justification.”. CRAs could provide general characteristics of the model without having confidentiality concerns, but the “information they use to create CBIS” appears to be far more specific.

If these provisions are meant to include information relating to the scoring models that CRAs use to create CBIS, there would be a significant new regulatory burden on CRAs and this would impede the relationship between insurers and consumers. These new burdensome requirements can inject unnecessary friction on to consumers who seek quick decisions and competitive prices from their insurers. Along with heightening the risk of disclosing proprietary information that is currently kept confidential because of its importance.

In “Selecting Model Input” under subsections A.1.a “Available Data Sources”,

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we appreciate the edits made to address our concerns around FCRA requirements being extended to all external data sources and the review for CBIS models being restricted to credit variables used in the model and not all credit variables.

We appreciate the task force’s comment related to being open to changing the level for A.2.b “Determine if the sub-model was previously approved (or accepted) by the regulatory agency,” the review level change is appreciated as it will eliminate unnecessary and duplicative reviews of third-party and vendor models that have been previously approved. To be consistent with the A.2.b review level change, a change from a review level 1 to a 3 or 4 is requested for current A.2.f, former A.2.e, “If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.”

Section A.4.c addresses “Identifying material findings the company had during their data review and obtain an explanation of any potential material limitations, defects, bias or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted”. This provision should be recategorized from its current score of 1 to a 3 or 4 score. Existing regulations around actuarial rate making standards and state regulations should prevent these items from entering a “final/proposed” model. This should be categorized as three of four (i.e. if model review uncovers issues).

We have several comments regarding Section B, “building the model”:

- Sec. B.2.c, “Obtain a description of univariate balancing and the testing that was performed during the model-building process, including an explanation of the thought processes involved and a discussion of why interaction terms were included (or not included).” Only included interactions should be discussed. Interactions not be included, but default are not in a model, and therefore should not need to be justified.
- Secs. B.3.a and B.3.c, Both subsections pose trade secret protection and confidentiality issues.
- Sec. B.3.b, “Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal”. The best practices and guidelines should be limited to only the variables that were in the final and proposed models.
- Sec. B.3.d, “Obtain an rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.” CDIA agrees with the current and actuarially accepted practice of rate making guidelines not requiring intuitive or rational explanations of predictive values. We support use of variables that are statistically and actuarially predictive of insurance losses.
Additionally, this subsection poses a risk exposing trade secret and confidential information.

- Secs. B.4.b, through B.4.b CDIA recommends recategorizing these scores from their current scores of two to a three or four score, along with only making this a requirement if deemed necessary.
- Sec. B.4.c “Identifying the threshold for statistical significance and explain why it was selected. Obtain a reasonable and appropriately supported explanation for keeping the variable for each discrete variable level where the p-values were not less than the chosen threshold”. We thank NAIC for accepting our recommended language change of adding “threshold for statistical significance” into the list of required elements and changing this score from its current one to a three or four.

We have several comments regarding “Section C, “The Filed Rating Plan”: 

- Sec. C.1.c, like many other areas, this provision creates potential trade secret and confidentiality issues.
- Sec. C.7.h, we thank NAIC for easing the FCRA requirement section here.

The “Supporting Data” section, specifically Secs. C.6.a and C.6.b, on “Obtaining an explanation of any material (especially directional) differences between model indications and state-specific univariate indications” pose some concerns for CRAs and could interfere with the insurance process for consumers.

Section VIII of the Whitepaper proposes several changes to the Handbook. Section X, “Other Considerations” of the Handbook suggest advisory organization regulation of model and algorithm vendors. As explained further in this comment, CIBS modelers are already heavily regulated.

Credit Based Insurance Scores are constructed using nationwide data sets. Scoring or grading their performance out at a state level may not be supported accurately with this approach. It is also a common occurrence for certain contracts to prevent model providers from sharing distinct or customer specific data with third parties. There are several factors besides credit information and CBIS that go into the rate setting process. Credit Information and CBIS may be the only ones that are consistent and transferrable across the country, while some of the other factors used can and do differ greatly on a state by state basis.
The insurance industry has been using CBIS models for decades and they have been approved by nearly every state’s insurance department for auto and home insurers. Adding the work CASTF proposes will be burdensome and repetitive. The lack of trade secret and proprietary information protection will always remain a source of concern. In the long run we see this as something only large insurers will be able to absorb and the small to medium sized insurers that rely on third parties help will get squeezed out. We strongly feel that this will give large insurers a competitive edge in the marketplace. This will come at great cost to the consumers when their options decrease because of the eventual lack of competition.

There is already a large regulatory review presence on the industry. It is already over seen at the federal level by the Consumer Financial Protection Bureau (CFPB) and Federal Trade Commission (FTC), along with several states implementing their own regulations and the Conference of State Banking Commissioners looking into the industry as well. This increased regulation not only hurts the industry, but the consumers it serves. It will significantly hamper speed to market for the products consumers need and does not appear to add much, if any, benefit to the outcome for the industry and its consumer.

In conclusion, we believe that these potential new best practices will create burdensome regulatory difficulties for our members, speed to market issues for insurance companies, their product and the consumers that need them. CDIA members provide quality products that are already regulated and accepted by the insurance industry. CDIA and its members respectfully request consideration and inclusion of its comments in the task force’s whitepaper. Thank you for the opportunity to comment and please feel free to contact us with any questions you may have.

Sincerely,

Eric J. Ellman
Senior Vice President, Public Policy & Legal Affairs

cc: Members of the Casualty Actuarial and Statistical Task Force (CASTF) of the Property and Casualty Insurance (C) Committee
Kris DeFrain, NAIC Staff
Jennifer Gardner, NAIC Staff
Comments for the Center for Economic Justice

To the Casualty Actuarial Task Force

Regulatory Review of Predictive Models White Paper

July 27, 2020

The Center for Economic Justice offers the following comments on the June 12, 2020 exposure draft of the “Regulatory Review of Predictive Models White Paper.”

CEJ greatly appreciates the effort CASTF has expended to grapple with regulatory review of complex models. However, the most recent exposure misses the mark in at least two foundational ways.

1. The use of “rational explanation” is used incorrectly and inappropriately; and

2. The absence of guidance to address proxy discrimination against protected classes is a huge hole in regulatory review and a baffling omission.

1. Rational Explanation

The terms “rational explanation,” “rational relationship” and “rational sense” are used several times in the exposure draft.

On page 12, as a topic for future discussion, the paper states, “Provide guidance for regulators that seek a causal or rational explanation why a rating variable is correlated to expected loss or expense, and why that correlation is consistent with the expected direction of the relationship.”

On page 20 in Appendix A, “Data Organization” Section A.4.b, the paper states: “Obtain documentation on the insurer’s process for reviewing the appropriateness, reasonableness, consistency and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable,” and “An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make rational sense. For example, if “murder” or “theft” data are used to predict the wind peril, provide support and a rational explanation for their use.”
On page 34, in Appendix B, “Predictor Variables” Section B.3.d, the paper states, “Obtain a rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted,” and “The explanation should go beyond demonstrating correlation. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate. For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection that variable has to increasing or decreasing the target variable.”

On page 30, in Appendix C, Section C 2 – Relevance of Variables and Relationship to Risk of Loss,” the paper states, “Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss (or expense) for the type of insurance product being priced,” and “The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model results should be consistent with the expected direction of the relationship. This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated.”

On page 46, the paper defines “Rational Explanation” -- A “rational explanation” refers to a plausible narrative connecting the variable and/or treatment in question with real-world circumstances or behaviors that contribute to the risk of insurance loss in a manner that is readily understandable to a consumer or other educated layperson. A “rational explanation” does not require strict proof of causality but should establish a sufficient degree of confidence that the variable and/or treatment selected are not obscure, irrelevant, or arbitrary. A “rational explanation” can assist the regulator in explaining an approved rating treatment if challenged by a consumer, legislator, or the media. Furthermore, a “rational explanation” can increase the regulator’s confidence that a statistical correlation identified by the insurer is not spurious, temporary, or limited to the specific data sets analyzed by the insurer.”

It is important to note that while “rational explanation” is defined, the undefined terms “rational relationship and “rational sense” are also used.

The paper also uses the term “rationale” in several instances. “Rationale” is used in Section A.4.a, B.2.b., B.3.a and B3.b. In each instance, the term “rationale” is synonymous with “explanation” or “justification.”
1.1 The use of “rational explanation” is inappropriate because it introduces subjective interpretation by the regulator in place of a valid statistical analysis to evaluate the potential for a spurious correlation.

The clear intent of the paper’s use of “rational explanation” or similar terms is two-fold. First, it is used to mean the insurer must provide a “rationale” for the purported relationship. Second, it is used to mean that this “rationale” must be “reasonable” or “plausible” to the regulator.

The clear intent of the use of “rational explanation” is to identify spurious correlations – correlations\(^1\) – “two or more events or variables that are associated but not causally related due to either coincidence or a third unseen factor.”\(^2\) The problem with a spurious correlation is that the purported relationship is either transitory or illusory. As discussed below, regulators have always had the authority and responsibility to identify and stop the use of classifications that are spuriously correlated to particular insurance outcomes. And as discussed below, spurious correlation can reflect and perpetuate systemic racism and lead to proxy discrimination against protected classes.

The problem with the use of “rational explanation” is that it is inherently subjective and, consequently, arbitrary. To point out the obvious, each of our views about what constitutes a reasonable or rational explanation is based in very large part on our cultural biases – where and how we grew up and what our life experiences have been. The Black Lives Matters movement – and the response of insurer CEO and NAIC leadership to address systemic racism and inherent bias and to start a dialogue on race and diversity – speaks to the fact that what might be seen as rational to one person is understood as irrational and racist by another. For example, leading up to the Civil War, many in the country viewed slavery as rational. In the 1950’s and 1960s, many viewed segregation of races as rational.

These historical examples are, of course, relevant. But, we can look at insurance examples today. Over the past few weeks and months, insurers have been offering “rational explanations” why they shouldn’t provide auto insurance premium relief or why the premium relief offered wasn’t greater. In some states, regulators have simply accepted those explanations as “rational,” while regulators in other states have found the rationales offered failed the test of reasonableness.

We fully support regulators’ interest in and actions to identify and eliminate spurious correlations in complex, predictive models. But relying upon a “rational explanation” is simply not the way to go because it is inherently subjective and lacks scientific rigor.

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1. [https://tylervigen.com/spurious-correlations](https://tylervigen.com/spurious-correlations)
In place of “rational explanation,” we suggest that the white paper utilize “rationale” when the intent is for the insurer to explain or justify a practice. We also suggest that the white paper include specific guidance for scientific inquiry not just when the regulator suspects a spurious correlation, but guidance for insurers to test for spurious correlations – particularly when the spurious correlation may be a proxy for discrimination against a protected class.

1.2 The NCOIL and industry trades’ argument that “rational explanation” usurps legislative authority is without merit or evidence.

We are aware of NCOIL passing a resolution declaring that legislative intent has always been that, other than specific prohibitions of particular risk classifications, the only requirement for use of a risk classification is a correlation. Attached, please find CEJ’s comments to NCOIL, in which we demonstrate that

- There is no support for this proposition is statutory or regulatory language
- There is no support for this proposition in actuarial standards of practice
- The statutory language in NAIC models clearly requires more than a simple correlation as justification for a risk classification
- Regulatory practice refutes the “correlation-only” argument as regulators have long believed of their authority to act and have acted to address spurious correlations.

While we urge the removal of “rational explanation” in the white paper, we also urge the CASTF to forcefully reject the false claim of legislative authority usurpation and to respond to the flawed NCOIL/Industry analysis regarding “correlation only.”

2. The white paper’s failure to address proxy discrimination against protected classes is a glaring omission and renders the white paper largely irrelevant.

In CEJ’s November 22, 2019 comments, we suggested that the white paper better address proxy discriminating against protected classes.

- We suggested a clarification that unfair discrimination means both the absence of a cost-based relationship and proxy discrimination against protected classes in Section.

- We also suggested the addition to the regulatory review of data used in the development and validation of the model the following:

  *Determine if data used for model development and testing are biased against protected classes of consumers, if insurers have tested the data for such bias and if any action has been taken to eliminate or reduce bias in data.*

- We also suggested the addition of a section “Testing for and Minimizing Disparate Impact Unfair Discrimination.”
All of CEJ’s suggestions were intended to identify and minimize the impact of systemic racism and inherent bias in insurance within the cost-based foundation of insurance.

CASTF did not respond to the first or third comment. In response to the second comment, CASTF largely rejected our comments. In response to CEJ’s comment on regulatory review of data for bias against protected classes, CASTF wrote:

*Industry does not collect information that could clearly demonstrate if there is disparate impact on protected classes. It is beyond the scope of this paper to propose that the collection of data on protected classes is necessary in order to review models underlying rating plans.*

Further, the white paper included the assessment of proxy discrimination as an “other considerations” that “were not within the scope of this paper.”

### 2.1 Proxy discrimination against protected classes must be a central focus of regulatory review and, consequently, of the white paper.

The use of predictive models in pricing is overwhelmingly oriented towards risk segmentation. While there are a few examples of predictive models used for estimating aggregate losses – catastrophe models – insurers use predictive models to develop and employ risk classification for underwriting, tier placement and rating. Traditional actuarial techniques are largely employed for overall rate need – the “not excessive” and “not inadequate” components of the rate standards. But predictive models are used – with few exceptions – for risk classification and are therefore subject to the “not unfairly discriminatory” rate standard.

With the understanding that the vast majority of predictive models used by insurers and reviewed by regulators for risk classification, the primary goal of regulatory review of these models is to identify and prevent unfair discrimination.

Given that the purpose of regulatory review of complex, predictive models is primarily – and overwhelmingly – to identify unfair discrimination, it is inconceivable that the white paper suggest that examining these models for unfair discrimination against protected classes is outside of the scope of the paper. CASTF has arbitrarily and mistakenly eliminated a core and crucial component of regulators’ statutory responsibility by claiming examination of proxy discrimination against protected classes is outside the scope of the white paper.

### 2.2 Proxy discrimination against protected classes is a clear concept.

“Proxy discrimination against protected classes” is a clear concept for regulators. It means discriminating against a class of consumers identified for protection in statutes or regulation by means of a proxy for the class identification. Both parts of the phrase are well understood – protected classes and proxy discrimination.
Further, we know before the murder of George Floyd that proxy discrimination against protected classes is one of the major consumer protection issues with big data analytics and predictive models. We also know that addressing such algorithm bias has been at the core of every set of AI principles produced around the world, including the current draft of the NAIC Principles on AI.

However, the murder of George Floyd and the Black Lives Matter movement has put proxy discrimination resulting from systemic racism and inherent bias into stark relief. The issue of proxy discrimination against protected classes is at last as important as the issue of cost-based justification in regulatory review of predictive models.

2.3 Proactive efforts to identify and minimize proxy discrimination against protected classes is not just consistent with the cost-based foundation of insurance, but improves cost-based pricing.

There is a lengthy history of applying disparate impact unfair discrimination analysis in a variety of industries, including insurance. The federal Fair Housing Act has recognized proxy discrimination or disparate impact against protected classes for over 40 years and the history of disparate impact challenges shows that such challenges, when successful, improve cost-based pricing.

For example, in the 1990’s, fair housing groups brought a disparate impact challenge against insurers’ use of age and value of the home for underwriting. The groups argued that these underwriting guidelines discriminated against minority communities because these communities’ housing was characterized by low value and old age. The challenges were largely successful and, in response, insurers developed more detailed underwriting based on, for example, age and type of electrical system and age and condition of the roof. The result was not just fairer treatment of minority communities, but improvements in cost-based pricing by insurers.

2.4 The fact that insurers do not collect protected class characteristics from applicants and policyholders is not an impediment to proactive efforts to identify and minimize proxy discrimination against protected classes.

As noted above, CASTF failed to address the core issue of proxy discrimination against protected classes in the white paper by, among other things, falsely equating insurers’ non-collection of protected class characteristics with insurers’ inability to analyze their data and models for proxy discrimination.
In fact, data and other tools are available for insurers to assign proxies for race to data records in order to test for proxy discrimination. In some instances, the tests will be simple. For example, in one of the CASTF book clubs, a vendor developing auto telematics pricing models stated they don’t do anything to test for bias against protected classes. Yet, it would be easy for this vendor to examine whether the telematics data used in the development of the models reflects fair and unbiased availability of the telematics program across all communities – by simply mapping the garaging address to Census data – namely, the majority racial composition of census blocks. Yet, the vendor dismissed even this simple test of bias in data despite the well-known evidence that biased data reflect and perpetuate historic discrimination.

Further, valid statistical proxies for race / ethnicity are available and have been used to test for proxy discrimination against protected classes. For example, attached to our comment letter, please find:

*Using publicly available information to proxy for unidentified race and ethnicity*, Consumer Financial Protection Bureau, 2014

”Assessing Fair Lending Risks Using Race/Ethnicity Proxies.” Yan Zhang, Office of the Comptroller of the Currency


“Awareness in Practice: Tensions in Access to Sensitive Attribute Data for Antidiscrimination,” Bogen, Ricke and Ahmed, 2020

These resources just touch the surface of possibilities for insurers to test for and minimize proxy discrimination against protected classes. If regulators were to routinely ask for – or include in the white paper as a routine part of the review of predictive models – insurer actions to detect and minimize proxy discrimination against protected classes, insurers – as well as data vendors and consulting firms – would develop the tools to fulfill this core analysis of unfair discrimination.

2.5 **CEJ asks the CASTF to include of guidance regarding testing for and minimizing proxy discrimination against protected classes.**

We ask CASTF to revise the white paper to include CEJ’s suggested guidance regarding identification and minimization of proxy discrimination against protected classes. CASTF’s rationales for exclusion – that protected class data are not available and that proxy discrimination against protected classes is outside the scope of the white paper – are demonstrably incorrect.
Data to perform analyses of proxy discrimination analysis are available, as noted above. The fact that the data may not be perfect is not a valid excuse. Data do not have to be perfect to be sufficiently valid to produce a reliable analysis.

Further, the issue of proxy discrimination against protected classes is directly related to CASTF’s concern about “rational explanations.” Just as proxy discrimination against protected classes represents a spurious correlation – as in the example above where the age and value of the home had a spurious correlation to claims – so does CASTF’s concern with “rational explanation.” The analytic tools to identify and minimize proxy discrimination against protected classes is a scientific, statistically-valid and objective approach to addressing the spurious correlation concern reflected in the “rational explanation” guidance. Pages 5 to 8 of the attached “CEJ’s Call on Insurers and Regulates to Address Systemic Bias and Inherent Racism in Insurance” explains the scientific foundation of a disparate impact analysis.

Finally, given the NAIC’s recent commitment to address race and diversity and the variety of actions that reflect this commitment, it would be contradictory for the CASTF to ignore the issues of systemic racism and inherent bias in a white paper providing guidance for regulatory review of predictive models.
Comments of the Center for Economic Justice

To NCOIL Regarding the Proposed

“Resolution Urging the National Association of Insurance Commissioners to Refrain from Intruding on the Constitutional Role of State Legislators.”

June 28, 2020

The Center for Economic Justice (CEJ) suggests that NCOIL withdraw the ill-conceived “Resolution Urging the National Association of Insurance Commissioners to Refrain from Intruding on the Constitutional Role of State Legislators.” The Resolution suffers from a number of false statements, fails to recognize the reality of current ratemaking and regulatory review, miscomprehends the oft-repeated term “correlation,” represents an endorsement of proxy discrimination against protected classes and misdiagnoses the problem with the white paper’s use of rational explanation. Among the problems with the resolution:

1. It is unclear why NCOIL has decided that a technical paper regarding review of complex pricing algorithms is the target for the proclamation of correlation as the intent and sole purview of state legislators. The fact that, among the many critical issues facing insurance consumers, NCOIL has prioritized an industry complaint feeds the perception by some that NCOIL’s actions reflect the priorities of its industry corporate sponsors.

2. The premise of the resolution – “established rate filing review is based on correlation” – is demonstrably false and unsupported by statutory language. Neither of the NCOIL rating models cited in the resolution used the term “correlation.” The purported reliance on “correlation-only” conflicts with the language of the NCOIL models regarding unfair discrimination.

3. As a former regulator charged with review and approval of rate filings and an expert witness in administrative and judicial proceedings on unfair discrimination and risk classification in insurance for nearly 30 years, simple correlation has never been sufficient justification for a risk classification.

4. The repeated references to “correlation” divorce the resolution from the reality of rate filings today. Insurers now use algorithms – whether for pricing, claims, anti-fraud or more – based on statistical techniques light years from simple correlation.
5. The repeated references to “correlation” are an endorsement of proxy discrimination. By declaring that any correlation is sufficient justification – even if that correlation is a proxy for discrimination against a protected class – and defending such proxy discrimination on the basis of states’ rights the resolution ignores and repudiates the commitment and efforts by industry and regulators to address systemic racism in insurance.

6. The problem with the use of “rational explanation” in the CASTF White Paper is not a usurpation of legislative prerogative. Rather, “rational explanation” is a subjective approach to the problem of identifying spurious correlations.

Why This Resolution Targeting a NAIC Technical White Paper Now?

Insurance regulators at the NAIC have been grappling for over five years with the revolution in insurance operations resulting from insurers’ use of big data analytics, complex algorithms, artificial intelligence and machine learning. The regulators’ concerns are being examined in the NAIC’s Artificial Intelligence Working Group, the Accelerated Underwriting Working Group, the Big Data Working Group, the Innovation and Technology Task Force, the Casualty Actuarial Task Force and more. Insurers’ use of big data analytics represents a revolution in insurer operations that has challenged both regulators’ ability to keep up with industry practices and for decades-old statutory authorities to provide the necessary consumer protections.

Of all the NAIC activities related to regulatory responses to insurers’ use of big data analytics, it is curious that NCOIL has prioritized – in the current period of pandemic and systemic racism issues – with a phrase in a 50-page NAIC white paper – to proclaim a resolution. The fact that NCOIL chooses to prioritize this particular industry complaint about a NAIC technical white paper will fuel the contention of some that NCOIL parrots the interests of its industry corporate sponsors.

As discussed further below, the problem with the term “rational explanation” in the white paper, is not that it challenges state legislative authority, but that it is a technically incorrect approach to addressing problems of spurious correlations.

False Foundation – “Correlation” Does Not Appear in NCOIL and NAIC Rating Models

The foundation of resolution is that claim, “WHEREAS, established rate filing review is based on correlation, which demonstrates that rating variables are valid so long as they correlate with a loss.”

Yet, the term “correlation” does not appear in either of the NCOIL rating models cited in the resolution. Nor does “correlation” appear in any of the NAIC property casualty rating
models.1 Nor does “correlation” appear in the Casualty Actuarial Society’s “Statement of Principles Regarding Property and Casualty Insurance Ratemaking.”2 Nor does it appear in the American Academy of Actuaries “Risk Classification Statement of Principles.”3 The term “correlative classes” appears once in the Risk Classification of Principles in a section on Credibility and not in the manner suggested by the resolution.4 These risk classification principles identify a variety of considerations in developing risk classifications, including stability in avoiding abrupt changes in prices, maximizing the availability of coverage, minimizing ability to manipulate or misrepresent a risk characteristic and the need for public acceptability.

Any risk classification system must recognize the values of the society in which it is to operate. This is a particularly difficult principle to apply in practice, because social values:

- are difficult to ascertain;
- vary among segments of the society; and
- change over time.

The following are some major public acceptability considerations affecting risk classification systems:

- They should not differentiate unfairly among risks.
- They should be based upon clearly relevant data.
- They should respect personal privacy.
- They should be structured so that the risks tend to identify naturally with their classification.

In fact, a simple “correlation” is not the basis for fair discrimination. NAIC models define unfair discrimination to exist if “after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses.” The NCOIL models don’t define unfair discrimination other than discrimination “on the basis of race, color, creed, or national origin.”

If, as claimed in the resolution that “rate filing review is based on correlation,” then the appropriate test for discriminating “on the basis of race, color, creed, or national origin” would also be a simple correlation between the rating factor and the prohibited classifications.

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2 https://www.casact.org/professionalism/standards/princip/sppcrate.pdf
4 "Accurate predictions for relatively small, narrowly defined classes often can be made by appropriate statistical analysis of the experience for broader groupings of correlative classes."
CEJ Comments to NCOIL on Proposed CASTF White Paper Resolution
June 28, 2020
Page 4

Miscomprehension of “Correlation” and Regulatory Review of Rate Filings

The resolution incorrectly equates simple correlation with the statutory standards for rates. A correlation is simply the extent to which a pair of variables are related. There are many correlations between variables that bear no relationship to one variable predicting the other variable – and that latter is the essence of a rating factor identifying price differentials among consumers in the cost of the transfer of risk.

Here are some examples of very highly correlated variables, which are also examples of “spurious correlation”5 – “two or more events or variables that are associated but not causally related due to either coincidence or a third unseen factor.”6 A perfect correlation is 100%. No correlation is 0%.

- There was a 94.7% correlation between per capita cheese consumption and the number of people who dies by becoming tangled in their bedsheets from 2000 to 2009.
- There was a 99.3% correlation between the divorce rate in Maine and per capita consumption of margarine from 2000 to 2009. As an aside, the Indiana Department of Insurance disapproved a rate filing in which the insurer sought to use per-capita margin consumption as a risk classification.
- There was a 98.5% correlation between total revenue generated by arcades and computer science doctorates awarded in the US from 2000 to 2009.

In the 30 years that I have been reviewing rate filings and risk classifications and regulatory activity in this arena, a simple correlation has never been a sufficient justification for a rating factor.

We offer two real life examples to demonstrate why this is the case. First, in the early 1990s in Texas, an insurer in Texas sought approval for a homeowners discount based on tenure with insurer – if an insured was with the company for several years, they would bet a discount. The insurer provided the following information7:

<table>
<thead>
<tr>
<th>Tenure (Years)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss Ratio</td>
<td>64.0%</td>
<td>63.4%</td>
<td>62.8%</td>
<td>62.2%</td>
<td>61.6%</td>
<td>61.0%</td>
<td>60.4%</td>
<td>60.0%</td>
</tr>
</tbody>
</table>

5 https://tylervigen.com/spurious-correlations
7 These are not the actual numbers, but an illustration of the actual situation.
Based on this simple “correlation,” the loss ratio seemed to track years of tenure with the company. By the standards of the resolution, this presentation of loss ratios would have been the end of discussion and prohibited any further inquiry by the regulator. In fact, the company was asked to produce loss ratios by years of tenure separate for homeowners (e.g., HO-3) policies and renters’ policies (e.g. HO-4). It turned out that the company had combined the experience.

When looked at separately, the loss ratios for each of the two types of policies didn’t vary with tenure. Homeowners loss ratios were consistent and consistently lower than those for renters’ policies. The spurious findings in the table above were a result of the percentage of renters’ policies declining as a share of total homeowners policies over time – far fewer people rent for five, six, or seven years than for one or two years so the declining loss ratios in the table were a result of fewer high-loss ratio renters’ policies for each additional year of tenure.

A second example comes from a disparate impact challenge under the federal Fair Housing Act. In the mid 1990s, fair housing groups challenged insurers’ use of age and value of the home as underwriting factors for homeowners insurance. The insurers used these factors because of a correlation to expected losses. The fair housing groups showed that using age and value of the home served as proxies for race and income. Because of historical discrimination in housing and mortgages, the housing in communities of color was characterized by older age and lower values. When confronted with the data, the insurers recognized they were using a proxy for condition of the home that was, in fact, a proxy for race. The insurers stopped using age and value of the home and started using more accurate variables like age and condition of the roof and type of electrical system. By responding to the disparate impact challenge, insurers stopped penalizing minority homeowners who maintained their homes with race-based underwriting.

**Miscomprehension of Insurer Rating Practices and the Challenges for Regulators**

The resolution’s references to “correlation” seem like a quaint reference to a long-gone – by 50 years – era. The same NAIC Casualty Actuarial Task Force holds monthly “book clubs” in which insurers and experts make presentations on current ratemaking practices. This past week was an example in which Allstate subsidiary Arity made a presentation on the development of their telematics pricing models for auto insurance. 8 The title of the presentation was “Modeling concepts, hyperparameter tuning, and telematics.” The presentation reviewed the parts of a scoring (pricing) model, including ordinary least squares regression, generalized linear models, generalized linear models with log link functions, decision tree models, neural nets, gradient descent, hyperparameters and extreme gradient boosting. Needless to say, that when a regulator is presented with rating factors based on such a model, it is meaningless to try to look for a simple correlation.

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8 https://content.naic.org/sites/default/files/call_materials/Modeling%20concepts%20hyperparameter%20tuning%20and%20telematics.pdf
It is this new and massive complexity – actuarial science merged with data science merged with astrophysics – that presents the challenge for regulators to enforce current statutes. We suggest that instead of a resolution harkening back to a by-gone era that never really existed, NCOIL’s efforts would be better spent working with regulators to modernize regulatory authorities and capabilities to deal with the reality of complex models in insurance.

A challenge for insurers and regulators that has always existed and continues to exist is whether a particular relationship – correlation – is real or spurious. When insurers have tried to utilize the closest thing to a simple correlation, insurers and regulators have found problems. Thirty or more years ago, insurers may have presented justification for a particular rating factor with what is known as a univariate analysis – comparing one predictive variable to, say, loss ratio. With traditional actuarial practices, looking at two or more variables at the same time was difficult because each additional variable required more data for a credible – or reliable – analysis. But the univariate analysis always had problems because insurers and regulators knew that, in addition to any correlation between particular rating factors and loss ratio, there was correlation between the rating factors with the result that univariate analysis led to double counting.

For example, both age and miles driven are related to expected losses. But as drivers get older – and retire from work – they drive less. So, a simple analysis of age and expected losses is reflecting the correlation miles driven and vice versa. So using both based on independent analyses yields double counting.

Since the early 1990s – at least – insurers have moved to new statistical techniques to develop and analyze rating factors. These techniques permit the simultaneous analysis of multiple variables and remove the correlation among the variables to eliminate double counting of impact on outcomes. Stated differently, the multivariate techniques used today advance from and address the limitations of “correlation.”

This issue is discussed in greater detail in the attached “CEJ Call to Insurers and Insurance Regulators to Address Systemic Racism in Insurance.”

Tacit Endorsement of Proxy Discrimination against Minority Consumers and Other Protected Classes in the name of States’ Rights.

The repeated references to “correlation” in the resolution are an endorsement of proxy discrimination. By declaring that any correlation is sufficient justification – even if that correlation is a proxy for discrimination against a protected class and defending such proxy discrimination on the basis of states’ rights – ignores the commitment and efforts by industry and regulators to address systemic racism in insurance.
By the standard espoused in the resolution, a rating factor that was a proxy for being a Black American is legitimate as long as there is a correlation to losses. Never mind that the factor is a proxy for a prohibited class or that that the factor discriminates on the basis of a prohibited factor.

Some data vendors offer a criminal history score that purports to score homeowners insurance on the basis of complaints filed with courts. Based on the resolution, as long as there was a “correlation,” that would not only be okay, but regulators are prohibited from further inquiry. What would the use of a criminal history score look like in the case of George Floyd, if he lived? What would the use of a criminal history score look like in Ferguson, Missouri, where the US Department of Justice found the following.

**US DOJ Investigation of the Ferguson Police Department**

Ferguson’s approach to law enforcement both reflects and reinforces racial bias, including stereotyping. The harms of Ferguson’s police and court practices are borne disproportionately by African Americans, and there is evidence that this is due in part to intentional discrimination on the basis of race.

Ferguson’s law enforcement practices overwhelmingly impact African Americans. Data collected by the Ferguson Police Department from 2012 to 2014 shows that African Americans account for 85% of vehicle stops, 90% of citations, and 93% of arrests made by FPD officers, despite comprising only 67% of Ferguson’s population.

FPD appears to bring certain offenses almost exclusively against African Americans. For example, from 2011 to 2013, African Americans accounted for 95% of Manner of Walking in Roadway charges, and 94% of all Failure to Comply charges.

Our investigation indicates that this disproportionate burden on African Americans cannot be explained by any difference in the rate at which people of different races violate the law. Rather, our investigation has revealed that these disparities occur, at least in part, because of unlawful bias against and stereotypes about African Americans.

It would be interesting to count the number of NCOIL members who have received citations for Manner of Walking in Roadway, let alone been penalized with higher insurance rates as a result.

In the aftermath of the murder of George Floyd, many insurer CEOs made statements declaring their personal and corporate opposition to inherent bias and systemic racism. The NCOIL resolution goes in the other direction – it defends systemic racism in insurance by prohibiting inquiry into proxy discrimination. This unfortunate position by NCOIL is also tone-deaf. It relies upon the same states’ rights argument used by those opposing the abolition of slavery and integration.
The Problem with the White Paper’s Use of “Rational Explanation” is Not a Challenge to Statutory Standards, but a Technical Issue with Identifying Spurious Correlations

The CASTF’s white paper use of “rational explanation” is problematic because it is a subjective approach to addressing spurious correlations. It is not a challenge to the mythical statutory standards in the resolution because regulators and actuarial standards of practice have always sought to distinguish between real and false relationships among predictive variables in insurance. “Rational explanation” is problematic because “rational” is subjective – a rational explanation to one person may not be rational to another. The way to address the problem with “rational explanation” is to urge regulators to utilize more of the advanced analytic and statistical tools to distinguish between fair and proxy discrimination. Again, the attached CEJ paper discusses this in more detail.

The NAIC Casualty Actuarial and Statistical Task Force deals generally with actuarial issues in property casualty lines of insurance. The Task Force is currently developing a white paper to provide best practices for regulatory review of complex pricing models used by insurers to justify rates. The current draft does not incorporate identification and minimization of systemic bias or disparate impact, but simply lists it as another consideration. Insurance rate standards include rates not being excessive, not being inadequate and not being unfairly discriminatory.

The use of complex predictive models for pricing by insurers is focused on risk segmentation and the development of risk classifications and rating factors. Traditional actuarial techniques – not complex predictive models – are generally used for overall rate level indications – the metric for assessing whether rates are excessive or inadequate. The overwhelming reason for close scrutiny of complex predictive models by regulators is to assess whether the risk classifications are fair or unfairly discriminatory. It is an understatement to say that the current draft white paper has a massive whole because of the failure to address proxy discrimination and disparate impact. Guidance to insurance regulators for regulatory review of complex insurance predictive models should prioritize the identifications and minimization of systemic bias and disparate impact.

Conclusion

For a myriad of reasons, CEJ suggests that NCOIL withdraw this deeply-flawed resolution.
The Center for Economic Justice’s Call to Insurers and Insurance Regulators

To Address Societal Systemic Bias and Inherent Racism in Insurance
By Explicit Recognition of Disparate Impact as Unfair Discrimination in Insurance

Submitted to the National Association of Insurance Commissioners’
Big Data Working Group
Artificial Intelligence Working Group
Market Regulation and Consumer Affairs Committee
Casualty Actuarial and Statistical Task Force
Accelerated Underwriting Working Group

June 18, 2020

Action, Not Just Words, Needed

The murder of George Floyd has led to widespread corporate recognition of and opposition to systemic bias and inherent racism in America. Corporate CEOs have spoken out, including major insurer CEOs.

“In the coming days, I encourage each of us to step outside of our comfort zones, seek to understand, engage in productive conversations and hold ourselves accountable for being part of the solution. We must forever stamp out racism and discrimination.” Those are the words of Kirt Walker, Chief Executive Officer of Nationwide.

Floyd’s death in Minneapolis is the latest example of “a broken society, fueled by a variety of factors but all connected by inherent bias and systemic racism. Society must take action on multiple levels and in new ways. It also requires people of privilege—white people—to stand up for and stand with our communities like we never have before,” Those are the words of Jack Salzwedel, the CEO of American Family.
Perhaps this will be a turning point in insurer and regulatory practices, but insurers have consistently opposed proposals to address systemic bias and inherent racism in insurance. This opposition has come in two general themes – opposition to any responsibility by insurers or regulators to identify and minimize disparate impact\(^1\) in insurance and opposition to any form of regulatory data collection to allow regulators and the public to assess market outcomes and thereby hold insurers accountable for their practices.

While insurers have been constant in opposing any responsibility to address systemic bias and inherent racism – in contrast to the recent public statements of insurer CEOs – most state insurance regulators believe they have the authority to stop proxy discrimination against protected classes. This belief, however, has never manifested itself, in regulatory standards, models laws or consistent approaches across states.

If insurers and insurance regulators truly want to address systemic bias and inherent racism in insurance, two long-overdue actions are needed.

1. Explicit recognition of disparate impact as unfair discrimination against protected classes in insurance coupled with responsibility for insurers and insurance regulators to identify such disparate impact and take steps to minimize this proxy discrimination within the overall regulatory framework of cost-based pricing.

2. Development of regulatory data collection and analysis infrastructure and capabilities for insurance regulators and the public to meaningfully monitor market outcomes for all consumers, to identify discriminatory outcomes and trace disparate impact to the causes.

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\(^1\) Disparate impact refers to practices that have the same effect as disparate treatment or intentional discrimination against protected classes. Protected classes refer to those consumer characteristics which may not be the basis for discrimination and include, in most states, race, religion and national origin. Disparate impact is also known as disparate effect or proxy discrimination – discrimination against the protected class through a proxy for the protected class characteristic. Dis disparate impact as unfair discrimination has long been recognized under federal employment and housing laws. In 2015, the U.S. Supreme Court affirmed disparate impact as unfair discrimination under the Fair Housing Act which covers a variety of housing-related issues, including insurance, with Justice Kennedy writing, “Recognition of disparate-impact liability under the FHA plays an important role in uncovering discriminatory intent: it permits plaintiffs to counteract unconscious prejudices and disguised animus that escape easy classification as disparate treatment.”
The mechanisms to accomplish these actions are straightforward.

1. Development of, and implementation by the states, through the National Association of Insurance Commissioners (NAIC) of a model law addressing algorithmic bias including recognition of disparate impact as unfair discrimination against protected classes in insurance with guidance and safe havens for insurers to identify and minimize disparate impact in marketing, pricing, claims settlement and anti-fraud efforts.

2. Development of, and implementation by the states, through the NAIC, of a market regulation data collection and analysis infrastructure to timely and meaningfully monitor consumer insurance outcomes – similar in scope and capability to what state insurance regulators and the NAIC currently have for monitoring the financial condition of insurers.

In the absence of the necessary actions by insurers and the states, Congress and federal agencies will eventually address these problems through civil rights legislation and enforcement.

In An Era of Big Data Analytics and Insurers’ Rapidly Growing Use of Third-Party Data and Complex Algorithms, the Potential For Algorithmic Bias and Proxy Discrimination Has Grown Dramatically.

The potential for big data, artificial intelligence, machine learning – implemented through rapid deployment of complex algorithms – has increased the potential for intentional or unintentional proxy discrimination through algorithmic bias. This potential is well recognized. Barocas and Selbst state the issue succinctly:

Advocates of algorithmic techniques like data mining argue that they eliminate human biases from the decision-making process. But an algorithm is only as good as the data it works with. Data mining can inherit the prejudices of prior decision-makers or reflect the widespread biases that persist in society at large. Often, the “patterns” it discovers are simply preexisting societal patterns of inequality and exclusion. Unthinking reliance on data mining can deny members of vulnerable groups full participation in society.

Most data sets of personal consumer information as well data sets of the built environment reflect historical discrimination against protected classes. For example, TransUnion has an insurance score used for pricing based on criminal violations filed with the courts – not just convictions, but all criminal filings regardless of the eventual outcome. TransUnion’s marketing materials state:

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2 https://content.naic.org/index_about.htm
“TransUnion recently evaluated the predictive power of court record violation data (including criminal and traffic violations)

“Also, as court records are created when the initial citation is issued, they provide insight into violations beyond those that ultimately end up on the MVR—such as violation dismissals, violation downgrades, and pre-adjudicated or open tickets.”

It did not take the recent murders of Black Americans by police to recognize that this “criminal history score” will reflect historic discrimination in policing against Black Americans and perpetuate that discrimination in insurance. Consider policing records in Ferguson, Missouri.

**US DOJ Investigation of the Ferguson Police Department**
Ferguson’s approach to law enforcement both reflects and reinforces racial bias, including stereotyping. The harms of Ferguson’s police and court practices are borne disproportionately by African Americans, and there is evidence that this is due in part to intentional discrimination on the basis of race.

Ferguson’s law enforcement practices overwhelmingly impact African Americans. Data collected by the Ferguson Police Department from 2012 to 2014 shows that African Americans account for 85% of vehicle stops, 90% of citations, and 93% of arrests made by FPD officers, despite comprising only 67% of Ferguson’s population.

FPD appears to bring certain offenses almost exclusively against African Americans. For example, from 2011 to 2013, African Americans accounted for 95% of Manner of Walking in Roadway charges, and 94% of all Failure to Comply charges.

Our investigation indicates that this disproportionate burden on African Americans cannot be explained by any difference in the rate at which people of different races violate the law. Rather, our investigation has revealed that these disparities occur, at least in part, because of unlawful bias against and stereotypes about African Americans.

One of the oft-cited benefits of big data analytics in insurance is greater personalization – the ability of insurers to develop products and pricing tailored to individual needs and characteristics. But the other side of personalization is exclusion. Insurers’ use of algorithmic techniques called price optimization, claim optimization and customer lifetime value are examples of the flip side of big data personalization – differential treatment of groups of consumers that reflect and perpetuate inherent bias and systemic racism.
The TransUnion Criminal History Score is just one example – egregious and obvious – of algorithms that reflect and perpetuate historic discrimination against protected classes in insurance – algorithms that reinforce inherent bias and systemic discrimination. Others include:

- Employment categories and education levels for marketing, underwriting and pricing
- Price Optimization and Customer Lifetime Value Algorithms used for marketing, underwriting, pricing and claims settlement
- Facial analytics used in life insurance underwriting
- Household composition used for underwriting and pricing
- Credit scores for marketing, underwriting, pricing, claims settlement and anti-fraud efforts
- Fraud detection models based on biased learning data

Many of these practices have shown to discriminate unfairly against protected classes, generally, and Black Americans, specifically. A number of cities – as well as Google and IBM – have stopped using facial recognition technology because of the biases against Black Americans. After the New York Department of Financial Services developed a regulation permitting the use of employment and education characteristics in auto insurance pricing only if the insurer could demonstrate the practice did not unfairly discriminate against protected classes, insurers’ use of the “risk” characteristics disappeared.

The Consumer Federation of America has produced a number of extraordinary studies of discriminatory market outcomes resulting from rating factors that reflect systemic racism. Insurance industry trade associations have dismissed the CFA’s discriminatory findings with the claim that insurers engage in cost-based, race-neutral practices – while refusing to both provide the data to back up these claims and refusing to recognize that systemic racism will show up as disparate impact.

If insurers and insurance regulators are serious about addressing inherent bias and systemic racism in insurance, then action is needed. Fortunately, the insurance industry has the precise skill set needed to identify and minimize disparate impact and insurance regulators have the resources to develop the necessary guidance and infrastructure.

**Disparate Impact Analysis is Straightforward and Particularly Suited to Insurance.**

The mechanics of a disparate impact analysis in insurance are straightforward and use well-accepted statistical and actuarial methods. Any algorithm – whether for pricing, anti-fraud, claims settlement, lifetime customer value, price optimization or other – takes the basic form of an equation in which certain variables or factors – the explanatory factors – seek to explain or predict a particular outcome.

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Consider the following general model.

\[ b_0 + b_1X_1 + b_2X_2 + b_3X_3 + e = y \]

Say that \( X_1, X_2 + X_3 \) are explanatory variables used to predict \( y \) – the frequency of an auto claim, for example.

Let’s assume that all three \( X \)s are statistically significant predictors of the likelihood of a claim and the \( b \) values associate with each \( X \) are how much each \( X \) contributes to the explanation of claim.

\( b_0 \) is the “intercept” – a base amount and \( e \) is the error term – the portion of the explanation of the claim not provided by the independent variables.

When the algorithm or model is developed, the modeler will typically data mine some database of personal consumer information, built environment or natural environment for characteristics that are correlated with the desired outcome. These variables are combined into a model, but a variable that might be predictive on its own can lose its predictive capability when combined with other variables because the variables might be correlated with one another. In that event, the variable serving as the proxy for the other variable loses its individual explanatory power. In our example, above, if, say, \( X_1 + X_2 \) are highly correlated, when the two variables are used in the same algorithm, one of the variables will lose its predictive power.

From a statistical and actuarial perspective, a disparate impact analysis does two things. First, it examines the amount of correlation between explanatory variables or factors and protected class characteristics to determine if any of the explanatory variables have significant correlation with, and thereby serve as proxies – in whole or in part – for protected class characteristics.

The second function of a disparate impact analysis is to remove the correlation between the explanatory variables and protected class characteristics with the result that the remaining explanatory power of the explanatory variables is the independent contribution – independent of correlation to protected class characteristics – of the explanatory variables relationship to the outcome.

Consider the following example. Suppose an explanatory factor was perfectly correlated with being a Black American. In statistical terms, this means a perfect or 100% correlation and the explanatory factor is a perfect proxy for being African-American. Assume that when used in an algorithm, this perfect proxy for being a Black American shows us as predictive of some outcome variable. Assume variable \( X_1 \) in our simple model above is the perfect proxy characteristic and further assume that the proxy variable shows a correlation to / is predictive of the outcome variable. Given our assumption that variable \( X_1 \) is a perfect proxy for being Black American, then the results of the model would be identical whether we used the proxy variable or used Black American explicitly. If the proxy variable is used, this would not be intentional discrimination – defined as explicit use of a protected class characteristic – even though it has
precisely the same effect. While most regulators believe they have the authority and obligation to stop the use of such proxies for protected class characteristics, the insurance industry view, as espoused by the American Property Casualty Insurance Association, is that even in this extreme case, there is no unfair discrimination against a protected class.

When the data are run through the model, variable \( X_1 \) shows some correlation to the outcome variable and is, therefore, “predictive.” But, what it is really doing is simply standing in for being Black American and indirectly discriminating on the basis of race. This proxy factor is, in fact, simply reflecting and perpetuating discrimination against Black Americans.

One approach to disparate impact analysis – among many which generally try to remove the correlation between predictive variables and protected class characteristics – is to include a control explanatory variable for being Black American in the algorithm. Let’s know add a new variable to algorithm – a specific variable for being Black American.

\[
b_0 + b_1X_1 + b_2X_2 + b_3X_3 + b_4R_1 + e = y
\]

In statistical and actuarial terms, this is known as adding a control variable. The purpose of the control variable is to remove known correlations and biases in the other explanatory variables in order to better assess the independent and unique explanatory power of these other explanatory variables. For example, in personal auto pricing models, an insurer developing a national pricing model will utilize a control variable for State to remove the effects of correlations with other explanatory variables of State-specific characteristics, such as different minimum liability limits, different tort and no-fault systems and different population distributions by age or other factors, among other things. In our example, our control variable \( R_1 \) is being Black American.

Now, when the data are run through the model, explanatory variable \( X_1 \) – the perfect proxy for being Black American – shows no explanatory power and the control variable now shows the explanatory power that explanatory variable \( X_1 \) had in the original model. This is statistical evidence that explanatory variable \( X_1 \) was discriminating on the basis of race.

Let’s consider two other examples – one in which there is a 50% correlation between variable \( X_1 \) and being Black American and a second in which there is a 0% correlation. In the 50% correlation, the variable \( X_1 \) may still show up as predictive of the outcome, but that predictive power will be different than from our first model without the control variable for being Black American. \( X_1 \)’s new contribution to explaining or predicting the outcome will now be its contribution independent of any correlation to being Black American. Consequently, disparate impact is recognized and minimized. Again, this is a common statistical and actuarial technique.5

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5 For example, the technique is explained in the chapter, “Credit Scoring and the Fair Lending Issue of Disparate Impact,” in *Credit Scoring for Risk Managers*, Elizabeth May, editor, 2004.
In our third example there is 0% correlation between the variables $X_i$ and $R_i$. In this situation, the predictive power of $X_i$ remains the same as in the original model because there is no disparate impact.

As noted above, disparate impact analysis is particularly suited to insurance because the actuarial justification required for insurance risk classifications is a statistical test – is the characteristic correlated with risk of loss? The same statistical test can be used to evaluate and minimize disparate impact. Stated differently – if a particular correlation and statistical significance is used to justify, say, insurance credit scoring, those same standards of correlation and statistical significance are reasonable evidence of disparate impact and unfair discrimination on the basis of prohibited factors.

In addition, the ability of insurers to identify and minimize disparate impact can be easily built into the development of pricing, marketing or claim settlement models by including consideration of prohibited characteristics as control variables in the development of the model and then omitting these prohibited characteristics when the model is deployed. Again, this is one of many ways to remove the correlations between explanatory variables in algorithms and the protected class characteristics that result in reflection of and perpetuation of historic discrimination or disparate impact.

Recognition by regulators and insurers of disparate impact as unfair discrimination in insurance against protected classes and requirements to identify and

- Minimizes Disparate Impact – Stop the Cycle of Perpetuating Historical Discrimination.
- Promotes Availability and Affordability for Underserved Groups
- Improves Cost-Based Insurance Pricing Models
- Improve Price Signals to Insureds for Loss Mitigation Investments
- Help Identify Biases in Data and Modelers / Improve Data Insights
- Improve Consumer Confidence of Fair Treatment by Insurers

What NAIC Committees and Working Groups Should Be Doing

The NAIC has spread work streams related to Big Data Analytics over a number of groups. With the exception of the Artificial Intelligence Working Group, none of these groups’ work efforts address systemic bias in insurance.
Artificial Intelligence Working Group

The NAIC Artificial Intelligence (AI) Working Group is developing insurance-specific principles for the governance and use of AI in insurance. While there are a number of consumer protection issues associated with insurers’ use of AI (or Big Data Analytics, generally), such as protection of personal data and transparency and accountability to consumers and regulators, the most important consumer protection is establishing a responsibility for insurers and regulators to identify and minimize algorithmic bias and proxy discrimination. Recognition of disparate impact and responsibility of insurers and regulators to minimize such systemic bias must be a core AI insurance principle.

Big Data Working Group

The NAIC Big Data Working Group is examining big data analytics issues across a variety of insurance operations and lines of business. The two actions called for by CEJ regarding disparate impact and data collection should be at the core of all the working group’s inquiries and activities. The Big Data Working Group should be developing the model law or revisions to existing model laws regarding explicit recognition of disparate impact, guidelines for identify and minimizing proxy discrimination and safe harbors for insurers.

Market Regulation and Consumer Affairs Committee

The NAIC Market Regulation and Consumer Affairs Committee is the parent committee for a number of working groups related to insurance market regulation, including data collection for market regulation, market surveillance, market conduct examinations and antifraud efforts. The Committee should be a contributor to the development of model laws regarding disparate impact, but must take the lead on market regulation data collection – both to identify the types of data and algorithms used by insurers and what these data are used for and to re-engineer market regulation data collection to match the granularity and frequency of financial regulation data collection.

Casualty Actuarial and Statistical Task Force

The NAIC Casualty Actuarial and Statistical Task Force deals generally with actuarial issues in property casualty lines of insurance. The Task Force is currently developing a white paper to provide best practices for regulatory review of complex pricing models used by insurers to justify rates. The current draft does not incorporate identification and minimization of systemic bias or disparate impact, but simply lists it as another consideration. Insurance rate standards include rates not being excessive, not being inadequate and not being unfairly discriminatory.

The use of complex predictive models for pricing by insurers is focused on risk segmentation and the development of risk classifications and rating factors. Traditional actuarial techniques – not complex predictive models – are generally used for overall rate level indications – the metric for assessing whether rates are excessive or inadequate. The overwhelming reason
for close scrutiny of complex predictive models by regulators is to assess whether the risk classifications are fair or unfairly discriminatory. It is an understatement to say that the current draft white paper has a massive whole because of the failure to address proxy discrimination and disparate impact. Guidance to insurance regulators for regulatory review of complex insurance predictive models should prioritize the identifications and minimization of systemic bias and disparate impact.

**Accelerated Underwriting Working Group**

The NAIC Accelerated Underwriting Working Group continues the NAIC’s multi-year examination of life insurers’ use of Big Data analytics and predictive models in place of traditional actuarial practices for underwriting and pricing life insurance. While the predictive models now used by life insurers have the same function as those used in auto, home and other property casualty lines of insurance – namely, using non-traditional data and an algorithm to predict claims (or other outcomes of value to the insurer). While there are requirements for property casualty insurers to file these predictive models for regulatory review for some purposes – justifying rates – and special laws and provisions governing property casualty insurers’ use of consumer credit information, there are no similar regulatory requirements for life insurers. The time is long overdue for this working group to develop the model laws for regulatory guidance and consumer protections to ensure consumer protections in the face of life insurers’ growing use of non-traditional, non-insurance data and complex algorithms. And the core of such models laws and regulatory guidance must be identification and minimization of disparate impact and systemic racism.

**Conclusion**

Recent events have highlighted a long-standing gaps in insurer and insurance regulatory practices – the failure to monitor consumer market outcomes for discriminatory impacts against protected classes and the failure to incorporate identification and minimization of proxy discrimination in insurers’ development of predictive models for all aspects of their operations and regulators’ review of these algorithms. The tools are available to address these problems – analysis of disparate impact and improved data collection. CEJ calls on insurers and regulators to match their statements of outrage over systemic racism with the actions needed to identify and minimize such unfair discrimination in insurance.
Using publicly available information to proxy for unidentified race and ethnicity

A methodology and assessment
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1. Executive summary

The Consumer Financial Protection Bureau (CFPB) is charged with ensuring that lenders are complying with fair lending laws and addressing discrimination across the consumer credit industry. Information on consumer race and ethnicity is required to conduct fair lending analysis of non-mortgage credit products, but auto lenders and other non-mortgage lenders are generally not allowed to collect consumers’ demographic information. As a result, substitute, or “proxy” information is utilized to fill in information about consumers’ demographic characteristics. In conducting fair lending analysis of non-mortgage credit products in both supervisory and enforcement contexts, the Bureau’s Office of Research (OR) and Division of Supervision, Enforcement, and Fair Lending (SEFL) rely on a Bayesian Improved Surname Geocoding (BISG) proxy method, which combines geography- and surname-based information into a single proxy probability for race and ethnicity. This paper explains the construction of the BISG proxy currently employed by OR and SEFL and provides an assessment of the performance of the BISG method using a sample of mortgage applicants for whom race and ethnicity are reported. Research has found that this approach produces proxies that correlate highly with self-reported race and national origin and is more accurate than relying only on demographic information associated with a borrower’s last name or place of residence alone. The Bureau is committed to continuing our dialogue with other federal agencies, lenders, advocates, and researchers regarding the methodology.
2. Introduction

The Equal Credit Opportunity Act (ECOA) and Regulation B generally prohibit a creditor from inquiring “about the race, color, religion, national origin, or sex of an applicant or any other person in connection with a credit transaction”\(^1\) with a few exceptions, including for applications for home mortgages covered under the Home Mortgage Disclosure Act (HMDA).\(^2\) Information on applicant race and ethnicity, however, is often required to conduct fair lending analysis to identify potential discriminatory practices in underwriting and pricing outcomes.\(^3\)

Various techniques exist for addressing this data problem. Demographic information that reflects applicants’ characteristics—for example, whether or not an individual is White—can be approximated by constructing a proxy for the information. A proxy may definitively assign a characteristic to a particular applicant—an individual is classified as being either White or non-White—or may yield an assignment that is probabilistic—an individual is assigned a probability, ranging from 0% to 100%, of being White. When characteristics are not reported for an entire population of individuals, as is usually the case for non-mortgage credit products, techniques focused on approximating the demographic data generally require relying on additional sources of data and information to construct proxies.

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\(^1\) 12 C.F.R. § 1002.5(b).

\(^2\) 12 C.F.R. § 1002.5(a)(2) and 12 C.F.R. § 1002.13. For HMDA and its implementing regulation, Regulation C, see 29 U.S.C § 2801-2810 and 12 C.F.R. Part 1003. For the Regulation B provisions concerning requests for information generally, see 12 C.F.R. § 1002.5.

\(^3\) The ECOA makes it unlawful for “any creditor to discriminate against any applicant, with respect to any aspect of a credit transaction (1) on the basis of race, color, religion, national origin, sex or marital status, or age (provided the applicant has the capacity to contract); (2) because all or part of the applicant’s income derives from any public assistance program; or (3) because the applicant has in good faith exercised any right under the Consumer Credit Protection Act.” 15 U.S.C. § 1691(a).
3. Using census geography and surname data to construct proxies for race and ethnicity

In a variety of settings, including the analysis of administrative health care data and the evaluation of fair lending risk in non-mortgage loan portfolios, researchers, statisticians, and financial institutions often rely on publicly available demographic information associated with an individual’s surname and place of residence from the U.S. Census Bureau to construct proxies for race and ethnicity when this information is not reported. A proxy for race and ethnicity may be based on the distribution of race and ethnicity within a particular geographic area. Similarly, a proxy for race and ethnicity may be based on the distribution of race and ethnicity across individuals who share the same last name. Traditionally, researchers and statisticians have relied on information associated with either geography or surnames to develop proxies.\(^4\)

A research paper by Elliott et al. (2009) proposes a method to proxy for race and ethnicity that integrates publicly available demographic information associated with surname and the geographic areas in which individuals reside and generates a proxy that is more accurate than those based on surname or geography alone.\(^5\) The method involves constructing a probability of

\(^{4}\) For example, in conducting fair lending analysis of indirect auto lending portfolios, the Federal Reserve relies on the U.S. Census Bureau’s Spanish Surname List to proxy for Hispanic borrowers. Information on the Federal Reserve’s methodology is available at: http://www.philadelphiafed.org/bank-resources/publications/consumer-compliance-outlook/outlook-live/2013/indirect-auto-lending.cfm.

\(^{5}\) Marc N. Elliott et al., Using the Census Bureau’s Surname List to Improve Estimates of Race/Ethnicity and Associated Disparities, HEALTH SERVICES & OUTCOMES RESEARCH METHODOLOGY (2009) 9:69-83.
assignment to race and ethnicity based on demographic information associated with surname and then updating this probability using the demographic characteristics of the census block group associated with place of residence. The updating is performed through the application of a Bayesian algorithm, which yields an integrated probability that can be used to proxy for an individual’s race and ethnicity. Elliott et al. (2009) refer to this method as Bayesian Improved Surname Geocoding (BISG).

The Office of Research (OR) and the Division of Supervision, Enforcement, and Fair Lending (SEFL) employ a BISG proxy methodology for race and ethnicity in our fair lending analysis of non-mortgage credit products that relies on the same public data sources and general methods used in Elliott et al. (2009).6 The following sections describe these public data sources, explain the construction of the BISG proxy, identify any differences from the general methods used by Elliott et al. (2009), and provide an assessment of the performance of the BISG proxy.

Statistical analysis based on proxies for race and ethnicity is only one factor taken into account by OR and SEFL in our fair lending review of non-mortgage credit products. This paper describes the methodology currently employed by OR and SEFL but does not set forth a requirement for the way proxies should be constructed or used by institutions supervised and regulated by the CFPB.7 Finally, our proxy methodology is not static: it will evolve over time as enhancements are identified that improve accuracy and performance.

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6 We also rely on a proxy for sex based on publicly available data from the Social Security Administration, available at: http://www.ssa.gov/oact/babynames/limits.html. The focus of this paper, however, is on the BISG methodology and the construction of the proxies for race and ethnicity.

7 The federal banking regulators have made it clear that proxy methods may be used in fair lending exams to estimate protected characteristics where direct evidence of the protected characteristic is unavailable. The CFPB adopted the Interagency Fair Lending Examination Procedures as part of its CFPB Supervision and Examination Manual. See CFPB Supervision and Examination Manual, Part II, C, ECOA, Interagency Fair Lending Examination Procedures at 19, available at http://files.consumerfinance.gov/f/201210_cfpb_supervision-and-examination-manual-v2.pdf (explaining that “[a] surrogate for a prohibited basis group characteristic may be used” in a comparative file review and providing examples of surname proxies for race/ethnicity and first name proxies for sex).
3.1 Data sources

3.1.1 Surname

Information used to calculate the probability of belonging to a specific race and ethnicity given an individual’s surname is based on data derived from Census 2000 that was released by the U.S. Census Bureau in 2007.\(^8\) This release provides each surname held by at least 100 enumerated individuals, along with a breakdown of the percentage of individuals with that name belonging to one of six race and ethnicity categories: Hispanic; non-Hispanic White; non-Hispanic Black or African American; non-Hispanic Asian/Pacific Islander; non-Hispanic American Indian and Alaska Native; and non-Hispanic Multiracial. These categories are consistent with 1997 Office of Management and Budget (OMB) definitions.\(^9,10\) In total, the list provides 151,671 surnames, covering approximately 90% of the U.S. population. Word et al. (2008) provides a detailed description of how the census surname list was constructed and describes the routines used to standardize surnames appearing on the list.\(^11\)

3.1.2 Geography

Information on the racial and ethnic composition of the U.S. population by geography comes from the Summary File 1 (SF1) from Census 2010, which provides counts of enumerated

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\(^8\) The data and documentation are available at: \url{http://www.census.gov/genealogy/www/data/2000surnames/}. The most recent census year for which the surname list exists is 2000. We will rely on more current data when it becomes available.

\(^9\) This classification holds Hispanic as mutually exclusive from the race categories, with individuals identified as Hispanic belonging only to that category, regardless of racial background. The Census relies on self-identification of both race and ethnicity when determining race and ethnicity for these individuals, with an exception made for classification to the “Some Other Race” category. In Census 2000, some individuals identifying as “Some Other Race” also specified a Hispanic nationality (e.g., Salvadoran, Puerto Rican); in these instances, the Census identified the respondent as Hispanic. OMB definitions are available at: \url{http://www.whitehouse.gov/omb/fedreg_1997standards}.

\(^10\) In the census surname data, the Census Bureau suppressed exact counts for race and ethnicity categories with 2-5 occurrences for a given name. Similarly to Elliott et al. (2009), in these cases we distribute the sum of the suppressed counts for each surname evenly across all categories with missing nonzero counts.


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individuals by race and ethnicity for various geographic area definitions, with census block serving as the highest level of disaggregation (the smallest geography). In the decennial Census of the Population, the Census Bureau uses a classification scheme for race and ethnicity that differs slightly from the scheme used by OMB. Census treats Hispanic as an ethnicity and the other OMB categories as racial identities. However, Census does report population counts by race and ethnicity in a way that allows for the creation of race and ethnicity population totals that are consistent with the OMB definition. Our method relies on race and ethnicity information for the adult (age 18 and over) population at the census block group, census tract, and 5-digit zip code levels, as discussed in the next section.

### 3.2 Constructing the BISG probability

Constructing the BISG proxy for race and ethnicity for a given set of applicants requires place of residence (address) and name information for those applicants, the census surname list, and census demographic information by census block group, census tract, and 5-digit zip code. The process occurs in a number of steps:

1. Applicants’ surnames are standardized and edited, including removing special characters and titles, such as JR and SR, and parsing compound names.

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12 The hierarchy of census geographic entities, from smallest to largest, is: block, block group, tract, county, state, division, region, and nation. Block group level information appears in Table P9 (“Hispanic or Latino, and Not Hispanic or Latino by Race”) in the SF1. Table P11 in the SF1 provides similar counts for the restricted population of individuals 18 and over. The public can access these data in a variety of ways, including through the American FactFinder portal at: [http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml](http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml).

13 In the 2010 SF1, Census produced tabulations that report counts of Hispanics and non-Hispanics by race. These tabulations include a “Some Other Race” category. As in Elliott et al. (2009), we reallocate the “Some Other Race” counts to each of the remaining six race and ethnicity categories using an Iterative Proportional Fitting procedure to make geography based demographic categories consistent with those on the census surname list.

14 Throughout this paper, we use 5-digit zip code, when referring to zip code demographics, as a synonym for ZIP Code Tabulation Areas (ZCTAs) as defined by the U.S. Census Bureau. More information on the construction of ZCTAs is available at: [https://www.census.gov/geo/reference/zctas.html](https://www.census.gov/geo/reference/zctas.html).

15 From the SF1, we retain population counts for the contiguous U.S., Alaska, and Hawaii in order to ensure consistency with the population covered by the census surname list.
2. Standardized surnames are matched to the census surname list. For applicants with compound surnames, if the first word of the compound surname successfully matches to the surname data, it is used to calculate the surname based probability. If the first word does not match, the second word is then tried. For example, if an applicant’s last name is Smith-Jones, the demographic information associated with Smith is used if Smith appears on the name list. If Smith does not appear on the name list, then the information associated with Jones is used if Jones is on the list.

3. For each name that matches the census surname list, the probability of belonging to a given racial or ethnic group (for each of the six race and ethnicity categories) is constructed. The probability is simply the proportion (or percentage) of individuals who identify as being a member of a given race or ethnicity for a given surname. For example, according to the census surname list, 73% of individuals with the surname Smith report being non-Hispanic White; thus, for any individual with the last name Smith, the surname-based probability of being non-Hispanic White is 73%. For applications with names that do not match the census surname list, a probability is not constructed. These records are excluded in subsequent analysis.\(^\text{16}\) Given that approximately 10% of the U.S. population is not included on the census surname list, one would reasonably expect roughly a 10% reduction in the number of records in a proxied dataset due to non-matches to the census surname list.

4. Applicant address information is standardized in preparation for geocoding. Standardization includes basic checks such as removing non-numeric characters from zip codes, making sure zip codes with leading zeroes are accurately identified, and ensuring address information is in the correct format, for example, that house number, street, city, state, and zip code are appropriately parsed into separate fields.

5. Addresses are mapped into census geographic areas using a geocoding and mapping software application.\(^\text{17}\) The geocoding application used by OR and SEFL in building the

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\(^{16}\) Elliott et al. (2009) retain records in their assessment data that do not appear on the surname list. To do so, they use the distribution of race and ethnicity appearing on the name list and the national population counts in the Census 2000 SF1 to characterize the unlisted population. OR and SEFL continue to evaluate the approach undertaken by Elliott et al. (2009) and may adopt a method for proxying the unlisted surname population in future updates to the proxy methodology.

\(^{17}\) We currently use ArcGIS Version 10.1 with Street Map Premium 2011 Release 3 to geocode data when building the proxy. We may rely on updated releases as they become available or may move to different geocoding technology in the future. The BISG proxy methodology does not require the use of a specific geocoding technology.
proxy identifies the geographic precision to which an address is geocoded, and the precision of geocoding determines the precision of the demographic information relied upon.\textsuperscript{18} For addresses that are geocoded to the latitude and longitude of an exact street address (often referred to as a “rooftop”), information on race and ethnicity for the adult population residing in the census block group containing the street address is used; if the census block group has zero population, information for the census tract is used. For addresses that are geocoded to street name, 9-digit zip code, and 5-digit zip code, the race and ethnicity information for the adult population residing in the 5-digit zip code is used. Addresses that cannot be geocoded or that can be geocoded only to a geographical area that is less precise than 5-digit zip code (for example, city or state) are excluded in subsequent analysis.

6. For geocoded addresses, the proportion (or percentage) of the U.S. adult population for each race and ethnicity residing in the geographic area containing the address or associated with the 5-digit zip code is calculated.

7. Bayes Theorem is used to update the surname-based probabilities constructed in Step 3 with the information on the concentration of the U.S. adult population constructed in Step 6 to create a probability—a value between, or equal to, 0 and 1—of assignment to each of the 6 race and ethnicity categories. These proxy probabilities can be used in statistical analysis aimed at identifying potential differences in lending outcomes.

Appendix A provides the mathematical formula associated with Step 7 and an example of the construction of the BISG proxy probabilities for an individual with the last name Smith residing in California. The statistical software code, written in Stata, and the publicly available census data files used to build the BISG proxy are available at: https://github.com/cfpb/proxy-methodology. Because OR and SEFL currently use ArcGIS to geocode address information when building the proxy, the geocoding of address information must occur before running the Stata code that builds the BISG proxy. The use of alternative geocoding applications may return slightly different geocoding results and, therefore, may yield different BISG probabilities than those generated using ArcGIS.

Steps 1 through 7 describe the general process currently undertaken by OR and SEFL to construct proxies for race and ethnicity for fair lending analysis. Unique features of a dataset

\textsuperscript{18} The precision of the geocoding is driven by the availability of address information and the geocoding software application’s assessment of the quality of address information provided.

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under review, for example, the quality of surname data and the ability to match individuals to the census surname list, or the quality of address information and the ability to geocode to an acceptable level of precision, may lead to a modification of the general methodology, as appropriate.
4. Assessing the ability to predict race and ethnicity: an application to mortgage data

Elliott et al. (2009) demonstrate, using health plan enrollment data with reported race and ethnicity, that the BISG proxy methodology is more accurate than either the traditional surname-only or geography-only methodologies. In this section, we discuss a similar validation of the BISG proxy in the mortgage lending context.

To assess the performance of the BISG proxy in this context, the geography-only, surname-only, and BISG proxies for race and ethnicity were constructed for applicants appearing in a sample of mortgage loan applications in 2011 and 2012 for which address, name, and race and ethnicity were reported. These data were provided to the CFPB by a number of lenders pursuant to the CFPB’s supervisory authority. Applications with surnames that did not match the surname list were excluded.

19 The geography-only probability proxy is constructed in a manner that is similar to the construction of the surname-only proxy. For each geocoded address, the probability of belonging to a given racial or ethnic group (for each of the six race and ethnicity categories) is constructed. The probability is simply the proportion (or percentage) of individuals who identify as being a member of a given race or ethnicity who reside in the block group, census tract, or area corresponding to the 5-digit zip code, depending on the precision to which an applicant’s address is geocoded.

20 The reported race and ethnicity used in the assessment are derived from the HMDA reported race and ethnicity contained in the mortgage data sample. Ethnicity (Hispanic) and race—American Indian/Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White—are reported at the applicant level. For a given applicant, up to five races may be reported. The reported HMDA race and ethnicity are used to classify applicants in a manner consistent with the six mutually exclusive race and ethnicity categories defined by the Office of Management and Budget and used on the census surname list. Applications for which race or ethnicity information was not provided were omitted from the initial sample.
and with addresses that could not be geocoded to at least the 5-digit zip code were omitted from the analysis. Table 1 shows that for the initial sample of 216,798 mortgage applications, 26,363 applications—approximately 12% of the initial sample—were omitted from the analysis, resulting in a final sample of 190,435.

<table>
<thead>
<tr>
<th>TABLE 1: MORTGAGE LOAN SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname did not match</td>
</tr>
<tr>
<td>Not Geocoded</td>
</tr>
<tr>
<td>Geocoded</td>
</tr>
<tr>
<td>Surname did match</td>
</tr>
<tr>
<td>Not Geocoded</td>
</tr>
<tr>
<td>Geocoded</td>
</tr>
</tbody>
</table>

For each applicant, three probabilities of assignment to each of the six race and ethnicity categories were constructed: a probability based on census race and ethnicity information associated with geography (geography-only); a probability based on census race and ethnicity information associated with surname (surname-only); and the BISG probability based on census race and ethnicity information associated with surname and geography (BISG). As previously discussed, the probabilities themselves may be used to proxy for race and ethnicity by assigning to each record a probability of belonging to a particular racial or ethnic group. These probabilities can be used to estimate the number of individuals by race and ethnicity and to identify potential disparities in outcomes through statistical analysis.

Assessing the accuracy of the proxy involves comparing a probability that can range between 0 and 1 (a continuous measure) to reported race and ethnicity classifications that, by definition, take on values of only 0 or 1 (a dichotomous measure). Accuracy can be evaluated in at least two ways: (1) by comparing the distribution of race and ethnicity across all applicants based on the proxy to the distribution based on reported characteristics and (2) by assessing how well the proxy is able to sort applicants into the reported race and ethnicity categories. The tendency for low values of the proxy to be associated with low incidence of individuals in a particular racial or ethnic group and for high values of the proxy to be associated with high incidence is measured by the correlation between the proxy and reported classification for a given race and ethnicity. Additional diagnostic measures, such as Area Under the Curve (AUC) statistics, reflect the extent to which a proxy probability accurately sorts individuals into target race and ethnicity and provides a statistical framework for assessing improvements in sorting attributable to the BISG proxy. Section 4 provides an evaluation of the use of the BISG probability proxy and
assesses performance relative to reported race and ethnicity, illustrating the merits of relying on the BISG probability proxy rather than on a proxy based solely on information associated with geography or surname alone.

### 4.1 Composition of lending by race and ethnicity

Table 2 provides the distribution of reported race and ethnicity (Reported) and the distributions based on the BISG, surname-only, and geography-only proxies. For the Reported row, the percentage in each cell is calculated as the sum of the reported number of individuals in each racial or ethnic group divided by the number of applicants in the sample (multiplied by 100). For the proxies, the percentage is simply the sum of the probabilities for each race and ethnicity divided by the number of applicants in the sample (multiplied by 100). For example, two individuals each with a 0.5 probability of being Black and a 0.5 probability of being White would contribute a count of 1 to both the Black and the White totals.

<table>
<thead>
<tr>
<th>Classifier or Proxy</th>
<th>Hispanic</th>
<th>White</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Multiracial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported</td>
<td>5.8%</td>
<td>82.9%</td>
<td>6.2%</td>
<td>4.5%</td>
<td>0.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>BISG</td>
<td>6.1%</td>
<td>79.7%</td>
<td>7.5%</td>
<td>5.0%</td>
<td>0.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Surname-only</td>
<td>7.4%</td>
<td>75.4%</td>
<td>10.0%</td>
<td>4.9%</td>
<td>0.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Geography-only</td>
<td>7.2%</td>
<td>78.6%</td>
<td>8.1%</td>
<td>4.8%</td>
<td>0.3%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

21 In this table and in subsequent tables, we refer only to the race for a non-Hispanic race group. For instance, the “White” category refers to “Non-Hispanic White.”
As the table indicates, all three proxies tend to approximate the reported population race and ethnicity. However, each also tends to underestimate the population of non-Hispanic Whites and overestimate the other race and ethnicity categories, which may reflect differences between the racial and ethnic composition of the census based populations used to construct the proxies and the racial and ethnic composition of individuals applying for mortgages.

Importantly, however, the BISG proxy comes closer to approximating the reported race and ethnicity than the traditional proxy methodologies, with the only exception being for Asian/Pacific Islanders and Multiracial. Though we see small absolute gains in accuracy from use of a BISG proxy for some groups relative to the traditional methods of proxying, these gains frequently represent a sizeable improvement in terms of relative performance. For example, the gap between reported race and estimated race for non-Hispanic Whites shrinks by 1.1% (from 82.9% – 78.6% = 4.3% to 82.9% – 79.7% = 3.2%) when moving from a geography-only to the BISG proxy. Given the initial gap of 4.3% this represents an almost 25% reduction in the difference between estimated and reported race. The gaps for non-Hispanic Black, non-Hispanic American Indian/Alaska Native, and Hispanic shrink in a similar manner. For non-Hispanic Asian/Pacific Islander, the gap between estimated and reported totals increases by 0.2% in absolute terms compared to the geography-only alternative and by 0.1% compared to the surname-only alternative. For the non-Hispanic Multiracial category, the BISG proxy does slightly better than the surname-only and slightly worse than the geography-only proxy in approximating the reported percentage.

4.2 Predicting race and ethnicity for applicants

4.2.1 Correlations between the proxy and reported race and ethnicity

Table 3 provides the correlations between reported race and ethnicity and the BISG, surname-only, and geography-only proxies.
TABLE 3: CORRELATIONS BETWEEN PROXY PROBABILITY AND REPORTED RACE AND ETHNICITY

<table>
<thead>
<tr>
<th>Proxy</th>
<th>Hispanic</th>
<th>White</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Multiracial</th>
</tr>
</thead>
<tbody>
<tr>
<td>BISG</td>
<td>0.81</td>
<td>0.77</td>
<td>0.70</td>
<td>0.83</td>
<td>0.06</td>
<td>0.05</td>
</tr>
<tr>
<td>Surname-only</td>
<td>0.78</td>
<td>0.66</td>
<td>0.40</td>
<td>0.81</td>
<td>0.03</td>
<td>0.05</td>
</tr>
<tr>
<td>Geography-only</td>
<td>0.45</td>
<td>0.54</td>
<td>0.58</td>
<td>0.38</td>
<td>0.05</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Correlation is a statistical measure of the relationship between different variables—in this case the race and ethnicity proxy and an applicant’s reported race and ethnicity. Positive values indicate a positive correlation (as one variable increases in value, so does the other), negative values imply negative correlation (as one variable increases in value, the other decreases), and 0 indicates no statistical relationship. By definition, a correlation coefficient of 0 means that the proxy probability has no predictive power in explaining movement in the reported value, while a coefficient of 1 means that an increase in the proxy probability perfectly predicts increases in the reported values. Higher values of the correlation measure indicate a stronger ability to accurately sort individuals both into and out of a given race and ethnicity classification.

Correlations associated with the BISG proxy probabilities for Hispanic and non-Hispanic White, Black, and Asian/Pacific Islander are large and suggest strong positive co-movement with reported race and ethnicity. This means, for example, that the Hispanic proxy value is higher on average for individuals who are reported as Hispanic than for those who are not. For non-Hispanic American Indian/Alaska Native and the Multiracial classifications, correlations are positive but close to zero for all proxy methods, suggesting a low degree of power in predicting reported race and ethnicity for these two groups.

Looking across the rows in Table 3, correlations associated with the BISG are higher than those associated with the surname-only and geography-only proxies, notably for non-Hispanic Black and non-Hispanic White, reflecting the increase in the strength of the relationship between the proxy and reported characteristic from the integration of information associated with surname and geography in the BISG proxy. These results align closely with those found in Elliott et al.
(2009), which, as previously noted, assessed the BISG proxy using national health plan enrollment data. 

4.2.2 Area Under the Curve (AUC)

While correlations illustrate the overall extent of co-movement between the proxies and reported race and ethnicity, it is also important to assess the extent to which the proxy probabilities successfully sort individuals into each race and ethnicity.

A statistic that can be used to calculate this is called the Area Under the Curve (AUC), which represents the likelihood that the proxy will accurately sort individuals into a particular racial or ethnic group. For example, if one randomly selects an individual who is reported as Hispanic and a second individual who is reported as non-Hispanic, the AUC represents the likelihood that the randomly selected individual reported as Hispanic has a higher proxy value of being Hispanic than the randomly selected individual reported as non-Hispanic. The AUC can be used to test the hypothesis that one proxy is more accurate than another at sorting individuals in order of likelihood of belonging to a given race and ethnicity. An AUC value of 1 (or 100%) reflects perfect sorting and classification, and a value of 0.5 (or 50%) suggests that the proxy is only as good as a random guess (e.g., a coin toss).

Table 4 provides the results of statistical comparisons of the geography-only, surname-only, and BISG probabilities. The AUC statistics associated with the BISG proxy for Hispanic and non-Hispanic White, Black, and Asian/Pacific Islander are large and exceed 90%. For instance, the AUC statistic associated with the BISG proxy for non-Hispanic Black is 0.9540, suggesting that 95% of the time, a randomly chosen individual reported as Black will have a higher BISG probability of being Black than a randomly chosen individual reported as non-Black.

---

22 Table 4 of Elliott et al. (2009): Non-Hispanic White (0.76); Hispanic (0.82); Black (0.70); Asian/Pacific Islander (0.77); American Indian/Alaska Native (0.11); and Multiracial (0.02).

23 The AUC is based on the Receiver Operating Characteristic (ROC) curve, which plots the tradeoff between the true positive rate and the false positive rate for a given proxy probability over the entire range of possible threshold values that could be used to classify individuals with certainty to the race and ethnicity being proxied. See Appendix B for more detail on the construction of the ROC curves and calculation of the AUC.
TABLE 4: LIKELIHOOD OF ASSIGNMENT OF HIGHER PROXY PROBABILITY FOR GROUP MEMBERSHIP GIVEN THAT BORROWER IS REPORTED AS MEMBER OF GROUP (AREA UNDER THE CURVE STATISTIC)

<table>
<thead>
<tr>
<th>Proxy</th>
<th>Hispanic</th>
<th>White</th>
<th>Black</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
<th>Multiracial</th>
</tr>
</thead>
<tbody>
<tr>
<td>BISG</td>
<td>0.9446</td>
<td>0.9430</td>
<td>0.9540</td>
<td>0.9723</td>
<td>0.6840</td>
<td>0.6846</td>
</tr>
<tr>
<td>Geography-only</td>
<td>0.8386</td>
<td>0.8389</td>
<td>0.8959</td>
<td>0.8359</td>
<td>0.6574</td>
<td>0.6015</td>
</tr>
<tr>
<td>Surname-only</td>
<td>0.9302</td>
<td>0.8968</td>
<td>0.8678</td>
<td>0.9651</td>
<td>0.5907</td>
<td>0.7075</td>
</tr>
<tr>
<td>p-value, H0: BISG=Geo</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>0.0262</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>p-value, H0: BISG=Name</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>0.0289</td>
</tr>
</tbody>
</table>

For each of these four race and ethnicity categories, the AUC for the BISG proxy probability is statistically significantly larger than the AUC for the surname-only and geography-only probabilities, suggesting that, at or above the 99% level of statistical significance, the BISG more accurately sorts individuals than the traditional proxy methodologies. The greatest improvements in the AUC are associated with the BISG proxy for non-Hispanic White and Black, as the AUC is considerably higher than the AUCs associated with the geography-only and surname-only proxies. For Hispanic and non-Hispanic Asian/Pacific Islander, this improvement is only marginal relative to the performance of the surname-only proxy. Performance for non-Hispanic American Indian/Alaska Native and Multiracial, while generally improved by the use of the BISG proxy probabilities, is weak overall regardless of proxy choice, with only an 18% improvement in sorting over a random guess. These results suggest that proxies based on census geography and surname data are not particularly powerful in their ability to sort individuals into these two race and ethnicity categories.

24 The p-values for the tests of equivalence of the AUC statistics for the BISG and geography-only proxies and the BISG and surname-only proxies for each race and ethnicity appear in the last two rows of Table 4.
4.2.3 Classification over the range of proxy values

The BISG proxy’s ability to sort individuals is made clear through an evaluation of the number of applicants falling within ranges of proxy probability values. For example, for 10% bands of the BISG proxy probability for Hispanics, Table 5 provides: the number of total applicants (column 1); the estimated number of Hispanic applicants based on the summation of the BISG probability (column 2); the number of reported Hispanic applicants (column 3); the number of reported non-Hispanic White applicants (column 4); and the number of reported other minority, non-Hispanic applicants (column 5). A few results are worth noting.

<table>
<thead>
<tr>
<th>Hispanic BISG Proxy Probability Range</th>
<th>Total Applicants (1)</th>
<th>Estimated Hispanic (BISG) (2)</th>
<th>Reported Hispanic (3)</th>
<th>Reported White (4)</th>
<th>Reported Other Minority (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 10%</td>
<td>176,116</td>
<td>1,129</td>
<td>1,677</td>
<td>153,974</td>
<td>20,465</td>
</tr>
<tr>
<td>10% - 20%</td>
<td>1,720</td>
<td>240</td>
<td>163</td>
<td>1,207</td>
<td>350</td>
</tr>
<tr>
<td>20% - 30%</td>
<td>653</td>
<td>163</td>
<td>130</td>
<td>414</td>
<td>109</td>
</tr>
<tr>
<td>30% - 40%</td>
<td>541</td>
<td>189</td>
<td>147</td>
<td>312</td>
<td>82</td>
</tr>
<tr>
<td>40% - 50%</td>
<td>557</td>
<td>251</td>
<td>226</td>
<td>261</td>
<td>70</td>
</tr>
<tr>
<td>50% - 60%</td>
<td>597</td>
<td>328</td>
<td>279</td>
<td>258</td>
<td>60</td>
</tr>
<tr>
<td>60% - 70%</td>
<td>802</td>
<td>522</td>
<td>455</td>
<td>263</td>
<td>84</td>
</tr>
<tr>
<td>70% - 80%</td>
<td>1,135</td>
<td>853</td>
<td>766</td>
<td>286</td>
<td>83</td>
</tr>
<tr>
<td>80% - 90%</td>
<td>1,788</td>
<td>1,529</td>
<td>1,347</td>
<td>347</td>
<td>94</td>
</tr>
<tr>
<td>90% - 100%</td>
<td>6,526</td>
<td>6,312</td>
<td>5,883</td>
<td>534</td>
<td>109</td>
</tr>
<tr>
<td>Total</td>
<td>190,435</td>
<td>11,516</td>
<td>11,073</td>
<td>157,856</td>
<td>21,506</td>
</tr>
</tbody>
</table>

*Estimated Hispanic (BISG) is calculated as the sum of the BISG probabilities for being Hispanic within the corresponding proxy probability range.
First, the distribution of the BISG proxy probability is bimodal with concentrations of total applicants for low (e.g., 0%-20%) and high (e.g., 80%-100%) values of the proxy, which illustrates the sorting feature of the proxy. Reported Hispanic applicants are concentrated within high values of the proxy. For example, 65% \( \frac{(1,347+5,883)}{11,073} \) of reported Hispanic applicants (column 3) have BISG proxy probabilities greater than 80%; this concentration is mirrored by the estimated number of Hispanic applicants (column 2), 68% of whom have BISG proxy probabilities greater than 80% \( \frac{(1,529+6,312)}{11,516} \). While the BISG proxy may assign high values to some non-Hispanic applicants, 98% \( \frac{(153,974+1,207)}{157,856} \) of the reported non-Hispanic White and 97% \( \frac{(20,465+350)}{21,506} \) of the reported other non-Hispanic minority borrowers have Hispanic BISG proxy probabilities that are less than 20%.

Second, there are reported Hispanic applicants over the full range of values of the BISG proxy; this is also reflected by the estimated counts in column 2. For example, there are 597 applicants with BISG proxy values between 50% and 60%, of whom 279 are reported as being Hispanic, while the BISG proxy estimate of the number of Hispanic applicants in this range—calculated by summing probabilities for individuals within this probability range—is 328.

As suggested by Table 5 the BISG proxy tends to overestimate the number of Hispanic applicants for the mortgage pool under review. In the final row of column (3) we see that the total number of reported Hispanic applicants is 11,073. The estimated total number of Hispanic applicants—calculated as the sum of the BISG probabilities for Hispanic applicants—is 11,516 (column 2), which overestimates the number of Hispanic applicants by 4%. This overestimation may reflect, as discussed in Section 4.1, the use of demographic information based on the population at large to proxy the characteristics of mortgage applicants. According to the 2010 Census of Population, 14% of the U.S. adult population was Hispanic; 67% non-Hispanic White; 12% non-Hispanic Black; 5% Asian/Pacific Islander; and 1% American Indian/Alaska Native. According to the 2010 HMDA loan application data for all reporting mortgage originators, only 7% of applicants for home mortgages were Hispanic; 80% non-Hispanic White; 6% non-Hispanic Black; 6% Asian/Pacific Islander; and less than 1% American Indian/Alaska Native. Mortgage borrowers tend to be disproportionately non-Hispanic White and, in particular, underrepresent Hispanic and non-Hispanic Blacks relative to the population of the U.S.

\(^{25}\) The HMDA distributions for race and ethnicity are based only on applicant information for which race and ethnicity is reported and for applications that were originated, approved but not accepted, and denied by lenders.
OR and SEFL rely directly on the BISG probability in our fair lending related statistical analyses. In contrast, some practitioners rely on the use of a probability proxy and a threshold rule to classify individuals into race and ethnicity. When a threshold rule is used, individuals with proxy probabilities equal to and greater than a specific value, for example 80%, are considered to belong to a group with certainty, while all others are considered non-members with certainty. Consider two individuals who are assigned BISG probabilities of being non-Hispanic Black: individual A with 82% and individual B with 53%. The application of an 80% threshold rule for assignment would force individual A’s probability to 100% and classify that individual as being Black and force individual B’s probability to 0% and classify that individual as being non-Black.

The threshold rule removes the uncertainty about group membership at the cost of decreased statistical precision, with that precision deteriorating with decreases in the proxy’s ability to create separation across races and ethnicity. In situations in which researchers can obtain clear separation between groups—for instance, situations for which the probabilities of assignment tend to be very close to 0 or 1—the consequences of using a threshold assignment rule, beyond simple measurement error, would be minor. However, when insufficient separation exists—for example, when there are a significant number of individuals with probabilities between 20% and 80% of belonging to a particular group—the use of thresholds can artificially bias, usually downward, estimates of the number of individuals belonging to particular racial and ethnic groups and potentially attenuate estimates of differences in outcomes between groups.

Table 5 makes clear the consequence of applying a threshold rule to the BISG proxy probability to force classification with certainty. If an 80% threshold rule is applied, the estimated number of Hispanic applicants is 8,314—the sum of all applicants in column (1) with a BISG probability equal to or greater than 80%—which underestimates the reported number of 11,073 Hispanic applicants by 25%. The underestimation is driven by the failure to count the large number of individuals in column (3) who are reported as being Hispanic in the mortgage sample but for whom the BISG probability of assignment is less than 80%.

It is worth noting that the application of an 80% threshold rule to classify individuals also yields false positives: individuals who are reported as being non-Hispanic but, nonetheless, are assigned BISG proxy probabilities of being Hispanic equal to or greater than 80%. For the mortgage pool under review, 881 applicants who are reported as being non-Hispanic White and 203 applicants who are reported as being some other minority would be classified as Hispanic by an 80% threshold rule. The false positive rate associated with these 1,084 observations is 0.6%, measured as the number of false positives (1,084) as a percentage of the total number of false positives plus the 178,278 true negative reported non-Hispanics with BISG probabilities.
less than 80%. The false discovery rate for these same 1,084 observations is 13%, measured as the number of false positives (1,084) as a percentage of 8,314 applicants identified as Hispanic by the 80% threshold rule.

Classification and misclassification tables for the other five race and ethnicity categories appear in Appendix C.
5. Conclusion

Information on consumer race and ethnicity is generally not collected for non-mortgage credit products. However, information on consumer race and ethnicity is required to conduct fair lending analysis. Publicly available data characterizing the distribution of the population across race and ethnicity on the basis of geography and surname can be used to develop a proxy for race and ethnicity. Historically, practitioners have relied on proxies based on geography or surname only. A new approach proposed in the academic literature—the BISG method—combines geography- and surname-based information into a single proxy probability. In supervisory and enforcement contexts, OR and SEFL rely on a BISG proxy probability for race and ethnicity in fair lending analysis conducted for non-mortgage products.

This paper explains the construction of the BISG proxy currently employed by OR and SEFL and provides an assessment of the performance of the BISG method using a sample of mortgage applicants for whom race and ethnicity are reported. Our assessment demonstrates that the BISG proxy probability is more accurate than a geography-only or surname-only proxy in its ability to predict individual applicants’ reported race and ethnicity and is generally more accurate than a geography-only or surname-only proxy at approximating the overall reported distribution of race and ethnicity. We also demonstrate that the direct use of the BISG probability does not introduce the sample attrition and significant underestimation of the number of individuals by race and ethnicity that occurs when commonly-relied-upon threshold values are used to classify individuals into race and ethnicity categories.

OR and SEFL do not require the use of or reliance on the specific proxy methodology put forth in this paper, but we are making available to the public the methodology, statistical software code, and our understanding of the performance of the methodology for a pool of mortgage applicants in an effort to foster transparency around our work. The methodology has evolved over time and will continue to evolve as enhancements are identified that improve accuracy and performance. Finally, the Bureau is committed to continuing our dialogue with other federal agencies, lenders, advocates, and researchers regarding the methodology.
6. Technical Appendix A: Constructing the BISG probability

For race and ethnicity, demographic information associated with surname and place of residence are combined to form a joint probability using the Bayesian updating methodology described in Elliott, et al. (2009). For an individual with surname $s$ who resides in geographic area $g$:

1. Calculate the probability of belonging to race or ethnicity $r$ (for each of the six race and ethnicity categories) for a given surname $s$. Call this probability $p(r|s)$.

2. Calculate the proportion of the population of individuals in race or ethnicity $r$ (for each of the six race and ethnicity categories) that lives in geographic area $g$. Call this proportion $q(g|r)$.

3. Apply Bayes’ Theorem to calculate the likelihood that an individual with surname $s$ living in geographic area $g$ belongs to race or ethnicity $r$. This is described by

$$Pr(r|g, s) = \frac{p(r|s)q(g|r)}{\sum_{r \in R} p * q}$$

where $R$ refers to the set of six OMB defined race and ethnicity categories. To maintain the statistical validity of the Bayesian updating process, one assumption is required: the probability of residing in a given geography, given one’s race, is independent of one’s surname. For example, the accuracy of the proxy would be impacted if Blacks with the last name Jones preferred to live in a certain neighborhood more than both Blacks in general and all people with the last name Jones.
Suppose we want to construct the BISG probabilities on the basis of surname and state of residence for an individual with the last name Smith who resides in California. Table 6 provides the distribution across race and ethnicity for individuals in the U.S. with the last name Smith. For individuals with the surname Smith, the probability of being non-Hispanic Black, based on surname alone, is simply the percentage of the Smith population that is non-Hispanic Black: 22.22%.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>1.56%</td>
</tr>
<tr>
<td>White</td>
<td>73.35%</td>
</tr>
<tr>
<td>Black</td>
<td>22.22%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>0.40%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>0.85%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1.63%</td>
</tr>
</tbody>
</table>

To update the probabilities of assignment to race and ethnicity, the percentage of the U.S. population residing in California by race and ethnicity is calculated. These percentages appear in Table 7.

---

26 In the example, we choose to use state to make the example easy to understand. In practice, a finer level of geographic detail is used as discussed earlier.

27 “Smith” is the most frequently occurring surname in the 2000 Decennial Census of the Population. There are 2,376,206 individuals in the 2000 Decennial Census of Population with the last name “Smith” according to the surname list (http://www.census.gov/genealogy/www/data/2000surnames/).
Given the information provided in these two tables, we can now construct the probability that Smith’s race is non-Hispanic Black, given surname and residence in California using Bayes’ Theorem. The probability of being non-Hispanic Black for the surname Smith (22.22%) is multiplied by the percentage of the non-Hispanic Black population residing in California (6.03%) and then divided by the sum of the products of the surname-based probabilities and percentage of the population residing in California for all six of the race and ethnicity categories:

\[
\frac{.2222 \times .0603}{.7335 \times .0791 + .0156 \times .2776 + .2222 \times .0603 + .0040 \times .3335 + .0085 \times .0786 + .0163 \times .1752} \approx 16.61\%
\]

This same calculation is performed for the remaining race and ethnicity categories. Table 8 provides the surname-only and updated BISG probabilities for all six race and ethnicity categories for individuals with the last name Smith residing in California.
TABLE 8: SURNAME-ONLY AND BISG PROBABILITIES FOR "SMITH" IN CALIFORNIA

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Surname-only</th>
<th>BISG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>1.56%</td>
<td>5.37%</td>
</tr>
<tr>
<td>White</td>
<td>73.35%</td>
<td>72.00%</td>
</tr>
<tr>
<td>Black</td>
<td>22.22%</td>
<td>16.61%</td>
</tr>
<tr>
<td>Asian and Pacific Islander</td>
<td>0.40%</td>
<td>1.65%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>0.85%</td>
<td>0.83%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1.63%</td>
<td>3.54%</td>
</tr>
</tbody>
</table>

The impact of the adjustment of the surname based probabilities is readily apparent: the surname probability is weighted downward or upward depending on the degree of overrepresentation or underrepresentation of the population of a given race and ethnicity in California relative to the percentage of the U.S. population residing in California. For example, just under 12% of the U.S. population resides in California but nearly 28% of Hispanics in the U.S. reside in California. Knowing that Smith resides in California and that California is more heavily Hispanic than the nation as a whole leads to an increase in the probability that Smith is Hispanic compared to the probability calculated based on surname information alone.
7. Technical Appendix B: Receiver Operating Characteristics and Area Under the Curve

One way to characterize the proxy’s ability to sort individuals into race and ethnicity is to plot the Receiver Operating Characteristic (ROC) curve. The ROC curve is constructed by applying a threshold rule for classification to each race and ethnicity, where probabilities above the threshold yield classification to a given race and ethnicity and those below do not, and then plotting the relationship between the false positive rate and the true positive rate over the range of possible threshold values.

Figures 1 through 6 show the ROC curves for the geography-only, name-only, and BISG probabilities by race and ethnicity. In each plot, the true positive rate is measured on the y-axis and the false positive rate is measured on the x-axis. The slope of the ROC curve represents the tradeoff between identifying true positives at the expense of increasing false positives over the range of possible threshold values. The ROC curve for a perfect proxy—one that could classify individuals into and out of a given race and ethnicity with no misclassification—moves along the edges of the figure from (0,0) to (0,1) to (1,1). The closer that the ROC curve is to the left and upper edge of the plot area, the better the proxy is at correctly classifying individuals.

---

28 The true positive rate is defined as the ratio of the number of applicants correctly classified into a reported race and ethnicity by a given threshold divided by the total number applicants reporting the race and ethnicity; the false positive rate is defined as the ratio of applicants incorrectly classified into a reported race and ethnicity by a given threshold divided by the total number of applicants not reporting the race and ethnicity.
that provides no useful information instead moves along the 45-degree line that runs through the middle of the figure. Movement along this line implies that a proxy measure has no ability to meaningfully identify more true members of a group without simultaneously identifying a similar proportion of non-members.

The graphs demonstrate that for Hispanic and non-Hispanic White, Black, and Asian/Pacific Islander, the BISG proxy is generally associated with a higher ratio of true positives to false positives across all possible threshold values, as shown by the general tendency for BISG’s ROC curve to be located to the left and above of the ROC curves for the surname-only and geography-only proxies. The BISG proxy’s overall ability to improve sorting, relative to the surname-only or geography-only proxy, is especially notable for non-Hispanic Whites and Blacks. The AUC statistic discussed in Section 4.2.2 simply represents the area beneath the ROC curve and above the x-axis.

**FIGURE 1: RECEIVER OPERATING CHARACTERISTIC (ROC) CURVES FOR NON-HISPANIC WHITE**
FIGURE 2: RECEIVER OPERATING CHARACTERISTIC (ROC) CURVES FOR NON-HISPANIC BLACK

FIGURE 3: RECEIVER OPERATING CHARACTERISTIC (ROC) CURVES FOR HISPANIC
FIGURE 4: RECEIVER OPERATING CHARACTERISTIC (ROC) CURVES FOR NON-HISPANIC ASIAN/PACIFIC

FIGURE 5: RECEIVER OPERATING CHARACTERISTIC (ROC) CURVES FOR NON-HISPANIC NATIVE
FIGURE 6: RECEIVER OPERATING CHARACTERISTIC (ROC) CURVES FOR NON-HISPANIC MULTIRACIAL
8. Technical Appendix C: Additional tables

### TABLE 9: CLASSIFICATION OVER RANGES OF BISG PROXY FOR NON-HISPANIC WHITE

<table>
<thead>
<tr>
<th>White BISG Proxy Probability Range</th>
<th>Total Applicants (1)</th>
<th>Estimated White (BISG) (2)</th>
<th>Reported White (BISG) (3)</th>
<th>Reported Minority (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 10%</td>
<td>20,108</td>
<td>506</td>
<td>2,114</td>
<td>17,994</td>
</tr>
<tr>
<td>10% - 20%</td>
<td>3,995</td>
<td>582</td>
<td>937</td>
<td>3,058</td>
</tr>
<tr>
<td>20% - 30%</td>
<td>2,738</td>
<td>680</td>
<td>962</td>
<td>1,776</td>
</tr>
<tr>
<td>30% - 40%</td>
<td>2,483</td>
<td>867</td>
<td>1,206</td>
<td>1,277</td>
</tr>
<tr>
<td>40% - 50%</td>
<td>2,748</td>
<td>1,240</td>
<td>1,596</td>
<td>1,152</td>
</tr>
<tr>
<td>50% - 60%</td>
<td>3,346</td>
<td>1,847</td>
<td>2,196</td>
<td>1,150</td>
</tr>
<tr>
<td>60% - 70%</td>
<td>4,480</td>
<td>2,927</td>
<td>3,477</td>
<td>1,003</td>
</tr>
<tr>
<td>70% - 80%</td>
<td>7,105</td>
<td>5,363</td>
<td>5,851</td>
<td>1,254</td>
</tr>
<tr>
<td>80% - 90%</td>
<td>15,620</td>
<td>13,409</td>
<td>14,201</td>
<td>1,419</td>
</tr>
<tr>
<td>90% - 100%</td>
<td>127,812</td>
<td>124,411</td>
<td>125,316</td>
<td>2,496</td>
</tr>
<tr>
<td>Total</td>
<td>190,435</td>
<td>151,832</td>
<td>157,856</td>
<td>32,579</td>
</tr>
</tbody>
</table>
### TABLE 10: CLASSIFICATION OVER RANGES OF BISG PROXY FOR NON-HISPANIC BLACK

<table>
<thead>
<tr>
<th>Black BISG Proxy Probability Range</th>
<th>Total Applicants (1)</th>
<th>Estimated Black (BISG) (2)</th>
<th>Reported Black (3)</th>
<th>Reported White (4)</th>
<th>Reported Other Minority (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 10%</td>
<td>160,733</td>
<td>1,859</td>
<td>1,466</td>
<td>139,684</td>
<td>19,583</td>
</tr>
<tr>
<td>10% - 20%</td>
<td>9,742</td>
<td>1,387</td>
<td>941</td>
<td>8,403</td>
<td>398</td>
</tr>
<tr>
<td>20% - 30%</td>
<td>4,916</td>
<td>1,207</td>
<td>906</td>
<td>3,814</td>
<td>196</td>
</tr>
<tr>
<td>30% - 40%</td>
<td>3,101</td>
<td>1,072</td>
<td>726</td>
<td>2,242</td>
<td>133</td>
</tr>
<tr>
<td>40% - 50%</td>
<td>2,229</td>
<td>997</td>
<td>738</td>
<td>1,408</td>
<td>83</td>
</tr>
<tr>
<td>50% - 60%</td>
<td>1,680</td>
<td>922</td>
<td>736</td>
<td>877</td>
<td>67</td>
</tr>
<tr>
<td>60% - 70%</td>
<td>1,417</td>
<td>920</td>
<td>765</td>
<td>596</td>
<td>56</td>
</tr>
<tr>
<td>70% - 80%</td>
<td>1,407</td>
<td>1,057</td>
<td>963</td>
<td>391</td>
<td>53</td>
</tr>
<tr>
<td>80% - 90%</td>
<td>1,517</td>
<td>1,293</td>
<td>1,222</td>
<td>241</td>
<td>54</td>
</tr>
<tr>
<td>90% - 100%</td>
<td>3,693</td>
<td>3,548</td>
<td>3,408</td>
<td>200</td>
<td>85</td>
</tr>
<tr>
<td>Total</td>
<td>190,435</td>
<td>14,262</td>
<td>11,871</td>
<td>157,856</td>
<td>20,708</td>
</tr>
</tbody>
</table>
TABLE 11: CLASSIFICATION OVER RANGES OF BISG PROXY FOR NON-HISPANIC ASIAN/PACIFIC ISLANDER

<table>
<thead>
<tr>
<th>Asian/Pacific Islander BISG Proxy Probability Range</th>
<th>Total Applicants</th>
<th>Estimated Asian and Pacific Islander (BISG)</th>
<th>Reported Asian and Pacific Islander</th>
<th>Reported White</th>
<th>Reported Other Minority</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 10%</td>
<td>178,533</td>
<td>867</td>
<td>861</td>
<td>154,872</td>
<td>22,800</td>
</tr>
<tr>
<td>10% - 20%</td>
<td>1,536</td>
<td>216</td>
<td>234</td>
<td>890</td>
<td>412</td>
</tr>
<tr>
<td>20% - 30%</td>
<td>657</td>
<td>160</td>
<td>147</td>
<td>366</td>
<td>144</td>
</tr>
<tr>
<td>30% - 40%</td>
<td>492</td>
<td>170</td>
<td>157</td>
<td>247</td>
<td>88</td>
</tr>
<tr>
<td>40% - 50%</td>
<td>385</td>
<td>174</td>
<td>145</td>
<td>176</td>
<td>64</td>
</tr>
<tr>
<td>50% - 60%</td>
<td>361</td>
<td>199</td>
<td>168</td>
<td>139</td>
<td>54</td>
</tr>
<tr>
<td>60% - 70%</td>
<td>411</td>
<td>267</td>
<td>223</td>
<td>156</td>
<td>32</td>
</tr>
<tr>
<td>70% - 80%</td>
<td>649</td>
<td>488</td>
<td>421</td>
<td>180</td>
<td>48</td>
</tr>
<tr>
<td>80% - 90%</td>
<td>1,268</td>
<td>1,085</td>
<td>923</td>
<td>270</td>
<td>75</td>
</tr>
<tr>
<td>90% - 100%</td>
<td>6,143</td>
<td>5,941</td>
<td>5,367</td>
<td>560</td>
<td>216</td>
</tr>
<tr>
<td>Total</td>
<td>190,435</td>
<td>9,567</td>
<td>8,646</td>
<td>157,856</td>
<td>23,933</td>
</tr>
</tbody>
</table>
### TABLE 12: CLASSIFICATION OVER RANGES OF BISG PROXY FOR NON-HISPANIC AMERICAN INDIAN/ALASKA NATIVE

<table>
<thead>
<tr>
<th>American Indian/Alaska Native BISG Proxy Probability Range</th>
<th>Total Applicants</th>
<th>Estimated American Indian/Alaska Native (BISG)</th>
<th>Reported American Indian/Alaska Native</th>
<th>Reported White</th>
<th>Reported Other Minority</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 10%</td>
<td>190,212</td>
<td>377</td>
<td>238</td>
<td>157,680</td>
<td>32,294</td>
</tr>
<tr>
<td>10% - 20%</td>
<td>137</td>
<td>19</td>
<td>3</td>
<td>106</td>
<td>28</td>
</tr>
<tr>
<td>20% - 30%</td>
<td>38</td>
<td>9</td>
<td>2</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td>30% - 40%</td>
<td>12</td>
<td>4</td>
<td>1</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>40% - 50%</td>
<td>15</td>
<td>7</td>
<td>1</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>50% - 60%</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>60% - 70%</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>70% - 80%</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>80% - 90%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>90% - 100%</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>190,435</td>
<td>431</td>
<td>248</td>
<td>157,856</td>
<td>32,331</td>
</tr>
</tbody>
</table>
### TABLE 13: CLASSIFICATION OVER RANGES OF BISG PROXY PROBABILITIES FOR NON-HISPANIC MULTIRACIAL

<table>
<thead>
<tr>
<th>Multiracial BISG Proxy Probability Range</th>
<th>Total Applicants (1)</th>
<th>Estimated Multiracial (BISG) (2)</th>
<th>Reported Multiracial (3)</th>
<th>Reported White (4)</th>
<th>Reported Other Minority (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 10%</td>
<td>187,964</td>
<td>2,102</td>
<td>682</td>
<td>156,439</td>
<td>30,843</td>
</tr>
<tr>
<td>10% - 20%</td>
<td>1,615</td>
<td>224</td>
<td>34</td>
<td>937</td>
<td>644</td>
</tr>
<tr>
<td>20% - 30%</td>
<td>443</td>
<td>107</td>
<td>8</td>
<td>255</td>
<td>180</td>
</tr>
<tr>
<td>30% - 40%</td>
<td>199</td>
<td>68</td>
<td>5</td>
<td>115</td>
<td>79</td>
</tr>
<tr>
<td>40% - 50%</td>
<td>113</td>
<td>50</td>
<td>9</td>
<td>47</td>
<td>57</td>
</tr>
<tr>
<td>50% - 60%</td>
<td>56</td>
<td>31</td>
<td>3</td>
<td>34</td>
<td>19</td>
</tr>
<tr>
<td>60% - 70%</td>
<td>33</td>
<td>21</td>
<td>0</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>70% - 80%</td>
<td>9</td>
<td>7</td>
<td>0</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>80% - 90%</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>90% - 100%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>190,435</td>
<td>2,612</td>
<td>741</td>
<td>157,856</td>
<td>31,838</td>
</tr>
</tbody>
</table>
A New Method for Estimating Race/Ethnicity and Associated Disparities Where Administrative Records Lack Self-Reported Race/Ethnicity

Marc N. Elliott, Allen Fremont, Peter A. Morrison, Philip Pantoja, and Nicole Lurie

Abstract

Objective

To efficiently estimate race/ethnicity using administrative records to facilitate health care organizations’ efforts to address disparities when self-reported race/ethnicity data are unavailable.

Data Source

Surname, geocoded residential address, and self-reported race/ethnicity from 1,973,362 enrollees of a national health plan.

Study Design

We compare the accuracy of a Bayesian approach to combining surname and geocoded information to estimate race/ethnicity to two other indirect methods: a non-Bayesian method that combines surname and geocoded information and geocoded information alone. We assess accuracy with respect to estimating (1) individual race/ethnicity and (2) overall racial/ethnic prevalence in a population.

Principal Findings

The Bayesian approach was 74 percent more efficient than geocoding alone in estimating individual race/ethnicity and 56 percent more efficient in estimating the prevalence of racial/ethnic groups, outperforming the non-Bayesian hybrid on both measures. The non-Bayesian hybrid was more efficient than geocoding alone in estimating individual race/ethnicity but less efficient with respect to prevalence ($p<.05$ for all differences).

Conclusions

The Bayesian Surname and Geocoding (BSG) method presented here efficiently integrates administrative data, substantially improving upon what is possible with a single source or from other hybrid methods; it offers a powerful tool that can help health care organizations address disparities until
self-reported race/ethnicity data are available.

**Keywords:** Bayes's theorem, health disparities, health plans, race, surname

Efforts to measure, monitor, and address racial/ethnic disparities in health care have been limited by the paucity of data regarding the race/ethnicity of users of the health care system. Indeed, until recently, many viewed the collection of such data as illegal (Fremont and Lurie 2004). One result is that the preponderance of studies on racial/ethnic differences in quality of care and patient outcomes has been limited to patients enrolled in Medicare or Medicaid. Several reports from the Institute of Medicine and the National Academy of Sciences recommend universal collection of self-reported data regarding race, ethnicity, and socioeconomic status as a first step toward addressing disparities (Institute of Medicine 2002; National Research Council 2004). While self-reported data are widely considered to be the gold standard, absent a mandate to do so, collection of such data will be slow and inconsistent.

Several efforts to collect and use such data are underway. For example, the Health Research and Educational Trust, an independent research affiliate of the American Hospital Association, has developed a toolkit for and is assisting a growing number of hospitals with collection of racial, ethnic, and language data. Similarly, a group of hospitals funded by the Robert Wood Johnson Foundation to address disparities in cardiovascular care have committed to collecting race/ethnicity data and monitoring quality of care for different racial/ethnic groups. State policy has also moved toward collecting racial/ethnic data. For example, as part of the Massachusetts health care reform legislation, collection of race/ethnicity data from all hospitalized patients is required by law (Boston Public Health Commission 2006). In California, SB 853 and related regulations require HMO plans to collect race, ethnicity, and language information (California State Senate 2007). Finally, several of the plans participating in the National Health Plan Collaborative to Improve Quality and Eliminate Disparities have begun voluntary collection of self-reported data on the race/ethnicity of their enrollees (National Health Plan Collaborative 2006). Aetna has the most experience in doing so, but even with a mandate from their CEO and significant investment of resources over the past 4 years, the plan has been able to obtain data on only one-third of their enrollees thus far. Although a few smaller regional plans that followed Aetna's lead have obtained a similar proportion of self-reported data in less time, completing the process will likely take several more years.

**Surname and Geocoding Approaches**

Because the process of obtaining self-reported race/ethnicity data can take years to complete, investigators have developed methods of estimating race/ethnicity indirectly from other sources. Two such methods are geocoding and surname analysis. Geocoding uses an individual's address to link individuals to census data about the geographic areas where they live. For example, knowing that a person lives in a Census Block Group (a small neighborhood of approximately 1,000 residents) where 90 percent of the residents are African American provides useful information for estimating that person's race.

Surname analysis infers race/ethnicity from surnames (last names). Insofar as a particular surname belongs almost exclusively to a particular group (as defined by race, ethnicity, or national origin), it is possible to identify its holder's probable membership in the group by using well-formulated surname dictionaries. Such dictionaries now exist for identifying Hispanics and various Asian nationalities (Perkins 1993; Abrahamse, Morrison, and Bolton 1994; Kestenbaum et al. 2000; Lauderdale and Kestenbaum 2000; Falkenstein 2002). Separate surname lists have been generated for Chinese, Indian, Japanese, Korean, Filipino, and Vietnamese Americans. Experimental dictionaries for identifying Arab Americans are under development (Morrison et al. 2003). Both surname analysis and geocoding have
recognized limitations—the former has almost no ability to distinguish blacks from non-Hispanic whites whereas the latter has little ability to identify Hispanics or Asians. Although these limitations have been partially overcome by combining the two approaches, the accuracy of prior combined approaches varies widely by geographic area, depending on the prevalence and degree of segregation of racial/ethnic groups (Fremont et al. 2005; Fiscella and Fremont 2006).

A New Hybrid Approach

To further address limitations of current indirect estimation approaches, we developed a new hybrid approach using Bayes's theorem. Bayes's theorem is commonly applied to medical diagnostic testing; in the context of evaluating diagnostic tests, the probability of a given individual having a disease depends both upon (1) an individual's prior probability of having the disease (usually determined from a base rate appropriate to the individual's risk group) and (2) the result of a diagnostic test. Bayes's Theorem updates prior probabilities with test results by considering the sensitivity, $S_e$ (probability of a positive test result for a positive individual), and specificity, $S_p$ (probability of a negative test result for a negative individual), of the diagnostic test to produce an updated (posterior) probability, called the positive predictive value, $PPV$, that efficiently incorporates both sources of information using the formula:

$$PPV = \frac{P \times S_e}{P \times S_e + (1 - P) \times (1 - S_p)}$$

Here, we extend the approach from the two-category prior probability that characterizes baseline disease prevalence rates and treat the racial/ethnic distribution of where an individual lives as a four-category prior, the categories being Hispanic, African American, Asian, and non-Hispanic white or other. Our “baseline prevalence” is based on the racial/ethnic composition of the Census Block Group to which the residence of the individual was geocoded. We treat the combined results of the Census Bureau Spanish Surname List and the Lauderdale–Kestenbaum Asian Surname List as another diagnostic test with three possible outcomes (surname appears on Asian list regardless of appearance on Hispanic list, surname appears on Spanish but not Asian list, surname appears on neither surname list).

Using a more general form of Bayes's Theorem, we then use the surname lists to update the prior probabilities of membership in each of the four race/ethnic categories with the surname list results to produce efficient, updated posterior probabilities of membership in the four groups. The extent of this updating increases with the sensitivity and specificity of the surname lists for the population in question. We refer to this new hybrid method as the Bayesian Surname and Geocoding method (BSG) to note that it uses a Bayesian approach to combine surname and geocoded information. These probabilities, in turn, can be used to estimate racial/ethnic composition. Though not the focus of the current validation analyses reported here, the estimates can also be used to identify possible disparities in health care or in health outcomes by race/ethnicity.

We compare the accuracy of BSG in estimating race/ethnicity to two other approaches, in all instances evaluating performance against a gold standard of self-report. The first alternative approach is a previous algorithm for combining the two information sources (Fremont et al. 2005; Fiscella and Fremont 2006) that we will here call the Categorical Surname and Geocoding approach (CSG) in order to note that it combines surname and geocoded information in a categorical fashion, described below. The second approach to which we compare BSG is one based solely on the geocoded racial/ethnic composition of the Census Block Group where each member lives. We call this final strategy the Geocoding Only (GO) approach. These three approaches are summarized in Table 1.
Table 1

<table>
<thead>
<tr>
<th>Method</th>
<th>Needs/Uses</th>
<th>How It Works</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSG</td>
<td>Yes</td>
<td>Uses surname lists to update geocoded information and derive posterior probabilities</td>
<td>Probability</td>
</tr>
<tr>
<td>GO</td>
<td>No</td>
<td>Uses geocoded probabilities directly</td>
<td>Probability</td>
</tr>
<tr>
<td>CSG</td>
<td>Yes</td>
<td>Classifies Asians and Hispanics using surname lists; classifies others according to prevalence of blacks in block group</td>
<td>Classification</td>
</tr>
</tbody>
</table>

Methods

Data

We used national enrollment data from Aetna, a large national health plan. The data set consists of self-reported race/ethnicity (as a “gold-standard” used for validation), surname, geocoded address of residence (Census 2000 Block Group level, using the SF1 file), and gender for all 1,973,362 enrollees who voluntarily provided this information to the plan for quality monitoring and improvement purposes. While voluntarily reported race/ethnicity was predominantly non-Hispanic white or other (78.1 percent), the data set included a reasonable distribution of Hispanics (8.9 percent), blacks (8.0 percent), and Asians (5.0 percent); 51.2 percent (1,010,043) were female. Data disclosed to RAND were done so in compliance with HIPAA regulations.

Implementation of the BSG

The Appendix S1 describes the implementation of the BSG algorithm in detail. If the BSG produced classifications instead of probabilities, we could describe its performance in terms of the sensitivity and specificity of the BSG. Instead, we use alternative measures described below. The sensitivities and specificities of the surname lists do play a role with BSG, however. They are inputs or tuning parameters that determine how the geocoded and surname data are combined to produce posterior probabilities, as detailed in the Appendix S1 (the greater the sensitivity and specificity, the more the surname results change the probabilities derived from geocoding). Thus these surname list sensitivities and specificities are not directly evaluative of performance in this context, but are primarily intermediate parameters.

As applied to the primary data set, the sensitivity of the Spanish and Asian surname lists themselves were calculated at 80.4 and 51.5 percent, respectively. The specificities are 97.8 and 99.6 percent, respectively. These sensitivities and specificities are characteristics of the surname lists, not of the BSG. Table S1 describes the probability of members of a given group appearing on each surname list or neither given these sensitivities and specificities. For example, Asians will appear on the Asian list 51.5 percent of the time (irrespective of appearance on the Spanish list), on the Spanish list but not the Asian list 1.1 percent of the time, and on neither list 47.4 percent of the time at these levels of sensitivity and
specificity under the assumptions stated earlier.

Because we find higher sensitivity for males than females (83.1 versus 77.8 percent on the Spanish Surname List; 52.7 versus 50.2 percent on the Asian Surname List, \( p < .05 \) for each) and slightly higher specificity for males than females for the Spanish Surname List (98.0 versus 97.5 percent, \( p < .05 \)) that are presumably related to retention of surnames after marriage, the BSG uses gender-specific sensitivities and specificities. Thus, for example, a male who appears on the Spanish surname list in a given block group receives a slightly higher posterior probability of being Hispanic than a female who appears on that same list from the same block group because the surname list is known to be more accurate for males than females. The Appendix S1 provides additional examples of how the BSG generates posterior probabilities as well as other details of its implementation.

Other Algorithms Used for Comparison with the BSG

The second method, GO, simply uses the racial/ethnic prevalences from Census Block Groups as probabilities. Surname lists provide no means by which to distinguish blacks from non-Hispanic whites, so do not permit estimates of disparities between these two groups. For this reason, a “surname only” approach is not considered.

Instead, we consider a previously described alternative combination of geocoding and surname information, the CSG (Fiscella and Fremont 2006). CSG categorizes individuals through a series of steps. It (1) labels a person Hispanic if their name appears on the Spanish surname list; if not, it (2) labels a person Asian if the name appears on the Asian surname list; if neither of these applies, geocoded race/ethnic information is used to adjudicate classifications among the remaining individuals into black or non-Hispanic white categories. In particular, (3) if an individual not appearing on either surname list resides in a block group that is at least 66 percent black, they are classified as black; (4) otherwise they are classified as non-Hispanic white. In an application using Medicare enrollees in a national health plan, this algorithm produced estimates of racial/ethnic health disparities that were similar to those obtained with self-reported race-ethnicity (Fremont et al. 2005; Fiscella and Fremont 2006).

Outputs of BSG, CSG, and GO: Classifications versus Probabilities

CSG discretely classifies each plan member into one of four racial/ethnic categories, whereas BSG and GO produce probabilities of membership in each of these four groups. As an illustration, consider a hypothetical Bob Jones living in a Census Block Group that was 67 percent white/other, 11 percent black, 11 percent Hispanic, and 11 percent Asian. CSG would note that “Jones” was on neither surname list and that his block group was <66 percent black and would therefore classify Mr. Jones as white/other. GO would simply use these four prevalences as probabilities and estimate that Mr. Jones had a 67 percent chance of being white/other and an 11 percent chance of being a member of each of the other three groups. As illustrated in Table 2, BSG would note that “Jones” was on neither surname list and integrate that information with the sensitivities and specificities of those lists, as well as the racial/ethnic composition of his block group to estimate that Mr. Jones has a 78.7 percent chance of being white/other, a 12.9 percent chance of being black, a 6.1 percent chance of being Asian, and a 2.2 percent chance of being Hispanic. Note that being on neither surname list makes white/other and black more likely than they were before surnames were considered, and that the probability of being Hispanic falls more than the probability of being Asian (because the Spanish surname list has greater sensitivity than the Asian list). Additional examples appear in Table S3.
Table 2

Illustration of BSG Posterior Probabilities of the Race/Ethnicity of a Male Individual Living in a Census Block Group That Was 67 Percent White/Other and 11 Percent Each Asian, Hispanic, and Black

<table>
<thead>
<tr>
<th>Surname</th>
<th>Asian</th>
<th>Hispanic</th>
<th>Black</th>
<th>White/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wang</td>
<td>0.937</td>
<td>0.008</td>
<td>0.008</td>
<td>0.048</td>
</tr>
<tr>
<td>Martinez</td>
<td>0.010</td>
<td>0.845</td>
<td>0.021</td>
<td>0.125</td>
</tr>
<tr>
<td>Jones</td>
<td>0.061</td>
<td>0.022</td>
<td>0.129</td>
<td>0.787</td>
</tr>
</tbody>
</table>

One can estimate prevalences, means, and disparities by race/ethnicity by working directly with probabilities, without ever producing individual classifications. For example, if one's goal were a prevalence estimate, averaging probabilities is more accurate than classifying and rounding before summing (McCaffrey and Elliott forthcoming). For example, in an area with 10 people who had a 57 percent chance of being white and a 43 percent chance of being black and another 10 people with a 69 percent chance of being white and a 31 percent chance of being black, racial/ethnic prevalences would be more accurately estimated as 63 percent white and 37 percent black (averaging probabilities) than as 100 percent white (classifying each person into the group that was most likely for them). Please see Table S4 for additional examples. Similarly, if the goal is to compare racial/ethnic groups in terms of a clinical process measure, such as adherence to diabetes care recommendations as measured by administrative records, one need not classify individuals into discrete categories. Instead, one can enter an individual's probabilities of membership in each of several racial/ethnic groups (omitting one as a reference group) as predictors in a linear or logistic regression and the coefficients will be unbiased estimates of the difference of each racial/ethnic group from the reference racial/ethnic group in the outcome. Moreover, McCaffrey and Elliott show that such direct use of these probabilities, while less accurate than truly knowing race/ethnicity with certainty for each individual, is more accurate and efficient than using categorical classifications based on these probabilities. In each of these instances, categorizing continuous probabilities into discrete classifications is an unnecessary step that discards substantial information by ignoring distinctions in probabilities. While there may be some instances in which one must make a discrete decision for specific individuals (e.g., whether to mail Spanish-language materials to specific addresses), direct use of probabilities will be more efficient for aggregate statistical inferences, including the comparison of racial/ethnic groups.

If we were only examining CSG, we could describe its accuracy of classification in terms of sensitivity, specificity, and positive predictive value. Because we are comparing both classification-based and probability-based methods, we employ different performance measures.

Evaluation

We compare BSG, CSG, and GO in terms of how closely the estimates of race/ethnicity that they produce match those derived from self-reported race/ethnicity for the same individuals. We develop two
performance metrics applicable to all three approaches (BSG, CSG, and GO). We then compare the relative efficiency of the three methods according to these two metrics. The first metric assesses accuracy in matching the four-category distribution of self-reported racial/ethnic prevalence in a population. The second metric assesses the accuracy of predicting individual race/ethnicity—the extent to which those who self-report a given race/ethnicity are assigned higher probabilities of that race/ethnicity (or are more likely to be classified as that race/ethnicity). The two measures are complementary in that the first detects systematic errors in four-category classifications (e.g., a method is overly likely to classify someone as white and insufficiently likely to classify someone as black), and the second measure detects unsystematic errors (e.g., a method doesn't overestimate or underestimate any group in aggregate, but is just not very accurate in predicting the race/ethnicity of specific individuals).

**Performance Metric for Predicting Racial/Ethnic Prevalence**

For each of the three methods, we report the prevalence estimates derived for each of four racial/ethnic groups and compare these with self-reported proportions. In order to summarize the accuracy across these four categories, we compute the average error of the four categorical racial/ethnic prevalences estimates, weighted by their true (self-reported proportions). Ratios of average squared errors can be used to measure the relative efficiency of two methods in estimating prevalences. To say that method one has a relative efficiency of 3.0 relative to method two means that the accuracy of method one using a given sample size is the same as what would be obtained with three times the sample size using method two.

**Performance Metric for Predicting Individuals’ Race/Ethnicity**

The Brier score ([Brier 1950](#)) is the mean squared deviation of a prediction from the true corresponding dichotomous outcome. The Murphy decomposition of the Brier score ([Yates 1982](#)) distinguishes (a) uncontrollable variation due to the prevalence of the outcome from (b) the extent to which predictions correlate with the dichotomous outcome. We use this correlation (b) as our measure of performance in predicting individual race/ethnicity. This metric rescales predictive performance to a (0, 1) scale regardless of prevalence.

In particular, we use the correlation of the dichotomous or probabilistic prediction with a dichotomous indicator of true self-reported race-ethnicity for each of four racial/ethnic groups. Whether a method produces classifications or probabilities, it is a comparable measure of the accuracy with which individual race/ethnicity is predicted. Estimates for the four racial/ethnic measures are not independent, but are negatively correlated. To summarize performance across all four racial/ethnic categories, we also calculate an average correlation, weighted by prevalence, for each method. By comparing ratios of squared correlations, we can compare the relative efficiency of methods in predicting individual race/ethnicity.

**Results**

**Predicting Racial/Ethnic Prevalences: Comparing BSG, CSG, and GO**

[Table 3](#) displays the overall proportions of self-reported race/ethnic data falling into the four categories, along with estimates derived from each of the three methods using the primary data set. The average deviation from self-report is also displayed for each method. When comparing methods, it may be noted that the sampling error in assessing accuracy in prevalence is sufficiently small that all differences of 0.1 percent or more are statistically significant. GO substantially overestimates the prevalence of Hispanics, moderately overestimates the prevalence of blacks, and moderately underestimates the
prevalence of Asians ($p < .05$ for each). CSG is very accurate for Hispanics, but it underestimates the prevalence of Asians by nearly a factor of two and underestimates the prevalence of blacks by nearly a factor of three ($p < .05$ for both). These patterns result in overestimating the proportion of plan members who are white.

### Table 3
Comparing Overall Racial/Ethnic Prevalence Estimates to Self-Report Estimates ($n=1,973,362$)

<table>
<thead>
<tr>
<th>Estimated Percentage in Each Group</th>
<th>Hispanic</th>
<th>Asian</th>
<th>Black</th>
<th>White/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF-REPORT</td>
<td>8.9</td>
<td>5.0</td>
<td>8.0</td>
<td>78.1</td>
</tr>
<tr>
<td>BSG</td>
<td>10.0</td>
<td>4.5</td>
<td>9.1</td>
<td>76.4</td>
</tr>
<tr>
<td>GO</td>
<td>10.8</td>
<td>4.2</td>
<td>9.0</td>
<td>76.0</td>
</tr>
<tr>
<td>CSG</td>
<td>9.2</td>
<td>2.9</td>
<td>3.0</td>
<td>84.9</td>
</tr>
</tbody>
</table>

**Weighted Average Overall Deviation from Self-Report**

<table>
<thead>
<tr>
<th>Estimated Percentage in Each Group</th>
<th>Hispanic</th>
<th>Asian</th>
<th>Black</th>
<th>White/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF-REPORT</td>
<td>0.0</td>
<td></td>
<td></td>
<td>0.0</td>
</tr>
<tr>
<td>BSG</td>
<td></td>
<td></td>
<td></td>
<td>1.6%</td>
</tr>
<tr>
<td>GO</td>
<td></td>
<td></td>
<td></td>
<td>2.0%</td>
</tr>
<tr>
<td>CSG</td>
<td></td>
<td></td>
<td></td>
<td>6.2%</td>
</tr>
</tbody>
</table>

Ninety-five percent margins of sampling error are <0.1% for a single prevalence estimate, a difference in prevalences estimates across methods.

BSG is the most accurate overall, with a weighted average prevalence error (deviation from self-reported) of 1.6 percent, followed by 2.0 percent for GO and 6.2 percent for CSG ($p < .05$ for all pairwise comparisons). BSG moderately overestimates Hispanic and black prevalence, while underestimating whites and Asians somewhat ($p < .05$ for each). BSG is 56 percent more efficient than geocoding alone in prevalence estimates, whereas CSG is less efficient for this purpose than geocoding alone.

**Predicting Individual Race/Ethnicity: Comparing BSG, CSG, and GO**

Table 4 displays the correlation with self-reported race/ethnicity for each of the three methods and four race/ethnic groups in the primary data set. All reported correlations are statistically significant and differ across methods at $p < .05$. BSG predictions correlate with individual indicators of race/ethnicity at 0.61 to 0.79, with a weighted average correlation of 0.70.
Table 4

Correlation of Individual Predicted Race/Ethnicity with Self-Reported Race/Ethnicity  
\( n=1,973,362 \)

<table>
<thead>
<tr>
<th>Correlation with Self-Reported Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>BSG</td>
</tr>
<tr>
<td>GO</td>
</tr>
<tr>
<td>CSG</td>
</tr>
</tbody>
</table>

All differences in correlations by methods are significant at \( p<.05 \).

CSG is the next best by this measure (average correlation 0.63), with similar performance for Hispanics and Asians, somewhat lower performance for whites, and notably lower performance for blacks. GO (average correlation 0.53) was near the performance of the BSG and notably better than CSG for blacks, but performed less well than the other two algorithms for all other groups, performing especially poorly for Hispanics and Asians. Overall, BSG was 74 percent more efficient than geocoding alone in estimating individual race/ethnicity and CSG was 41 percent more efficient than geocoding alone in predicting individual race/ethnicity. This means that 1,000 observations from BSG provide as much information as 1,740 observations using geocoding alone. For Hispanics and Asians, BSG has 2.6 and 3.9 times the efficiency of geocoding alone, respectively.

BSG performed better than each of the alternatives by both performance metrics and increases efficiency by 56–74 percent relative to geocoding alone. In contrast, the CSG improves upon direct use of geocoded data by only one of these metrics, highlighting the importance of how surname and geocoded information is combined.

Discussion

We have described a method for estimating race/ethnicity using administrative data. This approach, which applies Bayes's Theorem to a four-category geocoding and surname analysis, appears to be a particularly useful means of integrating these sources of information and substantially outperforms a classification-based means of combining this information (CSG). The advantage of BSG over CSG probably stems from two factors: (1) better identification of blacks in areas of low residential segregation and (2) greater precision through the direct use of probabilities.

In addition to its ability to estimate race/ethnicity, the BSG approach has substantial potential for use in routine assessment and monitoring of health disparities in a population. It can also be used when estimated race/ethnicity is to be a predictor in multivariate regression or other models; thus its usefulness is not limited to estimation of disparities or to health applications.

One limitation, which applies to all methods of inferring race/ethnicity, is that while BSG supports modeling at the individual level, it is not accurate enough to support individual-level interventions and
requires large sample sizes for good precision, because there is some inherent loss of information compared with self-reported race/ethnicity for a sample of the same size. Secondly, although results were evaluated on a large, racially and ethnically diverse national sample, results may differ somewhat for those not insured by this health plan or those who do not self-report race-ethnicity.

An additional limitation is that the direct use of predicted probabilities is somewhat more complex than the use of 1/0 categorical indicators of race/ethnicity and may be unfamiliar to some analysts. Traditionally, analysts have either used a single categorical variable with each level representing a particular racial/ethnic group, or a series of “dummies,” that is—separate variables (one for each race/ethnicity) that have a value of “0” if the person is not, for example, Asian, or “1” if the person is Asian. The posterior probabilities from the BSG and GO are continuous variables with values from 0 to 1 that are used somewhat differently. Nonetheless, this approach is still relatively straightforward, and one can interpret the coefficients as if they were from racial/ethnic dummy variables. The Appendix S1 provides examples of how these probabilities can be used within \textit{SAS}.

Our new method of estimating race/ethnicity substantially outperforms other widely used indirect methods and provides health plans and others a timely means to infer race/ethnicity among plan members. Although self-reported race/ethnicity represents a gold standard in many situations, indirect methods offer a powerful and immediate alternative for estimating health experiences by racial/ethnic status using only administrative data. In combination with geographic information systems (GIS) tools, these methods can be of great use to health plans, researchers, and others (\textit{National Health Plan Collaborative 2006}).

Future work can directly examine the accuracy of BSG in estimating health disparities, as well as seek further improvements in the accuracy of BSG estimates of race/ethnicity. One way to do the latter might be to develop regional sensitivity and specificity parameters. Such data would also provide insight into the extent to which BSG performance varies by plan or region. One could model racial-ethnic selection into health insurance within Block Group conditional on surname results, further improving BSG performance (because our results imply there are lower rates of health coverage for blacks and Hispanics than for Asians and whites/others even within the same Block Groups).

Finally, when applying BSG to a specific population, such as a commercially insured population, one could use Census racial/ethnic data within block groups that were restricted to ages that better matched the target population. To the extent that age differed by race/ethnicity, this would further reduce BSG bias and improve its performance. Future work should follow along these paths to refine an already promising and useful approach to inferring race/ethnicity from names and addresses alone.

**Acknowledgments**

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**Disclaimers:** The contents of the publication are solely the responsibility of the authors and do not necessarily reflect the official views of the CDC.

**Disclosure:** None

**Supplementary Material**

The following material is available for this article online:
Appendix S1: Implementation of Bayesian Surname and Geocoding Combination (BSG).

Appendix S2: Author Matrix.

Table S1: Probabilities of Joint Surname Test Results by True Race/Ethnicity.

Table S2: Posterior Probabilities of Group Membership by Surname List Results.

Table S3: BSG Posterior Probabilities of Race/Ethnicity for Hypothetical Block Groups A, B, C, D, and E for Males (N=963,319).

Table S4: Example of BSG, GO, and CSG estimates of Racial/Ethnicity of Plan Membership in a Hypothetical Block Group (67 Percent White/Other, 11 Percent Each Black, Hispanic, and Asian Overall), Based on 10 Male# Plan Members (2 on Asian Surname List, 3 on Spanish Surname List, 5 Unlisted).

This material is available as part of the online article from: [http://www.blackwell-synergy.com/doi/abs/10.1111/j.1475-6773.2008.00854.x](http://www.blackwell-synergy.com/doi/abs/10.1111/j.1475-6773.2008.00854.x) (this link will take you to the article abstract).

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REFERENCES


Assessing Fair Lending Risks Using Race/Ethnicity Proxies

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Abstract

Fair lending analysis of non-mortgage credit products often involves proxying for race/ethnicity since such information is not required to be reported. Using mortgage data, this paper evaluates a series of proxy approaches (geo, surname, geo-surname, and BISG) as compared with the race/ethnicity reported under HMDA. The BISG proxy predicts the reported race/ethnicity the best as judged by prediction bias, correlation coefficient, and discriminatory power. In assessing fair lending risks where classification of race/ethnicity is called for, we propose the BISG maximum classification, which produces a more accurate estimation of mortgage pricing disparities than the current practices. The above conclusions withhold various robustness tests. Additional analysis is performed to assess the proxies on non-mortgage credits by leveraging consumer credit bureau data.

Keywords: fair lending risk, race/ethnicity, proxy, BISG, Bayesian, measurement error, misclassification.
JEL classifications: C11, C81, D18, J15.
I. Introduction

The Equal Credit Opportunity Act (ECOA) prohibits a creditor from discriminating against any borrower on the basis of race, color, religion, national origin, sex, marital status, or age. Under ECOA, regulatory agencies assess fair lending risks of lending institutions by comparing lending outcomes based on the above-mentioned prohibited basis factors. Failure to comply with ECOA can subject a financial institution to civil liability for actual and punitive damages in individual or class actions.¹

Consumer lending products can be categorized into two groups: mortgage and non-mortgage products. Common non-mortgage products are credit card, auto loan, student loan, consumer loan, and small business loan. Historically, fair lending analysis and research have been more focused on mortgage than non-mortgage loans. One important reason for this is the availability of accurate data on prohibited basis factors. The Home Mortgage Disclosure Act (HMDA) authorizes lenders to collect information on the race, ethnicity, and gender of mortgage applicants and co-applicants. However, lenders generally are not permitted to collect such information for non-mortgage products.

Nonetheless, the fair lending evaluation of non-mortgage credit products is indispensable in ensuring that a lending institution is fully compliant with ECOA. Since its inception in July 2011, the Consumer Financial Protection Bureau (CFPB) has made multiple Department of Justice (DOJ) referrals on non-mortgage lending, especially indirect auto lending. In March 2013, the CFPB issued Bulletin 2013-02 regarding fair lending risks in indirect auto finance. As a result of the CFPB referral, Ally Bank was ordered to pay $80 million in damages to harmed applicants in December 2013. The proportion of non-mortgage referrals has also been increasing overall. Among the 18 referrals made by regulatory agencies to the DOJ for violation of ECOA in 2014, 15 involve discrimination in non-mortgage lending.²

The CFPB and DOJ used race/ethnicity proxies to estimate disparities in dealer markups on the basis of race and national origin at Ally Bank. Since mid-1990, proxy methods have been used in fair lending analysis when self-reported prohibited basis factors are not available (Baines and Courchane, 2014), leveraging findings from other fields, mainly epidemiology. For race/ethnicity, which this paper focuses on, the common approaches are surname and geocoding (or simply geo) methods, which use the Census surname list or geographic composition to impute race/ethnicity. Fiscella and Fremont (2006) provide a comprehensive review of literature that uses geocoding and surname approaches to assess disparities in health care. In addition, hybrid approaches have been suggested that attempt to create a more refined measure using both pieces of information. The most recent and advanced hybrid approach is the Bayesian Improved Surname Geocoding method (BISG) by Elliott et al. (2009), which is the proxy

¹ The Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank Act) granted rule-making authority under ECOA to the Consumer Financial Protection Bureau (CFPB).
method adapted by CFPB and DOJ in the Ally Bank case. The BISG method aims to improve upon the information in the Census surname list by incorporating the race/ethnicity composition of the applicant’s neighborhood of residence. Elliott et al. (2009) use health plan enrollment data with reported race/ethnicity to evaluate how well the BISG method predicts race/ethnicity and find that the BISG methodology is more accurate than the geo-only or surname-only approach. Simpler approaches to integrate multiple sources of information have also been proposed and evaluated. Coldman et al. (1988) compare four rules to combine first name, middle name, and surname to identify Chinese vs. non-Chinese. They find that the linear rule, which averages the three individual probabilities of name components, achieves the best sensitivity and specificity.

Assessing fair lending risks using imputed race/ethnicity is a timely topic, but relevant research is rather recent and still limited. Attempting to evaluate redlining risk of credit cards, Cohen-Cole (2011) links the location-based information on race to an individual borrower’s access to credit cards. The CFPB (2014) evaluates the BISG methodology using mortgage data and concludes that the BISG proxy is more accurate than the geo-only or surname-only proxy in predicting an individual applicant’s reported race/ethnicity. The CFPB study evaluates the accuracy of BISG over other proxies as measured by correlation coefficient and Gini index, but not its impact on fair lending risk assessment. Baines and Courchane (2014) claim that the BISG methodology produces biased race/ethnicity proxies, which result in inflated differences in assessing lending disparities. Using a mortgage dataset, they show that the classification errors of BISG are correlated with creditworthiness factors and conduct regression analysis to estimate the raw mortgage pricing disparities using the reported race/ethnicity vs. the BISG proxy. However, despite acknowledging the importance of considering creditworthiness factors, Baines and Courchane’s regression analysis does not control for legitimate factors that lenders consider in mortgage pricing decisions, which weakens their conclusion.3

The BISG proxy produces a continuous value between 0 and 1 as the probability of the borrower belonging to a specific race/ethnicity, with the probabilities of all race/ethnicity groups summing up to 1. Since fair lending assessment aims to estimate the lending differences between a particular prohibited basis group (PBG) and the control group (CG), borrowers need to be assigned to one of the race/ethnicity groups exclusively and completely, which requires the continuous BISG probability to be dichotomized into a binary race/ethnicity indicator. Practically, there have been two approaches adopted by fair lending analysis so far: one is to dichotomize the BISG probability using a fixed threshold (Baines and Courchane, 2014), while the other is to use the continuous probability as it is (CFPB, 2014). We term the former approach the BISG fixed and the latter the BISG continuous. Since CFPB (2014) does not

3 Baines and Courchane (2014) do evaluate the adjusted disparities using auto lending data, but as the data do not contain reported race/ethnicity, the potential bias caused by using the BISG proxy cannot be directly validated.
describe whether they conduct a regression analysis or how they use the BISG continuous in the
regression setting, we take the liberty to assume that regression analysis using the BISG continuous
estimates the disparities between all PBGs against the CG simultaneously in one equation. Conducting
separate regressions by PBG is not feasible because the BISG continuous does not assign a borrower to a
definitive race/ethnicity group. The one regression approach adopted by the BISG continuous restricts the
other explanatory variables in the regression to be of the same effect for all PBGs, which is an assumption
often too strong to be valid because loan and borrower characteristics tend to be correlated with
race/ethnicity. Moreover, the BISG continuous is subject to estimation bias: The population with a
specific credit product could be different from the U.S. population on which the reference surname and
geo databases are based; and the calculation of BISG probabilities assumes conditional independence,
which is often not satisfied in reality. Since the BISG fixed uses the BISG continuous as an input, the bias
of the BISG continuous can transit into the misclassifications of the BISG fixed. The fixed classification
approach itself might cause additional misclassifications. The BISG fixed requires a threshold to classify
the continuous probability into a binary indicator. False positives decrease with the threshold, but false
negatives increase with the threshold. If the threshold is too high, a borrower might not be assigned to any
of the race/ethnicity groups; if the threshold is too low, a borrower might end up in more than one
race/ethnicity group.

In the field of machine learning, the “maximum a posteriori” (MAP) decision rule is
recommended for the BISG type of naive Bayesian probability model, as naive Bayesian probability often
reserves the rank ordering of the probabilities among classes despite having estimation errors. Moreover,
not dependent on a fixed threshold, the MAP rule ensures that each probability is assigned to one class
exclusively and completely. Leveraging the expertise from machine learning, we propose the BISG
maximum classification (BISG max), which assigns a borrower to the race/ethnicity with the highest
BISG probability and compare it with the BISG continuous and BISG fixed threshold classification.

This paper contributes to the fair lending literature by providing a comprehensive review of the
race/ethnicity proxy methods and a rigorous analysis of their suitability for and limitations in fair lending
risk assessment. Using mortgage data, this paper compares a series of proxies with the race/ethnicity
reported under HMDA. In addition to the geo, surname, and BISG proxies, it also considers the linear rule
(Coldman et al., 1988), which combines the geo and surname information by taking their average.4 Our
analysis shows that the BISG produces the most accurate estimates of race/ethnicity probabilities among
the four proxies, as judged by estimation bias, correlation coefficient, and discriminatory power of the

4 Elliott et al. (2008) have already shown that the Bayesian Surname Geocoding (BSG) proxy, which is the
predecessor of BISG, performs better than the Categorical Surname and Geocoding (CSG) proxy (Fremont et al.,
2005). The CSG proxy uses either the surname or the geographic information to categorize race/ethnicity in a
sequential order of Hispanic, Asian, Black, and non-Hispanic White.
reported race/ethnicity. By merging HMDA with DataQuick, we obtain important factors typically considered in mortgage pricing decisions\(^5\) to enable a more comprehensive regression analysis. Our analysis shows that the BISG max greatly reduces the estimation bias in disparity coefficient as compared with the BISG continuous and BISG fixed, which holds true under a series of robustness analyses.

Furthermore, as a remedy to the lack of non-mortgage data, this paper links mortgages with non-mortgages using the credit bureau data (CBD) of the Office of the Comptroller of the Currency (OCC) to shed light on non-mortgages. Among the CBD borrowers who have at least one form of major credits (we consider mortgage, credit card, auto loan, and student loan), about 38% of the CBD borrowers have at least one mortgage, and almost all of them have one or more of the other three credit products. Therefore, despite being a population conditional on having a mortgage, the linked non-mortgage population covers a great portion of the non-mortgage universe. Though regression analysis is not feasible due to data limitations, the non-mortgage analysis replicates the univariate results of the mortgage analysis: The BISG is a better predictor of reported race/ethnicity than the geo, surname, and geo-surname proxies, and the BISG max has a better coverage than the BISG fixed.

This paper also adds to the research on dichotomization of mismeasured predictors. Using race/ethnicity proxies in fair lending regression analysis presents a complicated and yet intriguing case for such study. First, the continuous race/ethnicity probabilities are expected to have measurement errors (and moreover) with bias. Second, fair lending regression analysis often accounts for various legitimate factors, with which race/ethnicity could be correlated. Third, there are multiple race/ethnicity probabilities associated with one borrower. Fourth, separate regression is preferred to one general regression to allow the effect of other covariates to vary by PBG. This paper provides an empirical study that compares the effects of continuous covariate mismeasurement vs. dichotomized covariate misclassification involving the above-mentioned challenges. To the best of our knowledge, there has not been such a discussion in the existing relevant literature. McCaffrey and Elliott (2008) examine the efficiency of using predicted probability for a binary independent variable in predicting continuous outcome and recommend direct substitution rather than classification. Allowing for another predictor variable that is potentially correlated with the predictor of interest, Gustafson and Le (2002) find that dichotomization can actually reduce the estimation bias due to mismeasured covariate in some instances. However, both studies assume that there is only one dichotomous covariate and it is measured without bias; these conditions are not satisfied in the fair lending risk assessment.

Additionally, this paper contributes to the Bayesian literature by presenting an empirical application of Bayes’ rule. Comparing the BISG proxy that uses Bayes’ rule with the linear approach

\(^5\) Typical lending outcomes include underwriting and pricing. We focus on pricing disparity analysis because DataQuick data only report originated mortgage loans.
illustrates the benefit of using the more sophisticated BISG approach. This paper introduces the MAP rule from the field of machine learning into fair lending analysis. It confirms empirically that the max classification of naive Bayesian probability also leads to optimal results in assessing fair lending risks.

The rest of the paper is organized as follows. Section II discusses the race/ethnicity proxy methods: geo, surname, geo-surname, and BISG. Section III describes the mortgage data used. Section IV compares the performance of the continuous race/ethnicity proxies in predicting HMDA reported race/ethnicity. Section V lays out the classification methods. Section VI evaluates the mortgage pricing disparities using the proposed BISG max classification and existing approaches. Section VII assesses the proxies on non-mortgage data. Section VIII concludes the paper.

II. The Proxy Methodologies for Race/Ethnicity

The main methods to proxy for race/ethnicity can be summarized into two groups and four types: the single-sourced geocoding and surname approaches, and the hybrid geo-surname and BISG approaches.

II.A. Geocoding and Surname Methods

The geocoding method infers an individual’s race/ethnicity based on where he/she lives. The Census data provide socioeconomic status aggregated at various geographic area levels, among which is race/ethnicity. By linking the individual to the Census database, the prevalence of the race/ethnicity shown by the Census data is used as the probability of the individual belonging to the corresponding race/ethnicity. The geocoding approach can be mathematically expressed as the following

\[
p(r|g) = \frac{N_{rg}}{N_g}, \tag{1}
\]

in which \(N_g\) is the number of people in the geographic area \(g\) where the individual lives, and \(N_{rg}\) is the number of people belonging to race/ethnicity \(r\) in the same area \(g\). Geocoding is found to be effective in more segregated areas, where one race/ethnicity has a dominantly high concentration, and less predictive in integrated areas, where multiple races/ethnicities coexist without a dominant one. Among the various race/ethnicity categories, Blacks tend to live in more segregated areas; therefore, geocoding is deemed to be more powerful in identifying Blacks (Fiscella and Fremont, 2006).

The surname approach generates a probability of race/ethnicity using the surname of an individual. By matching the individual’s surname to an existing surname database with a corresponding percentage for each race/ethnicity, the race/ethnicity percentage is adopted as the race/ethnicity prediction of the individual. The calculation for the surname approach is

\[
p(r|s) = \frac{N_{rs}}{N_s}, \tag{2}
\]
where \( N_s \) is the number of people nationwide with surname \( s \), and \( N_{rs} \) is the number of people of race/ethnicity \( r \) with surname \( s \). In order to produce a high confidence in a race/ethnicity proxy, the surname needs to be highly associated with a certain race/ethnicity. Empirically, surnames of Hispanics and Asians are relatively easy to be identified due to their uniqueness, leading to higher imputation accuracy for them by this approach (Fiscella and Fremont, 2006).

II.B. The Geo-Surname and BISG Methods

As the prediction accuracy of geocoding and surname methods is limited to certain races/ethnicities, hybrid approaches that can integrate both the location and surname of an individual are proposed to generate more accurate race/ethnicity predictions across all race/ethnicity groups. Coldman et al. (1988) compare four rules (multiplicative, linear, maximum, last name) in integrating first name, middle name, and last name to identify the Chinese ethnic group and find that the linear rule performs best. Similarly, we test the linear rule in combining both the location and surname of a borrower, which, denoted as the geo-surname proxy, is constructed as

\[
Geo - surname = \frac{p(r|g) + p(r|s)}{2}.
\]

Elliott et al. (2008) develop the Bayesian Surname Geocoding (BSG) method, which uses a Bayesian approach to combine surname and geocoded information. The Bayesian method consists of two parts. The first is the creation of a “prior” probability of an individual belonging to a race/ethnicity using the surname information. The second generates the “posterior” probability, which involves updating the “prior” probability using the information on the demographic characteristics of the person’s place of residence. Elliott et al. (2009) further refine the BSG method by proposing the Bayesian Improved Surname Geocoding (BISG) method. The BISG method improves over the previous BSG method by using a more recent surname list to create the prior probability and using more categories of race and ethnicity, but the information integration technique remains the Bayesian approach.

Using the same notations as those for surname or geocoding proxy, let \( r \) denote race, \( s \) denote surname, and \( g \) denote geography or location. The prior probability is the person’s race based on his/her surname and can be written as \( p(r|s) \), where \( r \) takes on values 1 through 6 for each of the six mutually exclusive races: Hispanic, non-Hispanic White, non-Hispanic Black or African American, non-Hispanic Asian/Pacific Islander (API), non-Hispanic American Indian and Alaska Native (AIAN), and non-

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6 The surname list used by the BSG is derived from the 1990 Census, while the BISG method uses the list derived from Census 2000. The BSG method uses a four-category race/ethnicity definition, compared with the six categories used by BISG.
Hispanic multiracial.\(^7\) This probability is then updated using the race/ethnicity composition of the place of residence. The posterior probability \(p(r|g, s)\) is the BISG proxy. Using Bayes’ rule and the chain rule, the BISG proxy can be written as

\[
BISG: p(r|g, s) = \frac{p(r, g, s)}{p(g, s)} = \frac{p(r|s) p(g|r,s)}{\sum_r p(r|s) p(g|r,s)} = \frac{p(r|s) p(g|r,s)}{\sum_r p(r|s) p(g|r,s)},
\]

where \(p(g|r,s)\) is the probability of a borrower residing in a certain location given race \(r\) and surname \(s\). However, there is no nationwide public database for \(p(r|g, s)\), so Elliott et al. (2008) introduce the conditional independence assumption to enable the calculation of Eqn. (4). The assumption is that the probability of an individual residing in a certain location given a person’s race does not vary by surname; i.e., \(p(g|r, s) = p(g|r)\). Different from the geocoding probability \(p(r|g)\), the term \(p(g|r)\) is calculated as the proportion of the entire U.S. population with race \(r\) in location \(g\)

\[
p(g|r) = \frac{N_{rg}}{N_r},
\]

where \(N_r\) is the U.S. population with race \(r\), and \(N_{rg}\) is the number of residents with race \(r\) in location \(g\).

Assuming conditional independence and plugging Eqn. (2) and (5) into Eqn. (4), the BISG estimator can be simplified as:

\[
BISG\ simplified: p(r|g, s) = \frac{p(r|s) p(g|r)}{\sum_r p(r|s) p(g|r)} = \frac{N_{rg} N_{rg}}{\sum_r N_{rg} N_{rg}} = \frac{N_{rg}}{N_g},
\]

The BISG algorithm requires a geo-match to run, which is typically satisfied. When a surname does not match to the Census surname list, the BISG method first imputes the probability of race/ethnicity given the surname, \(p(r|s)\), using the national average of race/ethnicity. It then combines that with the geographic location information to calculate the final prediction using Bayesian probability theory. Theoretically, the resulting BISG prediction is the same as the geo-only prediction.\(^8\)

II.C. The Geocoding and Surname Databases

The BISG method uses the Census 2010 Summary File 1 (SF1) for calculating \(p(r|s)\) and Census 2000 surname list to extract \(p(r|g,s)\), as these two datasets are the most recent and comprehensive data sources for tabulating surname and geographic area with race/ethnicity. They are the same data sources that will be used by other proxy methods discussed here.

\(^7\) For simplicity, we omit “non-Hispanic” when referring to race throughout the rest of the paper; for example, White means non-Hispanic White.

\(^8\) Let \(N\) denote the total population of the U.S., so \(N_r = \frac{N_{rg}}{N}\) is the national average of race \(r\); inserting \(N_{rg} = \frac{N_r}{N}\) into Eqn. (6), the BISG prediction for race \(r\) given \(g\) for surname non-matches is \(BISG\ Surname\ nonmatch: p(r|g, s) = \frac{N_{rg}}{N_g}\), which reduces to the geo-only method.
The Census 2010 SF1 provides population counts by race/ethnicity across geographic regions at six levels (from largest to smallest): nation, state, county, tract, block group, and block. Imputation of race/ethnicity at a more granular geographic level enables capturing local level segregation, but on the other side, the smaller population for race/ethnicity imputation could impact the robustness of the race/ethnicity distribution. Based on the 2010 Census, there are 73,057 tracts, 217,740 block groups, and 11,078,297 blocks, with average populations of roughly 4,200, 1,200, and 28 respectively.\(^9\) The Census tract and block group are commonly used in geocoding race/ethnicity, as they contain a reasonably sufficient number of residents and yet are not too large.\(^10\) We present the results using Census SF1 data at the Census tract level. We also evaluate the proxies using block group SF1 data (details are provided in Appendix 1 of the e-companion\(^11\)), and the results are almost identical to the tract level results.

The Census surname database is based on Census 2000, which was released by the Census Bureau in 2007. The Census surname database contains 151,671 surnames listed by 100 or more individuals and represents about 89.8% of all individuals enumerated in Census 2000. For each surname, the surname database provides the percentage of individuals who belong to one of six mutually exclusive and exhaustive race/ethnicity categories: Hispanic, White, Black, API, AIAN, and multiracial.

In order to assign probabilities using the above-mentioned surname and geography databases, the dataset needs to be prepared so that it can be matched to the Census databases. Elliott et al. (2009) develop SAS programs to clean and standardize\(^12\) the surnames as a part of their BISG algorithm, which we leverage in our analysis. If the dataset does not contain the matching variables (such as Census tract or block group), geocoding software\(^13\) can be used to obtain such information using the exact street address as the input.

### III. Mortgage Data

We first use mortgage data to evaluate race/ethnicity proxies because race/ethnicity is self-reportable under HMDA.\(^14\) The data consist of mortgages originated for the purpose of home purchase

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\(^10\) Elliott et al. (2008, 2009) use Census SF1 at the block group level and go to the next higher geographic level (tract) if block group geocoding is not feasible; similarly, CFPB (2014) adopts a geocoding hierarchy composed of block group, tract, and five-digit zip code; and Baines and Courchane (2014) use Census demographics at the tract level.

\(^11\) An electronic companion to this paper is available as part of the online version that can be found at http://mansci.journal.informs.org/.

\(^12\) For example, removing special characters and titles, and parsing hyphenated or compound names.

\(^13\) For example, ArcGIS (http://www.esri.com/).

\(^14\) We acknowledge that reported race/ethnicity is potentially subject to reporting errors. But as this paper focuses on the accuracy of race/ethnicity proxies, we assume the reported race/ethnicity is true to the real race/ethnicity and use it as the benchmark for proxy comparison.
from 2004 through 2007 in 10 major Metropolitan Statistical Areas (MSAs) of the U.S.\textsuperscript{15} The 10 MSAs are selected so that the data cover major U.S. MSAs with various race/ethnicity compositions. We focus on originations of this time period because HMDA did not adopt the current race/ethnicity definition until 2004. Moreover, as we leverage the DataQuick private label securitized (PLS) loan database, ABS/MBS, to extract more detailed loan level information, we would like to select a time period for which PLS loans are more representative of U.S. mortgage loans. As Figure 1 shows, the private label securitization of residential mortgage loans went through unprecedented growth during 2004–2007, such that its loan volume became comparable to or exceeded that of the government-sponsored enterprises (GSEs). It began to decrease starting in 2007Q3 and became negligible after 2007.

To obtain surnames and locations needed to derive the proxies, we leverage DataQuick Property data. The Property database reports data compiled daily from local county recorder transactions on residential and commercial properties nationwide, including the full names and addresses of those listed on the title. We use the surnames of sole applicants or primary applicants if the mortgage is owned jointly. The addresses are geocoded to obtain the 2010 Census tracts. The Origination table of the DataQuick ABS/MBS data lists important information at loan origination, including FICO, loan-to-value (LTV) ratio, combined LTV (CLTV) ratio, interest rate in the form of note rate, origination date, collateral type, loan product, etc. The DataQuick ABS/MBS data contain nearly 23 million loan originations, consisting of about 95% of the non-agency securitized securities.\textsuperscript{16}

Through a meticulously crafted matching scheme, the analysis dataset is created by first merging HMDA with the Property data of DataQuick. Specifically, a match is declared between HMDA and DataQuick if they match exactly on loan amount, Census tract, loan type, and their closing dates are no more than 30 days apart. If multiple matches are found after imposing the above matching criteria, lender name is used to further narrow down. To be conservative, all the multiple matches are dropped if comparing lender names cannot produce a unique match. As some banks report to OCC with HMDA-plus data that append borrowers’ names to regular HMDA, we leverage such HMDA-plus data to examine the quality of HMDA-DataQuick (HMDA-DQ) matching. Based on the HMDA-plus data of a particular financial institution over a specific time period, we find a very low error rate of 0.6% for the name matching. Fully acknowledging its limited coverage, this validation analysis lends us comfort to the quality of the HMDA-DQ matching algorithm.\textsuperscript{17} The HMDA-DQ matched sample is then further

\textsuperscript{15} The 10 MSAs are 12060 (Atlanta-Sandy Springs-Marietta, GA), 14460 (Boston-Cambridge-Quincy, MA-NH), 16980 (Chicago-Naperville-Joliet, IL-IN-WI), 19820 (Detroit-Warren-Livonia, MI), 31080 (Los Angeles-Long Beach-Anaheim, CA), 33100 (Miami-Fort Lauderdale-Miami Beach, FL), 35620 (New York-Northern New Jersey-Long Island, NY-NJ-PA), 38300 (Pittsburgh, PA), 41740 (San Diego-Carlsbad-San Marcos, CA), and 41860 (San Francisco-Oakland-Fremont, CA).

\textsuperscript{16} Source: http://www.mbsdata.com/datasets_new.html.

\textsuperscript{17} For complete details of the data merge, please refer to appendix A of Mayock and Spritzer (2015).
enriched with detailed origination information by linking to the DataQuick ABS/MBS data through DataQuick internal property ID and origination date.

The final HMDA-DQ data contain 630,807 observations with non-missing surnames and Census tracts as well as origination information. All the 630,807 loans can be linked to the Census SF1 via Census tracts. We then ran the surname cleanup program and matched the cleaned surnames to the Census 2000 surname database. The overall surname matching rate of the HMDA-DQ data is 86.3%, which is quite close to the 89.8% matching rate of the Census surname database. In the range of 83-90%, the surname matching rate is fairly stable by the race/ethnicity category, MSA, or loan origination year.

Panel A of Table 1 contains the self-reported race/ethnicity composition of the HMDA-DQ data, as compared with the U.S., the 10-MSA, and the 10-MSA adult (with age equal to or older than 18) populations. We report four out of the six race/ethnicity categories (Hispanic, Black, API, and White) since AIAN and multiracial are very limited in the U.S. The 10-MSA population contains a high proportion of Hispanic, Black, and API, and a lower proportion of White, as compared with the entire U.S. population. Imposing the age restriction alleviates the difference to some extent, as shown by the race/ethnicity composition based on the 10-MSA adult population. The HMDA-DQ dataset is composed of 33.0% Hispanic, 11.5% Black, 9.9% API, and 45.1% White, providing sufficient numbers of racial/ethnic minorities to achieve a robust evaluation of proxy approaches. On the other hand, given the noticeable differences in the race/ethnicity composition between the Census and the HMDA-DQ data, the latter is unlikely to be a random sample of the former and therefore the race/ethnicity proxies constructed for the analysis data using Census information are subject to bias.

Panels B and C of Table 1 show that the analysis dataset covers various levels of race/ethnicity composition across MSAs and over time. As much as 52.1% of the population in the Miami MSA (33100) is Hispanic; the Atlanta MSA (12060) shows a high concentration of Black (45.0%); the San Francisco MSA (41860) has 24.2% API; and the Pittsburgh MSA (38300) is predominantly (87.5%) occupied by White. We observe a noticeable increase in purchases by White and API, and a similar decrease by Hispanic and Black in 2007, which coincides with the beginning of the subprime crisis.

IV. Comparing BISG with Other Proxies

In this section we compare the performance of BISG with the geo, surname, and geo-surname methods in predicting HMDA reported race/ethnicity. Since the direct output of all four proxies is a continuous race/ethnicity probability for a borrower, the comparison measures here are prediction bias, correlation coefficient, and discriminatory power, which are common statistics used to evaluate a continuous probability prediction of a binary outcome.
IV.A. Prediction Bias

Panel A of Table 2 lists the prediction bias of the BISG, geocoding, surname, and geo-surname for each race/ethnicity, which is calculated as the difference between the mean predicted probability of the proxy and the average of reported race/ethnicity indicator. Often, the prediction bias deviates from zero, which confirms that the proxies are biased, as discussed in Section III. In particular, the BISG shows the smallest bias and the geocoding the largest bias for Hispanic; the BISG predicts Black with the best accuracy and the surname the worst; for API and White, the geocoding is the most accurate and the surname is the worst. The prediction bias of the geo-surname falls between (is the average, to be exact) that of the geo’s and the surname’s because the geo-surname is an arithmetic average of the geo and surname.

IV.B. Correlation Coefficient

The correlation coefficient is used to measure how related two variables are. The correlation coefficient takes a continuous value from -1 to 1, and the closer its absolute value is to 1, the more related the two variables are. The sign of the correlation coefficient indicates the direction of the relationship, with positive indicating the two variables move in the same direction and negative the opposite. The Pearson correlation coefficient detects a linear relationship between two variables, and a rank correlation such as Spearman evaluates an ordinal relationship.

Panel B of Table 2 displays the Pearson correlation coefficient between each proxy and the self-reported race/ethnicity. There are several important findings. First, the BISG and geo-surname proxies are more highly correlated with the self-reported race/ethnicity than the geo-only and surname-only proxies across all four race/ethnicity categories. In addition, most correlation coefficients of the hybrid approaches are high, with absolute values above 70%, suggesting that they are reasonably well correlated with the actual values. This finding attests the benefit of considering both location and surname of a borrower. Second, between the two hybrid approaches, the correlation coefficients of the BISG are higher than those of the geo-surname, showing the advantage of using the more sophisticated Bayesian approach over the simple averaging approach. Third, with the exception of Black, the surname-only proxy has a higher correlation coefficient than the geo-only proxy. This is consistent with the prior assessment of the geo-only proxy that its effectiveness is limited to areas with a dominant race/ethnicity, usually Black.

IV.C. Discriminatory Power

18 Spearman correlation analysis leads to the same conclusion and is not provided here for brevity.
The Receiver Operating Curve (ROC) illustrates the discriminatory power of a probability prediction as its classification threshold varies from 0 through 1. It is created by plotting the true positive rate (sensitivity) on the y-axis against the false positive rate (1-specificity) on the x-axis for every possible value of the probability that the threshold may take. Each point on the ROC represents a trade-off between sensitivity and specificity. A perfect prediction will have a 100% true positive rate without any false positives; therefore, an ideal ROC would run vertically from the origin (0,0) upwards to point (0,1), and then run horizontally from there to point (1,1). The worst ROC is the 45 degree diagonal line, indicating that the corresponding prediction does not have any discriminatory power as it assigns equal chances of true positives and false positives. The Area under the Curve (AUC) is a quantitative measure of the discriminatory power of a probability prediction. Note that another commonly used measure of discriminatory power, the Gini coefficient, is just a monotonic transformation of AUC, which can be calculated as \((2 \times \text{AUC}-1)\). The higher the AUC or Gini coefficient is, the better a predictor can classify a binary outcome.

Figure 2 presents the ROC and AUC for each race/ethnicity. Consistent with the pattern found in the correlation analysis, the BISG has the highest AUC (all above 92%) among the proxies, followed by the geo-surname, the surname-only, and finally the geo-only, whose performance is the weakest among the four. Statistical tests show that under each race/ethnicity, the AUC of the BISG is higher than any of the other three methods at the 1% statistical significance level.

To summarize, the BISG produces the most accurate prediction of the reported race/ethnicity among the four proxies as measured by prediction bias, correlation coefficient, and discriminatory power.

V. Classification

As fair lending analysis compares lending differences between one particular PBG and the CG (which is usually White), it calls for a classification that dichotomizes the continuous probability of race/ethnicity into a binary indicator of race/ethnicity. We compare the classification methods using the BISG probability as the underlying continuous variable, since it has demonstrated better performance than the other three proxies in predicting race/ethnicity under a series of performance measures in Section IV.

A common approach to transforming a continuous probability into a binary indicator of race/ethnicity is to use a fixed threshold. Under the fixed threshold classification, if any of the six BISG probabilities of race/ethnicity (Hispanic, Black, API, White, AIAN, and multiracial) is greater than or equal to the threshold, the corresponding race/ethnicity indicator takes the value of 1; otherwise it takes the value of 0. Adjaye-Gbewonyo et al. (2014) find that cutoffs in the range of 0.50–0.57 optimize sensitivity and specificity for White, Black, API, and Hispanic health plan members. Using mortgage and auto loan data, Baines and Courchane (2014) evaluate classification errors of BISG under the 50% and
80% threshold and strongly urge using a threshold no smaller than 50% in evaluating disparities and calculating consumer harm.

Several limitations exist for the fixed threshold classification. First, there are situations in which none of the six BISG probabilities meet the threshold, and therefore the borrower will not be identified as belonging to any of the six race/ethnicity categories, especially when the threshold is set at a high level. We term this situation as “uncovered”. On the other side, if the cutoff is less than 50%, a borrower might be “over-covered” with more than one race/ethnicity assigned. Moreover, the distribution of the underlying continuous probability greatly impacts the choice of the threshold. Therefore, one threshold that proves to be optimal on one data sample might no longer be so on another. Generally speaking, the false positives decrease and the false negatives increase as the threshold increases. However, the sensitivity of such changes is determined by the probability distribution. Figure 3 plots the kernel densities of the BISG probabilities, which obviously do not follow a uniform distribution. The observations of Black and API are heavily skewed to the left, where the probability value is low. The density curves for Hispanic and White are bimodal, with high density occurring at the low and high ends of the probability line. For all the race/ethnicity groups, at the probability range 0.2–0.8, the kernel densities are flat and at a very low level, indicating that moving the threshold in this range is unlikely to lead to a significant change in classifying race/ethnicity. This paper presents the BISG fixed with 80% as the threshold (the BISG 80%).

The BISG type of models have been used not only in health studies but also in the machine learning field, under the name of naive Bayes (or simple Bayes, independence Bayes) models because they rely on the conditional independence assumption to simplify the calculation of the posterior probability. A common decision rule used in machine learning research is to pick the most likely classification outcome, which is known as the “maximum a posteriori” or MAP decision rule. Despite its seemingly strong assumption of conditional independence which is often hard to satisfy in reality, naive Bayes classifiers have proved to work quite well. Domingos and Pazzani (1997) provide a list of such studies and suggest that even though naive Bayes might produce an inaccurate probability estimate for each class, it tends to assign the highest probability to the correct class. Zhang (2004) provides further explanation for the optimality of naive Bayes. His rationale is that it is not just the dependencies between attributes that matter, rather, how they are distributed. In this paper, we leverage the relevant findings in machine learning and propose the max classification approach to dichotomize the BISG proxy. Under this approach, a race/ethnicity indicator takes the value of 1 if the corresponding race/ethnicity prediction is the maximum of the six predictions. The max classification has a full coverage in the sense that it

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19 We explore the BISG fixed with 50% cutoff as well. The conclusions remain unchanged.
guarantees an assigned race/ethnicity for each borrower, therefore eliminating the “uncovered” situation under the fixed threshold classification. It is rare to have “over-covered” either under the BISG max since BISG probabilities are likely to be different across the six race/ethnicity groups. In addition, without a fixed threshold, the race/ethnicity assignment is less dependent on the value of probability whose distribution could vary across data samples.

Panel A of Table 3 tabulates the coverage of the BISG max and BISG 80%. Judging by the number of borrowers with an assigned race/ethnicity, the BISG max has a coverage very similar to that of the self-reported race/ethnicity. The BISG 80% only covers 462,736 borrowers, about 74% of the 627,638 total borrowers for Hispanic, Black, API, and White. The under-coverage of the BISG 80% is more severe for Black, API, and White than for Hispanic.

The binary indicators derived using the two classification approaches are then compared with the reported race/ethnicity. Four outcomes can be created by overlaying the reported over the dichotomized race/ethnicity: No/No (true negatives, TN), No/Yes (false positives, FP), Yes/No (false negatives, FN), and Yes/Yes (true positives, TP). As the BISG 80% demands a high value of probability to assign 1 to a race/ethnicity, we expect it to have lower false positives and higher false negatives than the BISG max.20 Since the six race/ethnicity probabilities add up to 100%, a probability greater than or equal to 80% must be the maximum probability; however the maximum probability does not necessarily meet the 80% threshold criteria. Panel B of Table 3 tabulates the four outcomes for the BISG max and BISG 80% for each race/ethnicity and the corresponding false positive rate (FPR=FP/(FP+TN)) or Type I error rate and the false negative rate (FNR=FN/(TP+FN)) or Type II error rate. The results support our hypothesis. Taking Hispanic for example, the FPR is 8% for the max classification vs. 4% for the BISG 80%; the max classification FNR is 12%, lower than the 19% FNR for the BISG 80%. It is also noted that the absolute level of FNR for the BISG 80% is quite high for Black, API, and White, taking values of 51%, 48% and 36%, respectively.

Panel C of Table 3 lists the average values of mortgage price (note rate) and important variables in mortgage pricing decisions, including income, FICO, CLTV, and LTV, for each classification outcome (TN, FP, FN, and TP). The first thing observed is that note rate, income, FICO, and CLTV are significantly correlated with the classification outcome groups. Comparison of TN with TP shows that true Hispanic and Black on average have higher note rate and CLTV, and lower income and FICO, than the true non-Hispanic and non-Black, respectively; API and White are the opposite, with lower note rate and CLTV, and higher income and FICO. The mean statistics for the two misclassified groups (FP and FN)

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20 This feature of the BISG 80% makes it potentially more attractive for certain tasks where a lower FPR is valued more than a lower FNR, for instance, to identify consumers who are eligible for restitution or other remediation actions. However, in general, fair lending risks analysis treats FPR and FNR equally.
FN) are less extreme than for the TN and TP groups. Taking the BISG max classification for Hispanic for example, while the TP group has the highest note rate of 7.77% and TN has the lowest note rate of 6.95%, the FP and FN have a note rate in between, at 7.33% and 7.39% respectively. When the race/ethnicity classification errors interact with target and control variables in the regression, it is therefore expected that the disparity estimates will be impacted.

VI. Using the BISG Proxy in Assessing Pricing Disparities in Mortgage Lending

In this section, we evaluate the effect of using BISG proxy in fair lending regression analysis of mortgage pricing. Specifically we compare the proposed BISG max with the BISG 80% and BISG continuous. The pricing disparity estimate generated by the reported race/ethnicity is used as the benchmark to assess the estimation bias.

VI.A. Measuring Pricing Disparities in Mortgage Lending

Since Munnell et al. (1996) introduced multivariate regression into fair lending analysis in their famous Boston Fed study, this technique has been widely used in evaluating potential disparities in mortgage lending. Extensive literature exists in testing whether substantial differences exist in mortgage pricing between similarly situated PBGs and CGs. Similarly, we estimate the pricing disparities using ordinary least square (OLS) regression with the specification

\[
\text{Note Rate} = \beta_0 + \beta_r r + \beta_X X + \epsilon. \tag{7}
\]

The rate spread reported by HMDA is less informative than the continuous note rate, as the former is only reportable above a certain threshold. We obtain the continuous note rate from the DataQuick ABS/MBS to allow better capturing of mortgage price differences. The variable \( r \) identifies the race/ethnicity of the PBG (Hispanic, Black, API, AIAN, or multiracial) from the CG (White). The corresponding coefficient \( \beta_r \) flags potential pricing disparities if it is different from 0 with statistical significance. A significant and positive/negative \( \beta_r \) suggests that the PBG receives a higher/lower price than the CG.

The control vector is denoted as \( X \). When \( X \) is empty, \( \beta_r \) estimates the raw disparity; when \( X \) contains legitimate factors considered in pricing, \( \beta_r \) estimates the adjusted disparity. We control for common creditworthiness factors and loan characteristics, which include income (in the natural logarithm

\[21\] For example, Courchane and Nickerson, 1997; Crawford and Rosenblatt, 1999; Black et al., 2003; Boehm et al., 2006; Boehm and Schlottmann, 2007; Courchane, 2007; Bocian et al., 2008; and Zhang, 2013.

\[22\] Rate spread is the difference between the loan’s annual percentage rate (APR) and a survey-based estimate of APRs currently offered on prime mortgage loans of a comparable type. A lender reports rate spread in HMDA if it is equal to or greater than 1.5 percentage points for a first-lien loan or 3.5 percentage points for a subordinate-lien loan.

\[23\] Because we don’t know the full details of the pricing policies and procedures, and the data potentially lack certain factors considered, the disparities estimated in this paper should not be considered as indicative of existence or non-existence of disparities in mortgage pricing decisions.
form), FICO, LTV, and CLTV. Mortgage interest rate tends to differ by collateral type and product type; we therefore control for them in the regression as well. The DataQuick ABS/MBS database identifies collateral types, with the four major ones being jumbo A, Alt A, subprime, and second lien; Eqn. (7) thus includes dummies for the four collateral types with the remaining collateral types grouped as the reference. The DataQuick ABS/MBS product type provides detailed information on product features (such as fixed rate [FRM] vs. adjustable rate [ARM], interest only [IO], or balloon) and loan term for each corresponding product feature. Indicators are created for the top 14 products that comprise 90% of the loans. Certain lenders specialize in specific products or target certain borrowers, which we account for by including a subprime lender indicator\textsuperscript{24} in the regression. Furthermore, Eqn. (7) controls for fixed effect of lenders to account for individual lender differences within lender type (subprime vs. non-subprime). Dummies are created for the top 20 lenders that originated about 60% of the loans with the reference group containing the remaining miscellaneous lenders. The specification also includes fixed effects of MSA, loan origination year, and MSA×origination year. Appendix 2 of the e-companion provides more detail of the control variables.

We run regressions of note rate for raw and adjusted disparities using race/ethnicity under the reported, BISG max, BISG 80%, and BISG continuous. With the reported race/ethnicity, the variable $r$ is an indicator $I_r$ that takes the value of 1 if a borrower belongs to the PBG and 0 if he/she belongs to the CG. Under the BISG max, $r = 1$ if $p_r = \max_i p_i$ and $r = 0$ if $p_{\text{White}} = \max_i p_i$, with $i$ being Hispanic, Black, API, AIAN, multiracial, and White. Under the BISG 80%, $r = 1$ if $p_r \geq 80\%$ and $r = 0$ if $p_{\text{White}} \geq 80\%$. The regression compares all five PBGs simultaneously against the CG if the BISG continuous is used, so $r = \left(p_{\text{Hispanic}} p_{\text{Black}} p_{\text{API}} p_{\text{AIAN}} p_{\text{multiracial}}\right)$, which is a vector of continuous probabilities for all PBGs. There is an additional regression “Reported II” for adjusted disparity,\textsuperscript{25} which is introduced to help decompose the bias of using BISG continuous in estimating pricing disparities. Reported II estimates all reported PBG effects simultaneously with $r$ being a vector of the reported race/ethnicity dummies, i.e., \(\left(I_{\text{Hispanic}}, I_{\text{Black}}, I_{\text{API}}, I_{\text{AIAN}}, I_{\text{multiracial}}\right)\).

Table 4 Panel A tabulates the modeling sample composition for each regression. Separate regression is performed for each PBG under the reported, BISG max, and BISG 80%, so each sample consists of borrowers associated with the particular PBG and the CG. Due to misclassification, the data samples of BISG max and 80% are not exactly the same as those of the reported, but the samples of the

\textsuperscript{24} For the period 2004–2007, HUD produced subprime lender lists for 2004 and 2005 (http://www.huduser.gov/portal/datasets/manu.html). The 2004 and 2005 lists are very similar, so we decided to use the 2005 list to create the subprime lender indicator.

\textsuperscript{25} Since raw pricing disparity does not consider other control variables except race/ethnicity, the regression of reported II resolves to the reported for raw pricing disparity.
BISG max are much closer. One regression is fitted on the entire sample for all five PBGs against the CG under the reported II and BISG continuous. The count of the PBGs and CG for the BISG continuous is calculated as the weighted average of the corresponding BISG probability. Again it shows that the BISG continuous is a biased estimate of the reported race/ethnicity.

Table 4 then lists the estimated raw and adjusted pricing disparities in Panels B and C, respectively. The coefficient $\beta$, its standard error, and adjusted R-squared of each regression are provided. We observe that introducing control factors greatly reduces the estimated pricing disparities and improves the goodness of fit, indicating that much of the price differences can be explained by legitimate factors considered in the lender’s decision process. For example, based on the reported race/ethnicity, the raw disparity for Hispanic is 1.0143, suggesting that Hispanic paid a note rate 1 percentage point higher than that of White. However, the adjusted price difference is reduced to 11 basis points once considering for income, FICO, LTV, CLTV, collateral, product, lender, MSA, and origination year. Compared with similarly situated White, Black has the largest price difference of about 26 basis points, followed by Hispanic with a price difference of 11 basis points; API has the least price difference, of approximately 3 basis points.

The disparity estimates of the two BISG classifications are much closer to those of the reported than the BISG continuous, presenting a case that dichotomizing a mismeasured covariate reduces bias. The BISG continuous greatly (more than 100 percent) overestimates the pricing disparities for Hispanic, Black, and API, which we attribute to the measurement errors of the continuous probabilities and to the one regression approach that does not allow other covariates to vary by minority group. Comparing estimates under the reported with reported II shows that the impact of performing one regression instead of separate regressions is relatively small: Disparity estimate increases by 1–3 basis points for Hispanic, Black, and API. Therefore, most of the estimation bias displayed by the BISG continuous can be attributed to its measurement errors. For example, if the biased probability instead of reported race/ethnicity is used, ceteris paribus, the disparity estimate for Hispanic increases by 11 basis points from 12 basis points under the reported II to 23 basis points under the BISG continuous.

The BISG max produces disparity estimates closer to those of the reported with smaller standard errors than the BISG 80%, attesting that maximizing posterior probability is the optimal Bayesian decision rule. However, while the BISG max assesses the disparities quite accurately for Hispanic and API, its performance for Black is not as accurate as that for Hispanic and API.

VI.B. Robustness Analyses

We perform a series of analyses to ensure the robustness of the results.
VI.B.1. Bootstrap

We replicate the adjusted pricing disparity analysis using the bootstrap method (Efron, 1979). The HMDA-DQ dataset is 100% sampled with replacement for 1,000 times, then the regressions are run for each replicated sample, resulting in 1,000 regressions and 1,000 $\beta_i$ s for each scenario. We report the summary statistics (mean and standard error) of the coefficient $\beta_i$ in Table 5. The mean and standard error of $\beta_i$ based on the bootstrapped samples are highly consistent with the results contained in Panel C of Table 4.

VI.B.2. Performance by Subsample

We examine the performance of race/ethnicity proxies on subsamples to see if the proxies can capture pricing disparities accurately as they vary across subpopulations. The results are provided in Table 6.

As a prohibited basis, the borrower’s gender might be associated with differential pricing practice; therefore we compare the price received by single female vs. by single male applicants. The HMDA-DQ data contain about 172,000 single female applicants and 255,000 single male applicants, with a ratio of 40:60. Based on the reported race/ethnicity, Panel A of Table 6 shows that single female applicants receive a slightly higher, thus unfavorable, price than the single male applicants for API, but not for Hispanic and Black, after accounting for borrower’s creditworthiness and loan characteristics. Despite the variations in pricing disparities, the BISG max consistently produces more accurate estimates of pricing disparities than the BISG 80% and BISG continuous.

The same pattern is found when we compare the performance of BISG proxies on other subsamples. Panels B, C, D, and E of Table 6 tabulate the proxy performance by origination year, MSA, collateral type, and lender type, respectively. As the race/ethnicity composition differ by origination year and MSA (as shown in Table 1), or by types of collateral and lender (as shown in Table A2 in the e-companion), the price disparities might change as well. For example, Panel B of Table 6 shows that mortgage price received by Hispanic is 17 basis points higher than similarly situated White in 2004, but the difference decreases to 10, 4, and 11 basis points in 2005, 2006, and 2007, respectively. Among the 10 MSAs, the adjusted price difference between Black and White ranges from 44 basis points in Atlanta to 10 basis points in Boston. The pricing disparities vary by the underlying collateral, with second lien having the highest disparities. Among the first lien loans, Alt A loans show a higher adjusted price difference between a minority race/ethnicity and the White than jumbo A and subprime loans. This is possibly because Alt A loans are usually originated without full documentation and therefore more vulnerable to potential manipulation. Started with a higher raw price, after accounting for the loan and borrower characteristics, loans originated by subprime lenders actually have a smaller price difference for
Hispanic and Black as against White than non-subprime lenders. Despite the variations in price differences displayed by the subsamples, the BISG max consistently generates price disparity estimates with the smallest error among the three proxies, while the BISG continuous significantly over-predicts pricing disparities across subsamples.

VI.B.3. Quantile Regression

The existence of outliers might impact the performance of race/ethnicity proxies differently. To quantify the potential impact of outliers, we replace the OLS regression with quantile regression (Koenker and Bassett, 1978) in estimating the adjusted pricing disparities; specifically, we conduct the median regression (quantile=0.5). As Table 7 reveals, the pricing disparities becomes smaller if estimated using quantile regression, however the BISG max consistently delivers better performance than the other two proxies.

VI.B.4. Price Disparities Using Rate Spread

So far we have used the continuous note rate to measure the price differences. However, note rate is not publicly available as HMDA only reports the rate spread for mortgage pricing, which is a continuous variable truncated above certain thresholds. We compare the proxies using rate spread as another robustness analysis. To identify whether a borrower receives a highly priced mortgage loan or not, we generate a high rate spread indicator that equals 1 if the rate spread is above the threshold and 0 if below. The probability of the high rate spread incidence, \( \pi = \text{prob}(\text{High Rate Spread Indicator} = 1) \), can be modeled using the logistic regression

\[
\pi = \frac{1}{1 + \exp(\beta_0 + \beta_r r + \beta_x X)}^{-1},
\]

where the logit, \((\beta_0 + \beta_r r + \beta_x X)\), is essentially the right hand side of Eqn. (7). The variable of interest in the rate spread regression is the adjusted odds ratio for race/ethnicity, \(\exp(\beta_r)\). For example, Table 8 reports an adjusted odds ratio of 1.6807 if reported Hispanic is used, meaning that Hispanic is 1.6807 times more likely to have a highly priced mortgage than the CG White. Overall, the BISG max achieves the best performance among the proxies. However, the BISG 80% and BISG continuous predict API slightly better than the BISG max for the discrete outcome.

VII. Proxy Performance for Non-Mortgage Credit Products

Due to the lack of reported race/ethnicity for non-mortgage credits, our analysis so far is limited to mortgage loans. To gain insights on the performance of race/ethnicity on non-mortgage products, we leverage credit bureau data. Credit bureau data is borrower based, thus providing a common basis for mortgages to be linked to non-mortgages belonging to the same borrower. If a mortgage loan in the
HMDA-DQ data can be matched to a mortgage loan in the credit bureau data, a comprehensive view of a borrower’s credit profile can be obtained. Since the HMDA-DQ data now have both reported and imputed race/ethnicity for the borrower, by matching it to bureau data, we can then assess the accuracy of race/ethnicity proxies for various non-mortgage products, conditional on the borrower having had a mortgage loan at least once.

We extract borrower’s credit bureau information from the OCC’s CBD. The CBD is longitudinal, containing a 0.7% random sample of all Equifax credit files at the base year (calendar year of 2005), with new files added each year to rebalance the sample due to attrition. Information archived as of June 30 of each year is provided. The CBD contains five segments, covering consumer, tradeline, collections, inquiries, and public records, and this paper utilizes the first two segments. The consumer segment provides characteristics of a consumer, including a unique consumer identity key (CID), the age and gender, credit score, the archive year, credit record starting date, etc. The tradeline segment lists the detail of a credit account, including consumer and tradeline identity key, account description (account ownership, type of creditor, type of account, loan purpose, lender subscriber code), credit limit or the highest balance, term duration, current balance, payment performance (for the past 48 months and current month), and account dates (for example, open date, report date, close date). The consumer segment and the tradeline segment can be linked by the CID. Types of credit account include mortgage, credit card, auto loan/lease, student loan, consumer loan, small business loan, etc.

The population with mortgages represents a great portion of borrowers with credit products. Figure 4 shows the borrower composition by main credit products (here we consider mortgage, credit card, auto loan, and student loan). Out of the 1.9 million borrowers with 5.3 million transactions reported by CBD during the period 2005–2012, about 38% of them have at least one mortgage. A majority of the borrowers with mortgage have other credit products: 20% CBD borrowers also have credit card and auto loan; 9% have credit card; and 6% have credit card, auto loan, and student loan. The proportion of borrowers with only mortgage is very small (roughly 1%).

We carefully match the HMDA-DQ data with CBD mortgage trades of the period 2005–2012 by origination date, location of the property, loan amount, and loan term. Out of the 630,807 HMDA-DQ loans, 6,648 (1.06%)26 loans find a match in CBD. Then through the CID, we extract borrower’s non-mortgage (including credit card, auto loan, and student loan) tradelines. The tri-merged data is termed HMDA-DQ-CBD.27 Its distribution of borrowers is very similar to that of the mortgage subset of CBD (as

26 The matching rate of 1.06% is reasonable, given that CBD is a 0.7% random sample of Equifax data.
27 Note that the non-mortgage trades can be originated before or after the matched mortgage trade, as long as they have ever been reported to CBD during 2005–2012, which enables us to obtain more non-mortgage tradelines.
shown in Figure 5), suggesting that matching with PLS mortgages does not distort the population, which represents the universe of mortgage borrowers.

Panel A of Table 9 tabulates the race/ethnicity composition of the HMDA-DQ-CBD data by product. Compared with the HMDA-DQ data (as shown in Panel A of Table 1), the mortgage trades have very similar race/ethnicity composition, again suggesting the good quality of matching HMDA-DQ with CBD. Conditional on having a mortgage loan, borrowers on average have 3.6 credit cards, 1.4 auto loans, and 0.42 student loans. The race/ethnicity of credit card and auto loan remain similar to that of mortgage, but a significant shift is observed in student loan. The proportion of Hispanic decreases from 30.4% to 25.3% and the proportion of Black increases from 10.6% to 16.7%. Overall the distribution of race/ethnicity is intuitive given the product.

The BISG proxy is compared with the geo, surname, and geo-surname proxies in predicting the reported race/ethnicity for each product. Panel B of Table 9 lists the Pearson correlation coefficient between the proxy and the reported race/ethnicity. The BISG proxy is shown to have the highest correlation coefficient, followed by geo-surname proxy. The geo and surname proxies that use a single data source are less correlated with the reported race/ethnicity. The surname proxy performs better than the geo proxy for Hispanic, API, and White, but not for Black. The proxies demonstrate the same pattern as shown by the AUC statistics reported in Panel C of Table 9. We also evaluate the classification approaches using the HMDA-DQ-CBD data. As Panel D of Table 9 shows, the BISG max replicates the reported race/ethnicity fairly well, while the BISG 80% cannot assign a definitive race/ethnicity to almost 30% of the population for each credit product.

The bureau data do not report either underwriting or pricing outcome, therefore we cannot evaluate proxies in estimating disparities in non-mortgage lending. Despite the limitation of the non-mortgage analysis data, it is reassuring to see that the univariate results on mortgage are replicable on non-mortgage credits.

VIII. Conclusion and Future Developments

Often, as race/ethnicity is not available for non-mortgage products, conducting fair lending analysis involves imputing race/ethnicity first. One common remedy is to proxy for race/ethnicity using publicly available information provided by the Census Bureau on geographic and/or surname composition. Compared with the geo-only or surname-only proxy, hybrid approaches are proposed, mainly in other fields, to combine both surname and geographic information to improve accuracy, including the simple linear rule or the more sophisticated BISG proxy. The CFPB has adapted the use of...
the BISG methodology in regulating indirect auto lending, as showcased by the Ally Bank case. However, research on assessing fair lending risks using race/ethnicity proxies is still limited, and this paper aims to fill the void.

In addition to the geo or surname proxy which uses a single data source, we evaluate the hybrid BISG and the geo-surname proxy which is constructed using the linear rule. Based on mortgage data, we gauge the performance of the four proxies in predicting the reported race/ethnicity by prediction bias, correlation coefficient, and discriminatory power, and find that the BISG is the best predictor. Specifically, our analysis shows that considering both surname and geo instead of just one source of information significantly improves accuracy, and the BISG performs better than the geo-surname proxy. Furthermore, we evaluate the impact of using race/ethnicity proxies on fair lending assessment. Besides the BISG continuous and BISG fixed used in existing analyses, we introduce the BISG max, which assigns a borrower to the race/ethnicity with the maximum probability. Pricing disparities estimated using the three BISG proxies are compared with those using the reported race/ethnicity. The BISG max and BISG 80% produce more accurate pricing disparity estimates than the BISG continuous. Between the two BISG classifiers, the BISG max surpasses the BISG 80% as expected. The above conclusions withstand comprehensive robustness tests. We extend the univariate analysis to a non-mortgage dataset and again find the superiority of the BISG proxy in predicting race/ethnicity and the better coverage of the BISG max than BISG fixed.

While our analysis shows that the BISG method is more accurate in approximating race/ethnicity than other methods, it is important to recognize that it is still a proxy method and inevitably it has measurement errors compared with the reported race/ethnicity. Although we have shown that dichotomizing the imprecise race/ethnicity could reduce the impact of measurement errors in assessing disparities, as fair lending risks of non-mortgage credit products gain more and more attention, regulators might want to consider the ultimate solution, which is to require lenders to collect race/ethnicity and gender information for non-HMDA products as well.

In the interim, we ought to continually understand and improve the proxies. Besides refining the proxy algorithm, another direction to improve the proxies is to leverage additional information that is indicative of race/ethnicity. Our study, as well as existing research (Elliott et al., 2008 and 2009), has shown that proxies utilizing both geographic and surname surpass those single-sourced proxies. One promising data is the first name, for which currently there is no Census database, as there is for surname or geography. Nanchahal et al. (2001) develop an algorithm, the South Asian Names and Group Recognition Algorithm (SANGRA), to identify South Asian ethnicity based on surname and first name, surname only, first name only, or middle name only. Coldman et al. (1988) consider first and middle
names in addition to surname in identifying Chinese. A publicly available database on first name can facilitate more comprehensive assessment of using first name in proxying for race/ethnicity.

Acknowledgements
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References


Table 1: Reported Race/Ethnicity Composition

Panel A: Overall

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>U.S.</th>
<th>10-MSA</th>
<th>10-MSA Adult</th>
<th>HMDA-DQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>17.3%</td>
<td>20.2%</td>
<td>18.6%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Black</td>
<td>12.1%</td>
<td>16.3%</td>
<td>15.5%</td>
<td>11.5%</td>
</tr>
<tr>
<td>API</td>
<td>4.8%</td>
<td>8.0%</td>
<td>8.2%</td>
<td>9.9%</td>
</tr>
<tr>
<td>White</td>
<td>63.0%</td>
<td>53.2%</td>
<td>55.8%</td>
<td>45.1%</td>
</tr>
</tbody>
</table>

Panel B: by MSA

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Atlanta</th>
<th>Boston</th>
<th>Chicago</th>
<th>Detroit</th>
<th>Los Angeles</th>
<th>Miami</th>
<th>New York</th>
<th>Pittsburgh</th>
<th>San Diego</th>
<th>San Francisco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>5.0%</td>
<td>11.5%</td>
<td>25.4%</td>
<td>2.7%</td>
<td>41.7%</td>
<td>52.1%</td>
<td>23.3%</td>
<td>1.2%</td>
<td>32.3%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Black</td>
<td>45.0%</td>
<td>8.8%</td>
<td>19.2%</td>
<td>22.0%</td>
<td>5.4%</td>
<td>14.3%</td>
<td>13.1%</td>
<td>9.5%</td>
<td>3.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>API</td>
<td>3.6%</td>
<td>5.3%</td>
<td>5.4%</td>
<td>2.8%</td>
<td>13.6%</td>
<td>1.7%</td>
<td>8.5%</td>
<td>1.3%</td>
<td>10.6%</td>
<td>24.2%</td>
</tr>
<tr>
<td>White</td>
<td>46.0%</td>
<td>74.1%</td>
<td>49.6%</td>
<td>71.9%</td>
<td>38.7%</td>
<td>31.6%</td>
<td>54.6%</td>
<td>87.5%</td>
<td>53.3%</td>
<td>44.2%</td>
</tr>
<tr>
<td>% of Obs.</td>
<td>4.1%</td>
<td>4.4%</td>
<td>12.6%</td>
<td>2.0%</td>
<td>27.4%</td>
<td>18.2%</td>
<td>9.8%</td>
<td>0.7%</td>
<td>8.0%</td>
<td>12.8%</td>
</tr>
</tbody>
</table>

Panel C: by Origination Year

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>31.2%</td>
<td>32.9%</td>
<td>36.4%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Black</td>
<td>9.4%</td>
<td>11.5%</td>
<td>13.5%</td>
<td>9.3%</td>
</tr>
<tr>
<td>API</td>
<td>10.1%</td>
<td>10.2%</td>
<td>9.0%</td>
<td>12.3%</td>
</tr>
<tr>
<td>White</td>
<td>48.7%</td>
<td>45.0%</td>
<td>40.6%</td>
<td>53.9%</td>
</tr>
<tr>
<td>% of Obs.</td>
<td>21.2%</td>
<td>36.8%</td>
<td>33.4%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge.

* Calculated using Census 2010 SF1.
### Table 2: Prediction Performance of Race/Ethnicity Proxies

#### Panel A: Prediction Bias

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>BISG</th>
<th>Geocoding</th>
<th>Surname</th>
<th>Geo-Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>1.6%</td>
<td>-4.2%</td>
<td>-1.8%</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Black</td>
<td>-0.0%</td>
<td>2.1%</td>
<td>-2.5%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>API</td>
<td>-0.4%</td>
<td>0.2%</td>
<td>-2.4%</td>
<td>-1.1%</td>
</tr>
<tr>
<td>White</td>
<td>-2.8%</td>
<td>0.3%</td>
<td>4.8%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

#### Panel B: Correlation Coefficient

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>BISG</th>
<th>Geocoding</th>
<th>Surname</th>
<th>Geo-Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>0.83</td>
<td>0.58</td>
<td>0.80</td>
<td>0.81</td>
</tr>
<tr>
<td>Black</td>
<td>0.74</td>
<td>0.57</td>
<td>0.54</td>
<td>0.67</td>
</tr>
<tr>
<td>API</td>
<td>0.73</td>
<td>0.41</td>
<td>0.68</td>
<td>0.70</td>
</tr>
<tr>
<td>White</td>
<td>0.76</td>
<td>0.56</td>
<td>0.66</td>
<td>0.72</td>
</tr>
</tbody>
</table>

This table reports Panel A) the prediction bias of the proxies as the difference between their mean predicted probability and the mean reported race/ethnicity, and Panel B) the Pearson correlation coefficients of the proxies with self-reported race/ethnicity. The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. All the correlation coefficients are statistically significant at the 1% significance level.
Table 3: BISG Classification

### Panel A: Coverage

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>207,888</td>
<td>216,939</td>
<td>184,130</td>
</tr>
<tr>
<td>Black</td>
<td>72,596</td>
<td>67,387</td>
<td>41,477</td>
</tr>
<tr>
<td>API</td>
<td>62,727</td>
<td>51,632</td>
<td>37,324</td>
</tr>
<tr>
<td>White</td>
<td>284,427</td>
<td>294,069</td>
<td>199,805</td>
</tr>
<tr>
<td>Total</td>
<td>627,638</td>
<td>630,027</td>
<td>462,736</td>
</tr>
</tbody>
</table>

### Panel B: Classification Errors

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>TN</th>
<th>FP</th>
<th>FN</th>
<th>TP</th>
<th>FPR</th>
<th>FNR</th>
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<tbody>
<tr>
<td>BISG Max</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>389,918</td>
<td>33,001</td>
<td>23,950</td>
<td>183,938</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>Black</td>
<td>541,139</td>
<td>17,072</td>
<td>22,281</td>
<td>50,315</td>
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<td>31%</td>
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<tr>
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<td>557,244</td>
<td>10,836</td>
<td>21,931</td>
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<td>35%</td>
</tr>
<tr>
<td>White</td>
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<td>48,998</td>
<td>39,356</td>
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<td>14%</td>
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<tr>
<td>BISG 80%</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>406,225</td>
<td>16,694</td>
<td>40,452</td>
<td>167,436</td>
<td>4%</td>
<td>19%</td>
</tr>
<tr>
<td>Black</td>
<td>552,053</td>
<td>6,158</td>
<td>37,277</td>
<td>35,319</td>
<td>1%</td>
<td>51%</td>
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<tr>
<td>API</td>
<td>563,443</td>
<td>4,637</td>
<td>30,040</td>
<td>32,687</td>
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<td>48%</td>
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<tr>
<td>White</td>
<td>329,069</td>
<td>17,311</td>
<td>101,933</td>
<td>182,494</td>
<td>5%</td>
<td>36%</td>
</tr>
</tbody>
</table>

### Panel C: Classification Errors and Borrower/Loan Characteristics

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Variables</th>
<th>BISG Max</th>
<th>BISG 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>TN</td>
<td>FP</td>
</tr>
<tr>
<td>Hispanic</td>
<td>Note Rate</td>
<td>6.95</td>
<td>7.33</td>
</tr>
<tr>
<td></td>
<td>Income</td>
<td>163,411</td>
<td>134,987</td>
</tr>
<tr>
<td></td>
<td>FICO</td>
<td>700</td>
<td>690</td>
</tr>
<tr>
<td></td>
<td>CLTV</td>
<td>86</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>LTV</td>
<td>68</td>
<td>65</td>
</tr>
<tr>
<td>Black</td>
<td>Note Rate</td>
<td>7.06</td>
<td>7.84</td>
</tr>
<tr>
<td></td>
<td>Income</td>
<td>153,530</td>
<td>108,549</td>
</tr>
<tr>
<td></td>
<td>FICO</td>
<td>699</td>
<td>677</td>
</tr>
<tr>
<td></td>
<td>CLTV</td>
<td>87</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>LTV</td>
<td>66</td>
<td>67</td>
</tr>
<tr>
<td>API</td>
<td>Note Rate</td>
<td>7.30</td>
<td>6.74</td>
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<tr>
<td></td>
<td>Income</td>
<td>143,366</td>
<td>171,018</td>
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<tr>
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<td>FICO</td>
<td>691</td>
<td>708</td>
</tr>
<tr>
<td></td>
<td>CLTV</td>
<td>88</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>LTV</td>
<td>66</td>
<td>68</td>
</tr>
<tr>
<td>White</td>
<td>Note Rate</td>
<td>7.69</td>
<td>7.39</td>
</tr>
</tbody>
</table>
The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. The BISG max classification assigns a borrower to a race/ethnicity if the corresponding probability is the maximum among the six race/ethnicities probabilities; the BISG 80% classification assigns a race/ethnicity if the corresponding probability is greater than or equal to 80%. TN: true negatives, FP: false positives, FN: false negatives, TP: true positives, FPR: false positive rate, FNR: false negative rate.

<table>
<thead>
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<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>FICO</td>
<td>681</td>
<td>685</td>
<td>692</td>
<td>710</td>
<td>681</td>
<td>689</td>
<td>701</td>
<td>711</td>
</tr>
<tr>
<td>CLTV</td>
<td>90</td>
<td>89</td>
<td>88</td>
<td>85</td>
<td>90</td>
<td>88</td>
<td>87</td>
<td>84</td>
</tr>
<tr>
<td>LTV</td>
<td>64</td>
<td>66</td>
<td>67</td>
<td>69</td>
<td>65</td>
<td>67</td>
<td>68</td>
<td>69</td>
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</table>
Table 4: Assessing Pricing Disparities Using BISG Proxies

Panel A: Modeling Samples

<table>
<thead>
<tr>
<th>PBG</th>
<th>Population Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>PBG 207,888</td>
<td>216,939</td>
<td>184,130</td>
</tr>
<tr>
<td></td>
<td>CG 284,427</td>
<td>294,069</td>
<td>199,805</td>
</tr>
<tr>
<td>Total</td>
<td>492,315</td>
<td>511,008</td>
<td>383,935</td>
</tr>
<tr>
<td>Black</td>
<td>PBG 72,596</td>
<td>67,387</td>
<td>41,477</td>
</tr>
<tr>
<td></td>
<td>CG 284,427</td>
<td>294,069</td>
<td>199,805</td>
</tr>
<tr>
<td>Total</td>
<td>357,023</td>
<td>361,456</td>
<td>241,282</td>
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<tr>
<td>API</td>
<td>PBG 62,727</td>
<td>51,632</td>
<td>37,324</td>
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<tr>
<td></td>
<td>CG 284,427</td>
<td>294,069</td>
<td>199,805</td>
</tr>
<tr>
<td>Total</td>
<td>347,154</td>
<td>345,701</td>
<td>237,129</td>
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<table>
<thead>
<tr>
<th>Population</th>
<th>BISG Continuous</th>
<th>Reported II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>217,964</td>
<td>207,888</td>
</tr>
<tr>
<td>Black</td>
<td>72,883</td>
<td>72,596</td>
</tr>
<tr>
<td>API</td>
<td>60,417</td>
<td>62,727</td>
</tr>
<tr>
<td></td>
<td>959</td>
<td>1,596</td>
</tr>
<tr>
<td>Multiracial</td>
<td>12,016</td>
<td>1,573</td>
</tr>
<tr>
<td>CG</td>
<td>266,568</td>
<td>284,427</td>
</tr>
<tr>
<td>Total</td>
<td>630,807</td>
<td>630,807</td>
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</table>

Panel B: Raw Pricing Disparities

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<th>PBG</th>
<th>Statistics</th>
<th>Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
<th>BISG continuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>Coefficient</td>
<td>1.0143***</td>
<td>0.9519***</td>
<td>1.1040***</td>
<td>1.2055***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0069</td>
<td>0.0068</td>
<td>0.0076</td>
<td>0.0081</td>
</tr>
<tr>
<td></td>
<td>Adj. R-Squared</td>
<td>0.0420</td>
<td>0.0369</td>
<td>0.0515</td>
<td>0.0704</td>
</tr>
<tr>
<td>Black</td>
<td>Coefficient</td>
<td>1.6031***</td>
<td>1.5731***</td>
<td>1.8729***</td>
<td>2.1292***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0096</td>
<td>0.0100</td>
<td>0.0122</td>
<td>0.0125</td>
</tr>
<tr>
<td></td>
<td>Adj. R-Squared</td>
<td>0.0722</td>
<td>0.0647</td>
<td>0.0897</td>
<td>0.0704</td>
</tr>
<tr>
<td>API</td>
<td>Coefficient</td>
<td>-0.0810***</td>
<td>-0.2694***</td>
<td>-0.2939***</td>
<td>-0.3117***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0103</td>
<td>0.0112</td>
<td>0.0128</td>
<td>0.0132</td>
</tr>
<tr>
<td></td>
<td>Adj. R-Squared</td>
<td>0.0002</td>
<td>0.0017</td>
<td>0.0022</td>
<td>0.0070</td>
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</table>

Panel C: Adjusted Pricing Disparities

<table>
<thead>
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<th>PBG</th>
<th>Statistics</th>
<th>Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
<th>BISG continuous</th>
<th>Reported II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>Coefficient</td>
<td>0.1085***</td>
<td>0.1241***</td>
<td>0.1664***</td>
<td>0.2273***</td>
<td>0.1221***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0041</td>
<td>0.0039</td>
<td>0.0048</td>
<td>0.0048</td>
<td>0.0039</td>
</tr>
<tr>
<td></td>
<td>Adj. R-Squared</td>
<td>0.7617</td>
<td>0.7632</td>
<td>0.7634</td>
<td>0.7621</td>
<td>0.7610</td>
</tr>
<tr>
<td>Black</td>
<td>Coefficient</td>
<td>0.2584***</td>
<td>0.3320***</td>
<td>0.4513***</td>
<td>0.5250***</td>
<td>0.2840***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0057</td>
<td>0.0059</td>
<td>0.0078</td>
<td>0.0072</td>
<td>0.0055</td>
</tr>
<tr>
<td></td>
<td>Adj. R-Squared</td>
<td>0.7476</td>
<td>0.7493</td>
<td>0.7447</td>
<td>0.7621</td>
<td>0.7610</td>
</tr>
<tr>
<td>API</td>
<td>Coefficient</td>
<td>0.0294***</td>
<td>0.0357***</td>
<td>0.0441***</td>
<td>0.1011***</td>
<td>0.0584***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0055</td>
<td>0.0059</td>
<td>0.0069</td>
<td>0.0069</td>
<td>0.0055</td>
</tr>
<tr>
<td></td>
<td>Adj. R-Squared</td>
<td>0.7453</td>
<td>0.7481</td>
<td>0.7401</td>
<td>0.7621</td>
<td>0.7610</td>
</tr>
</tbody>
</table>
This table reports raw and adjusted pricing disparities (in note rate difference) using reported (also reported II for adjusted pricing disparities), BISG max, BISG 80%, and BISG continuous race/ethnicity, estimated by OLS regression. Regression of the adjusted pricing disparities controls for income (in the form of logarithm), FICO, LTV, CLTV, collateral type, product type, lender type, and fixed effects of lender, MSA, origination year, and MSA×origination year. The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. ***, **, and * denote statistical significance at 1%, 5%, and 10%, respectively.
Table 5: Adjusted Pricing Disparities: Bootstrap

<table>
<thead>
<tr>
<th>PBG</th>
<th>Statistics</th>
<th>Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
<th>BISG Continuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>Mean</td>
<td>0.1085***</td>
<td>0.1240***</td>
<td>0.1664***</td>
<td>0.2272***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0041</td>
<td>0.0041</td>
<td>0.0051</td>
<td>0.0049</td>
</tr>
<tr>
<td>Black</td>
<td>Mean</td>
<td>0.2583***</td>
<td>0.3317***</td>
<td>0.4508***</td>
<td>0.5247***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0063</td>
<td>0.0065</td>
<td>0.0087</td>
<td>0.0079</td>
</tr>
<tr>
<td>API</td>
<td>Mean</td>
<td>0.0294***</td>
<td>0.0358***</td>
<td>0.0442***</td>
<td>0.1013***</td>
</tr>
<tr>
<td></td>
<td>Std. Error</td>
<td>0.0053</td>
<td>0.0055</td>
<td>0.0065</td>
<td>0.0063</td>
</tr>
</tbody>
</table>

The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. Then the data is resampled with replacement for 1,000 times. Each sample is estimated for the adjusted pricing disparities (in note rate difference) using reported, BISG max, BISG 80%, and BISG continuous race/ethnicity. The OLS regression is used to estimate the disparities, controlling for income (in the form of logarithm), FICO, LTV, CLTV, collateral type, product type, lender type, and fixed effects of lender, MSA, origination year, and MSA×origination year. The 1,000 estimated pricing disparity coefficients are then used to calculate the mean and standard error. ***, **, and * denote statistical significance at 1%, 5%, and 10%, respectively.
### Table 6: Adjusted Pricing Disparities by Subsample

#### Panel A: by Applicant’s Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>PBG Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
<th>BISG Continuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>0.0863***</td>
<td>0.0996***</td>
<td>0.1374***</td>
<td>0.2012***</td>
</tr>
<tr>
<td>Black</td>
<td>0.2347***</td>
<td>0.2962***</td>
<td>0.3943***</td>
<td>0.4718***</td>
</tr>
<tr>
<td>API</td>
<td>0.0409***</td>
<td>0.0443***</td>
<td>0.0475***</td>
<td>0.1148***</td>
</tr>
<tr>
<td>Single Male</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>0.0883***</td>
<td>0.1092***</td>
<td>0.1584***</td>
<td>0.2124***</td>
</tr>
<tr>
<td>Black</td>
<td>0.2404***</td>
<td>0.3207***</td>
<td>0.4405***</td>
<td>0.5216***</td>
</tr>
<tr>
<td>API</td>
<td>0.0119</td>
<td>0.0218**</td>
<td>0.0318**</td>
<td>0.0838***</td>
</tr>
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#### Panel B: by Origination Year

<table>
<thead>
<tr>
<th>Year</th>
<th>PBG Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
<th>BISG Continuous</th>
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</tr>
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<td>Hispanic</td>
<td>0.1738***</td>
<td>0.1928***</td>
<td>0.2412***</td>
<td>0.3103***</td>
</tr>
<tr>
<td>Black</td>
<td>0.3244***</td>
<td>0.4097***</td>
<td>0.5614***</td>
<td>0.6477***</td>
</tr>
<tr>
<td>API</td>
<td>0.0206**</td>
<td>0.0189*</td>
<td>0.0168</td>
<td>0.0937***</td>
</tr>
<tr>
<td>2005</td>
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<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>0.1020***</td>
<td>0.1290***</td>
<td>0.1637***</td>
<td>0.2267***</td>
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<tr>
<td>Black</td>
<td>0.2412***</td>
<td>0.3150***</td>
<td>0.4244***</td>
<td>0.5099***</td>
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<tr>
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<td>0.0511***</td>
<td>0.0646***</td>
<td>0.1096***</td>
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<td>2006</td>
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<tr>
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<td>0.0461***</td>
<td>0.0812***</td>
<td>0.1347***</td>
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<tr>
<td>Black</td>
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<td>0.2396***</td>
<td>0.3304***</td>
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<tr>
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<td>0.0247**</td>
<td>0.0275**</td>
<td>0.0787***</td>
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<tr>
<td>2007</td>
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<tr>
<td>Hispanic</td>
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<td>0.1391***</td>
<td>0.1885***</td>
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<tr>
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<td>0.3696***</td>
<td>0.5198***</td>
<td>0.5606***</td>
</tr>
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<td>0.0229</td>
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<td>0.0722***</td>
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#### Panel C: by MSA

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<th>PBG Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
<th>BISG Continuous</th>
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<tr>
<td>Atlanta</td>
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<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>0.1415***</td>
<td>0.1904***</td>
<td>0.2316***</td>
<td>0.3778***</td>
</tr>
<tr>
<td>Black</td>
<td>0.4407***</td>
<td>0.5060***</td>
<td>0.6648***</td>
<td>0.7282***</td>
</tr>
<tr>
<td>API</td>
<td>0.0811*</td>
<td>0.0861</td>
<td>0.1165**</td>
<td>0.1031*</td>
</tr>
<tr>
<td>Boston</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>0.0922***</td>
<td>0.1138***</td>
<td>0.1399***</td>
<td>0.1945***</td>
</tr>
<tr>
<td>Black</td>
<td>0.1044***</td>
<td>0.1241***</td>
<td>0.1918***</td>
<td>0.2251***</td>
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<td>-0.0239</td>
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<th>BISG Continuous</th>
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### Panel E: by Lender Type

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This table reports adjusted pricing disparities (in note rate difference) using reported, BISG max, BISG 80%, and BISG continuous race/ethnicity by subsample. The OLS regression is used to estimate the disparities, controlling for income (in the form of logarithm), FICO, LTV, CLTV, collateral type, product type, lender type, and fixed effects of lender, MSA, origination year, and MSA×origination year. The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. ***, **, and * denote statistical significance at 1%, 5%, and 10%, respectively.

* Pittsburgh reports “NA” for Hispanic under BISG 80% classification as the algorithm categorizes no one as Hispanic.
Table 7: Adjusted Pricing Disparities by Quantile Regression

<table>
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<th>BISG Continuous</th>
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<td>0.4861***</td>
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This table reports adjusted pricing disparities (in note rate difference) using reported, BISG max, BISG 80%, and BISG continuous race/ethnicity. The quantile regression (at median) is used to estimate the disparities, controlling for income (in the form of logarithm), FICO, LTV, CLTV, collateral type, product type, lender type, and fixed effects of lender, MSA, origination year, and MSA×origination year. The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. ***, **, and * denote statistical significance at 1%, 5%, and 10%, respectively.

Table 8: Adjusted Pricing Disparities using Rate Spread

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<td>1.1191***</td>
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This table reports adjusted pricing disparities (in odds ratio of high rate spread incidence) using reported, BISG max, BISG 80%, and BISG continuous race/ethnicity. The logistics regression is used to estimate the disparities, controlling for income (in the form of logarithm), FICO, LTV, CLTV, collateral type, product type, lender type, and fixed effects of lender, MSA, origination year, and MSA×origination year. The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. ***, **, and * denote statistical significance at 1%, 5%, and 10%, respectively.
Table 9: Proxy Performance for Non-Mortgage Products

Panel A: Race/Ethnicity Composition

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<tr>
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<th>Auto Loan</th>
<th>Student Loan</th>
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<td>API</td>
<td>10.1%</td>
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<td>White</td>
<td>48.4%</td>
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Panel B: Correlation Coefficient

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<th>Geocoding</th>
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Panel C: AUC

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### Panel D: Coverage

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<td>2,806</td>
<td>1,984</td>
</tr>
</tbody>
</table>

Data source: HMDA-DQ-CBD tri-merged data. All the correlation coefficients are statistically significant at the 1% significance level.
Figure 1: Growth of Private Label Securitized Mortgage Loans

Data source: 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge.
Figure 3: Kernel Densities of BISG Proxy

Data source: 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge.

Figure 4: Borrower Composition by Credit Product

Source: OCC CBD database, 2005–2012, covering 1.9 million customers with 5.3 million transactions of mortgage, credit card, auto loan, and student loan. The credit product follows the naming convention of mortgage (M), credit card (C), auto loan (A), and student loan (S).
Figure 5: Borrower Composition Comparison: CBD and HMDA-DQ-CBD

Data source: 1.9 million borrowers from OCC CBD database with mortgage, credit card, auto loan, and student loan tradelines during 2005–2012, and 6,648 borrowers contained in the HMDA-DQ-CBD tri-merged data. The credit product follows the naming convention of mortgage (M), credit card (C), auto loan (A), and student loan (S).
Appendix 1: Compare Race/Ethnicity Proxies Using Census Block Group vs. Tract Level Data

If we use the race/ethnicity composition at the block group instead of tract level, the values of geo, geo-surname, and BISG proxies are subject to change. Out of the total 630,807 loans, 99.35% can be matched to the Census block group level SF1 file; 76 loans have a valid block group but it does not have SF1 population; the remaining 4,037 loans cannot be matched to a valid block group. For the latter two groups with no valid block group SF1 population, the BISG algorithm uses the tract level SF1 file instead. We compare kernel density curves (Figure A1) of the proxies using block group vs. tract level geographic data, and find only minor differences for the geo proxy and no visible differences for the geo-surname and BISG proxies. We further quantify the potential improvement of using the more granular block group level information in assessing price differences. The results are listed in Table A1. Comparing the results using block group level vs. tract level Census data (as shown in Table 4 Panel C), we conclude that there are no significant differences in proxying for race/ethnicity as to which geographic level to use.

Figure A1: Kernel Densities of Proxies using Census Block Group vs. Tract Level Data

![Kernel Densities of Proxies](image)

Data source: 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. Suffix “BLG” is for proxies calculated using block group Census SF1.
Table A1: Adjusted Pricing Disparities using Block Group Level Census Data

<table>
<thead>
<tr>
<th>Race</th>
<th>PBG Reported</th>
<th>BISG Max</th>
<th>BISG 80%</th>
<th>BISG Continuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>0.1085***</td>
<td>0.1278***</td>
<td>0.1695***</td>
<td>0.2300***</td>
</tr>
<tr>
<td>Black</td>
<td>0.2584***</td>
<td>0.3373***</td>
<td>0.4535***</td>
<td>0.5260***</td>
</tr>
<tr>
<td>API</td>
<td>0.0294***</td>
<td>0.0351***</td>
<td>0.0442***</td>
<td>0.0999***</td>
</tr>
</tbody>
</table>

This table reports adjusted pricing disparities (in note rate difference) using reported, BISG max, BISG 80%, and BISG continuous race/ethnicity using Census block group level data to proxy for race/ethnicity. The OLS regression is used to estimate the disparities, controlling for income (in the form of logarithm), FICO, LTV, CLTV, collateral type, product type, lender type, and fixed effects of lender, MSA, origination year, and MSA × origination year. The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. ***, **, and * denote statistical significance at 1%, 5%, and 10%, respectively.

Appendix 2: Control Variables Used in Regression Analysis of Mortgage Pricing Disparities

Table A2 provides summary statistics of note rate, income, FICO, LTV, CLTV, and reported race/ethnicities of the entire data sample, as well as subsamples, by types of collateral, product, and lender. It shows that loan pricing, borrower, and loan characteristics do vary significantly by collateral, product, and lender types. For example, compared with the overall population, loans originated with subprime collateral, on average, have a higher note rate, lower income and FICO, higher LTV and CLTV, more Hispanic and Black, and fewer API and White.
This table reports average values of observables for the overall as well as subsamples by types of collateral, product, and lender. The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge.

We also conduct an analysis of variance (ANOVA) to assess the contributions of the controls in Eqn. (7). Table A3 lists the ANOVA Type III F statistics. All the factors are statistically significant with LTV, FICO, CLTV, and collateral type being the top four with the largest F statistics, which is intuitive and supports the setup of the pricing regression analysis.

Table A3: ANOVA Analysis

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Hispanic</th>
<th>Black</th>
<th>API</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income (in Log)</td>
<td>1</td>
<td>21***</td>
<td>15***</td>
<td>58***</td>
</tr>
<tr>
<td>FICO</td>
<td>1</td>
<td>32,717***</td>
<td>22,845***</td>
<td>19,561***</td>
</tr>
<tr>
<td>LTV</td>
<td>1</td>
<td>66,454***</td>
<td>39,769***</td>
<td>37,096***</td>
</tr>
<tr>
<td>CLTV</td>
<td>1</td>
<td>16,382***</td>
<td>13,008***</td>
<td>14,737***</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>1</td>
<td>715***</td>
<td>2,046***</td>
<td>29***</td>
</tr>
<tr>
<td>Collateral Type</td>
<td>4</td>
<td>16,341***</td>
<td>11,252***</td>
<td>11,138***</td>
</tr>
<tr>
<td>Product Type</td>
<td>14</td>
<td>7,562***</td>
<td>5,591***</td>
<td>6,117***</td>
</tr>
<tr>
<td>Lender Type</td>
<td>1</td>
<td>954***</td>
<td>811***</td>
<td>766***</td>
</tr>
<tr>
<td>Lender FE</td>
<td>20</td>
<td>294***</td>
<td>214***</td>
<td>214***</td>
</tr>
<tr>
<td>MSA FE</td>
<td>9</td>
<td>844***</td>
<td>623***</td>
<td>503***</td>
</tr>
<tr>
<td>Origination Year FE</td>
<td>3</td>
<td>6,036***</td>
<td>6,202***</td>
<td>5,754***</td>
</tr>
<tr>
<td>MSA*Origination Year FE</td>
<td>27</td>
<td>78***</td>
<td>59***</td>
<td>57***</td>
</tr>
</tbody>
</table>

This table reports ANOVA Type III F statistics using reported race/ethnicity. The ANOVA is used to evaluate the explanation power of various factors used in Eqn. (7) for note rate. The data contain 630,807 mortgage purchases originated during 2004–2007 in 10 MSAs based on a HMDA and DataQuick merge. ***, **, and * denote statistical significance at 1%, 5%, and 10%, respectively.
Awareness in Practice: Tensions in Access to Sensitive Attribute Data for Antidiscrimination

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1 INTRODUCTION

Statistical models, including those created with machine learning, can reproduce biases in the historical data used to train them. As powerful institutions increase their reliance upon these models to automate decisions that affect people’s rights and life opportunities, researchers have begun developing new techniques to help detect and address these biases. The real-world implementation of these techniques could be an essential part of ensuring the continued viability of civil and human rights protections.

Many machine learning fairness practitioners rely on awareness of sensitive attributes—that is, access to labeled data about people’s race, ethnicity, sex, or similar demographic characteristics—to test the efficacy of debiasing techniques or directly implement fairness interventions. A significant body of research presumes the modeler has ready access to data on these characteristics as they build and test their models [13, 19, 21]. The need for this data is plain to see. As a 2003 analysis of racial disparities in healthcare powerfully concluded: “The presence of data on race and ethnicity does not, in and of itself, guarantee any subsequent actions ... to identify disparities or any actions to reduce or eliminate disparities that are found. The absence of data, however, essentially guarantees that none of those actions will occur.” [23]

Increasingly, companies that utilize machine learning are being asked to detect and address bias in their products. But they are not the first to grapple with these issues. This paper explores the legal and institutional norms surrounding the collection, inference, and use of sensitive attribute data in three key corporate domains. This analysis has significant implications for machine learning fairness research: If private institutions that mediate access to life opportunities are unable or hesitant to collect or infer sensitive attribute data, then emerging awareness-based techniques to detect and mitigate bias in machine learning models might never be implementable in real-world settings.

Notably, this paper does not discuss complex and important questions about how “fairness” should be measured or addressed, recognizing that definitions are manifold [53]. Rather, we make a simpler point: If sensitive attribute data are not available, interventions that rely on them will be severely impaired.

We conduct this exploration through the lens of U.S. civil rights law in the domains of credit, employment, and healthcare. For each domain, we describe when and how private companies collect or infer sensitive attribute data, then found. The absence of data, however, essentially guarantees that none of those actions will occur.” [23]

Increasingly, companies that utilize machine learning are being asked to detect and address bias in their products. But they are not the first to grapple with these issues. This paper explores the legal and institutional norms surrounding the collection, inference, and use of sensitive attribute data in three key corporate domains. This analysis has significant implications for machine learning fairness research: If private institutions that mediate access to life opportunities are unable or hesitant to collect or infer sensitive attribute data, then emerging awareness-based techniques to detect and mitigate bias in machine learning models might never be implementable in real-world settings.

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We conduct this exploration through the lens of U.S. civil rights law in the domains of credit, employment, and healthcare. For each domain, we describe when and how private companies collect or infer sensitive attribute data to pursue antidiscrimination goals. These are not the only contexts where collection of sensitive attributes is likely to be justified or important, but they are quintessential areas where such data are already being used to measure and mitigate discrimination. They also highlight major divergences in policy, motivation, and practice.

ABSTRACT

Organizations cannot address demographic disparities that they cannot see. Recent research on machine learning and fairness has emphasized that awareness of sensitive attributes, such as race and sex, is critical to the development of interventions. However, on the ground, the existence of these data cannot be taken for granted.

This paper uses the domains of employment, credit, and healthcare in the United States to surface conditions that have shaped the availability of sensitive attribute data. For each domain, we describe how and when private companies collect or infer sensitive attribute data for antidiscrimination purposes. An inconsistent story emerges: Some companies are required by law to collect sensitive attribute data, while others are prohibited from doing so. Still others, in the absence of legal mandates, have determined that collection and imputation of these data are appropriate to address disparities.

This story has important implications for fairness research and its future applications. If companies that mediate access to life opportunities are unable or hesitant to collect or infer sensitive attribute data, then proposed techniques to detect and mitigate bias in machine learning models might never be implemented outside the lab. We conclude that today’s legal requirements and corporate practices, while highly inconsistent across domains, offer lessons for how to approach the collection and inference of sensitive data in appropriate circumstances. We urge stakeholders, including machine learning practitioners, to actively help chart a path forward that takes both policy goals and technical needs into account.
Comparing these sectors, a complex and inconsistent story emerges. In credit, the law requires some lenders to collect sensitive attribute data, while largely prohibiting others from doing so. In employment, the collection of sensitive attribute data is a familiar part of large employers’ day-to-day practice. And in health care, companies’ motivation for collecting sensitive attribute data is not just basic antidiscrimination compliance, but rather a moral imperative to address staggering disparities in health outcomes.

We observe that these norms and practices, divergent as they are, typically extend only to traditionally regulated actors. Technology companies that mediate access to opportunities as platforms (e.g., social networks, job boards, and rental sites) or act as vendors to other companies rarely receive clear guidance about when to collect or infer sensitive attribute data. As a result, today, many major technology companies do not collect or infer certain kinds of sensitive attribute data and may therefore struggle to define, detect, and address harms to those protected groups.

We conclude that there are few clear, generally accepted principles about when and why companies should collect sensitive attribute data for antidiscrimination purposes. We emphasize the importance of the machine learning research community engaging on the future development of policy in this area, and urge conversations among stakeholders about whether and how to adapt existing practices or establish new ones.

### 1.1 Defining “sensitive attribute data”

Throughout this paper, we use the term “sensitive attribute data” to refer to details about people’s membership in “protected classes” as defined throughout U.S. civil rights laws. This approach to classification is not without its problems: Rigid categories such as these do not currently accommodate nonbinary identities or membership across multiple groups [3, 34, 37, 51]. We acknowledge the reductive and potentially harmful nature of these classification regimes, while simultaneously emphasizing the importance of understanding how they have motivated data collection practices for bias mitigation, and how the history of these practices can inform contemporary contexts.

### 1.2 Related work

The fair ML research community has long reflected on the social and policy contexts of its work, recognizing legal tensions [8], historical parallels in prior debates over definitions of fairness [37], and the limitations of data-dependent problem formulation [64, 70]. However, when emphasizing the importance of awareness of sensitive attributes in developing and implementing fairness-enhancing interventions, fair ML research and toolkits [9, 38, 67] often take for granted when framing problems and their solutions that sensitive attribute data are available as inputs [17, 32, 39, 40, 48, 50, 65].

When labeled data are not available, researchers have made powerful discoveries by augmenting existing data through the inference or construction of labeled data de novo [5, 10, 27, 46]. At times, this work has insufficiently acknowledged the full range of challenges to generating or obtaining those data in applied contexts [35, 76, 77].

Veale and Binns [76] and Kilbertus et al [41] propose approaches to dealing with such information deficits without collecting or revealing sensitive data. Chen et al propose a method to impute unavailable protected class data [13]. Veale et al [77] and Holstein et al [35] outline the contextual needs for implementing fairness. Zliobaite and Custers use theoretical and linear regression-based examples to argue that sensitive data must be included in the modeling process in order to avoid discrimination [79]. Focusing on the European regulatory environment, their study distinguishes between direct and indirect discrimination, but does not address how different sectoral laws enable or prevent detection of either type.

This paper aims to bridge gaps between theoretical approaches and practical constraints, extracting lessons for fair ML practitioners from three real-world case studies.

### 2 CASE STUDIES

#### 2.1 Credit

United States federal law prohibits creditors from discriminating on the basis of certain protected characteristics. However, across the credit sector, there are sharply divergent approaches to collecting sensitive attribute data. On one hand, mortgage lenders are required to collect such data from their borrowers. On the other, consumer lenders are largely prohibited from doing so. The reason for this difference is not immediately apparent, and likely turns on historical details underlying the development of overlapping legal doctrines.

2.1.1 Background. In the mid-1970s, policymakers acknowledged that discriminatory practices in the consumer credit and home mortgage industries shut out women, people of color, low-income groups, and others from accessing these vital economic resources. The Equal Credit Opportunity Act (ECOA), passed in 1974, initially made discrimination on the bases of marital status and sex illegal, and was later expanded to include other protected groups. The following year, the Home Mortgage Disclosure Act (HMDA) similarly made discriminating against low-income home mortgage borrowers illegal. Like ECOA, HMDA grew to encompass categories including race, gender, and national origin through subsequent amendments.

The origins of ECOA trace back to an era when lenders required unmarried women to have male cosigners on their loans. From the outset, regulators feared that mandatory collection of protected class data beyond gender for the purpose of detecting discriminatory lending might itself facilitate such practices. Thus, under ECOA, the collection of these data is banned. Regulation B, which implements ECOA, has made exceptions for some voluntary collection of data on applicants’ color, national origin, religion, race, and sex as “monitoring information” in instances where lenders conduct self-testing to determine whether loans are not being granted to individuals on discriminatory grounds.

The Federal Reserve Board (FRB) twice considered amendments to ECOA that would allow voluntary collection of protected class data for non-mortgage loan applicants in order to surface discriminatory lending decisions. In 1995, the first proposal to lift the ban on collecting sensitive attribute data garnered a mix of support and opposition. Noting that discrimination on protected class bases only covered a limited set of criteria for potential disparate treatment during in-person lending scenarios, supporters of the change pointed to the successful identification and reduction of biased
mortgage lending decisions that resulted from HMDA’s strict data collection practices [74]. These advocates disagreed with the FRB’s long-held claim that recording these data would lead to discrimination in consumer lending, noting that this predicted harm did not unfold in the home mortgage industry.

The argument that voluntary collection of protected characteristic information would lead to discriminatory lending persisted, however, in large part due to credit industry representatives’ complaint letters opposing the amendments. Banks and other lending institutions were not inclined to support a measure that would incur higher costs and stricter reporting standards and presumably may have revealed discriminatory practices. They additionally warned that being asked about sensitive attributes could deter some minority applicants. In response to these public comments following the proposed amendment in 1995, the FRB decided to leave the decision about collecting protected class data up to Congress.

After introducing a second proposal to remove the ban on collecting these data in 1998, the FRB once again determined in 2003 that consumer lending institutions should not gather this information. Standing by their original conviction that sensitive attribute information collection would lead to outright discrimination, the FRB also reasoned that making this a voluntary action could result in incomplete data collection and inconsistent data formatting that would hinder cross-market comparison between creditors [74].

The ECOA’s evolution was in many ways the opposite of HMDA’s expansive push to seek evidence of unfair practices in the mortgage lending industry. HMDA grew out of home mortgage depository institutions’ disproportionate withdrawal of investments in largely urban areas from which they drew their deposits: a form of redlining that devitalized older neighborhoods, since residents could not access the credit required to sell and refurbish their homes [42]. HMDA’s initial reporting requirements involved publicizing geographic data about lending patterns. As the contexts and causes of home mortgage lending discrimination changed, HMDA was amended between 1980 and the early ’00s to expand the scope of institutions covered and to call for reporting of sensitive attribute data on borrowers’ gender, race, income, and other categories. When regulators determined these data were insufficient to demonstrate discrimination, they called for further data collection including data about rejected applications and loan pricing.

2.1.2 Data practices. While ECOA prohibits collection of sensitive attribute data for most purposes, its implementing regulations allow banks and “anyone who, in the ordinary course of business, regularly participates in decisions about whether or not to extend credit or how much credit to extend” to collect, in a narrow set of circumstances, sensitive attribute data on individuals applying for non-mortgage loans [71]. If lenders opt to collect this data, they must indicate that the information is being recorded for self-testing and monitoring purposes. If an applicant prefers not to provide their race and sex information, the lender is allowed to make their own determinations of these characteristics from visual observation and surname analysis. If the self-test demonstrates that the institution may have violated ECOA, the lender must attempt to identify the cause and extent of the violation. Save for in some instances, the results of the self-test are considered privileged information that government agencies cannot access in investigations related to ECOA transgressions.

HMDA, by contrast, requires expansive collection of both sensitive attribute data and related mortgage loan application data that can be used to build arguments that discrimination has occurred. Under HMDA, protected data that must be collected as part of a Loan/Application Register (LAR) include sex, race, and ethnicity, with additional requirements that data on income, loan amount and type, property location, and reasons for loan denial (among others) must be reported [42]. Lenders are allowed to use visual observation and surname analysis to guess the sex, race, and ethnicity of applicants who choose not to self-identify these traits. The data are published in different formats depending on the intended recipient. Lenders submit these data to the FRB annually, whereas if a member of the public requested access they would be presented with a modified LAR scrubbed of any identifying information. Finally, the Federal Financial Institutions Examination Council (FFIEC) creates disclosure statements for each lender based on their LAR data, and publishes openly available aggregate reports of HMDA data at city, national, and census-tract levels.

2.1.3 Results and reactions. The question of whether sensitive attribute data should be collected to detect discrimination in consumer lending remains controversial. As one scholar put it, “Even if computerized credit scoring arguably has the potential to eliminate disparate treatment results, disparate impact discrimination may still occur” [74]. Another scholar has suggested creditors should be required to conduct self-testing using sensitive attribute data,[4] Lenders and other proponents of credit scoring systems may argue that expanded collection of data on race and other protected class characteristics would be insufficient to prove discrimination given the increasing complexity of how credit scores are calculated.

Today, as was the case when ECOA was passed, the absence of sensitive attribute data makes it difficult to document and mitigate inequitable consumer lending practices. For example, one of the few robust public studies on credit scores and discrimination in the United States was performed by the FRB in 2007, at the direction of Congress [56]. To conduct its analysis, the FRB created a database that, for the first time, combined sensitive attribute data collected by the Social Security Administration (SSA) with a large, nationally representative sample of individuals’ credit records. The FRB noted its study was unique in part because of the lack of sensitive attribute data in this domain, and this unusual undertaking would not have been possible without significant governmental time and resources.

The shortage of sensitive attribute data in the consumer lending space also complicates regulatory enforcement. For example, in 2013, the Consumer Financial Protection Bureau (CFPB) and the Department of Justice found that Ally Financial, an auto lending firm, overcharged over 230,000 minority borrowers on their car loans. Two years later, the CFPB required Ally Financial to send checks from its $80 million settlement to customers believed to have unfairly paid higher prices for their loans [66]. Lacking access to data on which exact individuals had overpaid, however, the CFPB instead used a Bayesian Improved Surname Geocoding (BISG) method to predict which customers were likely to be racial minorities, and were therefore more likely to be victims of Ally Financial’s allegedly
discriminatory pricing. Although BISG’s probabilistic means of using publicly available surnames and geographical information as proxies for race and ethnicity is regarded as among the most advanced technique of its kind [11], it is not without flaws. In the use of BISG during the Ally Financial payout, some white Americans were misidentified as having been overcharged for car loans on a discriminatory basis and received compensatory checks [7]. Had data collection practices in non-mortgage lending included sensitive attributes, such mistakes could have been averted. Moreover, predictive power of these techniques might diminish over time if housing and marital segregation patterns change.

By contrast, the amendments to HMDA that spurred collection of protected class data came into effect in 1990, and data from 1992 reflected a significant rise in mortgage lending to low- and moderate-income and minority communities [49]. Moreover, in the longer term, the publication of the 1991 data fueled community activism and helped change home mortgage lenders’ practices. Making HMDA data mutually accessible to lending institutions and community organizations is correlated with beneficial outcomes for banks and borrowers alike [20]. However, it remains difficult to know for certain to what extent this data led to reductions in discriminatory lending practices or merely documented changes that were already underway.

2.2 Employment

United States federal law prohibits employers and employment agencies from discriminating on the basis of certain protected attributes. In this context, the collection of demographic information is a familiar part of most employers’ day-to-day practice. For example, many large employers are required to collect demographic data about job applicants and employees to facilitate regulatory enforcement and research. And for many decades, employment selection procedures have been subject to regulatory guidelines that assume “adverse impact” can be readily quantified.

2.2.1 Background. Following sustained, nationwide demands to end racial discrimination and segregation, Congress passed sweeping protections in the Civil Rights Act in 1964. Title VII of the Act pertains specifically to employment, prohibiting employers from directly or indirectly discriminating in their employment practices and laying out expectations around data collection and reporting for enforcement purposes. The following year, President Lyndon B. Johnson signed Executive Order 11246, which prohibits federal contractors from discriminating in employment decisions, and also requires employers to take affirmative action to increase the representation of women and minorities in their workforces. The order, enforced by the Department of Labor’s Office of Federal Contract Compliance (OFCCP), also outlines related requirements around the documentation of recruitment activities, including the collection of demographic information about job applicants and employees in order to facilitate the detection of discrimination at different points in the recruitment pipeline.

Title VII requires employers and other covered entities to “make and keep such records relevant to the determinations of whether unlawful employment practices have been or are being committed,” as defined by the Equal Opportunity Employment Commission (EEOC), which enforces the law [1]. Since employers may be liable for employment practices that result in disparate impact on the basis of protected categories including race and gender, EEOC guidance points to Title VII as a legal basis for requiring the collection of applicant data as necessary to detect, mitigate, or defend against claims of disparate impact. The Uniform Guidelines on Employment Selection Procedures, which reflects the U.S. government’s unified position on employment tests, detail how employment tests must be evaluated for unjustified adverse impact on the basis of race, sex, or ethnicity. The EEOC may allow employers to use selection procedures with disparate impact provided that the procedure has been “validated” according to these guidelines [31].

In order to support enforcement of these legal protections, monitor progress in workplace diversity, and enable employer self-assessment, the EEOC also requires private employers with 100 or more employees and contractors with more than 50 employees to collect aggregate statistics about the demographics of their workforce and report them to regulators on a yearly basis, known as EEO-1 reports.

2.2.2 Data practices. Collection of sensitive attribute data in the employment sector is highly standardized, reflecting well-defined federal reporting requirements.

For EEO-1 reports, employers must collect data on sex, a binary field (male or female), as well as race, divided into predefined categories of Black, Hispanic, Asian/Pacific Islander, American Indian/Alaskan Native, white, or “two or more races” [16]. These categories were last updated in 2005 (after 40 years), and in 2007 the EEOC advised that employers were permitted—but not required—to collect more detailed demographic data [55, 63]. Employers must offer employees the opportunity to voluntarily self-identify in the predefined categories. If and only if an employee declines to self-identify, the employer may use “employment records or observer identification,” elsewhere described as “visual surveys of the workforce” to categorize the worker to complete their reporting requirements [16].

Although not all employers are required to track sensitive attributes from job applicants, many opt to solicit this information at the time of application, and federal contractors are required to do so. Contractors may solicit demographic data from applicants at any time during the employee selection process so long as the data is solicited from all applicants. Regulators advise that “voluntary self-reporting or self-identification is still generally the preferred method for collecting data on race, ethnicity, and gender, but in situations where self-reporting is not practicable or feasible, observer information may be used to identify race, ethnicity, and gender” [62]. After making “reasonable efforts to identify applicant race, gender, and ethnicity information,” contractors may record the applicant’s race and gender as “unknown”—with the exception that employers may visually identify applicants “when the applicant appears in person and declines to self-identify” [61]. Notably, employers may not use these data as a part of their employment selection procedures, but may use them to evaluate outcomes and inform changes to those procedures.

2.2.3 Results and reactions. As of 2017, nearly 70 thousand employers file EEO-1 reports per year, documenting data for over 50 million employees [14]. Multiple studies have used EEO and other sources of demographic data to measure trends in occupational
segregation, finding that it has declined since the passage of Title VII [44, 69, 78]. Others use this data to more closely examine race and sex inequality in managerial positions and within specific industries, as well as gender and racial pay gaps [36, 45, 69]. Several researchers were able to determine that OFCCP monitoring and enforcement in particular likely contributed to greater representation of Black workers in skilled occupations [47]. The EEOC and OFCCP themselves commonly use EEO-1 and other mandatorily collected data to support investigations of individual and systemic employment discrimination [15, 75].

Some have pointed out that unlike other government survey instruments, the EEOC merges data on race and ethnicity, which may lead to measurement errors [69]. Others critique the allowance of observed data, but concede that because observed data relate to how workers may be perceived, these data may still have utility in understanding employment discrimination [72]. However, we identified relatively little criticism of the overall exercise of collecting sensitive attribute data in the context of employment, perhaps because the law requiring and justifying their collection is so clear.

Here again, it is not clear that the relationship between demographic data collection and any occupational desegregation is a causal one. Without this disaggregated employment data, however, documentation of these trends would be significantly more difficult. Indeed, researchers have found that while EEO-1 data do have some constraints, they can be a particularly powerful tool to study workplace inequality and segregation, especially as compared with other data sources [69].

2.3 Health

United States federal law prohibits discrimination in the provision of various health care services. For example, those who qualify for federal health insurance programs such as Medicare or Medicaid may not be subjected to discrimination based on certain sensitive attributes. However, unlike in credit and employment, a major driving factor behind collection of sensitive attribute data in this sector has been voluntary industry efforts to address racial and ethnic disparities in health outcomes, rather than compliance with antidiscrimination laws alone.

2.3.1 Background. The passage of the Civil Rights Act in 1964 and the establishment of Medicare the following year created a need for data to confirm that patients had equal access to health care and that hospitals were not segregated. As a result, many hospitals initially collected data about sensitive attributes for compliance purposes only [68].

A shift in approach was prompted not long after by Secretary of Health and Human Services (HHS) Margaret Heckler’s observation in a 1983 national health report that minority health lagged behind that of white Americans, and the subsequent formation of the Task Force on Black and Minority Health to research this gap. The 1986 publication of the Report of the Secretary’s Task Force on Black and Minority Health (Heckler Report) marked the first study highlighting the significant health disparities racial minorities experienced in the U.S. [57]. Although the Heckler Report’s findings drew awareness to racial inequality in healthcare provision, they did not themselves effect a shift away from compliance-based sensitive attribute data collection toward a model of using these data to reduce discrimination.

At the request of Congress in 2003, the Institute of Medicine (IOM) published a follow-up report, Unequal Treatment, affirming that unacceptable levels of racial and ethnic disparities in health outcomes persisted [60]. The IOM report concluded that without data on patients’ race, ethnicity, socioeconomic status, and primary language, it would be impossible for healthcare providers to detect or address these disparities, and recommended the systematic collection and reporting of race and ethnicity data as a critical step toward eliminating them.

The IOM report jump-started health insurance and other care providers’ joint, voluntary effort to collect and use data for healthcare quality improvement and disparity reduction [68]. Organizations such as the National Health Plan Collaborative (NHPC) connected health research institutes to national and regional health plans in order for the former to provide these firms with educational tools and recommendations for how to detect and mitigate discrimination [73]. While initially, many insurance providers believed collecting race and ethnicity data was illegal, legal analysis determined that collection was justified under (though not explicitly required by) Title VI of the Civil Rights Act and the Affordable Care Act, as well as several state laws. Under these statutes, health plans are prohibited from using demographic data for discriminatory purposes, including steering patients toward certain healthcare products [18, 43]. However, health plans are allowed to use these data in order to report aggregate trends and join initiatives to provide equitable services.

2.3.2 Data practices. Some health providers have found it necessary to collect data on patients’ race, ethnicity, and primary spoken language (REL) to identify health care disparities [23]. However, there is substantial variability in the precise categories and level of granularity different health providers opt to use to do so. Industry-wide efforts to standardize these data are ongoing.

Physicians and hospitals often collect REL data at intake—usually by asking patients directly, though sometimes determined by intake specialist observation [28]. Health plans, on the other hand, tend to use surveys and incentive programs to collect data after people have signed up for coverage. In some cases, insurers are prohibited from asking for race/ethnicity data during the sign-up process [25, 29]. Some health providers also appear to be able to share and obtain data from federal agencies (e.g. Medicaid), though the exact mechanics of this process remain obscure.

Policymakers and practitioners recognize that in general, data that patients self-report are strongly preferred [24, 33], but in practice, providers have struggled to convince most patients to voluntarily self-report. In the interest of generating data necessary to reduce disparities, methods to estimate race and ethnicity have been widely adopted to supplement self-reported data [54]. Early inference methods involved basic geocoding and surname analysis; more advanced probabilistic techniques have since been developed to refine these estimates. These algorithms produce probabilities that individuals belong to a particular racial or ethnic group, which can then be used to assess disparities between subgroups at an
aggregate level [29, 68]. A number of health plans combine self-reported and estimated data to increase accuracy of their analysis [54].

Experts have recommended that race/ethnicity data based on indirect estimation methods should be stored separately from or be clearly marked in medical systems. Inferred data should not be placed in individuals’ clinical medical records—that is, probabilistic methods should not be used to assign someone a particular race or ethnicity classification [68]—but should only be used for aggregate statistical analysis [25]. The IOM recommended that when possible, estimations should be accompanied by their respective probabilities [68]. Whether actual data management practice follows these recommendations likely varies by institution.

2.3.3 Results and reactions. While significant healthcare disparities remain, they have narrowed since the publication of the IOM report that motivated increased data collection [22, 59]. Moreover, granular data has enabled ongoing monitoring and benchmarking of health outcomes, motivated substantial scientific and policy research, and supported federal, state, local, industry, and practitioner-driven disparity reduction initiatives.

Although many health plans have internal policies on confidentiality and use of race/ethnicity data [30], low rates of participation in voluntary data collection may indicate continued lack of trust in healthcare institutions that collect these data, and fear that demographic data might be used to discriminate against patients or otherwise be misused [33]. Health plans have admitted that they sometimes hesitate to collect data for fear of being accused of discrimination [25], on top of other challenges like privacy concerns, IT limitations, and inconsistency or insensitivity in the available categories [54]. But many healthcare providers circumvent these challenges by using techniques to generate demographic data in a probabilistic manner.

Critiques of direct and indirect data collection efforts in healthcare have also emerged on the grounds that concepts of race and ethnicity are merely sociopolitical constructs [25], and therefore categorizing patients using those constructs may reinforce and calcify them. However, the broadly recognized harms of race- and ethnicity-related health disparities seem to have outweighed this critical perspective for the time being.

3 DISCUSSION

Clearly, debates about collection of sensitive attribute data for antidiscrimination purposes are not new. There are decades of precedent that can inform the machine learning fairness research community, the broader technology industry, and other stakeholders.

It is important to reiterate that our case studies do not indicate whether collection of sensitive attribute data has contributed causally to more fair and equitable outcomes. A more fulsome analysis of this question remains for future work. However, we remain convinced that measurement is often a precondition for meaningful improvements.

While the case studies above merely scratch the surface, they offer some important insights. First, they show that U.S. legal frameworks do not offer consistent, extensible guidance about when and how corporations should collect sensitive attribute data. Rather, there are divergent and sometimes contradictory approaches: Some companies are required to collect sensitive data to comply with antidiscrimination laws, while others are explicitly prohibited from doing so. Second, they show that companies’ primary incentives for collecting sensitive attribute data may not—and need not—be compliance or legal requirements at all. The healthcare industry is one such example. Here, deliberate, sustained, and ongoing debates on data collection and inference practices across the industry and stakeholder communities were needed to align on an approach to combating disparities.

If awareness-based techniques remain a primary approach to bias mitigation in predictive modelling, there is a need to thoughtfully consider what efforts must be undertaken to expand collection of sensitive attribute data in a responsible manner.

3.1 Lessons regarding traditionally regulated companies

For traditionally regulated entities like banks and employers, modernization or clarification of laws and regulatory guidance may be needed to encourage the collection of sensitive attribute data for new antidiscrimination efforts. Because these companies can be liable for discriminatory outcomes, they are unlikely to voluntarily collect or analyze sensitive attribute data that could introduce new vectors for liability. Thus, they might resist legal reforms that make it easier to collect sensitive attribute data.

Looking ahead, policymakers, researchers, and and civil society will need to work together to assess what kinds of sensitive attribute data are needed to protect people against discrimination and create the policy conditions for that collection to occur. These stakeholders will need to consider what data ought to be collected and in what form, and the appropriate scope of “safe harbor” provisions to incentivize thorough and transparent study. These are not clear or settled questions, even with decades of practice under longstanding civil rights laws.

3.2 Lessons regarding less regulated companies

Many technology platform companies, including those using models to mediate access to important life opportunities, are not squarely covered by civil rights laws. These companies often operate as internet intermediaries, and thus enjoy some special legal protections from liability arising from content posted by third party users [26]. Nonetheless, many are grappling with how to prevent bias. For example:

- Airbnb recently assembled “a permanent team of engineers, data scientists, researchers, and designers whose sole purpose is to advance belonging and inclusion and to root out bias” [32]. The announcement came on the heels of reports of discrimination against African Americans seeking housing opportunities on its platform. The company has not yet publicly discussed the details of this work, or whether it collects or infers sensitive attribute data in its efforts to combat discrimination. However, it is difficult to imagine an approach that would avoid these questions.
- Facebook, in delivering advertisements on its platform, introduces demographic skews along gender and race lines [5]. This practice is currently being challenged in court by the
United States Department of Housing and Urban Development (HUD) [58]. Furthermore, as part of a legally enforceable settlement with civil rights organizations, Facebook recently committed to studying the potential for unintended biases in algorithmic modeling [6]. However, this research will likely be impossible without collecting or inferring sensitive attributes of the company’s users. It is not yet clear how Facebook will approach this issue.

- LinkedIn, in an effort to promote equity in hiring, recently updated its recruiter tools to balance the gender distribution in candidate search results, rather than sorting candidates purely by “relevance” [12]. With this update, if the pool of potential candidates who fit an employer’s search parameters reflects a certain proportion of women, LinkedIn will re-rank candidates so that every page of search results reflects that proportion. The company also plans to offer employers reports that track the gender breakdown of their candidates across several stages of the recruitment process, as well as comparisons to the gender makeup of peer companies. These features rely on inferring gender data about jobseekers on the platform, which the company was already doing for advertising purposes.

It’s not surprising that each of the above examples was motivated by some combination of public pressure or litigation. Technology companies are unsure about what kinds of sensitive attribute collection are appropriate. As a result, the path of least resistance is to simply not to collect or infer data that may create controversy or highlight disparities that may be difficult to address. This is especially true given that perceived violations of privacy are likely to garner intensive media coverage, or where applicable, increased attention from regulators. It will likely fall to a wide range of stakeholders, including advocates, researchers, and policymakers, to ensure that sensitive attribute data is collected and used under appropriate circumstances.

### 3.3 The need for multidisciplinary collaboration

The implementation of awareness-based antidiscrimination approaches cannot, and should not, move forward without robust involvement of public interest, technical, and regulatory stakeholders. Even amid clear and compelling risks of discrimination or unjust demographic disparities, it can be difficult for policymakers to recommend the collection of sensitive attribute data. There is no evidence this issue will become easier in the future, despite the rapid adoption of machine learning models involved in important life decisions for which these data may be critical to prevent harm.

Privacy laws can sometimes sit in tension with antidiscrimination goals, and might prevent well-meaning actors from collecting data that are necessary to detect and remediate bias in machine learning-based models. Privacy advocates will need to ensure that new legal requirements around data minimization and restrictions on the processing of sensitive data do not deter or impede companies from good faith self-testing and bias remediation. At least one recent U.S. legislative proposal provides an explicit exception for such testing [2], reinforcing the need for more detailed implementation guidance. Meanwhile, European laws and norms diverge significantly from the U.S. approach, prioritizing privacy heavily over awareness-based antidiscrimination approaches [79]. Private entities may need to navigate conflicting laws, guidance, and public expectations across social and geopolitical contexts.

Finally, there is no shortage of critical questions that still need to be answered:

- **When should sensitive attribute data be collected?** Given the practices described above, non-industry actors should consider under what conditions, if any, they would trust certain private actors with sensitive attribute data that are needed for antidiscrimination efforts. It’s obvious that data collection would be justified in some contexts, but the risks may outweigh potential benefits in others. It’s far less obvious (and beyond the scope of this paper to suggest) where those lines should be drawn. These norms are especially unsettled for technology companies, who have not had the same historical obligations as traditionally regulated entities, and suffer from significant trust deficits around their data practices.

- **How should sensitive attribute data be created?** Sensitive attribute data can be collected directly from subjects or inferred from non-sensitive data. However, inference presents challenges around consent, forced classification, and error. Stakeholders must work together to determine under what conditions inference is acceptable, appropriate inference methodologies, and how to treat inferred data responsibly. The cases considered in this paper offer instructive approaches, including retaining probabilistic values and uncertainty in inferred data, clearly marking when data are observed or inferred, and storing inferred data separately from data collected with permission. Other approaches might include enforceable commitments to use these data only for detecting and mitigating discrimination.

- **How should sensitive attribute data be treated and secured?** Ideally, sensitive data would be stored separately from other data and used only for limited purposes, but such technical safeguards may be difficult to guarantee. New privacy-protective techniques to access sensitive attribute data, including secure multi-party computation tools like private set intersection and homomorphic encryption, may allow companies to securely sequester these sensitive data from general purpose user data, or even enable trusted third parties to collect, infer, or hold sensitive data while making their insights available to the private entities whose products implicate people’s rights [76]. However, these techniques are still nascent and have yet to be broadly deployed for the purpose of bias testing or mitigation.

### 4 CONCLUSION

Policy debates about the collection and use of sensitive attribute data will decide the fate of awareness-based bias mitigation techniques. There is an urgent need for machine learning scholars to drive these conversations forward, along with other stakeholders, so policy and technical approaches can be developed in accordance with each other. The ability to detect and address bias in algorithms—and the durability of foundational civil rights protections—may hang in the balance.
July 27, 2020

Fair Isaac Corporation (FICO) appreciates the opportunity to submit these brief comments on the most recently released draft white paper, **Best Practices – Regulatory Review of Predictive Models**.

FICO fully understands and respects the value of regulatory scrutiny as well as the need for regulatory flexibility to help ensure that consumers continue to enjoy greater access to more affordable insurance through the industry’s use of credit-based insurance scores. We believe it is important to preserve this consumer benefit.

FICO remains concerned that the predictive model review provisions proposed in the white paper, if adopted and implemented by state departments of insurance, will reduce the effectiveness of the time-tested and proven regulatory processes that exists today with respect to credit-based insurance scores. FICO believes that implementation of the proposed provisions is likely to severely strain the strong competitive nature of the auto and home insurance industry, which leads to lower insurance costs for consumers. Greater competition drives to greater access of insurance and at lower costs for consumers.

More importantly, however, the majority of consumers who have benefitted—via lower premium payments—from the industry’s use of credit-based insurance scores for the past two decades will see their premiums increase as this key risk segmentation tool is restrained or restricted in those states that adopt the proposed provisions. Properly utilized and proven risk segmentation tools allow insurers to identify those risks requiring more or less premium based on the likelihood of future claim activity.

For nearly two decades, in support of successful rate filings throughout the nation by our FICO® Insurance Score clients, FICO has provided model documentation to all requesting departments of insurance that are able to provide appropriate confidentiality protections for FICO’s proprietary information. FICO’s submissions generally include specific consumer credit characteristics, attributes and weights for the filed model, reason code/factor definitions, and a general discussion of our model development process.
FICO will continue to provide that filing support for our clients’ use of FICO Insurance Scores by answering all appropriate regulatory questions to the best of our ability and by offering as much insight into FICO’s proprietary modeling analytics and technologies as possible, while still protecting our intellectual property.

Thank you for allowing FICO to once again comment on this important issue.

Sincerely,

Lamont D. Boyd, CPCU, AIM
Insurance Industry Director, Scores

LamontBoyd@FICO.com
602-317-6143 (mobile)

FICO® Insurance Scores Consumer website - https://insurancescores.fico.com/
July 27, 2020
Ms. Kris DeFrain, FCAS, MAAA, CPCU
Director, Research and Actuarial
NAIC Central Office

Re: CASTF Predictive Model White Paper – Proposed Edits

Dear Ms. DeFrain:

In support of the finalization of the Regulatory Review of Predictive Models White Paper, we respectfully submit the following suggested edits.

**COMMENTS**

Our comments are summarized in the following table:

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Exposure Draft Text</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>11</td>
<td>X. Other Considerations</td>
<td>Provide guidance for regulators on the value and/or concerns of data mining including how data mining may assist in the model building process, how data mining may conflict with standard scientific principles, how data mining may increase “false positives” during the model building process, and how data mining may result in less accurate models or models that are unfairly discriminatory.</td>
<td>Previous exposure draft comments have mentioned the potential issues of brief mentions of other topics that suggest concerns without sufficient discussion. “Data mining” is no longer defined within the paper, and we believe some readers may associate “data mining” with the general application of machine learning and statistical models. Done with appropriate validation, this use of “data mining” is not inherently problematic. We suggest this item be reworded to refer to “data dredging” or “the use of predictive modeling methods without sufficient validation.”</td>
</tr>
<tr>
<td>14</td>
<td>Appendix B, paragraph 2</td>
<td>Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose.</td>
<td>We suggest adding guidance based on ASOP 56 - Modeling, clarifying that “the degree of such documentation may vary with the complexity and purpose of the model.”</td>
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<tr>
<td>16</td>
<td>A.1.a</td>
<td>If the data is taken from an outside source, find out what steps were taken to verify the data was accurate, complete and unbiased in terms of relevant and representative time frame, representative of potential exposures and lacking in obvious correlation to protected classes.</td>
<td>We suggest an example to illustrate what would be considered “obvious correlation.”</td>
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<tr>
<td>18</td>
<td>A.2.e</td>
<td>Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses, when using a flood model, inclusion of freeze losses, when using a winter storm</td>
<td>It is not clear how including demand surge on catastrophe model output would create overlap/redundancy with historical claims data. We suggest a clarification, or the</td>
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<tr>
<td>18</td>
<td>A.2.e</td>
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<td></td>
<td>Note that, the rating plan or indications underlying the rating plan, may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large BI losses, in the case of personal automobile insurance, be capped or excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model’s training, test and validation data?</td>
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<tr>
<td>22</td>
<td>B.1.g</td>
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<td></td>
<td>The modeler should comment if any form of data mining to identify selected variables was performed and explain how the modeler addressed “false positives” which often arise from data mining techniques.</td>
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<td>22</td>
<td>B.1.h</td>
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<td></td>
<td>In conjunction with variable selection, obtain a narrative on how the company determine the granularity of the rating variables during model development.</td>
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<tr>
<td>25</td>
<td>B.4.b</td>
<td></td>
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<td></td>
<td>For all variables (discrete or continuous), review the appropriate parameter values, confidence intervals, chi-square tests, p-values and any other relevant and material tests. Determine if model development data, validation data, test data or other data was used for these tests.</td>
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<tr>
<td>26</td>
<td>B.4.d</td>
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<td>For overall discrete variables, review type 3 chi-square tests, p-values, F tests and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests.</td>
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<tr>
<td>26</td>
<td>B.4.f</td>
<td></td>
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<td></td>
<td>For continuous variables, provide confidence intervals, chi-square tests, p-values and any other relevant and material test. Determine if model development data, validation data, test data or other data was used for these tests.</td>
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<tr>
<td>27</td>
<td>B.4.g</td>
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<td></td>
<td>Obtain a description how the model was tested for stability over time.</td>
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</table>

This comment appears in sections A.2.e and A.3.a. We suggest removing it from A.2.e as it is not related to the issue of redundancy between modeled losses and historical claims.

The term “data mining” is used without definition. We suggest replacing with: “The modeler should comment on the use of automated feature selection algorithms to choose predictor variables, and explain how potential overfitting which can arise from these techniques was addressed.”

Replace “determine” with “determined.”

The “and” suggests that the best practice is to review not only multiple but every possible test of significance. We believe this unnecessary and impractical, and suggest that the information element should be reworded to “review the appropriate parameter values and relevant tests of significance, such as confidence intervals, chi-square tests, p-values, or F tests.”

Examples of how a modeler would perform such tests could help clarify what is meant by “stability over time.” Is this...
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<tbody>
<tr>
<td>28</td>
<td>B.5.b</td>
<td>It is expected that there should be improvement in the Gini coefficient. This element seems to suggest that the Gini coefficient is a “gold standard” for model selection. We suggest a clarification that the choice of a final model may be based on other technical measures of model performance, as well as business considerations.</td>
</tr>
<tr>
<td>31</td>
<td>C.4.c</td>
<td>A more granular rating plan implies that the insurer had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications. A more granular rating plan may also arise if the insurer interpolates factors for a continuous variable that was binned into a discrete variable for modeling purposes.</td>
</tr>
<tr>
<td>32</td>
<td>C.7.a</td>
<td>Obtain a listing of the top five rating variables that contribute the most to large swings in premium, both as increases and decreases. The comments do not provide much guidance on how an insurer or regulator would determine these variables in practice. An example would be helpful.</td>
</tr>
<tr>
<td>32</td>
<td>C.7.c</td>
<td>For the proposed filing, obtain the impacts on expiring policies and describe the process used by management, if any, to mitigate those impacts. Item C.7.c refers to “expiring policies” and item C.7.d refer to “renewal business (created by renewing the current book of business)”. Are these referring to the same thing (the insurance book of business)? If so it would be clearer to use consistent terminology. If not, please provide a comment that clarifies the difference between the two.</td>
</tr>
<tr>
<td>33</td>
<td>C.7.d</td>
<td>Obtain a rate disruption/disco location analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by renewing the current book of business), and sufficient information to explain the disruptions to individual consumers. It is not clear what it required for “sufficient information to explain the disruptions to individual consumers.” Since this is a Level 2 item, examples would be helpful for insurers that seek speed to market. Does the example analysis in the Appendix provide “sufficient information to explain the disruptions to individual consumers,” or is more required? Also “Appendix C” should be changed to “Appendix D.”</td>
</tr>
<tr>
<td>33</td>
<td>C.7.e</td>
<td>See Appendix C for an example of an exposure distribution. Revise “Appendix C” to “Appendix D.”</td>
</tr>
</tbody>
</table>
Ms. Kris DeFrain  
July 27, 2020  
Page 4 of 4 

CLOSING 

We appreciate the opportunity to comment on the exposure draft. Please feel free to reach out to me at (415) 394-3725 or peggy.brinkmann@milliman.com with any questions about the comments. 

Sincerely,  

Peggy Brinkmann  

Peggy Brinkmann, FCAS, MAAA, CSPA  
Principal & Consulting Actuary 

Nancy P. Watkins, FCAS, MAAA  
Principal & Consulting Actuary 

Cody Webber, FCAS, MAAA  
Principal & Consulting Actuary 

Greg Dejourn, FCAS, MAAA  
Consulting Actuary
July 27, 2020

NAIC Casualty Actuarial and Statistical (C) Task Force
c/o Kris DeFrain - kdefrain@naic.org
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: NAMIC Comments on CASTF’s Predictive Model White Paper – 6/12/2020 Exposure

Dear Chair and Members of the Task Force,

Please find included herein the following comments of the National Association of Mutual Insurance Companies (hereinafter “NAMIC”)1 regarding the June 12, 2020 exposure draft of the Casualty Actuarial and Statistical Task Force (CASTF) Regulatory Review of Predictive Models White Paper. NAMIC wishes to thank the task force for the ability to provide additional comments on the white paper as amended. As mentioned in previous comments, dealing with the concept of predictive modeling is an extremely important undertaking as it impacts industry and consumers. NAMIC is cognizant of the need to assure that there are appropriate parameters around predictive model usage to ensure appropriate implementation.

Throughout this more than year and one-half process, there have been many revisions and detailed analysis concerning the paper contents and comments submitted. NAMIC wishes to thank CASTF for its thorough and granular review of the submitted comments and its substantive review and response to each aspect of the submissions. The work of CASTF has been exemplary from a transparency and responsiveness viewpoint.

Woven into this discussion is also the need to recognize the current national discussion of race and discrimination that has rightfully permeated public discourse. Additionally, with the ongoing COVID-19 pandemic causing widespread loss to the world, CASTF has no doubt been mindful of these events and wants to center discussion on being responsive to consumer and regulatory concerns. NAMIC is firmly against intentional and unfair discrimination against any protected class and adamantly supports any efforts to eliminate such conduct. We believe that current regulatory authority is more than ample in assisting regulators in performing their required duties under the law but understand and appreciate the need to explore further.

1NAMIC membership includes more than 1,400 member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies write $278 billion in annual premiums. Our members account for 58 percent of homeowners, 44 percent of automobile, and 30 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
NAMIC also firmly supports risk-based pricing for insurance products that use facially neutral rating factors to objectively base pricing on a person’s correlated risk of future loss. This has been the insurance dynamic for many years. These discussions should and will continue and we are confident that common ground can be found in these areas with further elucidation.

The task force is charged with producing a white paper that helps provide guidelines and parameters to rate and form filings concerning predictive model usage for homeowner and auto personal lines insurance. We understand that this work is nearing its end and are mindful of the Chair’s admonition not to continue to re-visit prior comments. Therefore we would respectfully like to limit our comments to concerns with the new exposure draft and only very briefly note that some of our concerns from the beginning continue through the current draft so as to avoid any misinterpretation that we no longer believe they are issues that should be addressed.

First of all, we appreciate that there have been many positive changes to the paper such as dividing the informational elements into categories of need, removing extraneous or redundant elements, and attempting to clarify or remove some potentially problematic terminology. CASTF has also endeavored to remove issues from the paper that are beyond its scope and list topics for future discourse. These are positive and again we want to thank CASTF for the effort in this regard.

However, we would recommend additional edits to make the paper the best product for review and usage by the states in their respective roles and duties. NAMIC strongly supports clear and fair regulatory guidance that protects consumers and provides a level playing field for all participants.

With those principles in mind, we are concerned that the use of “rational explanation” does not clear up the issue of correlation versus causation. In fact, in the explanatory notes in information element B.3.d, it states “[t]he explanation should go beyond demonstrating correlation.” It goes on further to state that “[i]f no rational explanation can be provided; greater scrutiny may be appropriate.” This interjects a highly subjective standard and moves away from traditional actuarial justification based upon correlation. The paper goes on to state in C.2.a, that a narrative should include “a rational relationship to cost.” Finally, in the “Rational Explanation” definition in the Glossary of Terms the paper states – “A ‘rational explanation’ refers to a plausible narrative connecting the variable and/or treatment in question with real-world circumstances or behaviors that contribute to the risk of insurance loss in a manner that is readily understandable to a consumer or other educated layperson. A “rational explanation” does not require strict proof of causality but should establish a sufficient degree of confidence that the variable and/or treatment selected are not obscure, irrelevant, or arbitrary.”

The use of rational explanation is still a move to a heightened standard of actuarial justification from existing law. Rates must be adequate, not excessive, or unfairly discriminatory according to state laws across the country. Actuarial soundness is dependent upon correlation to loss. We appreciate that the paper stops short of recommending a causality standard, an impossible standard where there must be absolute linkage between a variable and loss (creating an expectation that insurers
accurately and with absolute precision predict the future). A rational explanation, utilizing the provided definition, does not protect against subjective interpretation and ambiguity and therefore does not meet the goal of providing clear regulatory guidance. Therefore, we respectfully would submit that the statements concerning rational relationship and the movement beyond correlation be removed, or at least moved to the list of issues for further consideration.

Mindful of the Chair’s admonition, we will only briefly touch upon concerns that we have previously raised but remain. In this regard, NAMIC would highlight among others:

- The prescriptive nature of the document is more akin to a model law or regulation and therefore should proceed in that fashion as opposed to a white paper;
- The remaining information elements (especially categories 1 and 2) still may cause a significant compliance burden, potentially slowing speed to market and ultimately stifling innovation;
- Broad terminology such as “improve” the rating plan or make the rating plan “fairer” can mean many different things to different people. Such words are not necessary to carry out the intent of the paper and may be creating a new standard;
- The sharing of proprietary models could cause irreparable harm to insurers’ research and development of suitable products (we appreciate the added language on this issue, but it is still unclear how this filing information will be utilized and potentially shared inside NAIC and with the states); and
- The need for the inclusion of robust confidentiality protections for proprietary information by regulators.2

Finally, and in summary, we mention these items not to be repetitive or unmindful of the concerns of CASTF, but to emphasize that the eventual output of NAIC and CASTF may be utilized or interpreted improperly which we are certain is not the intent. However, the paper cannot be summarily characterized as merely guidance or best practices that states can ignore. We believe that NAIC documents may be utilized in litigation or in administrative reviews to inappropriately apply standards that are not found in law. NAIC’s actions carry a great deal of weight in the public domain which is why NAMIC remains so focused on tethering NAIC work products - including aspirational products - to existing authority lest confusion develop.

NAMIC wants to thank the task force for its diligent and thorough process, the ability to respond to various drafts, and looks forward to providing continued input and finding common ground in this endeavor. We believe with a few, but significant surgical corrections the document can provide its intended goal without sacrificing the clarity and direction it intends to provide.

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2 NAMIC collaborated on a white paper concerning the CASTF white paper entitled, The State Rating Statutes and Constitutional Policymaking: Causation and Disparate Impact Standards in NAIC’s Draft White Paper, Shapo, 2020, that discusses these and other issues, although there have been updates to the CASTF paper since publication. See https://www.namic.org/pdf/publicpolicy/200309_castf_issuanalysis_final.pdf.
Sincerely,

Andrew Pauley, CPCU
Government Affairs Counsel
National Association of Mutual Insurance Companies (NAMIC)
July 27, 2020

Kris DeFrain, FCAS, MAAA, CPCU
Director, Research and Actuarial Services
National Association of Insurance Commissioners

Sent via email: kdefrain@naic.org


Pinnacle Actuarial Resources, Inc. (Pinnacle) is pleased to have the opportunity to provide the following comments in regards to National Association of Insurance Commissioner’s (NAIC) Casualty Actuarial and Statistical Task Force (CASTF) second draft of the Regulatory Review of Predictive Models White Paper.

Below are specific comments regarding the second draft of the white paper.

1. Page 3: The first bullet in the description of the GLM states that the target variable follows a probability distribution from the exponential family, but a GLM does not need to be from the exponential family. There are several different distribution family options for a GLM. The phrase “from the exponential family” should be deleted from the bullet.

2. Page 12: “Provide guidance for regulators to determine that individual input characteristics to a model or a sub-model, as well as associated relativities, are not unfairly discriminatory or a “proxy for a protected class.”

The only way this can be done definitively is by either having insurers collect this information or requiring insurance companies to provide detailed data to regulators and letting them add the protected data. Other approaches without having access to actual protected data will have statistical issues.

Commitment Beyond Numbers

The phrase “disparate impact” is used often, but is not really defined well anywhere. It will be important for the NAIC to be clear in defining what disparate impact really means. A definition of “disparate impact” should be added to the paper.

4. Page 12: “Provide guidance for regulators that seek a causal or rational explanation why a rating variable is correlated to expected loss or expense, and why that correlation is consistent with the expected direction of the relationship.”

Page 24 (B.3.d): “Obtain a rational explanation for why an increase in each predictor variable should increase or decrease frequency, severity, loss costs, expenses, or any element or characteristic being predicted.”

These items introduce very subjective criteria. A regulator can say that the explanation does not meet the standard or is not reasonable, and does not provide any real recourse for the insurance company. What options will an insurance company have if a regulator thinks a company explanation is not reasonable?

It can be difficult to prove causation for a correlated variable. It is going to be nearly impossible to define what is acceptable in a clear manner.

5. Page 19 (A.3.c): “Ask for aggregated data (one data set of pre-adjusted/scrubbed data and one data set of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data.”

The two data sets being described here are not aggregate data, but more granular data. “Aggregated” should be removed from the statement.

6. Page 34: “In the filed rating plan, be aware of any non-insurance data used as input to the model (customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors.”

What is meant by non-insurance data? Technically, an MVR could be considered as non-insurance data. Does “non-insurance data” mean data external to the insurance company? Non-insurance data should be defined in the paper.
The comments above are the collected comments of the consultants employed or affiliated with Pinnacle. If you have any questions regarding our comments, please contact Laura Maxwell, Pinnacle’s Professional Standards Officer, at lmaxwell@pinnacleactuaries.com.

Sincerely,

Laura A. Maxwell, FCAS, MAAA, CSPA
Senior Consulting Actuary
Kris DeFrain, FCAS, MAAA, CPCU
Director of Research and Actuarial Science
National Association of Insurance Commissioners (NAIC) Central Office
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

re: 6/12/20 Draft White Paper on Best Practices

Dear Ms. DeFrain,

Insurance Services Office, Inc. (ISO) is a countrywide licensed rating/advisory organization serving the property/casualty market. We have extensive experience and expertise in the development of advisory insurance pricing tools including prospective loss costs, rating plans and predictive analytics, including related regulatory issues.

ISO appreciates the opportunity to provide comments on the latest Draft White Paper on Best Practices for Regulatory Review of Predictive Models as published by the CASTF in June 2020. We would like to offer several general comments on the purpose and direction of the best practices document, as well as some specific comments and questions on particular elements within the document.

CASTF has identified 79 information items that should be included in a review of GLM's. The 79 information items appear to go far beyond the aggregation of the current regulatory review practices. We are concerned that the current draft could potentially have the unintended effect of stifling innovation. Given the extensive amount of information being requested some filers may decide that the burden of proof in supporting a GLM is too great and maybe forgo the advantage of a GLM given the cost of complying with the draft best practices.

Here are our detailed comments on the draft.

- On page 3 of the draft, the following sentence refers to the wrong appendix: “Lastly, provided in this paper are glossary terms (Appendix BC) and references.”
• The following statement appears on page 4

“Though the list of information is long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate for a regulator (approximately 25%).”

Can you identify which items the CASTF thinks will require minimal analysis and which will require deeper analysis? This information will be useful to regulators who are concerned with speed to market and want to minimize the additional burden on insurers.

• On page 5 in “Confidentiality” section the following statement is made:

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

Can you provide the NAIC legal analysis that concluded that that confidential, proprietary and trade secret protection from the state would apply to NAIC staff that reviews a model?

• B.1.a states “Identify the type of model underlying the rate filing (e.g. Generalized Linear Model – GLM, decision tree, Bayesian Generalized Linear Model, Gradient-Boosting Machine, neural network, etc.). Understand the model’s role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.”

The information items are intended for GLMs used for personal auto and personal property, so it inconsistent that other model types are mentioned

• B.1.c addresses how validation (hold out) data is used. The GLM paper (Generalized Linear Models for Insurance Rating) that is on the CAS Exam 8 syllabus addresses the use of hold out data. On page 39 it says “Once a final model is chosen, however, we would then go back and rebuild it using all of the data, so that the parameter estimates would be at their most credible.”

• B.3.b asks for a list of predictor variables considered but not used in the final model and the rationale for their removal. While we appreciate that this is a level 4 item we don’t see how the variables not used in a model are relevant to reviewing the filed model. This would be analogous to asking for policy wording considered but not used in a filed policy form.
• C.7.g Obtain a means to calculate the rate charged a consumer.

While it is feasible for a filer to provide the algorithm with proper trade secret protection, it may not be feasible for a regulator to get all of the input data necessary to produce the model output. Credit and telematics models are examples of model types where the input data would not be readily available to the regulator,

• On page 43, the following definition of Home Insurance is given “Home insurance covers damage to the property, contents, and outstanding structures (if applicable), as well as loss of use, liability and medical coverage. The perils covered, the amount of insurance provided, and other policy characteristics are detailed in the policy contract.”

The definition should mention that the policy needs to cover a residential dwelling in order for it to be home insurance.

• Appendix B – while we didn’t do an exhaustive review of Appendix B on pages 36-40 of the draft we did notice some inconsistencies between Appendix B: Table 1 and Appendix B: Table 2 regarding the mapping of Best Practice Code and Information Element.

For example, Best Practice Code 2.a in Table 2 references Information Element A.1.a but Best Practice Code 2.a is missing from the mapping in A.1.a in Table 1

<table>
<thead>
<tr>
<th>A. Selecting Model Input</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1. Available Data Sources</td>
</tr>
<tr>
<td>A.1.a</td>
</tr>
</tbody>
</table>

2. Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output.

a. Obtain a clear understanding of how the selected predictive model was built.

2.a

b. Determine that the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values and outliers are handled.

Another example if inconsistent mappings is Appendix B: Table 1 C.9 and Appendix B: Table 2 4.a, 4.b, 4.c.

<table>
<thead>
<tr>
<th>C.9. Efficient and Effective Review of a Rate Filing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C.9.a</td>
<td>4.a</td>
</tr>
<tr>
<td>C.9.b</td>
<td>4.a</td>
</tr>
<tr>
<td>C.9.c</td>
<td>4.a, 4.b</td>
</tr>
</tbody>
</table>

4. Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.

<table>
<thead>
<tr>
<th>a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided they are in compliance with state laws, particularly prohibitions on unfair discrimination.</th>
<th>4.a</th>
<th>C.9.b, C.9.c</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Protect the confidentiality of filed predictive models and supporting information in accordance with state law.</td>
<td>4.b</td>
<td>C.9.a, C.9.b, C.9.c</td>
</tr>
<tr>
<td>c. Review predictive models in a timely manner to enable reasonable speed to market.</td>
<td>4.c</td>
<td>C.9.a, C.9.b, C.9.c</td>
</tr>
</tbody>
</table>

Respectfully Submitted,

Stephen C. Clarke, CPCU
SOA CASTF RESEARCH IN PROGRESS - August 2020

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial Weather Extremes - March 2020</td>
<td>Highlight observations for extreme weather across North America, Europe, Asia for March 2020</td>
<td>Complete: On SOA web site. ¹</td>
</tr>
<tr>
<td>Actuarial Weather Extremes - April 2020</td>
<td>Highlight observations for extreme weather across North America, Europe, Asia for April 2020</td>
<td>Complete: On SOA web site. ²</td>
</tr>
<tr>
<td>Actuarial Weather Extremes - May 2020</td>
<td>Highlight observations for extreme weather across North America, Europe, Asia for May 2020</td>
<td>Complete: On SOA web site. ³</td>
</tr>
<tr>
<td>Climate Change and Mortgage Credit Risk</td>
<td>Evaluate the impact and evolution of risk management due to changes in frequency, severity, and variety of weather-related catastrophes.</td>
<td>Complete: On SOA web site. ⁴</td>
</tr>
<tr>
<td>Exposure Bases for Use in Pricing Cyber Insurance</td>
<td>Consider the nature of cyber risk exposure, review cyber coverages currently available, and list candidate exposure measures for the identified coverages; considering suitability.</td>
<td>Complete: On SOA web site. ⁵</td>
</tr>
<tr>
<td>Quantification of Cyber Risk for Actuaries: An Economic-Functional Approach</td>
<td>Develop an economics-based risk analysis framework to help actuaries quantify cyber security risk into monetary value.</td>
<td>Complete: On SOA web site. ⁶</td>
</tr>
</tbody>
</table>

⁴ https://www.soa.org/resources/research-reports/2020/casf/weather-flood-report/
⁵ https://www.soa.org/resources/research-reports/2020/exposure-measures-cyber-insurance/
⁶ https://www.soa.org/resources/research-reports/2020/quantification-cyber-risk/

Practice Research

Exposure Measures for Pricing and Analyzing the Risks In Cyber Insurance

• Joint SOA / CAS research project on cyber insurance

Current Research

<table>
<thead>
<tr>
<th>Project</th>
<th>Status</th>
<th>Expected publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users guide to ESGs for P&amp;C companies</td>
<td>Publication imminent</td>
<td>August 2020</td>
</tr>
<tr>
<td>Individual reserving techniques</td>
<td>First draft has been reviewed</td>
<td>Q3 2020</td>
</tr>
<tr>
<td>The peer-to-peer insurance market</td>
<td>Work underway</td>
<td>Q4 2020</td>
</tr>
<tr>
<td>Uninsurable risk with a focus on BI</td>
<td>Work underway</td>
<td>Q3 2020</td>
</tr>
<tr>
<td>Demand for Microinsurance</td>
<td>Work underway</td>
<td>Q4 2020</td>
</tr>
<tr>
<td>Credibility for excess insurance layers</td>
<td>Work underway</td>
<td>Q2 2021</td>
</tr>
<tr>
<td>Flood models using public data</td>
<td>Work underway</td>
<td>August 2021</td>
</tr>
</tbody>
</table>

Future Research

The following projects are under development, but have not yet been submitted for approval to the CAS Executive Council.

<table>
<thead>
<tr>
<th>Project</th>
<th>Expected inception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wildfire</td>
<td>Q3 2020</td>
</tr>
<tr>
<td>Cannabis legislation and auto loss frequency (joint project with CIA)</td>
<td>Q3 2020</td>
</tr>
</tbody>
</table>

Recent PE

<table>
<thead>
<tr>
<th>Item</th>
<th>Type</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring meeting</td>
<td>Seminar</td>
<td>May 11-13</td>
</tr>
<tr>
<td>An introduction to Git and GitHub</td>
<td>Microlearning series</td>
<td>Released Q2 2020</td>
</tr>
<tr>
<td>Opioid Epidemic - Who Is Responsible?</td>
<td>Webinar</td>
<td>June 4</td>
</tr>
<tr>
<td>COVID-19 Panel - Short Term Solutions, Long Term Outlook</td>
<td>Webinar</td>
<td>June 18</td>
</tr>
<tr>
<td>Beyond the Build - Model Implementation and Monitoring</td>
<td>Webinar</td>
<td>July 23</td>
</tr>
<tr>
<td>Ratemaking, Product, and Modeling Virtual Seminar</td>
<td>Seminar</td>
<td>July 28-29</td>
</tr>
<tr>
<td>CAS Virtual Workshop - Python for Actuaries</td>
<td>Short course</td>
<td>July 15 – Aug 19</td>
</tr>
</tbody>
</table>

Upcoming PE

<table>
<thead>
<tr>
<th>Item</th>
<th>Type</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS and IIHS/HLID Webinar Series: The Drive to Automation</td>
<td>Webinar</td>
<td>August 6</td>
</tr>
<tr>
<td>CAS Webinar: Reserving with Machine Learning</td>
<td>Webinar</td>
<td>August 13</td>
</tr>
<tr>
<td>Virtual Casualty Loss Reserve Seminar (CLRS) &amp; Workshops</td>
<td>Seminar</td>
<td>Sep 15-17</td>
</tr>
<tr>
<td>CAS R for the P&amp;C Practitioner Bootcamp</td>
<td>Short course</td>
<td>Sep 21-30</td>
</tr>
<tr>
<td>2020 in Focus Virtual Seminar</td>
<td>Seminar</td>
<td>Oct. 20-22</td>
</tr>
</tbody>
</table>
SURPLUS LINES (C) TASK FORCE

Surplus Lines (C) Task Force Aug. 5, 2020, Minutes ................................................................. 8-432
Surplus Lines (C) Task Force 2021 Proposed Charges (Attachment One) ........................................ 8-435
Proposed Referral to the Blanks (E) Working Group to Add a New Schedule T – Part 3 to the
Property/Casualty (P/C) Blank (Attachment Two) ........................................................................ 8-436
Comment Letters Regarding Proposed Referral to the Blanks (E) Working Group to Add a New
Schedule T – Part 3 to the P/C Blank (Attachment Three) ............................................................. 8-440
The Surplus Lines (C) Task Force met via conference call Aug. 5, 2020. The following Task Force members participated:
James J. Donelon, Chair, and Stewart Guerin (LA); Larry D. Deiter, Vice Chair (SD); Lori K. Wing-Heier represented by David Phifer (AK); Alan McClain represented by William Lacy (AR); Ricardo Lara represented by Kim Hudson (CA); Michael Conway represented by Eric Fletcher (ID); Robert H. Muriel represented by Marcy Savage (IL); Vicki Schmidt represented by Heather Droge (KS); Sharon P. Clark represented by DJ Wasson (KY); Kathleen A. Birrane represented by Todd Switzer (MD); Mike Causey represented by Fred Fuller (NC); Barbara D. Richardson and Gennady Stolyarov (NV); Glen Mulready represented by Eli Snowbarger (OK); Raymond G. Farmer represented by Ryan Basnett (SC); Mike Kreidler represented by Jeff Baughman (WA); Jeff Rude and Donna Stewart (WY). Also participating was: Robert Wake (ME).

1. **Adopted its 2019 Fall National Meeting Minutes**

Mr. Fletcher made a motion, seconded by Mr. Baughman, to adopt the Task Force’s Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Surplus Lines (C) Task Force). The motion passed unanimously.

2. **Adopted the Report of the Surplus Lines (C) Working Group**

Mr. Guerin reported that since the 2019 Fall National Meeting, the Surplus Lines (C) Working Group met Dec. 18, 2019; March 10, 2020; and June 29, 2020, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.

During these meetings, the Working Group heard a summary of eight applications for admission to the Quarterly Listing of Alien Insurers. All eight of the applying companies were discussed, and seven applicants were admitted to the listing.

Mr. Guerin updated the Task Force that on May 6, NAIC staff sent out a COVID-19 survey to the quarterly listed insurers and syndicates. The survey addressed equity market impact, writings exposed to COVID-19 claims, and claims status. Mr. Guerin indicated that survey responses would be analyzed in conjunction with the annual renewal analysis that staff completes.

Mr. Kaumann made a motion, seconded by Mr. Hudson, to adopt the report of the Surplus Lines (C) Working Group. The motion passed unanimously.

3. **Adopted its 2021 Proposed Charges**

Commissioner Donelon stated that the 2021 proposed charges for the Task Force and the Surplus Lines (C) Working Group contain nonsubstantive changes compared to the 2020 charges.

Ms. Droge made a motion, seconded by Mr. Stolyarov, to adopt the Task Force’s 2021 proposed charges (Attachment One). The motion passed unanimously.

4. **Discussed Model #870**

Commissioner Donelon referenced a March 16 NAIC staff memorandum on the Nonadmitted Insurance Model Act (#870). He stated that Model #870 was last modified in 2002, and it has not been updated since the passage of the Nonadmitted and Reinsurance Reform Act (NRRA) in 2001. He asked for a discussion as to whether Model #870 should be reviewed and brought up to date with current standards. He instructed Andy Daleo (NAIC) to provide a summary of the memorandum and supporting materials.

Mr. Daleo stated that NAIC staff completed a cursory review of Model #870 in March 2020 that led to the topic’s inclusion on the agenda. He stated that Model #870 came into existence as a result of the compilation of three previous NAIC surplus lines models that date back to 1983: 1) the Unauthorized Insurers Model Act; 2) the Model Surplus Lines Law; and 3) the Model Nonadmitted Insurance Act. He indicated that Model #870 was adopted in the third quarter of 1994, and it has been enacted by 31 states.
Mr. Daleo stated that the most recent activity regarding Model #870 was Oct. 11, 2011, following the implementation of the NRRA. He indicated that Model #870 was not modified; however, a Nonadmitted Insurance Reform Sample Bulletin (Bulletin) was released to state insurance departments following its adoption by the Executive (EX) Committee and Plenary, and it was subsequently distributed to state insurance departments. He summarized that the Bulletin outlined the nationwide regulatory changes that affected the placement of nonadmitted insurance, and it included the scope of the NRRA, the implementation of the “Home State” policy, licensure requirements for brokers, diligent search requirements, and eligibility requirements for nonadmitted insurers.

Mr. Daleo commented that the Task Force should consider one of three options:

- **Model Law Request** – Direct staff to develop a model law request for consideration at the next national meeting.
- **Develop a Drafting Group** – The drafting group would produce a summary document that outlines the significant updates to modernize Model #870 and present a recommendation to the Task Force at a future national meeting.
- **No Action** – Do not amend Model #870 and rely on the Bulletin for guidance.

Mr. Stolyarov supported pursuing Model #870 amendments, with a caveat to limit revisions only to update the sections affected by the NRRA. He stated that most states have revised their statutes to conform to the NRRA, so whatever revisions are made to Model #870 should be of a nature that is compatible with the actions that the states have already taken.

Bob Woody (American Property Casualty Insurance Association—APCIA) stated that his members do not have any objections to updating Model #870 to conform with the standards included in the NRRA. However, he expressed reservations to a model law request before knowing the exact portions of Model #870 that would be changed. He said his members would be more comfortable with the option two to develop a drafting group.

Keri Kish (Wholesale & Specialty Insurance Association—WSIA) stated that most states have accepted the NRRA in regulations. She said only two states have not accepted the NRRA, but they have issued declarations and bulletins and made comments that they recognize that the NRRA supersedes state laws. She offered her organization’s assistance in providing information as to what the states are currently doing from a regulatory perspective.

Jeff Klein (McIntyre & Lemon PPLC) agreed that option two to develop a drafting group would best conform to the consensus of opinions previously expressed. He said an outline of the areas of Model #870 to be amended would be appropriate.

Commissioner Donelon indicated that he also favors a drafting group. He asked Task Force members their preference on the three options.

Mr. Hudson, Ms. Droge, Mr. Baughman and Mr. Kelly all voiced support for the development of a drafting group. Commissioner Donelon said that their support constituted consensus, and he will discuss with Mr. Daleo and Director Deiter on how to proceed.

5. **Discussed a Blanks Proposal Regarding Home State Direct Premiums Written**

Commissioner Donelon reminded the Task Force that this proposal regarding the reporting of “Home State” direct premiums written was introduced at the 2019 Fall National Meeting, where discussion was halted due to time constraints. He stated that he would like to come to a consensus during this meeting on whether to refer the proposal (Attachment Two) to the Blanks (E) Working Group. He stated that if a referral is made to the Working Group, all technical details should be resolved by the Task Force, explaining that the Working Group will not discuss the technical issues.

Commissioner Donelon summarized that the proposal was exposed for a 45-day public comment period ending Oct. 10, 2019. He stated that comment letters were received from three interested parties (Attachment Three), which were discussed at the 2019 Fall National Meeting. Further, he stated that several states commented that this blanks proposal would provide a means for an insurance department to arrive at an estimate of surplus lines premium taxes and allow the states to better reconcile taxes collected.

Commissioner Donelon agreed that the proposal is not a perfect solution for the problem of reconciling surplus lines premiums taxes. He said it has been several years since Louisiana last conducted an audit of a surplus lines broker. However, audits performed pre- and post-NRRA discovered only a slight difference between what was reported by the broker compared to the audit.
Director Deiter said South Dakota utilizes the Florida Surplus Lines Service Office to track its nonadmitted premiums, but he understands that this may not be a viable option for some states with limited resources.

Mr. Wake said Maine’s tax department sought his advice on this issue last year because it thought the proposed Schedule T section would benefit Maine’s tax collection efforts. He commented that the big question relates to the degree of burden this would be for the companies. He said the industry analysis of surplus lines taxes prepared by the WSIA showed a minimal variance between their best aggregate guess and the aggregate guess provided by current reporting. However, he stated that the important point was not in the aggregate variance but what was occurring in each state.

Commissioner Donelon agreed, but he added that he did not see how the proposal would come close to solving the problem of creating a more efficient tax system for surplus lines.

Mr. Stolyarov said he is concerned that the proposal may cause confusion in how it would address the distinction between surplus lines premium and independently procured nonadmitted insurance. He indicated that in Nevada, surplus lines premiums are reported to the Nevada Surplus Lines Association (NSLA), whereas independently procured premiums are reported to the Nevada Department of Taxation. He said he is concerned that the proposed reporting by insurers might combine the two types of nonadmitted insurance premiums.

Mr. Wake stated that the industry had not persuaded him that there is not a problem, but industry had persuaded him that this proposal does not appear to be a solution worth pursuing.

John Meetz (WSIA) summarized the WSIA’s analysis of surplus lines premium taxes. He offered that there will always be differences between premium reported by carriers and the taxable transaction revenue reported by brokers. He stated that those differences will be caused by the timing of reporting, additional fees collected as part of the transaction, non-taxable premiums that brokers have no incentive to report, and the effect of cancellations and mid-term endorsements. Based on these differences, he said the reporting by carriers of “Home State” surplus lines premiums would be burdensome to carriers, state insurance regulators, and brokers.

Ms. Stewart suggested that if the Schedule T proposal is implemented, the Task Force would consider drafting a memorandum to the states noting the information that would be available in the new supplement and explaining some of the differences between “Home State” premium reporting by carriers and the surplus lines reporting by brokers.

Mr. Woody added that a joint trades letter submitted by the APCIA, the National Association of Mutual Insurance Companies (NAMIC) and the Council of Insurance Agents & Brokers (CIAB) opposes the blanks proposal.

Commissioner Donelon stated that based on the comments made, there does not appear to be consensus in favor of advancing the blanks proposal.

Mr. Hudson made a motion, seconded by Director Deiter, to table the blanks proposal. The motion passed unanimously.

Having no further business, the Surplus Lines (C) Task Force adjourned.
SURPLUS LINES (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

NAIC Support Staff: Andy Daleo/Robert Schump
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 7/12/2019

CONTACT PERSON: Andy Daleo/Bob Schump – NAIC staff

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ON BEHALF OF: Surplus Lines (C) Working Group

NAME: Stewart Guerin

TITLE: Chair of Surplus Lines (C) Working Group

AFFILIATION: Louisiana Department of Insurance

ADDRESS: ___________________________ ___________________________ ___________________________

FOR NAIC USE ONLY

Agenda Item # ____________
Year 2020
Changes to Existing Reporting [ ]
New Reporting Requirement [ X ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) ___________________________

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT [ X ] INSTRUCTIONS BLANK
[ ] QUARTERLY STATEMENT [ X ] SEPARATE ACCOUNTS [ X ] CROSSCHECKS
[ ] LIFE, ACCIDENT & HEALTH/FRATERNAL [ ] PROTECTED CELL [ ] TITLE
[ X ] PROPERTY/CASUALTY [ ] HEALTH (LIFE SUPPLEMENT) [ ] OTHER ___________________________

Anticipated Effective Date: 2020 Annual

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a new Schedule T – Part 3 to the Property/Casualty blank for the purpose of collecting direct premiums written data allocated by “home State.”

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The intent is to provide a basis for state regulators to reconcile broker reported surplus lines premium with company provided information to better ensure that states are receiving the proper amount of surplus lines premium taxes. Premium taxes on surplus lines premiums are based on the total policy premium and paid by surplus lines brokers solely to the “home State” of the insured as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010 of the Dodd-Frank Wall Street Reform and Consumer Protection Act. Currently, the only resource available to the state for tax reconciliation is Schedule T – Exhibit of Premiums Written, which allocates premium by geographic concentration of risk. Collecting premium information within the annual blank for “Home State Direct Premiums Written” provides the state a starting point for surplus lines premium tax reconciliation. Throughout the year NAIC staff receives frequent inquiries regarding assistance with surplus lines premium tax reconciliation and cannot provide a resource to the state. This blanks proposal will provide significant value to the states/territories regarding surplus lines tax reconciliation.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: __________________________________________

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

**SCHEDULE T – PART 3**

**EXHIBIT OF PREMIUMS WRITTEN**

**ALLOCATED BY HOME STATES AND TERRITORIES**

This schedule is intended to report surplus lines premiums written to a state or territory of the insured that conforms to the definition of “home State” as provided in the Dodd-Frank Wall Street Reform and Consumer Protection Act. Allocation of surplus lines premiums reported on this schedule should be based on the “home State” of the insured, regardless of jurisdiction where the risks are located.

All U.S. surplus lines business must be allocated to the “home State” of the insured, regardless of license status or concentration of risk.

<table>
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<th>Column 1</th>
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The following is provided to illustrate appropriate allocation bases for surplus lines of business:

- All surplus lines policy premiums are to be allocated to the appropriate state that conforms to the “home State” definition as provided in Section 527 of the Nonadmitted and Reinsurance Reform Act within the Dodd-Frank Wall Street Reform and Consumer Protection Act:

**Definition:**

(6)HOME STATE.

(A) IN GENERAL.—Except as provided in subparagraph (B), the term “home State” means, with respect to an insured—

(i) the State in which an insured maintains its principal place of business or, in the case of an individual, the individual’s principal residence; or

(ii) if 100 percent of the insured risk is located out the State referred to in clause (i), the State to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated.
(B) AFFILIATED GROUPS.—If more than 1 insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term “home State” means the home State, as determined pursuant to subparagraph (A), of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

Column 3  –  Percentage of Total Home State Direct Premiums Written

Amount represents the percentage of the individual line items in Column 2 to the Total Home State Direct Premiums Written amount presented in Column 2, Line 59.

Line 59 should equal 100%.

The allocation method established by the reporting entity in compliance with these instructions and the instructions of the domiciliary state should be consistently applied to all policies and reporting periods.

The data reported in Schedule T – Part 3 of the annual statement may or may not be used for the calculation of the amount of premium tax due to a state/jurisdiction. Individual states/jurisdictions may require a separate schedule to support premium tax calculations.

NOTE: Existing state laws and regulations need to be considered when applying these instructions.

Footnote (a):

Provide the total of each active status code in Column 1. The sum of all the counts of all active status codes should equal 57.
## ANNUAL STATEMENT BLANK – PROPERTY

### SCHEDULE T – PART 3

**EXHIBIT OF SURPLUS LINES PREMIUMS WRITTEN**

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(a) Active Status counts:

L – Licensed or Chartered – Licensed insurance carrier or domiciled RRG
B – Registered – Non-domiciled RRGs
E – Eligible – Reporting entities eligible or approval to write surplus lines in the state (other than their state of domicile – See DSLI)
Q – Qualified – Qualified or accredited reinsurer
D – Domestic Surplus Lines Insurer (DSLIs) – Reporting entities authorized to write surplus lines in the state of domicile
N – None of the above – Not allowed to write business in the state

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Dear Commissioners Donelon and Deiter,

Thank you for the opportunity to comment on the proposal to revise the manner by which surplus lines carriers report their annual premium in Schedule T. We would like to express our opposition for the proposal and our agreement with WSIA that the proposal will not achieve the goals of the task force for the reasons outlined in the WSIA letter dated March 12, 2020. We would like to reiterate the following points:

- The differences between carrier Schedule T reporting and surplus lines broker tax filings are too numerous to facilitate an accurate reconciliation of specific surplus lines broker taxes, even after accounting for home state premium.
- WSIA’s data analysis conclusively shows that national surplus lines tax revenues are virtually identical to expected revenues based upon carrier reporting.
- The clarity provided by the Nonadmitted and Reinsurance Reform Act of 2010 has facilitated a tremendous increase in surplus lines tax compliance.

The nonadmitted and surplus lines industry stands ready to assist the NAIC and its members where issues of surplus lines tax compliance exist but for these reasons, we urge the committee to oppose the proposed changes to the Schedule T.

Sincerely,

Robert W. Woody
Vice President & Counsel
American Property Casualty Insurance Association (APCIA)

Tony Cotto
Director, Auto and Underwriting Policy
National Association of Mutual Insurance Companies (NAMIC)

LeeAnn Goheen
NAIC/State Legislative & Regulatory Senior Advisor
Council of Insurance Agents and Brokers
SUBJECT: Surplus Lines Task Force Proposal Regarding Schedule T Modification

Dear Commissioner Donelon:

On behalf of the Excess Line Association of New York (“ELANY”), a nonprofit industry advisory association charged with facilitating and encouraging compliance with the excess line law of New York, thank you for the opportunity to comment on the Surplus Lines Task Force’s proposal regarding home state direct premiums written. ELANY supports uniformity in regulation whenever possible and practical. ELANY supported passage of the NRRA and works diligently to educate excess and surplus line brokers regarding the NRRA’s requirements.

After careful study we respectfully submit the Schedule T proposed modifications will produce duplicative, incomplete and inconsistent information, confuse insurers and prove to be too flawed to be useful for regulators. Due to the practical reasons discussed below, ELANY urges the Task Force to reject its adoption.

1. E&S brokers are licensees charged with the legal duty to determine the insured’s Home State and pay taxes accordingly. E&S insurers have no such legal obligation.
2. Many E&S insurers do not currently collect this data. A significant volume of business is written through brokers with binding authorities which allows insurers to reduce costs and not duplicate broker data collection.
3. 25% of New York E&S risks are written by alien insurer markets. These insurers are not required to produce Schedule T. To the extent, state by state, data is reported by Alien insurers at all, there is no requirement to segment it by Home State. As such the proposal will place a burden on U.S. insurers that is not placed on alien insurers with whom they compete. If adopted as proposed, 25% of the data sought will not be reported.
4. If the proposal is adopted, it is likely the insurers will obtain Home State information from the brokers which will mirror the information reported by brokers, making the new report of little value.
5. To the extent the proposal is intended to impose a duty on insurers to determine Home State independently, discrepancies are likely to occur. What happens then? Will brokers...
be audited against data provided by insurers which had no legal duty to determine Home State in the first place?

6. When determining Home State for an affiliated group, the broker is charged to determine home state by choosing the affiliate “to which the largest percentage of premium is attributable under the policy.” Is that determination based on “insured values” or perhaps “premiums based on rates charged by insured location” or some other criteria? If the broker and insurer choose different criteria, data discrepancies will occur. Furthermore, the states have adopted non uniform approaches to the reporting and taxation of purchasing group business and other master policy type transactions. This will create further complexity and discrepancies.

7. Requiring E&S insurers to attest to the accuracy of a new Schedule T, the data for which is not linked to statutory accounting nor financial analysis appears to go beyond the scope of what the attestation is intended to accomplish.

8. One last concern interested parties are compelled to raise, respectfully, is whether the proposal is within the province of the NAIC to require. Industry representatives are concerned about the direction of designing part of the Statutory Annual Statement primarily for tax reconciliation purposes. The long accepted purpose of the Statutory Annual Statement is financial analysis and helping regulators understand the financial performance, stability and solvency of an insurer. ELANY respectfully suggests that state tax revenue reconciliation is quite different from financial analysis and is inconsistent with the general understanding state policymakers may have as to the Statutory Annual Statement’s purpose. Is it the NAIC’s intent to make this exhibit an accreditation standard?

In light of the above, ELANY maintains that the proposed exhibit will not accomplish its stated goal and will create confusion among the states and marketplace participants. We therefore urge the Task Force to reject the proposed exhibit and to instead permit the NRRA to function as intended with the duty to select and report Home State squarely on the broker. If there is anything else you would like from ELANY, we will be happy to offer additional information.

Sincerely,

Daniel F. Maher
Executive Director
Excess Line Association of New York
One Exchange Plaza/55 Broadway, 29th Floor
New York, NY 10006-3728
Direct Line: (646) 292-5555
dmaher@elany.org | www.elany.org
March 12, 2020

Commissioner Jim Donelon  Commissioner Al Redmer, Jr.
Chair, NAIC Surplus Lines (C) Task Force  Vice Chair, NAIC Surplus Lines (C) Task Force

Sent in care of Andy Daleo, adaleo@naic.org

Dear Commissioners Donelon and Redmer,

Thank you for the opportunity to follow-up with additional details from the Task Force’s December 7, 2019 discussion of the proposal to revise the manner by which surplus lines carriers report their annual premium in Schedule T. Based on that discussion, we further developed our commentary to include specific illustrations that we believe can be helpful as the Task Force continues to consider this proposal.

Since the Austin meeting, we have analyzed surplus lines tax revenue data from Business Insurance (collected annually through a survey of state regulators and stamping offices) with surplus lines premium data from the NAIC Insurance Department Resources Report. Based on our analysis and comparison of these data sources, we expanded the comments of our October 4, 2019 letter to highlight three more specific comments with examples and illustrations, which follow in the attached materials.

We reiterate that we understand the motivation for states to reconcile carrier and broker premium reports. However, as you will see in the attached materials, we find that, when comparing taxes collected and premium reported on a nationwide basis, the variances are small considering the known and valid differences between carrier reporting and broker tax requirements. We believe this analysis illustrates that surplus lines premium taxes are being appropriately remitted and collected across the nation. Therefore, before implementing an imperfect, potentially time-consuming and costly reconciliation process, we encourage the NAIC and the Task Force to consider conducting similar analysis as that outlined in the attached.

We look forward to discussing our analysis with the Task Force on the April 9 conference call. If you or other members have questions or need any additional information, we are happy to assist in any way.

Sincerely,

Brady R. Kelley  Keri Kish  John Meetz
Executive Director  Director of Government Relations  Senior State Relations Manager
Comment One: A comparison of surplus lines premium tax through the comparison of premium reported by surplus lines carriers on the NAIC Schedule T to the premium reported and taxes remitted by surplus lines brokers will not result in an accurate or conclusive reconciliation.

Examples: Exhibit I illustrates that comparing broker tax reports to carrier premium reports will often not reconcile based on a variety of factors that we outlined in our October 4, 2019 comment letter (Attachment A), the most common of which include:

- **Fees.** Additional fees and costs beyond the carrier’s base premium are reported by the broker only and will not be reflected in the premium reported by a carrier. Some states require that surplus lines premium tax be paid on these fees as well, such that the tax base for the broker will be different than the premium reported by the carrier. Broker fee reporting is denoted by line 5 of Exhibit I.

- **Non-taxable premium.** Not all premium is taxable in some states. For example, it is not unusual for certain risks, such as inland marine, boiler & machinery, native lands and interstate commerce related railways, to be exempt from taxation. These are risks that carriers would report as premium but would not be reflected in broker tax filings, further distinguishing the carrier’s premium base from the broker’s tax base and skewing any reconciliation thereof. Non-taxable premium is denoted in line 3 of Exhibit I.

- **Home state.** It is the statutory responsibility of the surplus lines licensee to determine and report the home state of the insured, and a carrier may not always underwrite and report premium based on the same determination factors. Most carrier underwriting and reporting systems are designed based upon the physical location of the risk and underwriting requirements in those particular physical locations or states, such that carrier reporting by home state will require significant system and process changes. Such changes seem unwarranted when their purpose will not achieve the intended result for the reasons described herein. Brokers determine the home state of the insured for multi-state policies, which is denoted in line 1 of Exhibit I, whereas the carriers allocate and report premium based on the location of the risk as denoted in lines 1 and 2.

- **Return premium, midterm endorsements and cancellations.** Policies can change throughout the year and the original premium reported by a carrier may differ based on the broker reporting period for these factors. This is very common and another key reason why reconciliation will be ineffective. Return premium and the discrepancy in reporting timeframes between the broker and the carrier are denoted in lines 6 and 7 of Exhibit I.

In addition to those variables illustrated in Exhibit I, the following factors could also provide discrepancies between broker and carrier reporting:

- **Independent Procurement.** Some states exempt taxation or have a different tax requirement or structure if a consumer is allowed to procure policies without an insurance producer. These premiums are reported by carriers but there would be no record of the transaction from a broker to cross reference. Again, these would skew any reconciliation results.

- **Reporting.** States have different reporting and payment dates for surplus lines brokers, whereas all surplus lines carriers report their quarterly and annual premium at the same NAIC-required intervals.

Conclusion: Exhibit I illustrates known variances based on the difference in how surplus lines carriers report premium and how surplus lines brokers report and remit taxes. These differences are based on each parties’ regulatory responsibilities as well as underwriting standards and industry protocols. Even though both brokers and carriers each report premium, there are differences between the premium received and reported by the carrier in its Annual Statement and the premium (or tax basis) and related taxes collected and reported by the surplus lines broker. Carriers must establish premium based on the underwriting characteristics of the entire risk, which may be in many locations,
and only a small portion may be in the insured’s home state. However, the broker must determine the home state of the insured (i.e., where the premium tax is to be paid). The basis upon which the broker must calculate and remit tax to the state is different from the premium reported by the carrier for the reasons illustrated in Exhibit I. Therefore, if carriers reported premium data based upon the “home state,” the carrier and broker reports would still not be an “apples to apples” comparison. Conducting a reconciliation based on two irreconcilable bases will result in significant administrative investments by regulators, carriers and brokers. As is illustrated in Exhibit II, such administrative investments are unwarranted when there is no apparent gap in tax revenues nationwide.

The known variances illustrated in Exhibit I are for one surplus lines insurance policy. Should a state try to reconcile the total difference between carrier and broker reported premium, the illustration would grow much more complex as you factor in the volume of surplus lines policies with such variances. Add to that the number of surplus lines brokers and surplus lines carriers doing business in each state, parties for which there is no one-to-one direct reporting within the Annual Statement, and the reconciliation grows more complex. Our concern is that regulators will not know if the reconciling variance is one policy, thousands of policies, one broker and carrier, or multiple brokers and carriers. In fact, we anticipate the known variances to apply to a high volume of policies and nearly all brokers and carriers, which makes the reconciliation process administratively unworkable.

While we understand the motivation for states to seek a reconciliation method, we are concerned that the proposal installs sweeping changes that will lead to a lengthy reconciliation process for a relatively small number of jurisdictions. States with surplus lines stamping offices that serve as intermediaries between surplus lines brokers and state tax collection entities have more certainty that all necessary surplus lines tax revenues are being collected. These states collectively represent 64% of all surplus lines premium written in the U.S. in 2018 according to the NAIC Insurance Department Resources Report.

Finally, we do not believe that changing the carrier’s Schedule T reporting basis will result in a starting point for states. Rather, the proposal will facilitate significant work and cost to reconcile valid differences in carrier and broker reporting. It facilitates an extensive and costly process, impacting all parties with no benefit or gain in the end.
### Scenario A (Policy fees are not taxable)

**4% Tax**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Totals</td>
<td>Totals</td>
</tr>
<tr>
<td>Taxable premium located in home state</td>
<td>$1,000,000</td>
<td>$1,011,000</td>
</tr>
<tr>
<td>Taxable premium located outside home state</td>
<td>11,000</td>
<td>1) Taxable premium reported to home state</td>
</tr>
<tr>
<td>Tax-exempt premium</td>
<td>10,200</td>
<td>2) Taxable premium reported to other states</td>
</tr>
<tr>
<td>Endorsement premium (taxable in 2020)(^2)</td>
<td>10,030</td>
<td>3) Tax-exempt premium</td>
</tr>
<tr>
<td>Policy fees</td>
<td>10,005</td>
<td>4) Endorsement premium (taxable in 2020)(^2)</td>
</tr>
<tr>
<td>Return 2018 premium(^3)</td>
<td>(100,000)</td>
<td>5) Policy fees</td>
</tr>
<tr>
<td>Return 2019 premium(^4)</td>
<td>(50,000)</td>
<td>6) Return 2018 premium(^3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7) Return 2019 premium(^4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8) Broker's tax basis reported to home state</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 In this example, the carrier will credit $970,554 of premium to the home state and $10,676 of premium to other states within its 2019 Schedule T. This is based upon the allocation of taxable, tax-exempt, endorsement and return premium proportionately between the home state and other states in which the risk physically located.

2 If policy is endorsed and premium is paid in 2019, premium may be reported by the carrier in 2019 but not reported by the broker until tax is due in 2020.

3 If a policy is cancelled in 2018, premium will be returned to the consumer by the broker. However, the carrier and broker may report returned premium in different quarters or calendar years.

4 If a policy is cancelled in 2019, premium will be returned to the consumer by the broker. Again, the timing of carrier and broker reporting may vary.
Comment Two: Comparing carrier premium reporting within Schedule T to broker premium and tax reports will not result in substantial changes to surplus lines tax revenues for any of the states.

Example: Comparing surplus lines tax revenue data from Business Insurance (collected annually through a survey of state regulators and stamping offices) with NAIC Insurance Department Resource Report (IDRR) data (collected primarily from NAIC Schedule T filings) indicates miniscule variances in surplus lines taxes collected – variances which are expected as illustrated in Exhibit I. To illustrate this, WSIA has:

1. Estimated the tax revenue for each state based upon IDRR data from 2016 to 2018, based simply upon IDRR premium as collected predominately from all carriers’ Schedule T reporting multiplied by the applicable surplus lines tax rate in each state;
2. Calculated any variance between the tax estimated in item 1 above and the tax collected according to the Business Insurance survey; and
3. Calculated the 3-year average of the variances identified in item 2 above from 2016 to 2018.

From 2016 – 2018, the Business Insurance tax revenue lagged our estimated tax revenue by an average of 1.96%. However, Florida is the only state remaining to collect surplus lines taxes at rates based upon where the risk is located, rather than 100% at their 5% rate, which lowers Florida’s effective tax rate and has a fairly significant impact on the 3-year average given the size of the Florida surplus lines market. Excluding Florida illustrates actual tax revenue lagged expected revenue by only $3.7 million, or 0.22% when averaged for 2016-2018.

<table>
<thead>
<tr>
<th>3-Year Average</th>
<th>2016 - 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tax Rate</td>
</tr>
<tr>
<td>TOTALS</td>
<td>$1,689,797,891</td>
</tr>
<tr>
<td>As % of BI Tax Collected</td>
<td>-1.950%</td>
</tr>
<tr>
<td>TOTALS less Florida</td>
<td>$3,695,548</td>
</tr>
<tr>
<td>As % of BI Tax Collected</td>
<td>-0.223%</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>3.569%</td>
</tr>
<tr>
<td>MEDIAN</td>
<td>3.000%</td>
</tr>
<tr>
<td>MAX</td>
<td>6.000%</td>
</tr>
<tr>
<td>MIN</td>
<td>1.000%</td>
</tr>
</tbody>
</table>

See Exhibit II for complete detail by state and by year.

Conclusion: Taxes collected nationwide are falling within 0.22% of WSIA’s estimate of surplus lines taxes by state. Because WSIA’s estimated revenue is based solely on carrier reported premium, the miniscule variances can be explained by the premium reporting and tax remittance responsibilities between surplus lines brokers and carriers described in Exhibit I (e.g., taxation of fees, risk and premium tax exemptions, differences in the timing of broker and carrier reporting, etc.). Implementing home state premium reporting for carriers will require them to obtain additional information from the broker, with a significant and costly compliance impact that will have no demonstrable benefit. By way of example, suppose a carrier writes 8,000 policies worth $250 million in premium in a state through 300 surplus lines producers. To reconcile these figures, the state adds up the premium reported by all 300 surplus lines producers, compares the result to the carrier’s Schedule T, and finds a discrepancy of $500,000. That difference could be comprised
of hundreds of variances, which are not errors but known and valid differences between carrier reporting and broker tax requirements. It’s entirely possible that a lengthy reconciliation will find overpayment of premium tax requiring refunds and amended reductions to the overall tax revenue. Current data available, as summarized in Exhibit II, demonstrates that taxes are being accurately remitted for surplus lines premium. Therefore, before implementing an imperfect, potentially time-consuming and costly reconciliation process, we encourage the NAIC and the Surplus Lines Task Force to consider conducting similar analysis as that outlined in Exhibit II, to assess the reasonableness of surplus lines tax collections nationwide.
NAIC Proceedings – Summer 2020

8-449
Attachment Three
Surplus Lines (E) Task Force
8/5/20
Exhibit II

3-Year Average
2016 - 2018

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Dist. of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming
Totals

Florida
Totals Less Florida
As % of BI Tax Collected

Tax
Rate
6.00%
2.70%
3.00%
4.00%
3.00%
3.00%
4.00%
3.00%
2.00%
5.00%
4.00%
4.68%
1.50%
3.50%
2.50%
1.00%
6.00%
3.00%
4.85%
3.00%
3.00%
4.00%
2.00%
3.00%
4.00%
5.00%
2.75%
3.00%
3.50%
3.00%
5.00%
3.00%
3.60%
5.00%
1.75%
5.00%
6.00%
2.30%
3.00%
4.00%
6.00%
2.50%
5.00%
4.85%
4.25%
3.00%
2.25%
2.00%
4.55%
3.00%
3.00%

$

$

$

Variance
(3,033,887)
(662,915)
(584,185)
46,389
(1,051,893)
801,943
(1,637,097)
(4,536)
(264,647)
(28,783,029)
9,661,818
(7,665)
15,111
3,688
(1,629,013)
203,055
(25,075)
(805,849)
1,488,839
(155,369)
195,526
(3,065,109)

% Variance
-7.71%
-18.51%
-3.46%
0.40%
-0.51%
3.27%
-7.00%
-0.29%
-4.96%
-10.79%
30.06%
-0.04%
1.02%
0.01%
-8.24%
7.07%
-0.18%
-10.90%
2.16%
-5.11%
1.61%
-7.51%

WSIA Estimated
Revenue
$
37,229,478
3,519,912
16,454,987
9,989,898
220,171,230
23,948,098
23,119,247
4,143,561
5,662,154
266,460,486
38,183,300
12,169,836
1,620,617
52,264,965
15,298,142
2,823,203
13,773,674
7,048,006
68,058,596
3,040,756
15,357,193
41,996,352

551,063
234,780
(1,185,279)
(337,407)
94,428
(142,854)
26,399

3.55%
1.58%
-3.48%
-10.98%
2.04%
-1.20%
0.16%

14,904,089
15,881,854
33,517,236
3,078,874
4,811,621
11,410,872
3,431,359

496,802,953
397,046,347
670,344,717
111,959,049
160,387,352
326,024,921
114,378,631

15,455,151
16,116,633
32,331,957
2,741,467
4,906,049
11,268,018
3,457,758

(251,546)
657,215
(1,663,938)
(26,051)
(467,266)
(1,669,132)
196,972
527,871
(761,156)
(279,007)
13,331
2,688,892
(180,665)
(594,546)
(459,004)
(499,874)
1,202,069
(518,536)
(358,713)
17,279
(32,478,577)
-1.96%

-6.49%
0.47%
-4.64%
-1.48%
-1.26%
-4.79%
2.56%
1.45%
-12.26%
-0.63%
0.98%
9.08%
-0.06%
-5.51%
-22.08%
-2.76%
9.97%
-9.54%
-2.85%
1.15%

3,982,939
143,232,904
36,711,053
1,889,748
40,164,050
34,313,732
8,359,576
36,328,973
6,361,871
40,563,094
1,611,388
30,506,854
269,314,194
11,651,476
2,099,503
17,275,881
17,211,952
5,640,783
11,335,028
1,873,295
1,689,797,891

132,632,004
3,978,691,765
734,221,065
107,985,576
803,281,009
571,895,527
363,459,828
1,210,965,760
159,046,781
676,051,575
64,455,521
610,137,080
5,552,869,979
274,152,373
69,983,433
767,816,940
860,597,603
123,973,248
377,834,277
62,443,173
43,035,404,358

3,731,393
143,890,118
35,047,116
1,863,697
39,696,785
32,644,599
8,556,548
36,856,843
5,600,715
40,284,088
1,624,719
33,195,746
269,133,529
11,056,930
1,640,499
16,776,007
18,414,021
5,122,247
10,976,315
1,890,574
1,657,319,314

$

(28,783,029)
(3,695,548)
-0.223%

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10

$

$

NAIC IDRR
Premium
620,491,292
130,367,127
548,499,582
249,747,441
7,339,041,013
798,269,933
577,981,175
138,118,714
283,107,716
5,329,209,725
954,582,495
260,039,239
108,041,132
1,493,284,723
611,925,683
282,320,338
229,561,226
234,933,540
1,403,270,012
101,358,532
511,906,437
1,049,908,798

$

$

BI Tax
Collected
34,195,591
2,856,997
15,870,802
10,036,287
219,119,337
24,750,041
21,482,150
4,139,026
5,397,507
237,677,457
47,845,118
12,162,172
1,635,728
52,268,653
13,669,129
3,026,258
13,748,598
6,242,158
69,547,435
2,885,387
15,552,719
38,931,243


Comment Three: Surplus lines tax revenue is increasing at a higher rate than surplus lines premium growth.

Example: Since 2010, when the Nonadmitted and Reinsurance Reform Act (NRRA) was enacted, average annual tax revenue per state has increased by 7.67%. During this time period, five states (Delaware, Oregon, South Carolina, Tennessee and West Virginia) increased their tax rates and one state (Louisiana) lowered their rate. When these six states are removed from the data, there is no significant change to an annual increase in revenue per state, which reduces the total just slightly to 7.45%. According to NAIC Insurance Department Resource Reports data, surplus lines premium grew by only 6.57% annually during the same time period and only 6.46% when the same six states are removed.

See Exhibit III for complete detail by state.

Conclusion: Surplus lines tax collection has significantly improved as a result of the clarity brought about by the passage of the NRRA in 2010. The intent of the NRRA was to simplify the taxation and regulation of the surplus lines transaction. This change has led to significant improvements for the states and the industry clarifying the brokers' ability to clearly assign a “home state” to each surplus lines transaction. Exhibit III helps us conclude the tax revenue is growing at a faster rate than premium, which further suggests the need for some level of analysis on an annual basis, for purposes of assessing the reasonableness of surplus lines tax collections nationwide, before implementing an imperfect and potentially time-consuming and costly reconciliation process given the known causes of the variances that will exist between surplus lines broker and carrier premium reporting.
<table>
<thead>
<tr>
<th>State</th>
<th>Average Tax Revenue Change Since 2010</th>
<th>Tax Revenue Change Since 2010</th>
<th>Average Premium Change Per Year Since 2010</th>
<th>Premium Change Since 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>3.18%</td>
<td>46.10%</td>
<td>5.86%</td>
<td>55.78%</td>
</tr>
<tr>
<td>Alaska</td>
<td>2.05%</td>
<td>18.55%</td>
<td>2.13%</td>
<td>16.56%</td>
</tr>
<tr>
<td>Arizona</td>
<td>4.12%</td>
<td>56.28%</td>
<td>7.24%</td>
<td>73.43%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>2.70%</td>
<td>41.95%</td>
<td>2.86%</td>
<td>19.97%</td>
</tr>
<tr>
<td>California</td>
<td>7.22%</td>
<td>116.33%</td>
<td>9.03%</td>
<td>98.81%</td>
</tr>
<tr>
<td>Colorado</td>
<td>8.43%</td>
<td>99.60%</td>
<td>8.16%</td>
<td>85.58%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>8.06%</td>
<td>92.34%</td>
<td>6.37%</td>
<td>62.75%</td>
</tr>
<tr>
<td>Delaware</td>
<td>20.87%</td>
<td>322.50%</td>
<td>23.57%</td>
<td>160.52%</td>
</tr>
<tr>
<td>Dist. of Columbia</td>
<td>9.95%</td>
<td>96.64%</td>
<td>4.87%</td>
<td>37.03%</td>
</tr>
<tr>
<td>Florida</td>
<td>4.13%</td>
<td>47.66%</td>
<td>3.06%</td>
<td>20.03%</td>
</tr>
<tr>
<td>Georgia</td>
<td>6.59%</td>
<td>83.84%</td>
<td>10.38%</td>
<td>91.81%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>2.42%</td>
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October 4, 2019

The Honorable James J. Donelon
Chair, Surplus Lines (C) Task Force
National Association of Insurance Commissioners
1100 Walnut Street
Kansas City, MO 64106

Sent via email to: adalex@naic.org

Re: Surplus Lines Premium Home State Blanks Proposal

Dear Commissioner Donelon:

On behalf of the Wholesale & Specialty Insurance Association (WSIA), we appreciate the opportunity to comment on the Task Force’s proposal to include “home state” reporting of surplus lines premium through Schedule T on domestic carriers’ Annual Statement filings. As the professional trade association representing the wholesale, specialty and surplus lines industry, WSIA is unique in that we represent both surplus lines brokers and surplus lines carriers. Although this proposal is directed at the reporting of premium by insurance carriers, it will impact both carriers and brokers such that we have worked with various representatives of both to conduct our analysis of the proposal and provide these comments.

Our members fully understand the motivation for this proposal is to help individual states reconcile surplus lines premium reported by surplus lines carriers to surplus lines taxes remitted by surplus lines brokers. They also understand and take seriously their surplus lines tax obligations; however, we are concerned that the proposed premium reporting changes will not yield the desired results. We are further concerned that an imperfect reconciliation process will require a significant investment of financial and human resources for all parties (i.e., carriers, brokers and regulators) and will result in no substantial change in surplus lines revenues for any of the states.

Reconciliation of surplus lines premium tax through the comparison of premium reported by surplus lines carriers to the surplus lines taxes remitted by surplus lines brokers will not result in an accurate or appropriate outcome for the regulators. Some of the most significant reasons that this approach to reconciliation will not produce accurate results are:

- **Fees.** Additional fees and costs beyond the carrier’s base premium are reported by the broker only and will not be reflected in the premium reported by a carrier. Some states require that surplus lines premium tax be paid on these fees as well, such that the tax base for the broker will be different than the premium reported by the carrier.

- **Non-taxable premium.** Not all premium is taxable in some states. For example, it is not unusual for certain risks, such as inland marine, boiler & machinery, native lands and interstate commerce related railways, to be exempt from taxation. These are risks that carriers would report as premium but would
not be reflected in broker tax filings, further distinguishing the carrier’s premium base from the broker’s tax base and skewing any reconciliation thereof.

- **Independent Procurement.** Some states exempt taxation or have a different tax requirement or structure if a consumer is allowed to procure policies without an insurance producer. These premiums are reported by carriers but there would be no record of the transaction from a broker to cross reference. Again, these would skew any reconciliation results.

- **Home state.** It is the statutory responsibility of the surplus lines licensee to determine and report the home state of the insured, and a carrier may not always underwrite and report premium based on the same determination factors. Most carrier underwriting and reporting systems are designed based upon the physical location of the risk and underwriting requirements in those particular physical locations or states, such that carrier reporting by home state will require significant system and process changes. Such changes seem unwarranted when their purpose will not achieve the intended result for the reasons described herein.

- **Return premium, midterm endorsements and cancellations.** Policies can change throughout the year and the original premium reported by a carrier may differ based on the broker reporting period for these factors. This is very common and another key reason why reconciliation will be ineffective.

- **Reporting.** States have different reporting and payment dates for surplus lines brokers, whereas all surplus lines carriers report their annual premium at the same time each year (March 1) for the prior calendar year.

Based on these particular examples, we know that reconciliation is not a simple undertaking for any of the impacted parties (i.e., regulators, carriers or brokers). The above factors illustrate how difficult, if not impossible, it is to get an “apples to apples” accounting to effectively reconcile surplus lines premium taxes remitted by brokers to surplus lines premium reported by carriers. Attempts at reconciliation between broker and carrier data in the past on a state-by-state basis have rarely resulted in additional tax owed.

Finally, compliance with this proposal will have a significant impact on certain carriers. For some carriers, this change may be easier to implement because they generally write single state policies or monoline business. This could also be true for larger carriers writing personal lines or casualty risks where multistate policies are less common. However, this proposal gets much more complex and potentially costly, from a systems and administration perspective, when the surplus lines products are more complex and cover risks across many state lines. Regardless of the size of the carrier, all will be required to invest in technology changes to capture this information to comply with the proposal.

In closing, states should continue to rely on broker filings, with brokers remitting surplus lines taxes on 100% of the premium to the home state of the insured at the home state’s tax rate. While we understand that states desire an easy reconciliation, we are concerned that implementing this Schedule T proposal will not yield the desired results. Before the states decide to move forward with a reconciliation approach, we encourage a more detailed discussion with the carriers and brokers regarding any underlying state concerns. We further suggest discussing reconciliation efforts with representatives from the fifteen Stamping Offices because of their significant experience in this area, either in performing reconciliations or electing not to because of their experiences. We want to work with the states to better understand any concerns and/or help identify the right solution, and, for all of the above factors, we respectfully request that the Task Force table this proposal and further study it with the industry’s help.
We appreciate the opportunity to work with our members and provide their perspective on this proposal. Please contact us with questions or if you need any additional information.

Sincerely,

Keri Kish
Director of Government Relations
816.799.0855

Brady R. Kelley
Executive Director
816.799.0860

John Meetz
State Relations Manager
816.799.0863
TITLE INSURANCE (C) TASK FORCE

Title Insurance (C) Task Force Aug. 5, 2020, Minutes .......................................................... 8-456
The Title Insurance (C) Task Force met via conference call Aug. 5, 2020. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Kevin Gaffney (VT); James J. Donelon, Vice Chair, and Warren Byrd (LA); Elizabeth Perri (AS); Michael Conway represented by Damion Hughes (CO); David Altmaier represented by Anoush Brangaccio (FL); Colin M. Hayashida represented by Paul Yuen (HI); Vicki Schmidt represented by Heather Droge (KS); Kathleen A. Birrane represented by Erica Bailey (MD); Steve Kelley represented by Paul Hanson (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Fred Fuller (NC); Bruce R. Ramge (NE); Marlene Caride represented by Randall Currier (NJ); Barbara D. Richardson represented by Erin Summers (NV); Jillian Froment represented by Michelle Brugh Rafeld (OH); Jessica K. Altman represented by Shannen Logue and Michael McKenney (PA); Raymond G. Farmer represented by Joe Cregan (SC); Larry D. Deiter represented by Maggie Dell (SD); Scott A. White represented by Mike Beavers (VA). Also participating was Matthew Gendron (RI).

1. Heard a Presentation on Veritable Data Solutions’ New Title Fraud Prevention Smartphone App

David Fleck (Veritable Data Solutions) said Veritable Data Solutions created the new smartphone app to help notaries serve as gatekeepers against identity theft, forgery and title fraud. The app, called Veri-Lock, uses blockchain to ensure the authenticity of notarized documents. The first primary vector in title fraud is tricking the notary by using fake identification, which results in no leads for investigators, or using forged signatures on pre-signed deeds. The second primary vector is to skip the notary by using a fake or stolen stamp and forged signatures. The third primary vector is to force or trick the signer by false pretenses or undue pressure. The primary victims of title fraud are elderly homeowners because they tend to have a lot of equity and title insurance. Veri-Lock provides a solution by empowering the 4.4 million notaries to detect fake identifications, prevent forgeries, and preserve evidence. The app works by first verifying the identity and presence of the notary to prevent forged documents. It then verifies the identity and presence of the signer(s) to prevent identification theft. Its final step is to link the notary and signer(s) to signed documents on blockchain permanently and immutably. Blockchain provides decentralized and distributed chains of transactions by notaries and documents by address. It is encrypted end-to-end with permissioned access. In the worst-case scenario of the app not preventing a fraudulent claim, Veritable Data Solutions serves as an additional deep pocket to resolve claims through its liability insurance.

Mr. Gaffney said it is very interesting to see how blockchain is being used in this app to help shield vulnerable homeowners.

Mr. Gendron asked if Veri-Lock uses closed or open blockchain. Mr. Fleck said blockchain is basically the storage system. It is not public, but rather a permissioned blockchain, so various players will have different levels of access. The notaries, for example, will have access to their transaction. Title insurance carriers can have access to public and real estate information. There will also be some data, for example, that is totally private, and these will be permanently stored encrypted on the blockchain. In those rare circumstances when fraud does come up, it is accessible by court order. Mr. Gendron said he believes the app is using blockchain in a safe way. He also said most databases could probably work for such an application.

Mr. Cregan asked via chat who insures the notary for errors and omissions coverage. He also asked what creates liability for title insurers for the errors of the non-employee notary. Mr. Fleck said most states do not require errors and omissions insurance, but most insurance carriers do require it for their signing agent. He also said if the title issue is a title claim, the notary is in the position to stop the fraud that would lead to the title point.

Jeffrey M. Klein (McIntyre & Lemon) asked via chat if the app is secure against being hacked. Mr. Fleck said the app data is saved in the cloud with Amazon, and it services the encrypted blockchain. Worst case scenario, Veritable Data Solutions does have cyber security insurance.

Mr. McKenney said notaries in a lot of states are required to be bonded, and as Mr. Fleck said, state statutes define the business of title insurance and legal liability.

2. Heard a Panel Discussion on the Effectiveness of CPLs

Elizabeth Blosser (American Land Title Association—ALTA) said the pandemic changed the title industry overnight when it struck in March. The title industry is doing more digital transactions and touchless transactions like other industries. ALTA’s
May survey showed that nearly 30% of its members are offering some type of digital closing option, up from 17% in 2019. There are a lot of people who want to take advantage of the historically low interest rates. So, what was once talk about the digital closings of the future, has become the digital closings of the present. ALTA has a multi-pronged approach to growing consumer access to remote closing options. This includes working with state land title associations to get state legislation passed that allows for the use of remote, online notarization. Additionally, ALTA has also been working at the federal level to support the Securing and Enabling Commerce Using Remote and Electronic Notarization Act of 2020 (SECURE Notarization Act). The SECURE Notarization Act would allow for expanded use of remote online notarization and provide some certainty about its interstate recognition. ALTA has also become very interested in how short-term emergency orders can help facilitate remote closing options.

Ronald J. Blitenthal (Old Republic National Title Insurance Company) said title insurance is an agent centric business, with more than half of all title insurance transactions closed by title insurance agents. Title insurance agents are agents of title insurers for the issuance of title insurance policies, but not for escrow or settlement purposes. Closing protection letters (CPLs) were originally developed decades ago for commercial lending institutions to cover acts of independent title agents or approved attorneys, specifically to protect against misappropriation of funds or failure to follow closing instructions. Most states have monoline restrictions for title insurers, meaning they may not provide errors and omissions or fidelity coverage. For this reason, coverage under the CPL is confined to matters affecting the status of title to the subject property or the priority of the insured mortgage. Due to these regulatory restrictions, CPLs cannot and were never meant to cover every eventuality or loss that could take place resulting from a closing. Basic coverages include: 1) acts of fraud, theft, dishonesty or negligence in handling settlement funds or documents in connection with a closing, but only to the extent that the acts affect status or priority of title in the real estate insured by the title insurance; and 2) failure to comply with written closing instructions by a proposed insured when agreed to by the title agency or title agent relating to title insurance coverage, but only to the extent that the acts affect status or priority of title in real estate insured by the title insurance. There is no coverage under a CPL unless a title insurer has issued a title insurance policy or has legally committed to do so. Coverage under CPLs extends to proposed insureds (e.g., lenders, and borrowers) and, in a few states, to sellers. CPLs are subject to the oversight and regulation of state insurance regulators and title insurance laws. Where title insurance policies are subject to claims and unfair practices statutes, state insurance regulators consistently apply such laws to claims on CPLs. Common claims under a CPL include: 1) theft of settlement funds by title insurance agent/attorney; 2) fraudulent flips; 3) fraudulent down payment undisclosed by title insurance agent; 4) unresolved title defects; and 5) failure to comply with written instructions. A consumer wiring funds to a fraudster without authorization would not be covered. If the lender’s conduct solely caused the loss or the lender itself acted fraudulently or illegally, the underwriter is not liable under the CPL. A lender withholding information about a known tax lien from a loan investor would not trigger CPL coverage because the fraud was not connected to any closing instruction. Coverage is tied to the status of the title, and there needs to be a causal relationship between the closer’s actions and loss. To prevent loss, there is a lengthy application process, and insurers frequently do background, reputation and credit checks; require current errors and omissions coverage and/or fidelity bonds; verify licensing; and require submission to an examination and/or reconciliation of an agent’s escrow accounts. Onboarded agents receive regular audits by the title insurer. In some cases, title insurers have begun to offer centralized escrow disbursement services that bypass agent disbursement services and rely directly on the financial strength of the title insurer.

Diane Evans (Land Title Guarantee Company) said CPLs are used in every market but New York, and they are requested by most lenders and issued automatically, often at the time of order or commitment. Lenders do not distinguish between the agent and underwriter. Rates are collected by agents, but remitted in total to the underwriter, with the cost of issuance and remittance being absorbed by the agent. Now, almost every agent/attorney can issue CPLs, with authorization being reviewed by the underwriter. CPLs allow small agents to compete in markets. ALTA leads the industry to enhance procedures for consumers’ protections. Best practices are developed in consultation with technology providers, accountants, auditors, claims attorneys and industry. They encourage standardized training, strict protocols and procedures, and recommendations for additional insurance coverages. There are also certification processes included in the model. Agents follow written closing instructions, which often arrive late or conflict with the contract. Instructions are not uniform and subject to interpretation. Agent defalcations are rare—the loss that sometimes occurs is minimal, such as missed taxes and incorrect homeowner’s association (HOA) payments. If theft or misappropriation is intended, a CPL is a loss mitigation tool and not a preventative resource. The pandemic has created an urgency for technology development with title industry and lenders across the nation. Agents were forced to redefine how to safely engage with consumers, and they have been using creative approaches to deliver and execute closing documents. Closing and wire fraud most often involves a third-party hacker who may follow the consumer or realtor online and attempt to intersect wire transfer and/or instructions. Preventive measures include enhanced communications with parties, use of secure/password protected systems, and increased consumer awareness.

Director Ramge asked via chat if the industry maintains any statistics on CPL claims versus other title claims and whether there are loss statistics on file. Mr. Blitenthal said some underwriters might track those separately, but he is not aware of...
those statistics being collected on an industry basis.

Mr. Cregan asked how frequent claims by a lender citing to the CPL occur and if they are typically ultimately resolved by the firms’ errors and omissions coverage to recoup what was paid to the lender. Mr. Blitenthal said the coverage would be invoked in certain situations, but there is not a typical claim. Every situation would differ by the facts of the claim. Mr. Cregan asked if a representative from the title insurance industry could provide the Task Force with a sense of the volume and frequency of claims. Mr. Fleck said he is not sure if the industry collects such data. Ms. Blosser said she would investigate it and report back to the Task Force.

Mr. Byrd asked what the key differences are between a CPL from the buyer versus one for the seller. Mr. Blitenthal said the text will not necessarily be different, but what each wants from the CPL is different. The borrower wants a clean property title and the seller wants to make sure they get their money. There is no policy for the seller, but there is a policy for the buyer and the lender, if applicable.

Having no further business, the Title Insurance (C) Task Force adjourned.
WORKERS’ COMPENSATION (C) TASK FORCE

Workers’ Compensation (C) Task Force Aug. 5, 2020, Minutes................................................................. 8-460
Workers’ Compensation (C) Task Force July 22, 2020, Minutes (Attachment One)........................................ 8-464
Workers’ Compensation Policy and the Changing Workforce White Paper (Attachment One-A).................. 8-465
Workers’ Compensation (C) Task Force June 2, 2020, Minutes (Attachment Two)....................................... 8-499
The Workers’ Compensation (C) Task Force met virtually Aug. 5, 2020. The following Working Group members participated: James J. Donelon, Chair, Patrick Bell, Warren Byrd, Richard Piazza and Thomas Travis (LA); Jim L. Ridling, Vice Chair represented by Gina Hunt (AL); Andrew N. Maes represented by Susan Gozzo Andrews, George Bradner, Wanchin Chou, Jared Kosky, Lady Mendoza and Doris Schirmacher (CT); Karima M. Woods represented by Angela King (DC); Trinidad Navarro represented by Robin David, Leslie Ledogar and Tanisha Merced (DE); David Altmairer represented by Greg Jaynes, Jane Nelson and Sandra Starnes (FL); John F. King represented by Steve Manders and Elizabeth Nunes (GA); Colin M. Hayashida represented by Tiffany Chang, Randall Jacobson, Kathleen Nakasone, Colin Okutsu, Eunice Park, Ian Robertson, Grant Shintaku and Paul Yuen (HI); Dean L. Cameron represented by Michele MacKenzie and Randy Pipal (ID); Robert H. Muriel represented by Justin Hammersmith, Brad Lucchini, Judy Mottar, KC Stralka and Erica Weyhlenmeyer (IL); Vicki Schmidt represented by Heather Droege, Shannon Lloyd, Justin McFarland and Jennifer Ouellette (KS); Sharon P. Clark represented by Rob Roberts (KY); Eric A. Cioppa represented by Sandra Darby (ME); Steve Kelley represented by Erin Hadricts, Jonathan Kelly, Tammy Lohmann, Michael Marben, Connor Meyer, Philip Mosbrugger, Myra Morris, Jacqueline Olson, Christine Peters, Matthew Vatter, Megan Verdeja and Phil Vigliaturo (MN); Chlora Lindley-Myers, LeAnn Cox, Rebecca Shavers and Jeana Thomas (MO); Mike Causey represented by Fred Fuller (NC); Marlene Caride represented by Mark McGill (NJ); Russell Toal represented by Robert Doucette and Anna Krylova (NM); Barbara D. Richardson represented by Jack Childress, Mark Garratt, Tim Ghan, Gennady Stolyarov and Erin Summers (NV); Glen Mulready represented by Cuc Nguyen, Andrew Schallhorn and Ashley Scott (OK); Andrew R. Stolfi represented by Alexander Cheng, Brian Fordham, Ying Liu and Jan Vitus (OR); Jessica K. Altman represented by Inna Gnipp, Shannen Logue, Mike McKenney and Neel Vaidya (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Raymond G. Farmer represented by Ryan Basnett, Joe Cregan, Will Davis, Daniel Morris and Michael Shull (SC); Larry D. Deiter, Maggie Dell and Frank Marnell (SD); Todd E. Kiser represented by Tracy Klausmeier and Reed Stringham (UT); Michael S. Pieciak represented by Kevin Gaffney, Pat Murray, Rosemary Raszka, Jill Rickard, Wyatt Shea, Jessica Sherpa and Marcia Violette (VT); and James A. Dodrill, Greg Elam, Tonya Gillespie, Erin Hunter and Jamie Taylor (WV). Also participating were: Sydney Sloan (CO); Kevin Clark, Kim Cross, Travis Grassel, Scott Rupp and Andria Seip (IA); Rasheda Chairs and Gail Rice (MD); Amanda Felder and John Wells (MS); Chris Aufenthie (ND); Thomas Green and Connie Van Slyke (NE); Christian Citarella (NH); Marc Allen, Karen Curtin, Gloria Huberman, Sioin Lei, Alexander Vajda and Jia Zhang (NY); Rebecca Nichols and Michael Smith (VA); Mike Shinnick (TN); Monica Avila, Marianne Baker, Miriam Fisk, Andy Liao, John Mooney and Bethany Sims (TX); and Rebecca Rebholz (WI).

1. **Adopted its July 22 and June 2 Minutes**

Mr. Doucette made a motion, seconded by Director Wing-Heier, to adopt the Task Force’s July 22 (Attachment One) and June 2 (Attachment Two) minutes. The motion passed.

2. **Heard a Presentation on Workers’ Compensation Treatment Guidelines and Formularies**

Joseph Guerriero (Reed Group) said the Reed Group is the owner and publisher of MDGuidelines. He said many states know the Reed Group by the American College of Occupational and Environmental Medicine (ACOEM) clinical practice guidelines and drug formularies. Mr. Guerriero said the Reed Group acquired ACOEM and its clinical practice guidelines in 2013. At that time, the Reed Group began having conversations with the states after developing a drug formulary based on the ACOEM clinical practice guidelines. Mr. Guerriero said the Reed Group has an ongoing relationship with ACOEM, and all the guidelines must go through the ACOEM methodology and external peer review before publishing its guidelines. He said the Reed Group’s clinical practice guidelines and its drug formulary are developed by a research team located at the University of Utah, namely the Rocky Mountain Center for Occupational and Environmental Health. The guidelines and formulary meet all the criteria that was set forth by the National Academy of Medicine, formerly known as the Institute of Medicine. During 2015 and 2016, California went through a thorough review to decide what it was going to do in terms of its guidelines and its drug formulary.

Ms. Baker said the biggest concern faced during the California workers’ compensation reform was to make sure there was access to the best medical treatment by using an independent method and ensuring compliance with the treatment. She said the
group was able to improve medical care delivery; remove waste, friction, and fraud; and use the savings to increase benefits for employees and reduce workers' compensation rates for employers. Rates were decreased by approximately 40%.

Ms. Baker said workers’ compensation reductions were $3 billion a year and the pure premium rate has decreased 41% since 2015; the pure premium rate continues to decrease. She said the basis for these decreases are due to the proper guidelines and the proper formularies interacting with these guidelines. The independent medical review system ensures compliance with decisions made by independent providers to guarantee the appropriate care.

Ms. Baker said reforms led to significant improvements in the quality of care for injured workers. California’s workers’ compensation system has seen: 1) a 28% decrease in the overall number of medical services since 2013; 2) an 80% decrease in overall prescription cost per claim since the implementation of Senate Bill 863; 3) a 43% decrease in the number of claims with opioid prescriptions since the adoption of the formulary; 4) a 72% decrease in laboratory tests; 5) a 39% decrease in medical equipment purchases; 6) a 30% increase in payments for physical therapy; and 7) a 9% increase in physician evaluation and management. She said the treating physician is able to better manage the care.

Ms. Baker said, according to the California Workers’ Compensation Insurance Rating Bureau (WCIRB), claim settlement rates continue to accelerate. The claims community believes this acceleration is attributable to policy reforms that allowed the claims adjusters to concentrate more on claims handling than other frictional costs before the system and the court.

Ms. Baker said the way improvements were made in the workers’ compensation system in California were due to: 1) improving health care quality and delivery; 2) using evidence-based guidelines for presumptive first-level treatment decisions; 3) reducing over-care (i.e., providing evidence-based care first before consideration of surgery); 4) establishing protocols for escalating to other treatment regimens based on individual circumstances; and 5) eliminating litigation over issues that belong to the health care experts, not lawyers and judges.

Ms. Baker said the foundation of effective reform includes: 1) access to quality medical care through medical provider networks and ombudsman; 2) standardized reference material (i.e., medical treatment guidelines for first-level evidence-based treatment); 3) fully integrating a drug formulary with treatment parameters; 4) securing trust in the efficacy and integrity of guidelines for medical treatment, which fundamentally includes the use of drugs as part of treatment; and 5) an independent medical review (IMR) conducted by objective providers.

Ms. Baker said California contracted with the RAND Corporation to conduct a comprehensive study of existing medical treatment guidelines. She said the ACOEM guidelines overwhelmingly stood out as being the best choice, particularly with its adherence to evidence-based validation. Ms. Baker said ACOEM subsequently addressed recommendations of the RAND study for continuous improvement. She said the result of the evaluation was that ACOEM guidelines became the legal standard in California.

Ms. Baker said the ACOEM guidelines were selected in California because: 1) they provide the clinician with an analytical framework for the evaluation and treatment of injured workers in the workers’ compensation system; 2) they serve as the primary source of guidance for treating physicians and physician reviewers in workers’ compensation; 3) they are the presumed correct first-level standard for appropriate patient care, and enable streamlined approval of treatment requests; 4) they help to protect workers from over-care, under-care or otherwise inappropriate treatment; and 5) they include a comprehensive drug formulary as a fully integrated component of treatment.

Ms. Baker said California selected a drug formulary following the decision to select a guideline. She said the goals for implementing evidence-based formulary goals include: 1) implementing an evidence-based formulary as part of the medical treatment utilization schedule (MTUS); 2) facilitating the provision of appropriate medications to injured workers by establishing a list of preferred medications, with the goal of encouraging usage of the most appropriate medications, and minimizing disputes and associated medical costs; and 3) designing evidence-based formularies to maximize high-quality health care for injured workers and improve work-related outcomes through policies consistent with the MTUS.

Ms. Baker said the California Department of Industrial Relations (DIR) contracted the RAND Corporation to conduct a study of five existing formularies: 1) Washington State Department of Labor and Industries; 2) Reed Group ACOEM; 3) Work Loss Data Institute ODG; 4) Ohio Bureau of Workers’ Compensation; and 5) California Department of Health Care Services (Medi-Cal).

Ms. Baker said California selected the Reed Group ACOEM formulary for several reasons: 1) reliance on evidence-based criteria in determining drug lists; 2) compatibility with the MTUS; 3) transparency in the decision process to maintain the drug
list; 4) established process for regular updates to the formulary drugs; 5) ease of use by treating physicians; and 6) a focus on drugs needed for injured worker conditions.

Ms. Baker said California also looked at the independent medical review process. When looking at this process the following things were considered: 1) medical decisions made by independent medical professionals based on evidence-based medicine; 2) expedited medical decisions; 3) transparency on medical transactions; and 4) antifraud capability.

Ms. Baker said there is always resistance to change. She said California is exploring broadening the user base to include all levels of health care professionals, claims professionals, etc.

3. **Heard a Presentation from the NCCI on COVID-19 and Its Atlas Initiative**

Susan Donegan (National Council on Compensation Insurance—NCCI) said the NCCI is currently tracking 216 insurance-related COVID-19 bills. She said 95 of the 216 bills focus on items related to workers’ compensation. The NCCI is assessing the various workers’ compensation presumptions and compensability measures that have introduced and enacted. There are approximately 51 bills, both state and federal, addressing the topics of presumptions and compensability. Ms. Donegan said 20 states have proposed legislation regarding workers’ compensation issues, noting that there are multiple bills in some states. She said seven states have enacted some type of legislation addressing the issues of presumptions and compensability.

Ms. Donegan said seven states have issued executive orders, directives, emergency rules or department bulletins. She said bills regarding presumptions and compensability fall into three categories: 1) bills that primarily address first responders and health care workers; 2) bills that add frontline workers, such as a restaurant employees or pharmacy employees; and 3) bills that include broader classes of workers.

Ms. Donegan said the NCCI is also tracking post-traumatic stress disorder (PTSD), as it is unknown if there will be workers’ compensation claims related to COVID-19 that come about. She said some insurers are anticipating the possibility of receiving PTSD claims related to COVID-19, particularly from frontline health care workers.

Ms. Donegan said there are two categories of filings the NCCI has worked with regarding COVID-19. She said the first filing was for national item filings, and the NCCI worked quickly and extensively with its 36 state jurisdictions on three different filings and rule changes related to COVID-19. These three filings included: 1) creating class codes to report COVID-19 claims; 2) excluding COVID-19 claims from experience rating calculations; and 3) excluding payroll for furloughed employees in premium calculations. These measures have been approved in most all of the NCCI’s 36 state jurisdictions.

Ms. Donegan said July began the NCCI’s rate and loss cost season and some states have already been seeing those filings. This year, the NCCI is adding a new feature to the rate and loss cost filings. NCCI has added an executive summary providing a narrative discussing what the filings contain. This summary will include: 1) an introduction that includes filing details and numbers presented for insurance department recommendations; 2) a methodology section explaining what drove the recommendation, which will include state-specific issues if they exist; and 3) COVID-19. COVID-19 is not being addressed in the rate filings this year.

Ms. Donegan said the NCCI is in the process of gathering information to preliminarily gauge the impact of COVID-19 and looking for benchmarks to better understand future impact. She said there are tools referenced on the NCCI’s website. There is also a posting on the NCCI’s website titled, “2020-2021 Rate Filing Season: What You Need to Know,” which provides more details.

Director Wing-Heier asked if the NCCI has any projections or numbers regarding COVID-19. She said she knows, in some cases, people who have been diagnosed with COVID-19 are relatively symptom-free while, in other cases, a person may be in the intensive care unit (ICU) for months. Director Wing-Heier was curious to know if the NCCI had seen any of these costs begin to be reported.

Ms. Donegan said the NCCI has an estimator on its website for each state; however, the NCCI does not have any information regarding claims data. She said the NCCI will begin to see medical information in September or October; however, it will be the second quarter of 2021 before the NCCI will be able to get a true sense of medical costs. Ms. Donegan said the NCCI is hearing anecdotally from insurers that they are not receiving claims quickly. She said she is also hearing the concern that it is unknown medically what some of the long-term effects of COVID-19 might encompass.
Ms. Donegan said the NCCI’s Atlas initiative is a multi-year project intended to modernize accessibility and delivery of the NCCI’s manuals and circulars. She said the NCCI rolled out the Class Look-Up tool two years ago. Ms. Donegan said the NCCI is now ready to roll out the regulatory requests for the rewritten basic scopes and residual market manuals in the fourth quarter of 2020. She said NCCI states will be hearing from their state relations executive to learn more about this tool. Ms. Donegan said North Carolina and Michigan, which are both bureau states, are going to be part of a pilot program regarding this tool.

Having no further business, the Workers’ Compensation (C) Task Force adjourned.
Workers’ Compensation (C) Task Force
E-Vote
July 22, 2020

The Workers’ Compensation (C) Task Force of the Property and Casualty Insurance (C) Committee conducted an e-vote that concluded July 22, 2020. The following Working Group members participated: James J. Donelon, Chair (LA); Jim L. Ridling, Vice Chair, represented by Gina Hunt (AL); Lori K. Wing-Heier represented by Michael Ricker (AK); Evan G. Daniels represented by Tom Zuppan (AZ); Alan McClain (AR); Ricardo Lara represented by Mitra Sanandajifar (CA); Andrew N. Mais represented by George Bradner (CT); Trinidad Navarro represented by Frank Pyle (DE); Karima M. Woods represented by Angela King (DC); John F. King represented by Steve Manders (GA); Colin M. Hayashida (HI); Dean L. Cameron represented by Michele Mackenzie (ID); Vicki Schmidt represented by Heather Droge (KS); Sharon P. Clark (KY); Eric A. Cioppa (ME); Steve Kelley represented by Tammy Lohmann (MN); Chlora Lindley-Myers (MO); Barbara D. Richardson represented by Gennady Stolyarov (NV); Marlene Caride represented by Carl Sornson (NJ); Russell Toal represented by Robert Doucette (NM); Mike Causey represented by Fred Fuller (NC); Jessica K. Altman represented by Michael McKenney (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Raymond G. Farmer (SC); Larry Deiter (SD); Todd E. Kiser represented by Tracy Klausmeier (UT); Michael S. Pieciak represented by Kevin Gaffney (VT); and James A. Dodrill represented by Tanya Gillespie (WV).

1. Adopted the Workers’ Compensation Policy and the Changing Workforce White Paper

The Working Group conducted an e-vote the concluded July 22, 2020, to consider adoption of the Workers’ Compensation Policy and the Changing Workforce white paper. The motion passed, with a majority of the Working Group members voting in favor of adopting the white paper (Attachment One-A).

Having no further business, the Workers Compensation (C) Task Force adjourned.

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Workers’ Compensation Policy and the Changing Workforce

ABSTRACT

This paper explores how changes in work and the evolving landscape of legal employment are shifting responsibility for coverage and benefits for occupational injuries, illnesses, and fatalities. Policymakers and regulators need to understand how these changes may create gaps in coverage for workers and leave employers vulnerable to uncertain liability for injuries and deaths on the job. The paper also explores alternative policy solutions to ensure workers have access to benefits if they suffer workplace injury.

INTRODUCTION

Today’s workforce and workplace look very different from the workforce and workplace when the first workers’ compensation laws were passed. The cumulative impact of these changes has made it important to consider the role public policy plays in protecting workers from the health and economic consequences of an occupational injury, illness, or fatality. For most of the past century, a significant portion of workers in the U.S. labor force were protected against economic strain and physical harm through state workers’ compensation laws. As work relationships have grown increasingly complex, there is uncertainty in workers’ compensation protections for some in the labor force. The changes and discussions in this paper are a part of broader discussions on how employment benefits and protections might be revised, redesigned, or reimagined to reflect the contemporary work environment more accurately.

The twenty-first century workforce is more diverse, more de-centralized and more mobile than ever before. This is often at odds with employment classification laws, which were adopted when workers were predominately male and work was conducted in centralized facilities with a rigidly defined management hierarchy. Increasing work fluidity and the application of often conflicting state and federal law are resulting in business uncertainty and legislative proposals across the country. This paper presents an overview of the existing employment classification models and describes the latest legislation aimed at clarifying employment status.

Finally, the paper raises important policy questions that must be considered in light of the new work environment. Policymakers, in addition to business and labor leaders, will also appreciate the description of models and pilot programs that seek to deliver health and economic benefits to injured workers beyond the traditional workers’ compensation system. Discussion and development of solutions is essential for continued economic prosperity and social stability.
Part I: Changing Relationships with Work

Background

An individual’s connection to work shapes his or her life in visible and invisible ways – from lifestyle habits to self-esteem to social benefits. Throughout the last two centuries, those connections to work have become more formal and enshrined in local, state, and federal law. This work, or employment relationship, is important to individuals and their families as benefits and social protections are frequently gained through employment.¹

The first workers’ compensation laws in the United States arose out of changes in the nature and connection to work. The Industrial Revolution saw workers move from farms and villages to cities, transitioning from farm and community-based work to manufacturing and industrial jobs. These changes resulted in more workers in employee/employer relationships with defined wages, hours, and job requirements.

Workers’ compensation insurance prevents employees from taking legal action against their employers for workplace injuries, illnesses and deaths. In return, employees get defined benefits for covered injuries, illnesses and deaths regardless of fault or liability.²

Industrial work was dangerous, and work injuries and fatalities rose, reaching more than 61,000 deaths at work in the U.S. in 1914.³ Recognizing the economic and social cost of these injuries and deaths, state policymakers successfully passed workers’ compensation laws in the majority of states by 1920. Workers’ compensation was no-fault, providing guaranteed wage replacement and medical benefits for employees injured or killed at work.

A Century of Change

The past century has witnessed a transformation across the workforce and the workplace. The number of women in the labor force has steadily increased since 1948. Women represented 57.1% of the U.S. labor force in 2018.⁴ The labor force has increased in ethnic diversity. Hispanics represented 17% of the U.S. labor force in 2016 and all minorities (African-Americans, Asian-Americans, Hispanics/Latinos, and Native Americans) are projected to make up 37% of the working-age population by 2020.⁵ The labor force is steadily getting older. Workers 55 and older are projected to be close to 25% of the labor force by 2024. Union participation has been in decline; 10.7% of wage and salary workers were union members in 2017 (Figure 1).⁶ Higher education has also played a part in the labor force. Between 1992 and 2016, workers with college degrees, including advanced degrees, has increased steadily.⁷

¹ Employment benefits can include health, disability, and/or life insurance, retirement contributions, paid time off, flexible spending accounts, and/or tuition reimbursement. Social protections can include unemployment, workers’ compensation, accommodations, equal opportunity, etc.
⁴ https://www.bls.gov/opub/reports/womens-databook/2019/home.htm#:~:text=Women’s%20labor%20force%20participation%20was%2057.1%20percent%20in%202018%2C%20unchanged%20from%20the%20previous%20year.
⁶ Union Rates: https://www.bls.gov/news.release/union2.nr0.htm

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Attachment One-A
Workers’ Compensation (C) Task Force
8/5/20
The workplace is physically different. Offices that had rows of desks with telephones and typewriters have been replaced by flex workstations and collaboration rooms. It is estimated that 4.3 million employees, close to 3% of the U.S. labor force, worked at home at least half the time in 2016. Additionally, regular work-at-home by employees have grown 140% over the last decade.\(^8\) Manufacturing facilities have moved from manually operated heavy equipment to technology-run, highly automated processing. \(\text{https://globalworkplaceanalytics.com/telecommuting-statistics}\)

\(\text{https://qz.com/work/1392302/more-than-5-of-americans-now-work-from-home-new-statistics-show/}\)

The kind of work is changing. The last century saw steady decline in agricultural work, manufacturing has remained steady, and service work has dramatically increased. The U.S. Bureau of Labor Statistics (BLS) projects that nine out of 10 new jobs in the next decade will be in the service-providing sector.\(^9\) Healthcare, personal care, community and social services, and computer and mathematical employment are some of the expected fastest-growing occupations.

These changes have dramatically impacted the way people work and live across the U.S. The cumulative impact of these changes is an expansion of the U.S. economy. Real gross domestic product (GDP) has grown from approximately $3 trillion in 1957 to $19 trillion in 2019.\(^10\) Labor productivity was 3.8 times higher in 2016 than in 1950 (Figure 2).\(^11\)

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\(^8\) Work at home: \(\text{http://globalworkplaceanalytics.com/telecommuting-statistics}\)


\(^10\) Data source found at: \(\text{https://www.thebalance.com/us-gdp-by-year-3305543}\)

Over the century, work has also gotten safer. Workplace injuries and fatalities have declined dramatically. The workplace fatality rate was 3.5 workers per 100,000 in 2018\textsuperscript{12} contrasted with 61 workers per 100,000 in 1914\textsuperscript{13}. The rate of injuries/illnesses requiring time away from work was 2.8 per 100 workers in 2018 contrasted with five per 100 workers in 1914.\textsuperscript{14}

The decrease in occupational injuries, illnesses, and fatalities is especially good for workers’ compensation. These declines are keeping more employees engaged in the labor force and making it more affordable for businesses to obtain coverage. However, demographic and work changes have raised other challenges for the workers’ compensation system. The kinds of injuries and illnesses are different, compensability questions are different, and treatment options are different. These, taken with the evolving employment relationship landscape, raise important questions about the central principles of workers’ compensation and if and how they should evolve in the future.

Connections to Work

Another significant change happening within the U.S. labor force is how individuals are connected to work. From the legal perspective, there are two classifications of workers - employees and independent contractors. The common picture of an independent contractor is a person with specialized skills, talents, or expertise who works on a project basis. Independent contractors would typically have multiple clients and conduct their work with a fair degree of autonomy. Businesses would use independent contractors to supplement knowledge or experience of their existing workforce on a temporary basis to meet demand or deadlines.

Employee or Independent Contractor

Workers’ compensation is generally compulsory for employers,\textsuperscript{15} and each state has rules that define employees for the purpose of workers’ compensation coverage. Securing workers’ compensation coverage for each of its employees is a direct business cost. In contrast, independent contractors are generally not required to have workers’ compensation coverage.

\textsuperscript{12} https://www.bls.gov/news.release/pdf/cfoi.pdf
\textsuperscript{14} Bureau of Labor Statistics.
\textsuperscript{15} All states, except Texas and South Dakota, have compulsory workers’ compensation requirements for employers. Exclusions for certain employers or kinds of employees exist in most states. The IAIABC/WCRI Inventory of Workers’ Compensation laws describes coverage exclusions for each of the states.
Defining an employee or independent contractor has been a challenge within state workers’ compensation systems, but classification has become more difficult as employment relationships have increased in complexity. These changes have important implications for workers’ compensation, including which workers should be covered under workers’ compensation and who should bear the costs of coverage. Additionally, policymakers are needed to explore how coverage requirements align incentives for businesses and workers.

While many businesses use independent contractors for highly specialized or project-based work, many organizations have made contract labor a more permanent part of their workforce. July 2018 headlines noted that the number of contractors now exceeds the number of employees at Google. Countless large businesses, including Apple, Facebook, and Amazon, have noted the same trend. Contract labor is used by businesses for everything from security and food service to coding and sales.

The decision by a business in how to classify its workers is significant as many protections and benefits for workers are tied to employment, including workers’ compensation coverage requirements. Businesses weigh many factors when considering utilizing employees or independent contractors, but the direct cost to businesses for employees is estimated at 20-30% higher than independent contractors.

Table 1. Employee vs. Independent Contractor Status

<table>
<thead>
<tr>
<th>Business Considerations</th>
<th>Worker Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Consequences</strong></td>
</tr>
<tr>
<td>Employees</td>
<td></td>
</tr>
<tr>
<td>• Control over how, when, and where work is conducted</td>
<td>• Higher cost (contributions to Medicare, SS, UI, WC, other payroll contributions)</td>
</tr>
<tr>
<td>• Less turnover</td>
<td>• Compliance and enforcement with employment protections (ADA, minimum wage, FMLA, anti-discrimination, etc.)</td>
</tr>
<tr>
<td>• Reduced litigation from employment classification disputes</td>
<td>• Stability and security</td>
</tr>
<tr>
<td>Independent Contractors</td>
<td></td>
</tr>
<tr>
<td>· Reduced cost</td>
<td>· Less control over how, when, and where work is conducted</td>
</tr>
<tr>
<td>· More flexibility (on-demand labor)</td>
<td>· Potential liability for injuries/illnesses/deaths by contractor</td>
</tr>
<tr>
<td>· Gain specialized skills or experience</td>
<td>· Increased exposure to employment classification lawsuits</td>
</tr>
</tbody>
</table>

**Alternative Work Arrangements**

Whether a worker benefits from the protection of a workers’ compensation policy depends on whether he or she is classified as an employee or an independent contractor. However, several alternative work relationships exist that fall along the spectrum of employee and independent contractor. These alternative work relationships create additional complexity in determining employment classification. The following alternative work arrangements are defined and tracked by the BLS:

- **Independent contractors**: Workers identified as independent contractors, independent consultants, or freelance workers, regardless of whether they are self-employed or wage and salary workers.
- **On-call workers**: Workers called to work only as needed, although they can be scheduled to work for several days or weeks in a row.
- **Temporary help agency workers**: Workers paid by a temporary help agency, whether or not their job is temporary.
- **Workers provided by contract firms**: Workers employed by a company that provides them or their services to others under contract, are usually assigned to only one customer, and usually work at the customer’s work site.

For the purposes of this paper, alternative work arrangements refer to any work performed by anyone not legally defined as an “employee.” Alternative work arrangements raise important questions about coverage for injuries, illnesses, or fatalities occurred while working.

**Platform Work**

Alternative work arrangements are not new; however, expanded internet connectivity has created new ways to connect to work. Companies allowing workers or service providers to connect to clients or customers via the internet are often described as online platforms. Online platforms have created additional complexity in defining the legal work relationship. The rise of online platforms is often seen as being synonymous with the sharing or “gig” economy; however, these platforms reflect an example of a way to facilitate an alternative work arrangement.

Some platform workers may use this type of work as supplemental income while having a full-time job. Others work for multiple platforms at one time, piecing together a living wage.17 Platform work has expanded broadly across industries, with many types of work and services offered.

<table>
<thead>
<tr>
<th>Table 2. Examples of Online Platforms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Industry</strong></td>
</tr>
<tr>
<td>Human Intelligence Tasks</td>
</tr>
<tr>
<td>Service (cleaning, installation, etc.)</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Shipping/Logistics</td>
</tr>
<tr>
<td>Legal</td>
</tr>
<tr>
<td>Design/Communications</td>
</tr>
</tbody>
</table>

**By the Numbers**

Quantifying the number of individuals within these various work arrangements is important in understanding how many workers are not covered if they have an occupational injury, illness or fatality. A rising number of individuals in alternative work arrangements could necessitate the need for new private or public solutions to address coverage gaps. Design and implementation of new programs will be influenced by who and how many workers they will serve.

Numerous public and private research efforts have attempted to quantify individuals in various work arrangements. Estimates range from less than 3% to more than 40% of the workforce. There are many

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17 It is estimated that 40% of platform workers work for multiple platforms at one time. 2015 1099 Economy Report by Requests for Startups published May 2015.
reasons for the significant difference in estimates, including data sources, survey methodology, definitions of work arrangements, and counting primary or supplemental income.¹⁸

**Estimates of Alternative Work Arrangements**

<table>
<thead>
<tr>
<th>Date</th>
<th>Publication</th>
<th>Description</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2018</td>
<td>BLS Contingent Worker Supplement</td>
<td>Published by the Bureau of Labor Statistics, the supplement measures workers in contingent (short-term or temporary) or alternative arrangements (independent contractors, temporary, on-call, or contract) as their primary source of income.</td>
<td>10.1% workforce in alternative arrangements for “primary income source”</td>
</tr>
<tr>
<td>May 2018</td>
<td>Report on Economic Well-Being of U.S. Households in 2017</td>
<td>Released by the Federal Reserve System, the survey measures adults engaged in “gig work” including both offline and online services and sales.¹⁹</td>
<td>31% adults engaged in “gig work”</td>
</tr>
<tr>
<td>2018</td>
<td>State of Independence in America 2018</td>
<td>Longitudinal study by MBO Income that quantifies workers with independent work arrangements, including consultants, freelancers, contractors, temporary and on-call workers.</td>
<td>26.9% of employed population in independent work</td>
</tr>
<tr>
<td>October 2017</td>
<td>Freelancing in America, 2017</td>
<td>Published by the Freelancers Union and Upwork, the publication estimates the number of workers in supplemental, temporary, project or contract-based work.</td>
<td>36% of the workforce in alternative work</td>
</tr>
</tbody>
</table>

This broad range and lack of research consensus has resulted in inconsistent focus and no clear mandate for policy change.

Beyond measuring the number of individuals in different types of work arrangements, it is also useful to examine multi-year trends. Besides the 2017 BLS Contingent Workforce Supplement, most studies have charted an increase over the last decade in the percentage of individuals engaged in independent or alternative work for primary or supplemental income. If this trend continues it may have important implications for labor and employment policy, including workers’ compensation programs.

**Impact of Change**

These changes and continued technological advancement will influence the U.S. workforce and workplace in the years to come.

Some of these changes have a direct impact on workers’ compensation systems. The long-term trend of declining injuries and illnesses has translated to stable or reduced premiums for employers and robust private insurance markets in most states. Other changes have influenced how care is delivered and return-to-work opportunities for those displaced from work.

Other changes, including labor force demographics and new work environments, could influence workers’ compensation both directly and indirectly. Demographic changes are influencing who, how, and where individuals are connecting to work. The differing needs (flexibility, portability, supplemental income, debt repayment, etc.) of these diverse workers may result in accelerating growth in alternative work arrangements. The ability to engage and perform services in new ways, virtual and remote, blurs lines between control and the direction of work.

Taken in whole, these changes are increasing the need to examine existing labor law and how social benefits and protections are delivered in the future. The workers’ compensation system does not exist in a vacuum. Coverage for an occupational injury, illness, or fatality must be considered in the context of the large-scale changes within the

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¹⁸ Cornell University’s School of Industrial and Labor Relations and the Aspen Institute’s Future of Work Initiative maintain the Gig Economy Data Hub which catalogues public and private research efforts to quantify various alternative work arrangements.

¹⁹ Offline services could include caregiving or house-cleaning and offline sales could include flea markets or thrift sales; online services could include platform or app work and online sales could include selling items online.
economy. At the heart of this discussion is how workers are connecting to work and who will bear responsibility for any occupational injury, illness, or fatality that occurs.

**Part II: Determining Employment Status**

Employment status is essential for understanding the benefits and protections to which a worker is entitled and the financial obligations a business must pay. The rules for this determination are found in federal and state statute. This is a complex and nuanced area of the law, with determinations of employment status dependent on the application of various tests and characteristics.\(^{20}\) There is no coordination of employment determination between federal and state law.

**Federal Standard**

Federal statutes define “employee” in many different ways. Employment related tests are considered by the Internal Revenue Service (IRS), U.S. Social Security system, Federal Insurance Contributions Act (FICA), federal Fair Labor Standards Act (FLSA), federal Civil Rights Act, federal Age Discrimination in Employment Act (ADEA), Americans with Disabilities Act (ADA), Federal Unemployment Tax Act (FUTA), and many others.

Three tests have been used in employment determination under federal law. Depending on the law, test used, and case-specific facts, a worker could be considered an employee under one law and an independent contractor under another. Employee determination under federal law does not influence workers’ compensation coverage obligations under state law. However, there are similarities in the many characteristics considered at the state and federal level. In addition, continued changes in how workers connect to work may result in pressure to clarify and/or align employment under various areas of the law.

**Tests for Employment Determination under Federal Law**\(^{21}\)

- **Common law (control):** The common law test hinges on control of the means and methods of work. This can include a variety of different factors including direction and supervision of work activities, tools and materials, payment, and intent of the relationship. The IRS uses the common law test and advises three broad categories of consideration: 1) behavioral control; 2) financial control; and 3) relationship of the parties.\(^{22}\)

- **Economic realities:** The economic realities test looks at the financial dependence of a worker on services performed for a specific business. This can include a variety of different factors, including the level of financial risk, whether services are integral to the business operation, and investment in facilities and equipment. The economic realities test is commonly applied under the FLSA which governs minimum wage and overtime requirements. The economic realities test is broader than the control test and generally favors employee status.

- **Hybrid:** The hybrid test looks at both economic and common law factors. Under the hybrid test, economic realities are more heavily weighted than common law characteristics. The hybrid test has been applied in employment determinations under Title VII of the Civil Rights Act. (see https://www.bls.gov/opub/mbr/2002/01/art1full.pdf)

Numerous cases have tested the interpretation of federal law in determining employment status. A series of FedEx cases across 20 states\(^{23}\) found the company improperly classified ground delivery drivers as independent contractors. The decisions hinged largely on the direction and control of drivers. Factors considered included requirements by FedEx drivers to wear uniforms, adhere to appearance standards, drive approved vehicles, and deliver packages on specific days and within certain times.

Decisions of the National Labor Relations Board (NLRB) have also been influential in the interpretation of federal law in this area. Most recently, a January 2019 ruling overturned a 2014 decision\(^{24}\) in favor of employee status based on the application of factors related to entrepreneurial opportunity. The NLRB decision in SuperShuttle DFW noted the independence of drivers in setting hours, ownership/lease of vans, and control of payment methods results in

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\(^{20}\) Even the courts have expressed frustration in the lack of clarity in employment determinations. The Supreme Court, for example, has referred to the definition of an employee under the Americans with Disabilities Act as a “mere ‘nominal definition,’” Clackamas Gastroenterology Assocs. v. Wells, 538 U.S. 440, 444 (2003), and has stated that the definition of an employee under the Employee Retirement Income Security Act is “completely circular and explains nothing,” Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318, 323 (1992)


\(^{22}\) See IRS at https://www.irs.gov/newsroom/understanding-employee-vs-contractor-designation

\(^{23}\) Numerous lawsuits against FedEx were filed beginning in 2004. Two class action lawsuits were heard and decided by the Seventh Circuit Court of Appeals and the Ninth Circuit Court. The decisions resulted in mediated settlements with FedEx of more than $400 million.

\(^{24}\) NLRB in a 2014 FedEx case found in favor of employee status for drivers based on application of the common law test emphasizing direction and control.
significant entrepreneurial opportunity. The greater the entrepreneurial opportunity the more likely it is an independent business which would favor independent contractor status. *(see SuperShuttle DFW, Inc. and Amalgamated Transit Union Local 1338.)*

This decision was influential in shaping the NLRB Advice Memorandum related to Uber and Uber drivers’ ability to unionize. The memo finds drivers for Uber are independent contractors based on the factors discussed in SuperShuttle DFW, with significance placed on control over manner and means and how the driver is compensated. Both decisions cite entrepreneurial independence as a key consideration in independent contractor status.

The NLRB notes, “Whether to take advantage of these opportunities were among the many entrepreneurial judgments UberX drivers made due to their freedom to set their work schedules, choose log-in locations, and pursue earnings opportunities outside the Uber system.” The ability to work for competitors beyond Uber outweighed other factors of control asserted by the platform, including baseline fares, inability to subcontract work or repeated rejection of trips. Additionally, they noted that minimum service standards and driver ratings had little impact on the driver’s earning potential. *(see Uber Technologies, Inc. Cases 13-CA-163062, 14-CA-158833, and 29-CA-177483).*

In considering platform workers, the U.S. Department of Labor (DOL) issued an opinion letter in April 2019 which designated service providers of one platform as independent contractors under the FLSA. In applying the “economic realities” test, the U.S. DOL considered six factors of service providers who secured jobs through the virtual platform. The opinion letter described the platform as a referral service not an employer.

These recent opinions have been interpreted by many as a signal of the current administration’s leaning toward liberal application of independent contractor status. It is noted again these interpretations have no bearing in employment classification status under state workers’ compensation laws. It remains to be seen if state courts will evaluate control or economic realities tests in similar ways.

**State Standards**

In 2017, more than 140 million U.S. jobs were covered under state workers’ compensation systems (NASI, Workers’ Compensation Benefits, Cost, and Coverage, 2019). State law defines workers’ compensation coverage requirements across the U.S. In all states but Texas and South Dakota, coverage is compulsory for employers. However, coverage exemptions are common. Many states do not require that workers’ compensation coverage be purchased for domestic and agricultural workers and small employers.

The general trend over the past century has been expansion of coverage to increase the number of workers protected under the workers’ compensation system. The rise of alternative employment relationships may signal a reversal of this trend. The more workers that find themselves in alternative work arrangements, the more likely they will fall outside the protection of workers’ compensation.

Much like federal law, there may be multiple definitions of “employee” within a state that apply to different areas of the law. This can include intra-state variation across the department of revenue, unemployment insurance, and/or workers’ compensation.

In an effort to simplify and reduce confusion from differing “employment” determinations across state agencies, some states have sought to develop a statewide definition of “employee.” One such effort was in Maine, when the governor created a cross-agency task force comprised of the Maine DOL, Maine Workers’ Compensation Board, and the Maine Attorney General’s Office, to develop a single definition of “employee.” The result was the following:

> Services performed by an individual for remuneration are considered to be employment subject to this chapter unless it is shown to the satisfaction of the bureau, that the individual is free from the essential direction and control of the employing unit, both under the individual's contract of service and in fact, the employing unit proves that the individual meets all of the criteria in Number 1 and three (3) of the criteria in Number 2 as listed below. *(See [https://www.maine.gov/labor/misclass/employment_standard.shtml](https://www.maine.gov/labor/misclass/employment_standard.shtml))*

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25 The six factors included control; permanency of relation; investment in facilities, equipment, and helpers; skill, initiative, judgment, or foresight required; opportunity for profit and loss; and integrality.

26 Workers’ compensation is voluntary in both Texas and South Dakota. In both states, employers lose the right to the exclusive remedy if they fail to purchase coverage.

27 Recently, exemptions for agricultural workers have been challenged. The New Mexico Supreme Court ruled in 2016 that the agricultural exemption was unconstitutional.

28 A list of state-by-state exemptions can be found in Table 2 of the WCRI/IAIABC Workers’ Compensation Laws as of January 1, 2019.
A similar effort is underway in Alaska, which is in response to the adoption of a new eight-part independent contractor test passed in 2018. (See HB 79).

**State Employment Classification**

Classification of a worker as an employee or independent contractor is essential for the workers’ compensation system as it determines the coverage obligation. From the legal perspective, states are varied in their approach to employment classification. In general, states fall into the following categories:

**“Employee” Presumption:** Twenty-five states presume a worker is an employee unless they meet the requirements of an independent contractor. A worker may be found to be an independent contractor by meeting certain criteria as defined by law (i.e. they meet all nine provisions set forth in statute) or as determined by an opinion of a judicial body (i.e., determination by a commissioner or judge based on case specific facts).

**“Independent Contractor” Presumption:** Two states presume independent contractor status for those workers who have completed necessary requirements before beginning work. These requirements generally include a written contract/form filed with the state confirming independent contractor status. The presumption of independent contractor status can be overcome.

**Silent:** Twenty-three states have no presumption of status for a worker. The criteria for determining employment status may be described but are applied to cases individually.

Appendix A compiles the state standards used to determine employment classification status for purposes of workers’ compensation coverage.

**State Employment Tests**

Similar to federal law, states have developed a variety of tests and/or criteria that are used in the decision of employment status. There are numerous factors considered in state law but generally states evaluate based on:

**Control of the means, manner, and methods of work:** Rooted in common-law, decisions about what work must be accomplished and how it should be done are central to considering control in the employment relationship. Factors of control vary across states but include who sets days/hours of work, manner in how work is conducted, service standards, appearance requirements, quality specifications or other factors interpreted as giving direction to a worker.

**Relative nature of work:** Considers the type of work and how it relates to core business functions. Examines how fundamental the work is to what the business does or how it operates.

**Hybrid:** Weights factors of both control and the relative nature of work.

Each state has a body of case law that interprets statutes and rules based on case-specific facts. A single decision may be precedential, resulting in more or less workers considered employees for purposes of workers’ compensation coverage. The opinion of the California Supreme Court in Dynamex demonstrates the time, cost, complexities and impact a case can have with respect to employment classification.

In 2004, Dynamex converted its delivery drivers to independent contractors. The company was sued, and the final ruling was issued in 2018, which found the delivery drivers were in fact employees of the company. In the decision, the California Supreme Court applied the ABC test, which requires all three factors be met to be considered an independent contractor. The three factors include:

1. Freedom from control or direction in the performance of work under the contract or engagement.
2. Work is outside the work of the hiring entities normal business.
3. Worker is engaged in an independently established trade, occupation or business of which they are performing the work.

Many have interpreted the application of the ABC test as significantly expanding those workers considered employees in California.

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29 Employment status may also affect the funding mechanism of state worker’s compensation agencies. In many states, the agency is funded through a maintenance tax or surcharge of gross workers’ compensation insurance premiums. Typically, workers’ compensation premium is calculated based on an employer’s payroll. The lower the payroll, the lower the premium, which results in less maintenance tax collected to support the workers’ compensation system administration in the state.

30 The ABC test standard for employment classification in California took effect on January 1, 2020 as a result of the passage of House Bill 5.
In contrast, courts in other states did not find an employer-employee relationship based on similar factors. In 2018, the New York Appellate Division held there was no employer-employee relationship in Vega vs. Postmates Inc. because couriers failed to provide sufficient proof of Postmates’ control over the way work was performed. Sebago vs. Boston Cab Dispatch in 2015 found that taxicab drivers were independent contractors because they were free from control and direction of the cab companies.

**Marketplace Contractors**

The state-by-state nature of employment law, uncertainty, cost and time to confirm employment status creates a volatile business environment. In the past several years, platform companies have worked to change laws to clarify the status of platform service providers as independent contractors. A new term of art, marketplace contractors, was defined, which applies to service providers who are connecting to work through a virtual platform.

Between 2016 and 2018, eight states successfully passed legislation or rule related to marketplace contractors. The eight states are: Arizona, Florida, Indiana, Iowa, Kentucky, Tennessee, Texas, and Utah. Under these new laws, platform service providers are independent contractors if they meet certain requirements. Common marketplace contractor criteria include:

- Written agreement between the platform and the marketplace contractor that says the marketplace contractor is providing services as an independent contractor and not an employee. Most of the legislation granted retroactive status if these agreements were in place previously.
- The platform must be virtual: a web, mobile application or software program. Some legislative language specifically excludes phone or fax services or prohibits services being carried out in a physical location within the state.
- Payment for services performed must be paid on a contract or rate basis. The marketplace contractor is responsible for all tax obligations.
- The marketplace contractor is responsible for providing their own tools or materials to complete the work.
- The marketplace contractor can set his or her own hours.

Some states may have exclusions include transportation networking companies (TNCs), freight transportation, political subdivisions, religious/charitable/educational organizations, and American Indian tribes.

**Impact of Legal Uncertainty of Employment Classification**

Changes in the workforce noted in Part I raise questions about the application and applicability of current methods of determining employment status, especially as related to control of means and methods of work. Work is being organized and performed in ways that allow both independence and oversight in ways that does not fit neatly within current legal frameworks described in Part II. The continued evolution of workers connecting and performing work in new ways may require revision or a redesigned framework for employment classification.

**Part III: Alternative Coverage Models**

Changes in work relationships raise important public policy questions about the protections and benefits currently linked to employment. A continued increase in alternative work arrangements may necessitate new models and programs for social protections, including wage replacement and medical care for occupational injuries, illnesses and fatalities. New programs might exist within the current workers’ compensation system or outside of it. Regardless, consideration of the human, economic and social costs of injuries, illnesses and fatalities at work is an important element to be included in future policy conversations.

Several ideas have emerged that consider benefits and protections in new forms. The following are strategies considered for protecting workers and businesses from the health and economic costs of a work injury:

**Independent Contractor Coverage**

One way to extend coverage is to amend the state workers’ compensation statute to allow a business to optionally provide workers’ compensation coverage to designated independent contractors. Elective coverage for an independent contractor would extend exclusive remedy for the business and be considered

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31 The Texas Workforce Commission adopted a rule (40 T.A.C. § 815.134) which defines a “Marketplace Contractor” as an independent contractor and makes those individuals ineligible for unemployment benefits. Since workers’ compensation is optional in Texas it has no impact on workers’ compensation coverage.

32 There have been discussion papers on alternative options for employment classification. Some have argued for dependent contractor and others have lobbied for independent workers. Any new direction would clearly need to identify which benefits and protections, including workers’ compensation, would be conferred by that status.
a benefit for the contractor. If properly structured, this would not affect the individual’s independent contractor status for unemployment insurance and wage purposes. Texas allows this option for hiring contractors in Texas Labor Code, Section 406.144.

**Black Car Fund**

The Black Car Fund is a mechanism that provides workers’ compensation coverage for more than 70,000 black car drivers in New York. The Fund was created in 1999 and is funded by a surcharge paid by the customer on each ride provided by an eligible driver.33 Drivers obtain coverage through their dispatch organizations, which are members of the Fund. The unique statutory nature of the Black Car Fund designates drivers as “employees,” so they are eligible for workers’ compensation benefits under New York state law. They retain independent contractor status for all other purposes.

More generically, this concept could be considered a “guild model” where workers providing services in a specific industry (transportation, hairdressing, engineering, etc.) could access workers’ compensation coverage collectively. This could be an attractive alternative for platform companies because the statutory nature of the fund gets around paying “benefits” that could be interpreted as “employee status.”

**Occupational Accident Insurance**

The private insurance market offers occupational accident insurance policies for those workers not eligible for workers’ compensation. These policies are often associated with high-risk industries with a significant number of independent operators/contractors (i.e. long-haul trucking). An occupational accident insurance policy offers defined coverage for a work-related injury or fatality by the policyholder. Coverage can be purchased directly by an operator/independent contractor or offered by a platform/contracting company.

As a general matter, occupational accident insurance typically includes coverages and benefits associated with workers’ compensation insurance including medical, wage replacement and death benefits. However, there are important differences in a workers’ compensation policy and an occupational accident policy. Occupational accident policies generally have a total benefits cap: a cap on medical benefits, and a cap on wage replacement. In addition, there may be no compensation for permanent impairment or consideration of vocational rehabilitation. There are often exclusions for kinds of injuries/illnesses covered, and abbreviated injury or claim reporting requirements. While there is limited access to an external dispute resolution system, occupational accident insurance is subject to the standard insurance claim dispute processes (e.g., a claimant is permitted to file a complaint with his/her state insurance department, and the insurer is subject to fair claims handling and bad faith laws).

One example is the driver injury protection policy offered to Uber drivers by Aon and Atlantic Specialty Insurance. Uber drivers pay $0.03 per mile, and coverage includes medical benefits, wage replacement benefits and death benefits if they suffer a covered injury while on the app is on. Likewise, as of June 2019, DoorDash now maintains occupational accident insurance on behalf of all U.S. “Dashers” while on a delivery.

Occupational accident insurance is regulated under a different line of insurance than workers’ compensation. This may create a disconnect or confusion for both businesses and workers regarding benefits across the two types of coverage.

**Disability Insurance**

Another mechanism for providing coverage is expanded use of disability insurance. Disability insurance provides wage replacement benefits for an individual who suffers a sickness or injury. Disability insurance has both private and public insurance options, and five states34 have mandatory disability insurance programs.

There are key differences between disability insurance and workers’ compensation: Disability insurance does not pay medical benefits, wage replacement is capped, and there is no consideration of either permanent partial or total disability or fatalities.

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33 The current surcharge is 2.5%, [https://www.nybcf.org/faqs](https://www.nybcf.org/faqs)
34 California, Hawaii, New Jersey, New York, and Rhode Island
Portable Benefits

Portable Benefit accounts de-couple social protections from the employer and offer coverages to an individual worker. An account is funded and can then be used to obtain various coverages including healthcare, disability or occupational accident insurance, and/or workers’ compensation. Funding of the account could be designed in many ways but could include contributions from an employer(s), platform(s), contract organization(s), client(s), and/or the worker.

Portable benefit accounts have been conceptually supported by policymakers, businesses, labor leaders, and think tank organizations but have not been widely piloted. Important policy, design, and administrative questions must be defined in order to understand if portable accounts would be effective in deliver benefits for work-related injuries, illnesses, and fatalities.

Each of these mechanisms could serve as a model for extending work-related injury, illness and fatality coverage for workers in alternative work arrangements.

Policy Questions and Considerations

Exclusive remedy: One of the central principles of workers’ compensation is exclusive remedy. Employees who have a work-related injury, illness or fatality receive the medical and wage replacement benefits afforded to them by state law. Once those have been received, employers have no further liabilities. If alternative coverage mechanisms are developed, should exclusive remedy be afforded to those businesses? What provisions or standards must be met to have exclusive remedy?

Universal coverage: Workers’ compensation started off as a voluntary program but trended toward universal coverage (with some exceptions). Coverage had clear benefit for both employers and employees. If universal coverage is desirable, you must decouple the mandate from the employment relationship (i.e., employee only) and determine how coverage can be delivered in different environments (i.e., Do independent contractors have to purchase a workers’ compensation policy?).

Standard benefits: Workers’ compensation benefits (wage replacement and medical) are defined in state statute and applied in the same way for all employees in a state. The advantage of a statutory benefit scheme is that it creates equity across all employees/employers and promotes societal stability (given adequacy of benefits). The disadvantage of this scheme is that benefits may not always be “fair” (i.e., account for pain/suffering; maximums penalize high income earners, etc.).

Funding/Delivery: Workers’ compensation policies are funded by employers who pay premiums or self-fund. In nonstandard work arrangements, the financial responsibility for an occupational injury is ambiguous and, therefore, who funds coverage bears discussion. Is it the contracting firm’s responsibility (i.e. for all workers regardless of employment status), or is there a cost-sharing obligation by classification or work type?

Market Access: Workers’ compensation has developed market solutions for businesses who are unable to purchase coverage in the voluntary market (residual market or insurer of last resort). Is a solution like this required or desired for workers in alternative work arrangements? Should the cost of coverage be a consideration in developing or determining solutions (i.e., if you are making $1,000 a year in additional income should you have to buy a policy that costs you some fraction of that?).

Safe Harbor: Should safe harbor provisions exist for businesses who purchase or offer some coverages (health, workers’ compensations, etc.) to ensure they are not interpreted as employment status? What provisions would need to be met for safe harbor? What liabilities would the business and worker face in these situations?
Conclusions

Workers’ compensation is an essential element of the protections and benefits businesses and workers have had in the last century. Employers gain certainty and limit their liability to injuries, illnesses, or fatalities that occur at work. Employees receive healthcare and wage replacement to heal and recover with lessened financial burden. This fragile balance has resulted in sustained stability and equity for most American businesses and their workers.

The employee-employer framework on which the U.S. workers’ compensation system is built has become increasingly complex. Businesses are relying more and more on a labor force that does not neatly fit within legally defined employees and independent contractors. These external changes have the potential for significantly changing employment related protections and benefits.

This presents real questions for the workers’ compensation system. Policymakers, labor, management, and other system stakeholders need to begin considering and preparing for these impacts. 100 years ago, workers’ compensation was adopted after countless lives were lost or seriously damaged by a work injury. Proactively addressing new changes in work and the workplace are the key to responding without more lives lost by American workers.
### Appendix A: State Standards Used to Determine Independent Contractor Status (2019)

<table>
<thead>
<tr>
<th>State</th>
<th>Presumption of Employee Status</th>
<th>Special Rules Specific Occupations</th>
<th>General Description of Criteria</th>
</tr>
</thead>
</table>
| AL    | No provision                  | ALA. CODE § 25-5-50 (2017)        | If the employer’s right of control over the individual extends no further than directing what is to be ultimately accomplished, the individual is an independent contractor. The employer must not retain the right to dictate the manner of operation or how the work should be done. The factors to be considered in determining whether an individual or an entity has retained the right of control include:  
  (1) Direct evidence demonstrating a right or an exercise of control.  
  (2) The method of payment for services.  
  (3) Whether equipment is furnished.  
  (4) Whether the other party has the right to terminate the employment.  
| AK    | No                            | ALASKA STAT. § 23.30.230 (2017)   | The Alaska Supreme Court has adopted the “relative nature of the work” test for distinguishing between employees and independent contractors. The test first considers the character of the individual’s work or business, which is determined by considering three factors:  
  (1) The degree of skill involved.  
  (2) Whether the individual holds himself out to the public as a separate business.  
  (3) Whether the individual bears the accident burden.  
The test then considers the relationship of the individual’s work or business to the purported employer’s business, which is also broken into three factors:  
  (1) The extent to which the individual’s work is a regular part of the employer’s regular work.  
  (2) Whether the individual’s work is continuous or intermittent.  
  (3) Whether the duration of the work is such that it amounts to hiring of continuous services rather than a contract for a specific job.  
The Alaska Workers’ Compensation Board applies a similar “relative nature of the work” test. The test weighs six factors, the first two being the most important; at least one of these two factors must be resolved in favor of an “employee” status for the board to find that a person is an employee. The six factors are whether the work:  
  (1) Is a separate calling or business. If the person performing the services has the right to hire or terminate others to assist in the performance of the service for which the person was hired, there is an inference that the person is not an employee. If the employer:  
  (a) Has the right to exercise control of the manner and means to accomplish the desired results, there is a strong inference of employee status.  
  (b) And the person performing the services has the right to terminate the relationship at will, without cause, there is a strong inference of employee status.  
  (c) Has the right to extensive supervision of the work, then there is a strong inference of employee status.  
  (d) Provides the tools, instruments and facilities to accomplish the work and they are of substantial value, there is an inference of employee status; if the tools, instruments and facilities to accomplish the work are not significant, no inference is created regarding the employment status.  
  (e) Pays for the work on an hourly or piece rate wage rather than by the job, there is an inference of employee status. |
(f) And person performing the services entered into either a written or oral contract, the employment status the parties believed they were creating in the contract will be given deference. However, the contract will be construed in view of the circumstances under which it was made and the conduct of the parties while the job is being performed.

(2) Is a regular part of the employer’s business or service. If it is a regular part of the employer’s business, there is an inference of employee status.

(3) Can be expected to carry its own accident burden. This element is more important than factors (4)-(6). If the person performing the services is unlikely to be able to meet the costs of industrial accidents out of the payment for the services, there is a strong inference of employee status.

(4) Involves little or no skill or experience. If so, there is an inference of employee status.

(5) Is sufficient to amount to the hiring of continuous services, as distinguished from contracting for the completion of a particular job. If the work amounts to hiring of continuous services, there is an inference of employee status.

(6) Is intermittent, as opposed to continuous. If the work is intermittent, there is a weak inference of no employee status.

**ALASKA ADMIN. CODE tit. 8, § 45.890 (2017); ALASKA STAT. § 23.30.395 (2017).**

**ARIZ.**

**Rebuttable presumption of independent contractor status created upon the execution of a written agreement compliant with ARIZ. REV. STAT. ANN. § 23-902 (2017).**

An independent contractor is a person engaged in work for a business who is:

1. Independent of that business in the execution of the work and not subject to the rule or control of the business for which the work is done.
2. Engaged only in the performance of a definite job or piece of work.
3. Subordinate to that business only in effecting a result in accordance with that business design.

As for the first element, Arizona courts have adopted the “right to control” test, which examines the following factors:

1. The duration of the employment.
2. The method of payment.
3. Who furnishes necessary equipment.
4. The right to hire and fire.
5. The extent to which the employer may exercise control over the details of the work.
6. Whether the work was performed in the usual and regular course of the employer’s business.


A business or independent contractor may prove the existence of an independent contractor relationship by executing a written agreement stating that the business:

1. Does not require the independent contractor to perform work exclusively for the business.
2. Does not provide the independent contractor with any business registrations or licenses required to perform the specific services set forth in the contract.
3. Does not pay the independent contractor a salary or hourly rate instead of an amount fixed by contract.
4. Will not terminate the independent contractor before the expiration of the contract period, unless the independent contractor breaches the contract or violates the Arizona law.
5. Does not provide tools for the independent contractor.
6. Does not dictate the time of performance.
7. Pays the independent contractor in the name appearing on the written agreement.
8. Will not combine business operations with the person performing the services rather than maintaining these operations separately.

**ARIZ. REV. STAT. ANN. § 23-902 (2017).**

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| AR | Yes | **Silvicraft, Inc. v. Lambert**, 661 S.W.2d 403 (Ark. Ct. App. 1983) | **ARK. CODE ANN. § 11-9-102 (2017)** | Various factors are considered to determine the status of a worker:

1. The right to control the means and the method by which the work is done.
2. The right to terminate the employment without liability.
3. The method of payment.
4. The furnishing, or the obligation to furnish, the necessary tools, equipment, and materials.
5. Whether the person employed is engaged in a distinct occupation or business.
6. The skill required in a particular occupation.
7. Whether the employer is a business.
8. Whether the work is an integral part of the regular business of the employer.
9. The length of time for which the person is employed.

However, the “right to control” test is usually sufficient to decide most disputes. The ultimate question in these cases is whether the employer has the right to control over the doing of the work, not whether the employer actually exercises such control. **ARK. CODE ANN. § 11-9-102 (2017); Riddell Flying Service v. Callahan, 206 S.W.3d 284 (Ark. Ct. App. 2005).** |
| CA | Yes | **CAL. LAB. CODE § 2750.5 (2017)** | **CAL. LAB. CODE § 3352 (2017)** | California adopted Assembly Bill No. 5, effective Jan. 1, 2020. This bill addresses employment status when a hiring entity claims that the person it hired is an independent contractor. AB 5 requires the application of the “ABC test” to determine if workers are employees or independent contractors.

Under the ABC test, a worker is considered an employee and not an independent contractor, unless the hiring entity satisfies all three of the following conditions:

1. The worker is free from the control and direction of the hiring entity in connection with the performance of the work, both under the contract for the performance of the work and in fact.
2. The worker performs work that is outside the usual course of the hiring entity’s business.
3. The worker is customarily engaged in an independently established trade, occupation or business of the same nature as that involved in the work performed.

Cal. Labor Code § 2750.3 (West 2019) |
| CO | Yes | **COLO. REV. STAT. ANN. § 8-40-202 (West 2017)** | **COLO. REV. STAT. ANN. § 8-40-202 (West 2017)** | Colorado courts have adopted both the “control” test and the “relative nature of the work” test for purposes for determining a worker’s status. If either test is met, the worker is considered an employee for workers’ compensation purposes. The “control” test primarily considers whether the alleged employer exercises control over the means and methods of accomplishing the contracted service. Other factors include:

1. Whether compensation is measured by time or lump sum.
2. Which party furnishes the necessary tools and equipment to perform the work.

The “relative nature of the work” test considers the following factors:

1. The character of the individual’s work.
2. The relationship of the individual’s work to the alleged employer’s business.

<table>
<thead>
<tr>
<th>State</th>
<th>No.</th>
<th>Provision</th>
<th>Statute/Code</th>
<th>Courts Adopted Test/Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>No</td>
<td>CT No. provision</td>
<td>CONN. GEN. STAT. § 31-275 (2017)</td>
<td>Connecticut courts have adopted the “right to control” test to determine a worker’s status. The test asks whether the employer has “the right to control the means and methods” used by the worker in the performance of his or her job. As such, an independent contractor is defined as one who, exercising an independent employment, contracts to do a piece of work according to his or her own methods and without being subject to the control of his employer, except as to the result of his work. Hanson v. Transp. Gen. Inc., 716 A.2d 857 (Conn. 1998); Chute v. Mobil Shipping &amp; Transportation Co., 627 A.2d 956 (Conn. App. Ct. 1993); CONN. GEN. STAT. § 31-275 (2017).</td>
</tr>
<tr>
<td>DE</td>
<td>No</td>
<td>DE No. provision</td>
<td>DEL. CODE. ANN. tit. 19, §§ 2301; 2307; 2308; 2316 (2017)</td>
<td>Delaware courts have adopted § 220 of the Restatement (Second) of Agency in determining a worker’s status. The Restatement requires consideration of the following factors: (1) The extent of control, which, by the agreement, the master may exercise over the details of the work. (2) Whether or not the one employed is engaged in a distinct occupation or business. (3) The kind of occupation, with reference to whether, in the locality, the work is usually done under the discretion of the employer or by a specialist without supervision. (4) The skill required in the particular occupation. (5) Whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work. (6) The length of time for which the person is employed. (7) The method of payment, whether by the time or by the job. (8) Whether or not the work is a part of the regular business of the employer. (9) Whether or not the parties believe they are creating the relation of master and servant. (10) Whether the principal is or is not in business. Falconi v. Coombs &amp; Coombs, Inc., 902 A.2d 1094 (Del. 2006); Restatement (Second) of Agency § 220 (1958); DEL. CODE. ANN. tit. 19, § 2301 (2017).</td>
</tr>
<tr>
<td>DC</td>
<td>No</td>
<td>DC No. provision</td>
<td>D.C. CODE § 32-1501 (2017)</td>
<td>The Department of Employment Services (DOES) applies the “relative nature of the work” test to determine a worker’s status, which focuses on whether the individual is hired to do work in which the company specializes. There are two prongs to the test. First, the nature and character of the individual’s work or business is considered by analyzing three factors: (1) The degree of skill involved. (2) The degree to which it is a separate calling or business. (3) The extent to which it can be expected to carry its own accident burden. The second prong analyzes the relationship of the individual’s work to the purported employer’s business. 3 factors are considered: (1) The extent to which the individual’s work is a regular part of the employer’s regular work. (2) Whether individual’s work is continuous or intermittent. (3) Whether the duration is sufficient to amount to the hiring of continuous services, as distinguished from contracting for the completion of a particular job. D.C. CODE § 32-1501 (2017); Gross v. D.C. Dept. of Emp’l Serv., 826 A.2d 393 (D.C. 2003).</td>
</tr>
<tr>
<td>FL</td>
<td>No</td>
<td>FL No. provision</td>
<td>FLA. STAT. § 440.02 (2017)</td>
<td>A worker is considered an independent contractor provided at least 4 of the following criteria are met: (1) The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations. (2) The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal regulations. (3) The independent contractor receives compensation for services rendered or work performed, and such compensation is paid to a business rather than to an individual.</td>
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</table>
The independent contractor holds one or more bank accounts in the name of the business entity for purposes of paying business expenses or other expenses related to services rendered or work performed for compensation.

The independent contractor performs work or is able to perform work for any entity in addition to or besides the employer at his or her own election without the necessity of completing an employment application or process.

The independent contractor receives compensation for work or services rendered on a competitive-bid basis or completion of a task or a set of tasks as defined by a contractual agreement, unless such contractual agreement expressly states that an employment relationship exists.

If four of the criteria above do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions:

1. The independent contractor performs or agrees to perform specific services or work for a specific amount of money and controls the means of performing the services or work.

2. The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.

3. The independent contractor is responsible for the satisfactory completion of the work or services that he or she performs or agrees to perform.

4. The independent contractor receives compensation for work or services performed for a commission or on a per-job basis and not on any other basis.

5. The independent contractor may realize a profit or suffer a loss in connection with performing work or services.

6. The independent contractor has continuing or recurring business liabilities or obligations.

7. The success or failure of the independent contractor’s business depends on the relationship of business receipts to expenditures.

If four of the criteria above do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions:

1. The independent contractor performs or agrees to perform specific services or work for a specific amount of money and controls the means of performing the services or work.

2. The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.

3. The independent contractor is responsible for the satisfactory completion of the work or services that he or she performs or agrees to perform.

4. The independent contractor receives compensation for work or services performed for a commission or on a per-job basis and not on any other basis.

5. The independent contractor may realize a profit or suffer a loss in connection with performing work or services.

6. The independent contractor has continuing or recurring business liabilities or obligations.

7. The success or failure of the independent contractor’s business depends on the relationship of business receipts to expenditures.

FLA. STAT. § 440.02 (2017).

An individual is an independent contractor if such person meets all of the following criteria:

1. Is a party to a contract which intends to create an independent contractor relationship.

2. Has the right to exercise control over the time, manner, and method of the work to be performed.

3. Is paid on a set price per job or a per unit basis, rather than on a salary or hourly basis.


Both the “control” and “relative nature of the work” tests are used to determine an individual’s status.

Under the “control” test, an employment relationship exists when the person in whose behalf the work is done has the power to dictate the means and methods by which the work is to be accomplished. Conversely, “[o]ne who contracts with another to do a specific piece of work for him [or her], and who furnishes and has the absolute control of his [or her] assistants, and who executes the work entirely in accord with his [or her] ideas, or with a plan previously given him [or her] by the person for whom the work is done, without being subject to the latter’s orders in respect of the details of the work, with absolute control thereof…is an independent contractor.”

The “relative nature of the work test” involves a balancing of factors regarding the general relationships which the employee has with regard to the work performed for each of his employers. Relevant factors include:

1. Whether the work done is an integral part of the employer’s regular business.

2. Whether the worker, in relation to the employer’s business, is in a business or profession of his own.


HI. REV. STAT. § 386-1 (2017).
<table>
<thead>
<tr>
<th>State</th>
<th>Status</th>
<th>Reference</th>
<th>Text</th>
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</thead>
<tbody>
<tr>
<td>ID</td>
<td>Yes</td>
<td>Moore v. Moore, 269 P.3d 802 (Idaho 2011)</td>
<td>The test to determine an individual’s status is whether the contract gives, or the employer assumes, the right to control the time, manner and method of executing the work, as distinguished from the right merely to require certain definite results. The Idaho courts use a four-factor test to determine an individual’s status: (1) There must be evidence of the employer’s right to control the employee. (2) The method of payment. (3) Whether the employer or individual furnishes major items of equipment. (4) Whether either party has the right to terminate the relationship at will, or whether one is liable to the other in the event of a preemptory termination.</td>
</tr>
<tr>
<td>IL</td>
<td>No provision</td>
<td>820 ILL. COMP. STAT. 305/1 (2017)</td>
<td>A number of factors are considered in determining an individual’s status. The most important factor is whether the purported employer has a right to control the actions of the individual, followed by the nature of the work performed by the individual in relation to the general business of the employer. Additional relevant, albeit less important, factors include: (1) The method of payment. (2) The right to discharge. (3) The skill the work requires. (4) Which party provides the needed instrumentalities. (5) Whether income tax has been withheld. (6) The label the parties place upon their relationship.</td>
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<tr>
<td>IN</td>
<td>Yes</td>
<td>Walker v. State, 694 N.E.2d 258 (Ind. 1998)</td>
<td>The Indiana Supreme Court has adopted the test articulated in § 220 of the Restatement (Second) of Agency in determining a worker’s status. The Restatement requires consideration of the following factors: (1) The extent of control which, by the agreement, the master may exercise over the details of the work. (2) Whether or not the one employed is engaged in a distinct occupation or business. (3) The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision. (4) The skill required in the particular occupation. (5) Whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work. (6) The length of time for which the person is employed. (7) The method of payment, whether by the time or by the job. (8) Whether the work is a part of the regular business of the employer. (9) Whether the parties believe they are creating the relation of master and servant. (10) Whether the principal is or is not in business.</td>
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<tr>
<td>IA</td>
<td>Yes</td>
<td>Daggett v. Nebraska-Eastern Exp., Inc., 107 N.W.2d 102 (Iowa 1961)</td>
<td>Iowa courts have adopted two tests for determining a worker’s status. First, in determining the existence of an employer-employee relationship, the courts analyze the following five factors: (1) The right of selection, or to employ at will. (2) Responsibility for payment of wages by the employer. (3) The right to discharge or terminate the relationship. (4) The right to control the work. (5) The identity of the employer as the authority in charge of the work or for whose benefit it is performed. Second, in determining whether a worker qualifies as an independent contractor, the courts consider the following eight factors:</td>
</tr>
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</table>
The existence of a contract for the performance by a person of a certain piece or kind of work at a fixed price.

The independent nature of the business or of a distinct calling.

The employment of assistants, with the right to supervise their activities.

The obligation to furnish necessary tools, supplies and materials.

The right to control the progress of the work, except as to final result.

The time for which the worker is employed.

The method of payment, whether by time or by job.

Whether the work is part of the regular business of the employer.

Above all, the “right to control” is the most important consideration.

The parties’ intent may also be considered as a factor in the analysis, although the courts have warned that this analysis should not be determinative and should only be considered if the “right to control” factor is debatable.


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<thead>
<tr>
<th>State</th>
<th>Status</th>
<th>Statutory Reference</th>
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<tbody>
<tr>
<td>KS</td>
<td>No provision</td>
<td>KAN. STAT. ANN. § 44-508 (2014)</td>
</tr>
<tr>
<td>KY</td>
<td>Yes</td>
<td>KY. REV. STAT. ANN. § 342.640 (2014)</td>
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</tbody>
</table>

Kansas courts have adopted the Restatement factors in determining a worker’s status. However, the single most important factor is whether the employer controls, or has the right to control, the manner and methods of the worker in doing the particular task. Additional considerations include:

1. Whether or not the one employed is engaged in a distinct occupation or business.
2. The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision.
3. The skill required in the particular occupation.
4. Whether the employer or the workman supplies the instrumentalities, tools and the place of work for the person doing the work.
5. The length of time for which the person is employed.
6. The method of payment, whether by the time or by the job.
7. Whether the work is part of the regular business of the employer.
8. Whether the parties believe they are creating the relation of master and servant.
9. Whether the principal is or is not in business.


Kentucky courts analyze four predominant factors to determine a worker’s status:

1. The alleged employer’s right to control the details of the work.
2. The nature of the work as related to the business generally carried on by the alleged employer.
3. The professional skill of the individual.
4. The true intent of the parties.

The “right to control” factor is the most important in the analysis, which is determined by analyzing the following factors:

1. Method of payment.
2. Which party furnishes the equipment.
3. Whether the alleged employer has the right to discharge the individual performing the work.


Louisiana courts consider the following factors in determining a worker’s status:

1. Whether there is a valid contract between the parties.
2. Whether the work being done is of an independent nature such that the individual may employ non-exclusive means in accomplishing it.
3. Whether the contract calls for specific piecework as a unit to be done according to the individual’s own methods without being subject to the control and direction of the principal, except as to the result of the services to be rendered.
4. Whether there is a specific price for the overall undertaking.
Whether the specific time or duration is agreed upon and not subject to termination at the will of either side without liability for breach.


Maryland courts consider five criteria in determining a worker’s status. The decisive consideration is the “control” test: whether the employer has the right to control and direct the employee in the performance of the work and in the manner in which the work is done. The following factors are also relevant:

(1) The power to select and hire the employee.
(2) The power to discharge.
(3) The power to control the details of the work.
(4) Whether the work is part of the regular business of the employer.


The standard in determining a worker’s status is the same as the common law agency standard, the primary factor being the right to control. Massachusetts courts consider the factors set out in the Restatement (Second) of Agency, which are as follows:

(1) The extent of control which, by the agreement, the master may exercise over the details of the work.
(2) Whether or not the one employed is engaged in a distinct occupation or business.
(3) The kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision.
(4) The skill required in the particular occupation.

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<thead>
<tr>
<th>State</th>
<th>Provision</th>
<th>Statute/Regulation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>MI</td>
<td>No provision</td>
<td>Mich. Comp. Laws §§ 418.115 to 418.120; 418.161 (2017)</td>
<td>In order for a worker to be considered an employee, three criteria must be met. The worker must not:</td>
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<td>(1) Maintain a separate business.</td>
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<td>(2) Hold himself or herself out to and render service to the public.</td>
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<td>(3) Be an employer subject to the worker’s compensation act.</td>
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<tr>
<td>MN</td>
<td>No provision</td>
<td>Minnesota regulations set forth criteria for 34 specific occupations. Minn. R. 5224.0010 to 5224.0340 (2017).</td>
<td>Minnesota courts have adopted a five-factor test to determine the status of workers not specifically engaged in the occupations enumerated in Minn. R. 5224.0010 to 5224.0340 (2017):</td>
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<td>(1) The right to control the means and manner of performance.</td>
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<td>(2) The mode of payment.</td>
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<td>(3) The furnishing of tools and materials.</td>
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<td>(4) Control over the premises where the work was done.</td>
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<td>(5) The right of discharge.</td>
</tr>
<tr>
<td>MS</td>
<td>No provision</td>
<td>Miss. Code Ann. §§ 71-3-3; 71-3-5 (West 2017)</td>
<td>Mississippi courts have adopted the “right to control” test to determine a worker’s status. The test consists of the following factors:</td>
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<td>(1) Direct evidence of right or exercise of control.</td>
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<td>(2) The method of payment.</td>
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<tr>
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<td>(3) The furnishing of equipment.</td>
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<tr>
<td></td>
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<td></td>
<td>(4) The employer’s right to fire.</td>
</tr>
<tr>
<td>MO</td>
<td>No provision</td>
<td>Mo. Rev. Stat. § 287.020 (2017)</td>
<td>The primary test to determine a worker’s status is the right to control. If an employer has the right to control the means and manner of a worker’s service, the...</td>
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<tr>
<td>State</td>
<td>Code</td>
<td>Section</td>
<td>Case Law</td>
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<tr>
<td>MT</td>
<td>Yes</td>
<td>MONT. CODE ANN. § 39-71-118 (2017)</td>
<td>McCracken v. Wal-Mart Stores East, LP, 298 S.W.3d 473 (Mo. 2009)</td>
</tr>
<tr>
<td>NE</td>
<td>Yes</td>
<td>NEB. REV. STAT. § 48-106 (2010)</td>
<td>Industry Exceptions</td>
</tr>
<tr>
<td>State</td>
<td>Independent Contractor Definition</td>
<td>Criteria for Presumption of Independent Contractor</td>
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</table>
| NV    | Nevada’s worker’s compensation law defines an independent contractor as any person who renders service for a specified recompense for a specified result, under the control of the person’s principal as to the result of the person’s work only and not as to the means as to which the result is accomplished. Under Nevada’s Industrial Insurance Act, if a worker meets three or more of the following criteria, there is a presumption that the worker is an independent contractor:  
(1) The person has control and discretion over the means and manner of the performance of any work and the result of the work, rather than the means or manner by which the work is performed, and is the primary item bargained for by the principal in the contract.  
(2) The person generally has control over the time the work is performed.  
(3) The person is not required to work exclusively for one principal unless a law, regulation or ordinance otherwise prohibits the person from providing services to more than one principal or the person has entered into a written contract to provide services to only one principal.  
(4) The person is free to hire employees to assist with the work.  
(5) The person contributes a substantial investment of capital in the business of the person, including without limitation:  
(a) Purchase or lease of ordinary tools, material and equipment.  
(b) Obtaining of a license or other permission from the principal to access any work space of the principal to perform the work.  
(c) Lease of any work space from the principal required to perform the work for which the person was engaged.  
The fact that a person does not satisfy three or more of the listed criteria does not automatically create a presumption that the person is an employee. | NEV. REV. STAT. §§ 608.0155 (2015); 616A.255. |
| NH    | Under New Hampshire’s worker’s compensation law, the presumption of employee status can be rebutted if a person meets all of the following criteria:  
(1) The person possesses or has applied for a federal employer identification number or a social security number, or in the alternative, has agreed in writing to carry out the responsibility imposed on employers under this chapter.  
(2) The person has control and discretion over the means and manner of performance of the work, in that the result of the work, rather than the means or manner by which the work is performed, is the primary element bargained for by the employer.  
(3) The person has control over the time when the work is performed, and the time of performance is not dictated by the employer, although the employer may still prescribe a completion schedule, range of work hours and maximum number of work hours to be provided by the person.  
(4) The person hires and pays the person’s assistants, if any, and to the extent such assistants are employees, supervises the details of the assistants’ work.  
(5) The person holds himself or herself out to be in business for himself or herself or is registered with the state as a business and the person has continuing or recurring business liabilities or obligations.  
(6) The person is responsible for satisfactory completion of work and may be held contractually responsible for failure to complete the work.  
<table>
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<tr>
<th>State</th>
<th>Yes/No</th>
<th>Code/Reference</th>
<th>Summary</th>
</tr>
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</table>
| NJ    | Yes    | N.J. STAT. ANN. § 43:21-19 (2010) | Under New Jersey’s unemployment law, services provided for remuneration shall be deemed to be under an employment relationship unless it is shown that:  
1. An individual has been and will continue to be free from control or direction over the performance of such service, both under his contract of service and in fact.  
2. Such service is either outside the usual course of the business for which such service is performed, or that such service is performed outside of all the places of business of the enterprise for which such service is performed.  
3. Such individual is customarily engaged in an independently established trade, occupation, profession or business.  
The New Jersey Supreme Court in Hargrove v. Sleepy’s, LLC, 106 A.3d 449 (2015) adopted the above test for worker’s compensation purposes and stated that for determining whether an individual is an employee or an independent contractor, the courts must consider twelve factors:  
1. The employer’s right to control the means and manner of the worker’s performance.  
2. The kind of occupation and whether the work is supervised or unsupervised.  
3. The amount of skill involved.  
4. Who furnishes the equipment and workplace.  
5. The length of time in which the individual has worked.  
6. The method of payment.  
7. The manner of termination of the work relationship.  
8. Whether there is annual leave.  
9. Whether the work is an integral part of the business of the employer.  
10. Whether the worker accrues retirement benefits.  
11. Whether the employer pays social security taxes.  
12. The intention of the parties.  
| NM    | Yes    | No provision | New Mexico courts will first employ a “right-to-control” test to determine whether a worker is an employee or independent contractor. If the right-to-control test points to independence, the court will then apply a “relative-nature of the work” test.  
Factors that may be considered in determining existence of employment relationship include:  
1. Direct evidence of exercise of control.  
2. The right to terminate employment relationship at will by either party without liability  
3. The right to delegate work or to hire and fire assistants.  
4. The method of payment whether by time or by job.  
5. Whether the party employed engages in distinct operation or business.  
6. Whether the work is part of employer’s regular business.  
7. Skill required in particular occupation.  
8. Whether the employer supplies instrumentalities, tools or place of work.  
9. Duration of person’s employment.  
10. Whether the person works full-time or part-time of control by one and submission to control by the other.  
| NY    | Yes    | Presumption for employment for construction workers unless the worker is a “separate business entity” § 861-c; N.Y. WORKER’S | An independent contractor is one who is:  
1. Free from control and direction in performing the job, both under his contract and in fact.  
2. The service is performed outside the usual course of business for which the service is performed.  
3. The individual is customarily engaged in an independently established trade, occupation, profession or business that is similar to the service at issue.  
When making a determination of whether an employer-employee relationship exists, the New York courts will consider factors such as the right to control the |
**Compensation Law**

<table>
<thead>
<tr>
<th>State</th>
<th>Code</th>
<th>Presumption that taxicab drivers are independent contractors</th>
</tr>
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</table>
| NC    | § 97-5.1 (2013) | North Carolina courts define “independent contractor” as one who exercises an independent employment and contracts to do certain work according to his own judgment and method, without being subject to his employer except as to the result of his work. The determinative factor in North Carolina courts as to whether a person is an employee or independent contractor for purposes of workers’ compensation is control. North Carolina courts will use the “right to control” when determining whether a person is an employee or an independent contractor for purposes of the Workers’ Compensation Act. Generally, where an employer has the right to control over the means and the methods of an employee’s work, there will be an employer-employee relationship. The requirement of control is sufficiently met where its extent is commensurate with that degree of supervision that is necessary and appropriate considering the type of work to be done and the capabilities of the person doing it. The North Carolina courts will also look at eight factors which indicate classification as independent contractor, including:

1. The worker is engaged in independent business, calling, or occupation.
2. The worker has independent use of his or her special skill, knowledge, or training in execution of work.
3. The worker is doing specified piece of work at fixed price or for lump sum or upon quantitative basis.
4. The worker is not subject to discharge because he adopts one method of doing work rather than another.
5. The worker is not in regular employ of other contracting party.
6. The worker is free to use such assistants as he or she may think proper.
7. The worker has full control over such assistants.
8. The worker is able to select his or her own time. |
| ND    | N.D. CENT. CODE § 65-01-03 | N.D. ADMIN CODE § 92-01-02-49 (2012) states that 20 factors are to be considered when determining whether a worker is an independent contractor or an employee:

1. The amount of instructions given to the employee by the employer.
2. The amount of training given to the employee.
3. The amount of integration of a person’s services into the business operations.
4. Services rendered personally. If the services must be rendered personally, the person whom the services are performed for are interested in the methods used, which goes towards employer-employee relationship.
5. The ability to hire, supervise, and pay assistants.
6. The continuing relationship between the person and person(s) for whom the services are performed.
7. Set hours of work.
8. Whether full-time is required. An independent contractor is one who is free to work when and for whom he or she chooses. Full-time required suggests an employer-employee relationship.
9. Where the work is performed.
10. The order or sequence set the work must be performed.
11. Whether there is a requirement for regular oral or written reports.
12. How the worker is paid.
13. Whether there is payment of business or traveling expenses, or both.
14. Who is responsible for furnishing of tools and materials.
15. Whether there is significant investment in facilities used by the workman.
16. Realization of profit or loss: A person who may realize a profit or suffer a loss as a result of the person’s services (in addition to the profit or loss ordinarily realized by employees) is generally an independent contractor, but the person who cannot is an employee. |
<table>
<thead>
<tr>
<th>OH</th>
<th>No provision</th>
<th>Industry Exceptions</th>
<th>Industry Exceptions</th>
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<tbody>
<tr>
<td></td>
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<td>§ 4123.01 (2015)</td>
<td>states that a person who meets at least 10 of the following criteria are excluded from the definition of employee:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Industry Exceptions</td>
<td>(1) The worker is required to comply with instructions from the other contracting party regarding the manner or methods of performing services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Industry Exceptions</td>
<td>(2) The person is required by the other contracting party to have particular training.</td>
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<td>Industry Exceptions</td>
<td>(3) The person’s services are integrated into the regular functioning of the other contracting party.</td>
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<td>Industry Exceptions</td>
<td>(4) The person is required to perform the work personally.</td>
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<td>Industry Exceptions</td>
<td>(5) The person is required to supervise their activities and has the right to control the progress of the work except as to final results.</td>
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<td>Industry Exceptions</td>
<td>(6) The person is required to supervise the work of assistants with the right to control the progress of the work except as to final results.</td>
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<td>Industry Exceptions</td>
<td>(7) The person is required to perform the work on the premises of the other contracting party.</td>
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<td>Industry Exceptions</td>
<td>(8) The person is required to follow the order of work set by the other contracting party.</td>
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<td>Industry Exceptions</td>
<td>(9) The person is required to make oral or written reports of progress to the other contracting party.</td>
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<td>Industry Exceptions</td>
<td>(10) The person is required to provide the necessary tools, supplies, and materials.</td>
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<td>Industry Exceptions</td>
<td>(11) The person is required to perform the work personally.</td>
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<td>Industry Exceptions</td>
<td>(12) The person is required to end the relationship with the other contracting party without incurring liability pursuant to an employment contract or agreement.</td>
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There is no certain number of the 20 factors of the common-law test that must be met to qualify as an independent contractor, and the degree of each factor varies depending on the occupation and the factual context in which the services are performed.


The general test for determining independent contractor status considers the following factors: who has the right to direct what shall be done and when and how it shall be done; the existence of a contract for the performance by a person of a certain piece or kind of work at a fixed price; the independent nature of the worker’s business; the worker’s employment of assistants with the right to supervise their activities; his or her obligation to furnish the necessary tools, supplies, and materials; his or her right to control the progress of the work except as to final results; the time for which the workman is employed; the method of payment, whether by time or by job; and whether the work is part of the regular business of the employer.

Gillum v. Ind. Com’n, 141 Ohio St. 373 (1943).
Department of Labor excludes business owners, volunteers, co-partners, and joint venturers from the definition of “employee”

Oklahoma’s case law and the DOL set out several factors to be considered when determining whether an employee/employer relationship exists, including:

1. The nature of the contract between the parties.
2. The degree of control the employer may exercise on the details of the work.
3. Whether the one employed is engaged in a distinct occupation or business for others.
4. The kind of occupation with reference to whether in the locality the work is usually done under the direction of the employer.
5. The skill required in the particular occupation.
6. Whether the employer or the workman supplies the instrumentalities, tools, and place of work for the person doing the work.
7. The length of time for which the person is employed.
8. The method of payment.
9. Whether the work is part of the regular business of the employer.
10. Whether the parties believe they are creating the relationship of master and servant.
11. The right of either to terminate the relationship without liability.

No one factor is controlling, and the court will look into the set of particular facts of each case.


Certain holders of professional licenses

OR. REV. STAT. § 670.600 (2005) defines an independent contractor as a person who provides services for remuneration and who is:

1. Free from direction and control over the means and manner of providing the services, subject only to the right of the person for whom the services are provided to specify the desired results.
2. Except as provided in subsection (4) of this section, is customarily engaged in an independently established business.
3. Is licensed under Oregon Revised Statutes Chp. 671 or 701 if the person provides services for which a licensed is required under those chapters.
4. Is responsible for obtaining other licenses or certificates necessary to provide services.

This definition of independent contractor has been adopted into the worker’s compensation statute. OR. REV. STAT. § 656.005 (2017)

Oregon case law states that in determining whether a person is an independent contractor, the right to control is decisive. The principal factors in determining independent contractor status are:

1. The evidence of the right to or actual exercise of control.
2. The method of payment.
3. The furnishing of equipment.
4. The right to fire.


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<th>State</th>
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<th>Text</th>
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| PA    | Yes       | Domestic Service, Real Estate, Construction Workers 77 P.S. § 676; 43 P.S. § 933.3 In determining employee or independent contractor status, the following factors should be considered, but all do not need to be present:  
(1) Control of the manner in which work is to be done.  
(2) Responsibility for result only.  
(3) Terms of agreement between the parties.  
(4) Nature of the work or occupation.  
(5) Skill required for performance.  
(6) Whether one employed is engaged in distinct occupation or business.  
(7) Who supplies the party tools.  
(8) Whether payment is by time or by job.  
(9) Whether work is part of regular business or alleged employer.  
(10) Whether alleged employer had right to terminate employment at any time.  
Control over the work to be completed and the manner in which it is to be performed are the primary factors in determining employee status for purposes of the worker’s compensation act.  
| RI    | No provision | 28 R.I. GEN. LAWS. ANN. §§ 28-29-2; 28-29-7 to 28-29-7.2; 28-29-15 Certain industries have special status or are exempted Under Rhode Island’s workers’ compensation law, an independent contractor is a person who has filed a notice of designation as independent contractor with the director pursuant to or as otherwise found by the workers’ compensation court. In determining whether a worker is an employee or independent contractor, the status depends on the employer’s right or power to exercise control over methods and means of performing the work and not the exercise of actual control. Whether an injured worker is an employee or independent contractor must be decided by the employment contract in the particular case and the surrounding particular circumstances.  
| SC    | Yes | S.C. CODE ANN. § 42-1-360 (2007) Exemption of casual employees and certain other employments from worker’s compensation law Case law establishes the criteria for distinguishing between employee and independent contractor under South Carolina’s worker’s compensation law. Determination of whether a worker’s compensation claimant is an employee or independent contractor focuses on the issue of control. In determining whether an employer had a right to control a workers’ compensation claimant in performance of his or her work, there are four factors the court will look at:  
(1) Direct evidence of the right or exercise of control.  
(2) Furnishing of equipment.  
(3) Method of payment.  
(4) Right to fire.  
It is not actual control exercised, but whether there exists a right and authority to control and direct the particular work or undertake as to the manner or means of its accomplishment.  
| SD    | No provision | S.D. CODIFIED LAWS §§ 62-1-4 to 62-1-5.1 Certain industry exceptions There are three primary factors South Dakota courts look at to determine whether one is employee or independent contractor include:  
(1) Whether individual has been and will continue to be free from control or direction over performance of services.  
(2) Both under contract of service and in fact.  
(3) Whether the individual is customarily engaged in independent established trade, occupation, profession or business. Specifically, courts will employ a “right of control” test is used to determine independent contractor status, which includes consideration of the following factors:  
(1) Direct evidence of rate of control.  
(2) Method of payment. |
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<th>State</th>
<th>Requirement</th>
<th>Description</th>
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<tr>
<td>TN</td>
<td>Yes</td>
<td>Construction workers are exempt from the statutory classification test if requirements of TENN. CODE ANN. § 50-6-102(10) are met. Tennessee’s workers’ compensation law states that to determine whether an individual is an employee or independent contractor, the following factors will be considered: (1) The right to control the conduct of the work. (2) The right of termination. (3) The method of payment. (4) The freedom to select and hire helpers. (5) The furnishing of tools and equipment. (6) Self-scheduling of working hours. (7) The freedom to offer services to other entities. For purposes of determining whether employee’s relationship is employee or independent contractor, courts consider whether work being performed by contractor is same type of work usually performed by the company that hired the contractor and whether the company has right to control employees of contractor. TENN. CODE ANN. § 50-6-102 (2017); Barber v. Ralston Purina, 825 S.W.2d 96 (1991).</td>
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<td>TX</td>
<td>No provision</td>
<td>TEX. INS. CODE ANN. §§ 406.091 to 406.165 Special coverage to members of certain industries, construction workers and farm and ranch employees. Texas’ workers’ compensation act defines an independent contractor as a person who contracts to perform work or provide a service for the benefit of another and who ordinarily: (1) Acts as the employer of any employee of the contractor by paying wages, directing activities, and performing other similar functions characteristic of an employer-employee relationship; (2) Is free to determine the manner in which the work or service is performed, including the hours of labor of or method of payment to any employee; (3) Is required to furnish or to have employees, if any, furnish necessary tools, supplies, or materials to perform the work or service. (4) Possesses the skills required for the specific work or service. The Texas courts will also consider the following factors when considering whether one is an independent contractor: the independent nature of the worker’s business; the worker’s obligation to furnish necessary tools, supplies and material to perform the job; the worker’s right to control progress of work, except as to final results; the time for which (s)he is employed; and method of payment, whether by time or by job. TEX. INS. CODE ANN. § 406.121 (1993); Industrial Indem. Exchange v. Southard, 138 Tex. 531 (1942); INA of Texas v. Torres, 808 S.W.2d 291. (1991).</td>
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<td>UT</td>
<td>Yes</td>
<td>UTAH CODE ANN. § 34A-2-104 (2017) Excludes certain industries from the definition of “employee” for purposes of the statute. Utah’s workers’ compensation law defines an independent contractor as any person engaged in the performance of any work for another who, while so engaged, is: (1) Independent of the employer in all that pertains to the execution of the work. (2) Not subject to the routine rule or control of the employer. (3) Engaged only in the performance of a definite job or piece of work. (4) Subordinate to the employer only in effecting a result in accordance with the employer’s design. The Utah court will consider whatever agreements exist concerning the right of control, as well as the actual dealings between the parties and the control that was in fact asserted. Determination of status of individual as an employee or an independent contractor is based on various factors, and of primary concern is the control, direction, supervision, or the right to control, direct or supervise on behalf of the employer. UTAH CODE ANN. § 34A-2-103 (2017); Utah Home Fire Ins. Co. V. Manning, 985 P.2d 243 (1999); Ruster Lodge v. Industrial Commission, 562 P.2d 227 (1977).</td>
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<td>Provision</td>
<td>Code References</td>
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<td>VT</td>
<td>No provision</td>
<td>Vt. Stat. Ann. tit. 21, §§ 601; 706</td>
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<td>VA</td>
<td>Yes</td>
<td>VA CODE ANN. §§ 65.2-101- to 65.2-104</td>
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<td>WA</td>
<td>No provision</td>
<td>WASH. REV. CODE ANN. §§ 51.12.010 to 51.12.185 (1996)</td>
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<td>State</td>
<td>Yes/No</td>
<td>Provision</td>
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| WV    | Yes    | W. VA. CODE R. § 85-8-6 (2008) | Under West Virginia’s worker’s compensation law, the burden of proving that an individual is an independent contractor is on the party asserting independent contractor status. The following factors are dispositive of whether a worker is an independent contractor:  
(1) Whether the individual holds himself or herself out to be in business for himself for herself, including whether he or she possesses a license, permit or other certification required to engage in the type of work the worker is performing; whether the individual enters into verbal or written contracts with the persons and/or entities for whom the work is being performed; and whether the individual has the right to regularly solicit business from different persons or entities to perform for compensation the type of work that is being performed.  
(2) Whether the individual has control over the time when the work is being performed.  
(3) The individual has control and discretion over the means and manner of the work being performed and in achieving the result of the work.  
(4) Unless expressly required by law, the individual is not required to work exclusively for the person or entity for whom the work is being performed.  
(5) If the use of equipment is required to perform the work, the individual provides most significant equipment required to perform the job.  

The West Virginia courts will look at the following factors to determine if a worker is an employee or independent contractor: the right or lack of right to supervise work, the method of payment, who owns substantial equipment to be used on the job, who determines what hours are worked, and the nature and terms of the employment contract.  
| WI    | Yes    | No provision | Wisconsin’s worker’s compensation law lists nine criteria, all of which must be met to be considered an independent contractor:  
(1) Maintains a separate business with his or her own office, equipment, materials and other facilities.  
(2) Holds or has applied for a federal employer identification number with the IRS or has filed business or self-employment income tax returns with the IRS based on that work or service in the previous year.  
(3) Operates under contracts to perform specific services or work for specific amounts of money and under which the independent contractor controls the means of performing the services or work.  
(4) Incurs the main expenses related to the service or work that he or she performs under contract.  
(5) Is responsible for the satisfactory completion of work or services that he or she contracts to perform and is liable for a failure to complete the work or service.  
(6) Receives compensation for work or service performed under a contract on a commission or per job or competitive-bid basis and not on any other basis.  
(7) May realize a profit or suffer a loss under contracts to perform work or service.  
(8) Has continuing or recurring business liabilities or obligations.  
(9) The success or failure of the independent contractor’s business depends on the relationship of business receipts to expenditures.  

The presumption that a person injured while performing service for another is an employee rather than an independent contractor is rebuttable and ceases to have force or effect when evidence to the contrary is adduced.  
WIS. STAT. ANN. § 102.07 (2016); J. Romberger Co. v. Industrial Commission, 234 Wis. 226, 229 (Wis. 1940). |
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<td>Wyoming’s workers’ compensation law defines independent contractor as “an individual who performs services for another individual or entity” and:</td>
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<td>(1) Is free from control or direction over the details of the performance of services by contract and by fact.</td>
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<td>(2) Represents his services to the public as a self-employed individual or an independent contractor.</td>
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<td>(3) May substitute another person to perform his services.</td>
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<td>The Wyoming Supreme Court has defined an independent contractor as “one who, exercising an independent employment, contracts to do a piece of work according to his or her own methods and without being subject to the control of his or her employer except as to the result of the work.” An express contract between the parties is not conclusive on whether a worker is an independent contractor. However, it is an important factor in defining the relationship between the employer and the worker. The Wyoming Supreme Court stated other factors that are important to the determination, including:</td>
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<td>(1) The method of payment.</td>
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<td>(2) The right to determine the relationship without incurring liability.</td>
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<td>(3) The furnishing of tools and equipment.</td>
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<td>(4) The scope of the work.</td>
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<td>(5) The control of the premises where the work is to be done; and whether the worker devotes all of his or her efforts to the position or if he or she also performs work for others.</td>
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The Workers’ Compensation (C) Task Force met via conference call June 2, 2020. The following Task Force members participated: James J. Donelon, Chair (LA); Jim L. Ridling, Vice Chair, represented by Gina Hunt (AL); Lori K. Wing-Heier represented by Michael Ricker (AK); Christina Corieri represented by Tom Zuppan (AZ); Alan McClain (AR); Ricardo Lara represented by Mitra Sanandajifar and Patricia Hein (CA); Andrew N. Mais represented by Qing He (CT); Trinidad Navarro represented by Frank Pyle (DE); Karima M. Woods represented by Angela King (DC); David Altmaier (FL); John F. King represented by Steve Manders (GA); Colin M. Hayashida (HI); Dean L. Cameron represented by Katie Deaver and Michele Mackenzie (ID); Robert H. Muriel represented by Reid McClintock and Erica Weyhenmeyer (IL); Vicki Schmidt represented by Heather Droge and Brenda Johnson (KS); Sharon P. Clark represented by Kevin Gaffney (VT); and Millicent M. Landrum (VA). Also participating were: Robert Wake (ME); Bob Lutton (MI); Tom Green (NE); David Dahl (OR); Mike Shinnick (TN); Marianne Baker and Nicole Elliott (TX); and Millcent M. Landrum (VA).

1. **Adopted its 2019 Fall National Meeting Minutes**

Ms. Droge made a motion, seconded by Commissioner Dodrill, to adopt the Task Force’s Dec. 9, 2019, minutes *(see NAIC Proceedings – Fall 2019, Workers’ Compensation (C) Task Force)*. The motion passed unanimously.

2. **Considered Adoption of the Workers’ Compensation Policy and the Changing Workforce White Paper**

Commissioner Donelon said the NAIC/IAIABC Joint (C) Working Group produced a white paper, *Workers’ Compensation Policy and the Changing Workforce*. This white paper addresses the changing relationships with work, a discussion regarding the determination of employee status, and alternative coverage models. The white paper was exposed for comments, and comments were received in January 2020 and incorporated into the white paper.

Commissioner Altmaier made a motion, seconded by Director Lindley-Myers, to adopt the white paper.

Mr. Stolyarov asked that the adopted version of the white paper incorporate some changes. The first change is to correct the formatting in the chart in Appendix A, as the letter “e” in the word “state” and the letter “n” in the word “presumption” spill over into the second line. He also asked that the word “once” in the “NV” section, page 51, bullet 3 be changed to read “one.” Finally, he said item 5 in the same section is missing punctuation at the end of the preface and the sub items. NAIC staff agreed to make these changes. Mr. Stolyarov made a motion, seconded by Mr. Kelly, to make these changes. The motion passed unanimously.

Ms. Sanandajifar said she had some formatting changes she would like to suggest making. The first change was under the “State Employment Tests” section, under the “Hybrid” subsection. The word “weights” should be changed to “weighs.” The next change suggested was to change the word “cap” to “cab” in the last paragraph of the “State Employment Tests” section. NAIC staff agreed to make these changes.

Ms. Sanandajifar said she had some formatting changes she would like to suggest making. The first change was under the “Marketplace Contractors” section should not be a bullet-point uten, but it should lie outside of the bulleted section. The bullet-point item will be removed from the sentence “Common exclusions include…organizations, and Indian tribes.” NAIC staff agreed to make these changes.

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Ms. Sanandajifar said there was a grammatical error in the “Black Car Fund” section. The sentence currently reads, “This is could be… ‘employee status.’” This sentence should read, “This could be… ‘employee status.’” The footnote in this same section should be changed to reflect the correct source, which is, “The current surcharge is 2.5%, https://www.nybcf.org/faqs.” NAIC staff agreed to make these changes.

Ms. Sanandajifar said under the “Policy Questions and Considerations” section, in the “Exclusive remedy” subsection, the word “business,” should be replaced with the word “businesses.” NAIC staff agreed to make these changes. Ms. Sanandajifar said she was unable to check all of the links in the footnotes. NAIC staff will check the links in the footnotes ensure that they are all referencing the correct information.

Ms. Sanandajifar made a motion, seconded by Commissioner Altmaier, to amend the white paper with the changes she suggested. The motion passed unanimously.

Commissioner McClain made a motion, seconded by Commissioner Altmaier, to adopt the amended white paper. The motion passed unanimously.

Commissioner Donelon, however, asked for a motion for the Task Force to reconsider adoption of the white paper by e-vote once the changes are made to the document.

Mr. Doucette made a motion, seconded by Commissioner Dodrill, to reconsider adoption of the white paper by e-vote once changes are made. The motion passed.

3. Discussed Possible Collection of Workers’ Compensation Data Related to COVID-19

Commissioner Donelon said the NAIC is currently collecting information from insurers regarding business interruption coverage due to the COVID-10 pandemic. The Property and Casualty Insurance (C) Committee formed a drafting group to draft the business interruption data call. The drafting group is currently discussing the need to consider collection of some type of workers’ compensation data. The financial regulators have raised the possibility of collecting information regarding exposures to address possible solvency needs for certain professions, such as health care workers and first responders like law enforcement.

Bruce Jenson (NAIC) said the drafting group held some discussion on its last call regarding the possible collection of workers’ compensation data. He said the drafting group identified the areas where some additional information might provide some valuable information. One of these areas includes exposure for workers that are classified as essential workers that may have COVID-19 claims.

Mr. Jenson said focusing on essential workers, such as first responders and health care workers would be the most important, as this is where most of the activity is being seen regarding presumptions. The drafting group has suggested that getting information from insurers writing these “essential workers” might prove helpful to state insurance regulators.

Mr. Jenson suggested finding out what percentage of business an insurer writes in these areas, as well as the percentage of employees the insurer provides workers’ compensation coverage to that fall into those categories. The idea would to be to try to identify individual insurers that may have a concentration in that market.

Mr. Jenson said, in speaking to some of the state insurance regulators, it was indicated that some insurers focus on writing workers’ compensation for market segments such as health care workers and first responders to see how heavy that concentration is so that state insurance regulators can monitor those insurers more closely from a solvency perspective. The second item the drafting group discussed obtaining for the workers’ compensation line of business is claims data. State insurance regulators expressed the desire to know the number of COVID-19 claims being received, the dollar amounts of those claims, the number of claims being approved, and the number of claims being denied. State insurance regulators also expressed the desire to collect this information by “essential worker” status.

Mr. Jenson said some of the state insurance regulators indicated that they have concerns with the possibility of premium declines due to payroll decreases across the country. Some of this information will come to light with the P/C quarterly financial statement filings; however, state insurance regulators are suggesting we may want to be more proactive in this regard.
Mr. McKenney said the COVID-19 pandemic is ongoing, and there is a possibility that there will be an increase in infection rates in the fall. He asked if the data collection drafting group was looking to conduct a data call in the immediate future and then do another data call at a later date.

Mr. Jenson said the data call would include a one-time data call to identify the insurers that may have a concentration of exposure to “essential workers.” The claims portion of the data call would be an ongoing data call that would be refreshed on a monthly basis so the development of claims over time can be tracked.

In addition to collecting claims data on an ongoing basis, Mr. Stolyarov said the exposure data should also be tracked on an ongoing basis. He said this should be done as long as the pandemic exists, and there will likely be a socioeconomic impact. Even if a second wave of the pandemic arises, there could be different implications as to any payroll reduction. One reason might be a lack of mandatory lockdown during a subsequent wave of the pandemic, if for instance there are improved medical measures to keep the virus under control, or if it is recognized that lockdowns have largely failed as a strategy. In either of these situations, payroll reductions may be less pronounced than they were during the first wave of the pandemic.

Mr. Stolyarov said that while working with the Nevada governor’s office to estimate premium tax reductions, using unemployment insurance claims data was the only data that was granular enough to use for his estimations. He said this data allowed him to create a rough proxy for an unemployment rate to be used on a weekly basis. Mr. Stolyarov said it would be ideal to have the data regarding payroll or other insured exposures directly from the insurer.

Mr. McKenney asked Mr. Stolyarov if he was concerned that the decrease in payroll may not be known until after the policy expires and the audit is completed.

Mr. Stolyarov said there could be preliminary estimates or adjustments. Nevada has encouraged self-audits or virtual audits and to make the adjustments sooner rather than later, with the understanding that there would be a final verification process at a later date. In the meantime, Mr. Stolyarov said he believes that a lot of insurers have adjusted their adjustments of payroll in recognition of the pandemic and its impact. He said there could be refinements to those figures in the course of subsequent audits, but if it is just random variation that is driving those refinements, they should roughly cancel one another. The only way this would not be the case would be if there was some systemic factor that almost everyone, including the insurers and the employers miss in providing and accepting estimates of payroll.

Mr. Kelly said he understands the desire to find the concentration of “essential workers” and the claims data. He asked if there would be anything in future data calls that would look at health care workers’ compensation data. Mr. Kelly said one of the major issues being faced in Minnesota is that health care workers are self-insured employers and a presumption for these workers and first responders was put into legislation in Minnesota.

Mr. Jenson said the drafting group did not focus on this issue; however, he does believe it was brought up in conversation. He said the challenge is that the data call has to be limited to entities that file data with the NAIC. It would be difficult for the NAIC to collect data from entities that do not file financial statements with the NAIC.

Mr. Doucette said he agrees that it would be difficult to collect data from self-insureds. He said New Mexico’s workers’ compensation office could obtain data from self-insureds. He said he did not know if this was the case for other states.

Mr. Wake said Maine would be able to collect this information, noting that most health care workers in Maine are self-insured.

Mr. McKenney agreed and said police, fireman and municipalities are largely self-insured in Pennsylvania, as well.

Mr. Kelly said Minnesota has a workers’ compensation reinsurance pool that is a quasi-private/public entity with a board that is overseen by the Minnesota Labor and Industry Commissioner. He said the Department of Commerce provides actuarial assistance. Minnesota has a self-insured security fund that only steps in to pay claims in the event of a bankruptcy. Mr. Kelly said Minnesota has found that the U.S. Department of the Treasury (Treasury Department) guidance allows for federal
Coronavirus Aid, Relief, and Economic Security (CARES) Act dollars to pay for government frontline workers, but they are still looking for backstops for the private self-insureds.

Mr. McKenney said he could see where a solvency group would not be as concerned with the self-insured companies, but he believes this is where the various state special funds would come into play if a self-insured was not able to cover its exposure. He said there is a desire to capture data for self-insureds’ exposures.

Mr. Kelly said they have entities that are health insurers, health care workers, and hospitals, so they are both a regulated entity and an insurance company, but they also have the health care system where they employ lots of frontline health care workers. He said that while they have a program, the retention limit varies from $500,000 to $5,000,000 and a lot of these costs cover COVID-19. This leaves only two weeks across the entire frontline workforce, and they are never going to hit that limit to trigger that program. This is front and center for Minnesota right now.

Mr. Dahl said it is his understanding that many self-insureds a lot of times set their contributions based on a reserve review, and they are not actually priced based on exposure.

In Pennsylvania, Mr. McKenney said they have large group municipalities and self-insured trusts that largely deal with first responders, and they are not insurance companies; however, they get an exemption in Pennsylvania law. He said there might be some state-by-state differences in the way this is handled.

4. Discussed Key Topics and Future Work Product Regarding Workers’ Compensation Issues Related to COVID-19

Commissioner Donelon said COVID-19 has raised several issues regarding workers’ compensation. Some of the issues include presumptions for certain workers, possible premium increases due to presumptions, possible solvency issues for insurers that write niche businesses, and possible economic effects due to the effects of COVID-19. Commissioner Donelon asked the Task Force members if they had any input regarding initiatives or future work products they might want to consider.

No Task Force members had topics they wanted to discuss at this time. Commissioner Donelon asked for a motion to invoke the help of the NAIC/IAIABC Joint (C) Working Group to help with possible work products concerning COVID-19 in the future.

Mr. Doucette made a motion, seconded by Ms. Lohman, to invoke the help of the NAIC/IAIABC Joint (C) Working Group to help with possible work products concerning COVID-19 in the future. The motion passed.

Having no further business, the Workers’ Compensation (C) Task Force adjourned.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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Market Regulation and Consumer Affairs (D) Committee  
Virtual Summer National Meeting  
August 11, 2020

The Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 11, 2020. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Trinidad Navarro (DE); Dean L. Cameron (ID); Robert H. Muriel (IL); Chlora Lindley-Myers and Cindy Amann (MO); Matthew Rosendale represented by Jeannie Keller (MT); Russell Toal represented by Robert Doucette (NM); Kent Sullivan represented by Ignatius Wheeler (TX); Michael S. Pierrick represented by Kevin Gaffney and Phil Keller (VT); and Mark Afsbile and Rebecca Rebolz (WI). Also participating were: Doug Ommen (IA); Bruce R. Ramge and Laura Arp (NE); Larry D. Deiter (SD); and John Haworth (WA).

1. **Adopted its July 27 Minutes**

Commissioner Richardson said the Committee met July 27 and took the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) adopted standardized data requests (SDRs) for farmowners claims and farmowners policy in force; and 3) adopted revised Market Conduct Annual Statement (MCAS) data call and definitions for life and annuities, homeowners, private passenger auto, and lender-placed auto and homeowners. Mr. Doucette made a motion, seconded by Ms. Biehn, to adopt the Committee’s July 27 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its Task Force and Working Group Reports**

   a. **Antifraud (D) Task Force**

Commissioner Navarro said the Antifraud (D) Task Force met Aug. 3 and adopted its May 20 minutes. He said the Task Force continues to collaborate with the states, industry and antifraud organizations monitoring insurance fraud directly related to the COVID-19 pandemic. He said the Task Force received updates from California, Florida and Texas.

Commissioner Navarro said the Task Force received updates from the Coalition Against Insurance Fraud (CAIF) and the National Insurance Crime Bureau (NICB). He said the Task Force advised it will continue monitoring the pandemic and conference calls will be scheduled as necessary to continue its discussions and bring awareness to the public.

Commissioner Navarro said the Task Force received and update from the Antifraud Education Enhancement Working Group. He said the Working Group updated the “Safety Training for Private Sector Field Employees” course (EDU 330-130) to include COVID-19 safety precautions. He a webinar for the private sector will be held Aug. 26. In addition, the Working Group worked with fraud directors to finalize the content of the NAIC Investigator Safety Training Program. He said the program was initially offered several years ago and the was incorporated into the “Basic Fraud Investigations” course (EDU 330-107). This training will be held Sept. 30. He said the Working Group is also planning to present additional webinars to benefit both the state and private industry investigators.

Commissioner Navarro said the Task Force also received an update from the Antifraud Technology (D) Working Group. He said the Working Group has two projects it is working on or monitoring. The first project is the Online Fraud Reporting System (OFRS) redesign, which is being worked on by NAIC staff. They are finalizing the conversion of the existing system over to the new platform and are planning a demonstration of the new platform during the NAIC Insurance Summit in September. He said the second project is the creation of a single-point online repository for insurers to file their antifraud plans. He said the Working Group is in the initial stages of this process and currently revising the 2011 Antifraud Plan Guideline (#1690) before proceeding with the creation of the repository. He said the Working Group will be distributing a new draft of Guideline #1690 for a public comment period ending Aug. 28.

   b. **Market Information Systems (D) Task Force**

Director Wing-Heier said the Market Information Systems (D) Task Force met Aug. 4. She said that during the meeting, the Task Force heard a report from the Market Information Systems Research and Development (D) Working Group concerning its work during its July 8 and July 22 meetings. She said the Task Force adopted the Working Group’s approval of two Uniform System Enhancement Request (USER) forms to add additional codes to the NAIC’s Complaints Database System (CDS). The codes to be added are a new subject code for “pandemic” and three new coverages codes for “business interruption,” “lender-
placed insurance” and “pet insurance.” Director Wing-Heier said the Task Force also heard a presentation from Birny Birnbaum (Center for Economic Justice—CEJ) regarding the use of artificial intelligence (AI) in market analysis and market regulation.

c. Producer Licensing (D) Task Force

Director Deiter said the Producer Licensing (D) Task Force met Aug. 3 and adopted its May 6 minutes. Director Deiter said the Task Force discussed producer licensing issues arising from COVID-19. He said the Task Force continues to focus on access to producer licensing examinations. He noted that while 30 states issued bulletins offering temporary licensing, 15 states reported the implementation of online, proctored examinations and that increased to 20 states since Aug. 3. He said for those states offering online examinations, approximately 50%–60% of all examinations have been taken online. He said for the latest information on state bulletins, he encourages everyone to visit the NIPR’s COVID-19 message center. Director Deiter said examination vendors (PSI, Pearson Vue and Prometric) all reported they can implement online examinations for a state in less than 60 days, but it could be as quick as one week. Director Deiter also said the Task Force will have additional discussions on licensing uniformity and reciprocity for independent adjuster licensing in the coming months.

d. Market Conduct Examination Standards (D) Working Group

Director Ramge said the Market Conduct Examination Standards (D) Working Group met July 23, 2020; March 4, 2020; and Dec. 18, 2019.

Director Ramge said that during its July 23 meeting, the Working Group welcomed Illinois as a new member state, and new regulator representation for New Mexico and Ohio. The Working Group also adopted new examination standards addressing limited long-term care insurance for inclusion in the Market Regulation Handbook. He said the new examiner guidance is based on the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643). He said the Working Group also adopted a new inland marine in-force policies SDR and a new inland marine claims SDR for inclusion in the reference documents of the Market Regulation Handbook.

Director Ramge said that during its March 4 meeting, the Working Group welcomed North Carolina as a new member state, and new regulator representation for Nevada, Oklahoma and Oregon. The Working Group also discussed its 2020 charges and potential tasks. He said the Working Group also continued its discussion of limited long-term care insurance draft examination standards.

Director Ramge said that during its Dec. 18, 2019, meeting, the Working Group adopted a new farmowners policy in force SDR and a new farmowners claims SDR. He said the Working Group also reviewed and discussed comments received on draft examination standards addressing limited long-term care insurance.

e. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met July 30 and adopted its March 23 minutes, which included the adoption of travel insurance as the next line of business in MCAS. He said also during its March 23 meeting, the Working Group agreed to a 60-day extension of the 2020 MCAS due date to allow companies to address COVID-19-related issues. Because of the extension, most lines of business were due June 30 and the health and disability lines of business are due at the end of August. Mr. Haworth said that during its July 30 meeting, the Working Group adopted scorecard ratios for the private flood MCAS blank. He noted that the MCAS will require companies to file private flood data for the first time on the next MCAS due date in April 2021.

f. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met July 31. During this meeting, the Working Group adopted its June 24 minutes. Ms. Rebholz said the Working Group discussed homeowners MCAS clarifications related to newly added underwriting data elements; life and annuity MCAS reporting of national producer numbers (NPNs) for third party administrators (TPAs) within the interrogatories; and homeowners and private passenger automobile MCAS reporting of NPNs for TPAs and managing general agents (MGAs) within the interrogatories. Additionally, the Working Group discussed possible reporting of accelerated underwriting within the life MCAS; placement options for the complaints and lawsuit data elements within the homeowners and private passenger automobile MCAS; and possible homeowner MCAS claims reporting of digital claims settlements and other than digital claims settlements in the dwelling and personal property coverage types. Ms. Rebholz said the Working Group also heard and discussed industry concerns about the addition of a newly adopted data element to collect claims closed without payment below the deductible for the private passenger automobile MCAS.
g. **Market Regulation Certification (D) Working Group**

Mr. Haworth said the Market Regulation Certification (D) Working Group has not met since February because of the need to address the COVID-19 crisis. He said that during the Working Group’s Feb. 20 and Jan. 30 meetings, the Working Group considered suggestions submitted by interested parties and interested insurance regulators. Mr. Haworth said the Working Group also began discussions on the pass/fail metrics for the Market Regulation Certification Program. He said the Working Group is still planning to provide its draft revisions to the Committee during the Fall National Meeting.

h. **Privacy Protections (D) Working Group**

Ms. Amann said the Privacy Protections (D) Working Group met July 30 and adopted its May 5 minutes. Ms. Amann said the Working Group received updates on data privacy legislation by NAIC Legal Division staff, which included federal privacy legislation and state data privacy legislation. Ms. Amann said the Working Group also heard a presentation that included a comparative analysis and comments from the Blue Cross and Blue Shield Association (BCBSA) and Arbor Strategies LLC, representing a coalition of several insurers. Ms. Amann said the Working Group also reviewed plans to begin a gap analysis discussion by Working Group members, interested state insurance regulators and interested parties using the *Privacy of Consumer Financial and Health Information Regulation* (#672) as a baseline model.

i. **Market Actions (D) Working Group**

Commissioner Richardson thanked Mr. Wheeler his leadership as chair of the Market Actions (D) Working Group in 2020, as well as his long-term service to state insurance regulation. She congratulated him on his retirement at the end of August. Commissioner Richardson said Matt Gendron (RI), the current vice chair of the Working Group, will assume the role of chair, and Ms. Biehn will serve as the new vice chair for the rest of this year.

j. **Advisory Organization Examination Oversight (D) Working Group**

Commissioner Ommen said the Advisory Organization Examination Oversight (D) Working Group was appointed to coordinate and provide oversight of the examinations of multistate advisory organizations, which includes rating organizations and statistical agents. He said the goal is to be more efficient than having multiple single-state exams of advisory organizations and leverage the collective expertise of the Working Group members.

Commissioner Ommen said the Working Group met July 28 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. He said that during the meeting, the Working Group agreed to ask three companies to complete a Comprehensive Annual Audit (CAA) form seeking more information about their operations. He noted the Working Group is considering adding these three advisory organizations to the Working Group’s current list of companies that the Working Group members regularly examine. Additionally, he said the Working Group heard a final update on the conclusion of one examination and discussed the planning of the next examination to begin in about a month.

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the following reports: 1) Antifraud (D) Task Force; 2) Market Information Systems (D) Task Force, including its recommendation to add a “pandemic” subject code and the coverage codes for “business interruptions,” “lender-placed insurance” and “pet insurance” to the CDS; 3) Producer Licensing (D) Task Force; 4) Market Analysis Procedures (D) Working Group, including its July 30 minutes (Attachment Two) and its recommendation to add travel insurance as the next line of business for MCAS and implement new scorecard ratios for the private flood MCAS blank; 5) Market Conduct Annual Statement Blanks (D) Working Group, including its July 31 minutes (Attachment Three) and its recommended clarification to the definition of “individual indexed variable annuity” for the MCAS blank; 6) Market Conduct Examination Standards (D) Working Group, including its July 23 minutes (Attachment Four); 7) Privacy Protections (D) Working Group, including its July 30 minutes (Attachment Five); 8) Market Regulation Certification (D) Working Group, including its Feb. 20 minutes (Attachment Six); 9) Market Actions (D) Working Group; and 10) Advisory Organization Examination Oversight (D) Working Group. The motion passed unanimously.

3. **Heard Presentation from Alliance Health Care Sharing Ministries**

Katy Talento (Alliance of Health Care Sharing Ministries—Alliance) provided background on what health care sharing ministries (HCSMs) are and noted they are defined in and exempted from the federal Affordable Care Act (ACA). She said Alliance is a nonprofit, nonpartisan coordinating body of seven HCSMs. Alliance provides issue advocacy and public relations on behalf of its member HCSMs. She said the member HCSMs must be certified by the federal Centers for Medicare &
Medicaid Services (CMS) and adhere to Alliance’s standards. Additionally, she said Alliance is moving toward developing accreditation requirements to be an Alliance member.

Ms. Talento said the U.S. Department of Health and Human Services (HHS) has certified that 108 HCSMs meet the federal definition of “health care sharing ministry.” She said 1.5 million Americans are active members of an HCSM and reside in all 50 states. She said HCSM are not insurance. She noted that HCSMs share 100% of eligible medical bills and, in 2019, there were $1.3 billion in shared medical expenses.

Ms. Keller said the use of the term “accreditation” can create confusion. This term is used by the state departments of insurance (DOIs) to demonstrate that a DOI has met certain NAIC requirements in its conduct of financial analysis and regulations and their financial regulation activities can be relied on by other DOIs. Commissioner Clark agreed with Ms. Keller. Ms. Talento acknowledged their concerns and noted that many different entities outside the field of insurance use the term “accreditation.” Commissioner Clark asked who would conduct the accreditation audits. Ms. Talento said it would be an outside vendor.

Director Cameron asked if Alliance is opposed to the DOIs doing the accreditation audits. Ms. Talento said the concern would be that Alliance HCSMs want to be treated as religious organizations, not insurers. She suggested maybe the state attorneys general offices could do the audits. Director Cameron said he understood the concern but noted that DOIs regulate multiple types of organization and have the resources and experience. He said he believes audits could be done by the DOIs without indicating an HCSM is an insurer.

Superintendent Toal questioned the figure that 100% of eligible expenses have been shared. He said it implies that all medical bills are paid when they are, in fact, not all paid. Ms. Talento said each HCSM has guidelines that explain what types of medical bills are eligible and paid, and which are not eligible. She appreciated the feedback and said Alliance strives to be clear about eligible and non-eligible expenses. Commissioner Clark asked what percentage of the total submitted eligible expenses the $1.3 billion in shared expenses represent. Ms. Talento said she would have to get back with that information. Ms. Arp asked if Alliance could provide a list of the 108 HHS-certified HCSMs.

Commissioner Oommen asked if Alliance is concerned that if the definition of HCSM is little more than an ethical or shared belief in human health, then this will collapse the concept as an exclusion from insurance. Ms. Talento said she could only speak on behalf of the Alliance members that require common religious, biblical beliefs. She said the ACA definition requires a common ethical or religious belief, but Alliance members are strictly biblically based religious HCSMs.

Ms. Biehn asked if the Alliance HCSM could share the eligibility guidelines used by its members. Ms. Talento said she believes each HCSM has its guidelines posted online. She said she would provide links. Mr. Keller asked whether any non-religious HCSMs have wanted to be an Alliance member. Ms. Talento said all of Alliance’s HCSMs have religious affiliations. She said Alliance believes that makes for the clearest distinction.

4. **Discussed Template for Waiver of On-Site Reviews**

Commissioner Richardson said the American Property Casualty Insurance Association (APCIA) produced a template for a state bulletin on the waiver of on-site reviews requirements during a public health emergency. She said this is not a bulletin developed by the Committee or any of its working groups. She said the APCIA raised this issue with NAIC staff and, in response, NAIC staff worked with the APCIA to draft the bulletin template. Commissioner Richardson said this is an important enough issue to provide Lisa Brown (APCIA) an opportunity to make some comments on the topic and briefly review the template for state use in the event a state would like to issue such a bulletin.

Tim Mullen (NAIC) said Ms. Brown reached out to him to discuss what the states were doing about waiving on-site reviews of MGAs and TPAs during the current COVID-19 crisis. He said the APCIA suggested the use of its state bulletin template. He said NAIC staff provided information on the model laws related to on-site reviews for reference in the template. He said similar templates have been used for producer licensing. He said this is an informational document for members to consider for use.

Ms. Brown said the APCIA worked with NAIC leadership regarding regulatory relaxations during the early stages of the crisis. She said on-site reviews were overlooked and she asked the Committee to please consider this bulletin template to waive on-site reviews until the end of the COVID-19 crisis.
5. **Adopted New Examination Standards and SDRs**

Director Ramge said that on July 23 the Market Conduct Examination Standards (D) Working Group adopted new examination standards addressing limited long-term care; a new inland marine policy in force SDR; and a new inland marine claims SDR. Director Ramge said the limited long-term care examination standards are based on Model #642 and Model #643 and will be included in the *Market Regulation Handbook*. Director Ramge said the inland marine SDRs will be incorporated in the *Market Regulation Handbook* reference documents. Director Cameron made a motion, seconded by Commissioner Afable, to adopt the limited long-term care examination standards (Attachment Seven) and the two inland marine SDRs (Attachment Eight and Attachment Nine). The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

W:\National Meetings\2020\Summer\Cmte\D\8-D Cmte
The Market Regulation and Consumer Affairs (D) Committee met via conference call July 27, 2020. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain represented by Jimmy Harris (AR); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron (ID); Robert H. Muriel represented by Erica Weyhenmeyer (IL); Anita G. Fox represented by Michele Ridering (MI); Chlora Lindley-Myers represented by Cynthia Amann (MO); Russell Toal represented by Robert Doucette (NM); Mike Causey represented by Tracy Biehn (NC); Kent Sullivan represented by Doug Slape, Matthew Tarpley, Jamie Walker and Ignatius Wheeler (TX); Michael S. Pieciak represented by Christina Rouleau (VT); and Mark Afable represented by Jo LeDuc and Rebecca Rebholz (WI). Also participating was: Bruce R. Ramge (NE).

1. **Adopted its 2019 Fall National Meeting Minutes**

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the Committee’s Dec. 9, 2019, minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee). The motion passed unanimously.

2. **Adopted Farmowners SDRs**

Director Ramge said the Market Conduct Examination Standards (D) Working Group adopted on Dec. 18, 2019, a farmowners claims standardized data request (SDR) and a farmowners policy in-force SDR. There were no questions or comments on the SDRs.

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the farmowners claims SDR (Attachment One-A) and the farmowners policy in-force SDR (Attachment One-B). The motion passed unanimously.

3. **Adopted Revised MCAS Blanks**

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met May 28, May 27, May 21 and May 20 and adopted edits to existing Market Conduct Annual Statement (MCAS) lines of business. The Working Group also met June 24 and adopted instructional clarifications needed that related to changes adopted in May. Ms. Rebholz provided the following summary of changes.

   a. **Life and Annuities Data Call and Definitions**

Two data elements were added that related to policy surrenders. An interrogatory was added to identify third-party administrators (TPAs) used by the company along with their function. Reporting was added for external replacements of unaffiliated company policies and external replacements of affiliated company policies. Lawsuits data elements were added for consistency across the MCAS lines of business. Reporting for individual fixed annuities was broken out into individual indexed fixed annuities and individual other fixed annuities. Reporting for individual variable annuities was broken out into individual indexed variable annuities and individual other variable annuities.

   b. **Homeowners Data Call and Definitions**

Wording for interrogatories related to the explanation of company changes was updated for clarity. Interrogatories were added to report managing general agents (MGAs) and TPAs used by the company. Lawsuits data elements and definitions were updated to be consistent across MCAS lines of business. Policy count data elements were added to the underwriting for the reporting of: 1) dwelling fire policies; 2) homeowners policies; 3) tenant/renter/condo policies; and 4) all other residential property policies.
c. **Private Passenger Auto Data Call and Definitions**

Wording for interrogatories related to the explanation of company changes was updated for clarity. Interrogatories were added to report MGAs and TPAs used by the company. Lawsuits data elements and definitions were updated to be consistent across MCAS lines of business. An interrogatory was added to report the use of telematics or usage-based data. A data element was added for “claims closed without payment because the amount claimed is below the insured’s deductible.”

d. **Lender-Placed Data Call and Definitions**

Separate reporting of blanket vendor single interest (VSI) auto and blanket VSI homeowners was added.

Ms. Rebholz said interrogatories I-28 and I-20, which ask for the percentage of lender-placed coverage, were inadvertently included and should be deleted from the interrogatories for lender-placed auto insurance and lender-placed homeowners insurance.

Commissioner Clark made a motion, seconded by Mr. Doucette, to adopt the four revised MCAS blanks—life and annuities (Attachment One-C), homeowners (Attachment One-D), private passenger auto (Attachment One-E) and lender-placed (Attachment One-F)—with the deletion requested by Mr. Rebholz to the lender-placed interrogatories. The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
CLAIMS STANDARDIZED DATA REQUEST

Property & Casualty Line of Business
Farmowners

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of Farmowners claims within the scope of the examination.
- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted;
- Cross-reference with the company’s in force data file to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper adjuster licensure.

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POLICY IN FORCE STANDARDIZED DATA REQUEST

Property & Casualty Line of Business
Farmowners

Contents: This file should be downloaded from company system(s) and contain one record for each property insured under a Farmowners policy issued in [applicable state] which was in force at any time during the examination period.

For multiple dwellings, non-dwelling structures, and scheduled farm property, please repeat records as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of Farmowners policies in [applicable state] within the scope of the examination.

- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state(s) licensing information to ensure proper producer licensure.

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<tr>
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<td>Reason for cancellation/termination of coverage (i.e.,) If codes are used, provide a list of codes along with their meanings</td>
</tr>
<tr>
<td>CanTerNt</td>
<td>893</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date the cancellation/termination notice was mailed [MM/DD/YYYY]</td>
</tr>
<tr>
<td>PremRef</td>
<td>903</td>
<td>11</td>
<td>N</td>
<td>2</td>
<td>Amount of premium refunded to the insured</td>
</tr>
<tr>
<td>RfndDt</td>
<td>914</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date premium refund mailed [MM/DD/YYYY]</td>
</tr>
<tr>
<td>RefMthd</td>
<td>924</td>
<td>25</td>
<td>A</td>
<td></td>
<td>Refund method (i.e., 90%, pro rata, etc.) If codes are used, provide a list of codes along with their meanings</td>
</tr>
<tr>
<td>EndRec</td>
<td>949</td>
<td>1</td>
<td>A</td>
<td></td>
<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
</tr>
</tbody>
</table>
MCAS Blanks (D) Working Group Approved
Changes May20 and May 21, 2020 and Additional Clarifications June 24, 2020

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Lines of Business:
- Individual Life Cash Value Products
- Individual Life Non-Cash Value Products
- Individual Fixed Annuities
- Individual Indexed Fixed Annuities
- Individual Other Fixed Annuities
- Individual Variable Annuities
- Individual Indexed Variable Annuities
- Individual Other Variable Annuities

Reporting Period: January 1, 2021 through December 31, 2021
Filing Deadline: April 30, 2022

Contact Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

Life and Annuity Product Types

<table>
<thead>
<tr>
<th>Product Identifiers</th>
<th>Explanation of Product Identifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICVP</td>
<td>Individual Life Cash Value Products (Includes Variable Life, Universal Life, Variable Universal Life, Term Life with Cash Value, Whole Life, &amp; Equity Index Life)</td>
</tr>
<tr>
<td>INCVP</td>
<td>Individual Life Non-Cash Value Products (Any life insurance policy that does not contain a cash value element)</td>
</tr>
<tr>
<td>IFA</td>
<td>Individual Fixed Annuities (Includes Equity Index Annuity Products)</td>
</tr>
<tr>
<td>IIFA</td>
<td>Individual Indexed Fixed Annuities</td>
</tr>
<tr>
<td>IOFA</td>
<td>Individual Other Fixed Annuities</td>
</tr>
<tr>
<td>IVA</td>
<td>Individual Variable Annuities</td>
</tr>
<tr>
<td>IIVA</td>
<td>Individual Indexed Variable Annuities</td>
</tr>
<tr>
<td>IOVA</td>
<td>Individual Other Variable Annuities</td>
</tr>
</tbody>
</table>
## Market Conduct Annual Statement
### Life & Annuities Data Call & Definitions

#### Schedule 1A—Life Interrogatories

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A-01</td>
<td>Individual Life Cash Value – Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-02</td>
<td>Individual Life Non-Cash Value – Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-03</td>
<td>Is there a reason that the reported Individual Life Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-04</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1A-05</td>
<td>Is there a reason that the reported Individual Life Non-Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-06</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1A-07</td>
<td>Does the company use third party administrators (TPAs) for purposes of supporting the individual life business being reported?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-08</td>
<td>If yes, provide the names and functions of each TPA.</td>
<td>Comment</td>
</tr>
<tr>
<td>1A-09</td>
<td>Individual Life Cash Value comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1A-10</td>
<td>Individual Life Non-Cash Value comments</td>
<td>Comment</td>
</tr>
</tbody>
</table>

#### Schedule 1B—Individual Life Cash Value (ICVP) and Non-Cash Value (INCVP) Products

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B-11</td>
<td>Number of New Replacement Policies Issued During the Period (Include only the number of replacement insurance policies issued)</td>
</tr>
<tr>
<td>1B-12</td>
<td>Number of Internal Replacements Issued During the Period</td>
</tr>
<tr>
<td>1B-13</td>
<td>Number of External Replacements Issued During the Period</td>
</tr>
</tbody>
</table>
**Market Conduct Annual Statement**

**Life & Annuities Data Call & Definitions**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B-14</td>
<td>Number of External Replacements of Affiliated Company Policies Issued During the Period.</td>
</tr>
<tr>
<td>1B-15</td>
<td>Number of Policies Replaced Where Age of Insured at Replacement was &lt;65 (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-16</td>
<td>Number of Policies Replaced Where Age of Insured at Replacement was Age 65 and Over (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-17</td>
<td>Number of Policies Surrendered Under 2 Years from Policy Issue (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-18</td>
<td>Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-19</td>
<td>Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-20</td>
<td>Number of Policies Surrendered More Than 10 Years from Policy Issue (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-21</td>
<td>Total Number of Policies Surrendered During the Period (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-22</td>
<td>Number of Policies Surrendered with a Surrender Fee (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-23</td>
<td>Number of Policies Issued During the Period where age of insured at issue was &lt;65 (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-24</td>
<td>Number of Policies Issued During the Period where age of insured at issue was Age 65 and over (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-25</td>
<td>Total Number of New Policies Issued by the Company During the Period</td>
</tr>
<tr>
<td>1B-26</td>
<td>Number of Policies Applied for During the Period</td>
</tr>
<tr>
<td>1B-27</td>
<td>Number of Free Looks During the Period</td>
</tr>
<tr>
<td>1B-28</td>
<td>Number of Policies In-Force at the End of the Period (The number of active policies that the company has outstanding at the end of the reporting period)</td>
</tr>
<tr>
<td>1B-29</td>
<td>Dollar Amount of Direct Premium During the Period</td>
</tr>
<tr>
<td>1B-30</td>
<td>Dollar Amount of Insurance Issued During the Period (Face Amount)</td>
</tr>
<tr>
<td>1B-31</td>
<td>Dollar Amount of Insurance In-Force at the End of the Period (Face Amount)</td>
</tr>
<tr>
<td>1B-32</td>
<td>Number of Complaints Received Directly from Any Person or Entity Other than the DOI</td>
</tr>
<tr>
<td>1B-33</td>
<td>Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the claim was received)</td>
</tr>
<tr>
<td>1B-34</td>
<td>Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the claim was received)</td>
</tr>
<tr>
<td>1B-35</td>
<td>Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the claim was received)</td>
</tr>
</tbody>
</table>
Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

1B-36 Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the date of due proof of loss occurred)

1B-37 Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the date of due proof of loss occurred)

1B-38 Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the date of due proof of loss occurred)

1B-39 Number Of Death Claims Denied, Resisted or Compromised During The Period

1B-40 Number of Death Claims Closed With Payment During the Period, Which Occurred Within the Contestability Period

1B-41 Number of Death Claims Denied During the Period, Which Occurred Within the Contestability Period

1B-42 Total Number of Death Claims Received During the Period (Include any claim received during the period as determined by the first date the claim was opened on the company system)

1B-43 Number of Lawsuits Open At the Beginning of the Period

1B-44 Number of Lawsuits Opened During the Period

1B-45 Number of Lawsuits Closed During the Period

1B-46 Number of Lawsuits Closed During the Period with Consideration for the Customer

1B-47 Number of Lawsuits Open at the End of the Period

Schedule 2A—Annuity Interrogatories

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A-01</td>
<td>Individual Indexed Fixed Annuities – Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-02</td>
<td>Individual Other Fixed Annuities – Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-03</td>
<td>Individual Indexed Variable Annuities – Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-04</td>
<td>Individual Other Variable Annuities – Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
# Market Conduct Annual Statement

## Life & Annuities Data Call & Definitions

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A-05</td>
<td>Is there a reason that the reported Individual (Indexed or Other) Fixed Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-06</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>2A-07</td>
<td>Is there a reason that the reported Individual (Indexed or Other) Variable Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-08</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>2A-09</td>
<td>Does the company use third party administrators (TPAs) for purposes of supporting the individual annuity business being reported?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-10</td>
<td>If yes, provide the names and functions of each TPA.</td>
<td>Comment</td>
</tr>
<tr>
<td>2A-11</td>
<td>Individual Fixed Annuities comments</td>
<td>Comment</td>
</tr>
<tr>
<td>2A-12</td>
<td>Individual Variable Annuities comments</td>
<td>Comment</td>
</tr>
</tbody>
</table>
# Market Conduct Annual Statement

## Life & Annuities Data Call & Definitions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2B-22</td>
<td>Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80</td>
</tr>
<tr>
<td>2B-23</td>
<td>Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was &gt; 80</td>
</tr>
<tr>
<td>2B-24</td>
<td>Total Number of New Deferred Contracts Issued By the Company During the Period</td>
</tr>
<tr>
<td>2B-25</td>
<td>Number of Contracts Surrendered Under 2 Years from Issuance</td>
</tr>
<tr>
<td>2B-26</td>
<td>Number of Contracts Surrendered Between 2 Years and 5 Years of Issue</td>
</tr>
<tr>
<td>2B-27</td>
<td>Number of Contracts Surrendered Between 6 Years and 10 Years of Issue</td>
</tr>
<tr>
<td>2B-28</td>
<td>Number of Contracts Surrendered Over 10 Years from Issuance</td>
</tr>
<tr>
<td>2B-29</td>
<td>Total Number of Contracts Surrendered During the Period</td>
</tr>
<tr>
<td>2B-30</td>
<td>Total Number of Contracts Surrendered with a Surrender Fee</td>
</tr>
<tr>
<td>2B-31</td>
<td>Number of Contracts Applied for During the Period</td>
</tr>
<tr>
<td>2B-32</td>
<td>Number of Free Looks During the Period</td>
</tr>
<tr>
<td>2B-33</td>
<td>Number of Contracts In-Force at the End of the Period (The number of active contracts that the company has outstanding at the end of the reporting period)</td>
</tr>
<tr>
<td>2B-34</td>
<td>Dollar Amount of Annuity Considerations During the Period</td>
</tr>
<tr>
<td>2B-35</td>
<td>Number of Complaints Received Directly From Any Person or Entity Other than the DOI</td>
</tr>
<tr>
<td>2B-36</td>
<td>Number of Lawsuits Open At the Beginning of the Period</td>
</tr>
<tr>
<td>2B-37</td>
<td>Number of Lawsuits Opened During the Period</td>
</tr>
<tr>
<td>2B-38</td>
<td>Number of Lawsuits Closed During the Period</td>
</tr>
<tr>
<td>2B-39</td>
<td>Number of Lawsuits Closed During the Period with Consideration for the Customer</td>
</tr>
<tr>
<td>2B-40</td>
<td>Number of Lawsuits Open at the End of the Period</td>
</tr>
</tbody>
</table>

In determining what business to report for a particular state, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages and in accordance with each applicable state’s regulations.

**Definitions:**

**Annuity** – A contract under which an insurance company promises to make a series of periodic payments to a named individual in exchange for a premium or a series of premiums. Data is being requested for individual annuities only; data for group annuity contracts are not being requested.

**Annuity Considerations** – Funds deposited to or used to purchase annuity contracts issued by the company. For the purpose of this statement, annuity considerations should be determined in the same manner used for the state pages of the company's financial annual statement. Do not report “Other Considerations” or “Deposit-Type Contract” considerations. MCAS requires that you report only allocated considerations on contracts that have a mortality or morbidity risk.
**Market Conduct Annual Statement**  
**Life & Annuities Data Call & Definitions**

**Cash Value Product** – A life insurance policy that generates a cash value element. Term life policies with cash value are considered cash value products.

**Claim** – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Claims with multiple beneficiaries should be counted as one claim. If a single insured dies and has multiple policies (for individual life products), a claim should be reported for each of the insured’s policies (for example, if an insured had 3 individual life policies (2 cash value products and one non-cash value product), 3 claims would be reported (2 claims under schedule 1B ICVP and 1 claim under schedule 1B INCVP.) It does not include events that were reported for “information only” or an inquiry of coverage since a claim has not actually been presented (opened) for payment.

**Claim Closed with Payment** – A claim where the final decision was payment of the claim.

**Complaint** – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:
- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties

**Contestability Period** – The period of time before a policy’s incontestability clause becomes effective. During this period, a company may contest a claim based upon material misrepresentation or concealment during the policy application process. The contestability period is usually 2 years.
- Do not report claims on guaranteed issue life policies
- Do not report claims that are contested after the incontestability clause is in effect.

**Conversion** – The process by which a policyholder exercises his/her right under the policy contract to exchange a policy without submitting evidence of insurability. In most cases this involves exchanging a term policy for a permanent policy (e.g., whole life insurance, universal life, variable.)

**Corporate Owned Life Insurance** – Insurance on the life of an individual, paid for by the company, with the company being a beneficiary under the policy. Corporate Owned Life Insurance policies are included in the scope of this statement and should be reported in the applicable schedule.
Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Date Claim Received – The date the company, or a third party acting on the company’s behalf, is notified of the claim.

Date of Due Proof of Loss – The date the company received the necessary proof of loss on which to base a claim determination.

Denied Claim - A claim where a demand for payment was made but payment was not made under the contract.

Direct Written Premium – The actual amount of direct premiums written during the reporting period and should be determined in the same manner used for the financial annual statement. Data for subject business reported by the company on the financial annual statement should be reported for the purposes of this project regardless of any 1) reinsurance agreements or 2) arrangements to administer the business that may exist with another insurer. (See also: “Life Insurance Premium” and “Annuity Considerations”)

External Replacement - An external replacement is when the policy and/or annuity to be replaced was issued by another company.

External Replacement of Affiliated Company Policies – An external replacement of an affiliated company policy is when the policy and/or annuity to be replaced was issued by a company affiliated to the MCAS reporting company.

External Replacement of Unaffiliated Company Policies – An external replacement of an unaffiliated company policy is when the policy and/or annuity to be replaced was issued by a company not affiliated to the MCAS reporting company.

Face Amount – Sum of insurance provided by a policy at death or maturity. In determining the face amount to be reported, companies should follow the same methodology/definitions used to file the financial annual statement and its corresponding state pages. For example, the face amount would include the basic policy plus any riders or amounts for policies with increasing death benefits if these amounts in addition to the basic policy are reported on the company’s financial annual statement.

Fixed Annuity – An annuity under which the insurer guarantees that at least a defined amount of monthly annuity benefit will be provided for each dollar applied to purchasing the annuity.

Free Look – A set number of days provided in an insurance or annuity contract that allows time for the purchaser to review the contract provisions with the right to return the contract for a full refund of all monies paid. Report the number of policies or contracts that were returned by the owner under the free look provision during the period, regardless of the original issuance date. Count any policy returned under the Free Look provision even if an alternative policy was ultimately purchased by the insured.
**Market Conduct Annual Statement**

**Life & Annuities Data Call & Definitions**

**Immediate Annuity** – An annuity (either fixed or variable) that begins its payment stream to the policyholder within 12 months after a single premium is paid. Immediate annuities are included within the scope of this statement and should be reported as a new immediate contract issued when issued during the reporting period. In addition, immediate annuities still in force at the end of the period should be included as well.

**Individual Indexed Fixed Annuity** – A fixed annuity whose accumulation or policy value is, in whole or in part, linked to an index or indices and offers principal protection. Indexed fixed annuities include equity indexed annuities or fixed indexed annuities that offer principal protection through a 0% floor feature.

**Individual Indexed Variable Annuity** – A variable annuity whose accumulation or policy value is, in whole or in part, linked to an index or indices and may offer some principal protection. Variable indexed annuities include buffer annuities or registered index-linked annuity that offer some principal protection but do not provide a guaranty against loss of principal.

**Internal Replacement** - An internal replacement is when the policy and/or annuity to be replaced was also issued by your company.

**Issued During the Period** - Report the number of policies that have an issue date within the reporting period.

- When reporting the policies/contracts that are broken out by the age of the insured or annuitant
  - for joint policies/contracts, use the age of the oldest insured or annuitant for determining the age category
- Internal and external replacements should be reported as new policies or contracts issued during the reporting period as well as reported in the number of internal and external replacements.

**Lawsuit**—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for Life & Annuities products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Life Insurance Premiums – Funds used to purchase life insurance products issued by the company. Exclude Group Life and Credit Life premiums. For the purpose of this statement, life insurance premiums should be determined in the same manner used for the state pages of the company's financial annual statement.

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which file a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of an insurance holding company.

Non-Cash Value Product – A life insurance policy that does not contain a cash value element. Do not include life insurance covering only Accidental Death and Dismemberment (AD&D.)

Policies/Contracts Applied For – Applications for life insurance or annuities that are submitted to the company which have or will result in a formal offer of an insurance or annuity contract or a formal declination of the application by the company. Applications that are declined by a broker-dealer or producer and never reviewed by the company are not included in this count.

Replacement Policy – A policy and/or annuity contract application received by your company that is intended to replace an existing policy and/or annuity contract according to each states definition of a replacement. This may include both external and internal replacements according to each state's replacement law.
Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Include:
- loan purchases, if the original policy is surrendered,
- surrenders, if a replacement policy is issued in conjunction with the surrender
- 1035 exchanges

Do not include:
- policy conversions
- exchanges of a group policy for an individual policy

Resisted Claim – A claim is considered resisted when it is in dispute and not resolved on the financial statement date for the reporting period. Where the company is holding up payment for sufficient evidence or where a beneficiary has made a claim and then withdraws it, such items should be considered as in the course of settlement.

Surrendered Policy/Contract – A life insurance policy or annuity contract terminated at the request of the policy owner. It does not include life insurance policies or annuity contracts not taken or cancelled during the free look period. For annuities, systematic withdrawals (the withdrawal of a certain amount on a predetermined periodic basis for deferred annuities) and partial withdrawals should not be reported as “surrenders” for this statement.

Term Life Insurance – Life insurance that provides a death benefit if the insured dies during the specified period.

Universal Life Insurance – A form of whole life insurance that is characterized by flexible premiums, flexible face amounts and flexible death benefit amounts and its unbundling of the pricing factor.

Variable Annuity – An annuity under which the amount of the contract’s accumulated value and the amount of the monthly annuity benefit payment fluctuate in accordance with the performance of a separate account.

Variable Life Insurance – A form of whole life insurance under which the death benefit and the cash value of the policy fluctuate according to the investment performance of a separate account.

Variable Universal Life Insurance – A form of whole life insurance that combines the premium and death benefit flexibility of universal life insurance with the investment flexibility and risk of variable life insurance.

Withdrawal – For annuity contracts, see Surrendered Policy/Contract.

Whole Life Insurance – Life insurance that provides lifetime insurance coverage. Whole life insurance policies generally build cash value and cover a person for as long as he or she lives if premiums are paid as required. It would include life insurance policies that start accumulating cash value once the insured reaches a certain age as specified in the terms of the policy.
**Homeowner Data Call & Definitions**

**Line of Business:** Homeowners

**Reporting Period:** January 1, 2021 through December 31, 2021

**Filing Deadline:** April 30, 2022

<table>
<thead>
<tr>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MCAS Administrator</strong></td>
</tr>
<tr>
<td><strong>MCAS Contact</strong></td>
</tr>
<tr>
<td><strong>MCAS Attestor</strong></td>
</tr>
</tbody>
</table>

**Schedule 1—Interrogatories**

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies in-force during the reporting period that provided Dwelling coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>Were there policies in-force during the reporting period that provided Personal Property coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-03</td>
<td>Were there policies in-force during the reporting period that provided Liability coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>Were there policies in-force during the reporting period that provided Medical Payments coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-05</td>
<td>Were there policies in-force during the reporting period that provided Loss of Use coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-06</td>
<td>Was the Company still actively writing policies in the state at year end?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-07</td>
<td>Does the Company write in the non-standard market?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-08</td>
<td>If yes, what percentage of your business is non-standard?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-09</td>
<td>If yes, how is non-standard defined?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-10</td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-11</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-12</td>
<td>Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-13</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-14</td>
<td>How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim</td>
<td>Comment</td>
</tr>
<tr>
<td>1-15</td>
<td>Does the company use Managing General Agents (MGAs)?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-16</td>
<td>If yes, list the names of the MGAs.</td>
</tr>
<tr>
<td>1-17</td>
<td>Does the company use Third Party Administrators (TPAs)? Yes/No</td>
</tr>
<tr>
<td>1-18</td>
<td>If yes, list the names of the TPAs.</td>
</tr>
<tr>
<td>1-19</td>
<td>Claims Comments</td>
</tr>
<tr>
<td>1-20</td>
<td>Underwriting Comments</td>
</tr>
</tbody>
</table>

Coverages

<table>
<thead>
<tr>
<th>Dwelling (includes – Other Structures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Property</td>
</tr>
<tr>
<td>Liability</td>
</tr>
<tr>
<td>Medical Payments</td>
</tr>
<tr>
<td>Loss of Use</td>
</tr>
</tbody>
</table>

Schedule 2—Homeowners Claims Activity, Counts Reported by Claimant and by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two liability claimants, two medical payment claims, one dwelling claim for the insured, and one personal property claim for the insured, you would report as follows: Dwelling – 1; Personal Property – 1; Liability – 2; Medical Payments – 2. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-21</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-22</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-23</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-24</td>
<td>Number of claims closed during the period, without payment</td>
</tr>
<tr>
<td>2-25</td>
<td>Number of claims open at the end of the period</td>
</tr>
<tr>
<td>2-26</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-27</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-28</td>
<td>Number of claims closed with payment within 31-60 days</td>
</tr>
<tr>
<td>2-29</td>
<td>Number of claims closed with payment within 61-90 days</td>
</tr>
<tr>
<td>2-30</td>
<td>Number of claims closed with payment within 91-180 days</td>
</tr>
<tr>
<td>2-31</td>
<td>Number of claims closed with payment within 181-365 days</td>
</tr>
<tr>
<td>2-32</td>
<td>Number of claims closed with payment beyond 365 days</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-33</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
<tr>
<td>2-34</td>
<td>Number of claims closed without payment within 31-60 days</td>
</tr>
<tr>
<td>2-35</td>
<td>Number of claims closed without payment within 61-90 days</td>
</tr>
<tr>
<td>2-36</td>
<td>Number of claims closed without payment within 91-180 days</td>
</tr>
<tr>
<td>2-37</td>
<td>Number of claims closed without payment within 181-365 days</td>
</tr>
<tr>
<td>2-38</td>
<td>Number of claims closed without payment beyond 365 days</td>
</tr>
<tr>
<td>2-39</td>
<td>Number of lawsuits open at beginning of the period</td>
</tr>
<tr>
<td>2-40</td>
<td>Number of lawsuits opened during the period</td>
</tr>
<tr>
<td>2-41</td>
<td>Number of lawsuits closed during the period</td>
</tr>
<tr>
<td>2-42</td>
<td>Number of lawsuits open at end of period</td>
</tr>
<tr>
<td>2-43</td>
<td>Number of lawsuits closed with consideration for the consumer.</td>
</tr>
</tbody>
</table>

Schedule 3—Homeowners Underwriting Activity

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-44</td>
<td>Number of dwellings which have policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-45</td>
<td>Number of dwelling fire policies in force at the end of the period.</td>
</tr>
<tr>
<td>3-46</td>
<td>Number of homeowner policies in force at the end of the period.</td>
</tr>
<tr>
<td>3-47</td>
<td>Number of tenant/renter/condo policies in force at the end of the period.</td>
</tr>
<tr>
<td>3-48</td>
<td>Number of all other residential property policies in force at the end of the period.</td>
</tr>
<tr>
<td>3-49</td>
<td>Number of new business policies written during the period</td>
</tr>
<tr>
<td>3-50</td>
<td>Dollar amount of direct premium written during the period</td>
</tr>
<tr>
<td>3-51</td>
<td>Number of Company-Initiated non-renewals during the period</td>
</tr>
<tr>
<td>3-52</td>
<td>Number of cancellations for non-pay or non-sufficient funds</td>
</tr>
<tr>
<td>3-53</td>
<td>Number of cancellations at the insured’s request</td>
</tr>
<tr>
<td>3-54</td>
<td>Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-55</td>
<td>Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-57</td>
<td>Number Of Complaints Received Directly From Any Person or Entity Other than the DOI</td>
</tr>
</tbody>
</table>
Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Exclude lender-placed or creditor-placed policies.

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of dwellings insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium or non-sufficient funds.
  - These should be reported every time a policy cancels for the above reasons. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)
- Policies cancelled at the insured’s request.
- Policies cancelled for underwriting reasons.

Exclude:

- Policies cancelled for ‘re-write’ purposes where there is no lapse in coverage.

Cancellations within the first 59 days – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations from 60 to 90 days – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
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- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Each claimant/insured reporting a loss is counted separately.

Include:
- Both first and third party claims.

Exclude:
- An event reported for “information only”.
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also “Date of Final Payment”.

Exclude:
- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Clarification:
- If a claim is reopened for the sole purpose of refunding the insured’s deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:
- For each coverage identifier, the sum of the claims closed with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on that supplemental payment from
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Homeowner Data Call & Definitions

the time the request for supplemental payment was received to the date of the final payment was made.

**Claims Closed Without Payment** – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also “Date of Final Payment”.

Include:
- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Calculation Clarification:
- For each coverage identifier, the sum of the claims closed without payment across each closing time interval should equal the total number of claims closed without payment during the reporting period.

**Complaint** – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:
- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties.

**Coverage - Dwelling (includes – Other Structures)** – Coverage for dwellings under Homeowners Policies and Dwelling Fire and Dwelling Liability Policies. It includes coverage for Other Structures.

**Coverage - Loss of Use** – Loss of Use provided under Homeowners Policies.

**Coverage - Personal Property** – Personal Property provided under Homeowners Policies.

**Coverage - Liability** – Liability insurance provided under Homeowners Policies.

**Coverage - Medical Payments** – Medical Payments provided under Homeowners Policies.
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Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:
- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment date was made during the reporting period regardless of the date of loss or when the claims was received.
- Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period.
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:
- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
  - The claim would be reported as open in the “00” MCAS submission and closed in the “01” MCAS submission.
  - The number of days to final payment would be calculated as 30 days and reported in the “01” MCAS submission.

Date the Claim was Reported – The date an insured or claimant first reported his or her loss to either the company or insurance agent.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarification:
- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement filing in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Dwelling – A personally occupied residential dwelling.
Calculation Clarification:
- A 2 or 3 family home covered under one policy would be considered 1 dwelling.

**Dwelling Fire and Dwelling Liability Policies** – Coverage for dwellings and their contents. It may also provide liability coverage and is usually written when a residential property does not qualify according to the minimum requirements of a homeowner's policy, or because of a requirement for the insured to select several different kinds of coverage and limits on this protection.

Include:
- Dwelling Fire and Dwelling Liability policies should be included ONLY IF the policies written under these programs are for personally occupied residential dwellings, not policies written under a commercial program and/or on a commercial lines policy form.

**Homeowners Policies** – Policies that combine liability insurance with one or more other types of insurance such as property damage, personal property damage, medical payments and additional living expenses.

Include:
- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.
- Renters insurance.-Policies covering log homes, land homes, and site built homes are included.
- Inland Marine or Personal Articles endorsements.
- Include policies written on the HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 policy forms.

Exclude:
- Farmowners is not included as it is considered to be Commercial Lines for purposes of this project.
- Umbrella policies.
- Lender-placed or creditor-placed policies.

**Inland Marine or Personal Articles Endorsements** – Provides coverage via endorsement to a homeowners policy for direct physical loss to personal property as described in the endorsement.

Exclude:
- Stand-alone Inland Marine Policies.

**Lawsuit**—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.
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For purposes of reporting lawsuits for Homeowners products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Liability Insurance – Coverage for all sums that the insured becomes legally obligated to pay because of bodily injury or property damage, and sometimes other torts to which an insurance policy applies.

Loss Of Use – Coverage for additional living expenses incurred by the insured or fair rental value when the insured dwelling becomes uninhabitable as the result of an insured loss or when access to the dwelling is barred by civil authority.

Median Days to Final Payment – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:

- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:

- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:

- Subrogation payments.
Calculation Clarification / Example:
- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

**Median** - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

<table>
<thead>
<tr>
<th>Claim Nbr</th>
<th>Days to Settle</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>20</td>
</tr>
</tbody>
</table>

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

<table>
<thead>
<tr>
<th>Claim Nbr</th>
<th>Days to Settle</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>20</td>
</tr>
</tbody>
</table>

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

**Closing Time # of Claims**

- < 30: 22
- 31-60: 13
- 61-90: 18
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<table>
<thead>
<tr>
<th>Closing Time Interval</th>
<th>Reported Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval “61-90 days.” Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

**Medical Payments Coverage** – Provides coverage for medical expenses resulting from injuries sustained by a claimant regardless of liability.

**NAIC Company Code** – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

**NAIC Group Code** – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

**New Business Policy Written** – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:
- ‘Re-written’ policies unless there was a lapse in coverage.

**Non-Renewals** – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the “non-renewal” clause of the policy.

Include:
- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

Exclude:
- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

**Calculation Clarification:**
- The number of nonrenewals should be reported on a policy basis regardless of the number of dwellings insured under the policy.

**Other Structures** – Structures on the residence premises (1) separated from the dwelling by a clear space or (2) connect to the dwelling by a fence, wall, wire, or other form of connection but not otherwise attached.
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

**Personal Property Damage Coverage** – Provides coverage for damage to dwelling contents or other covered personal property caused by an insured peril.

**Personally Occupied** – A dwelling in which the person owning the policy personally occupies the dwelling and lives there.

**Property Damage Coverage** – Provides coverage for damage to the dwelling and/or other insured structures caused by an insured peril.

**Policy In-force** – A policy in which the coverage is in effect as of the end of the reporting period.

**Tenant/Renters/Condo Policies** – Policies that provide coverage for the personal property of tenants, renters, condominium and cooperative unit owners. Include policies typically written on the HO-4 and HO-6 policy forms.
Private Passenger Auto Data Call & Definitions

Line of Business: Private Passenger Auto

Reporting Period: January 1, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

Contact Information

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies in-force during the reporting period that provided Collision coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>Were there policies in-force during the reporting period that provided Comprehensive/Other Than Collision coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-03</td>
<td>Were there policies in-force during the reporting period that provided Bodily Injury coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>Were there policies in-force during the reporting period that provided Property Damage coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-05</td>
<td>Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-06</td>
<td>Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-07</td>
<td>Were there policies in-force during the reporting period that provided Medical Payments coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-08</td>
<td>Were there policies in-force during the reporting period that provided Combined Single Limits coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-09</td>
<td>Were there policies in-force during the reporting period that provided Personal Injury Protection coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-10</td>
<td>Was the Company still actively writing policies in the state at year end?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-11</td>
<td>Does the Company write in the non-standard market?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
**Property & Casualty Market Conduct Annual Statement**

**Private Passenger Auto Data Call & Definitions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-12 If yes, what percentage of your business is non-standard?</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-13 If yes, how is non-standard defined?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-14 Has the company had a significant event/business strategy that would affect data for this reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-15 If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-16 Has this block of business or part of this block of business been sold, closed or moved to another company during the <strong>reporting period</strong>?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-17 If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-18 How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim</td>
<td>Comment</td>
</tr>
<tr>
<td>1-19 Does the company use Managing General Agents (MGAs)?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-20 If yes, list the names of the MGAs.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-21 Does the company use Third Party Administrators (TPAs)?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-22 If yes, list the names of the TPAs.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-23 Does the company use telematics or usage-based data?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-24 Claims Comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-25 Underwriting Comments</td>
<td>Comment</td>
</tr>
</tbody>
</table>

**Coverages**

<table>
<thead>
<tr>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collision</td>
</tr>
<tr>
<td>Comprehensive/Other Than Collision</td>
</tr>
<tr>
<td>Bodily Injury</td>
</tr>
<tr>
<td>Property Damage</td>
</tr>
<tr>
<td>Uninsured Motorists and Underinsured Motorists (UMBI)</td>
</tr>
<tr>
<td>Uninsured Motorists and Underinsured Motorists (UMPD)</td>
</tr>
<tr>
<td>Medical Payments</td>
</tr>
<tr>
<td>Combined Single Limits</td>
</tr>
<tr>
<td>Personal Injury Protection</td>
</tr>
</tbody>
</table>

**Schedule 2—Private Passenger Auto Claims Activity, Counts Reported by Claimant, by Coverage**
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two bodily injury claimants (one property damage claimant, one collision claim for the insured, and one medical payment claim for the insured), it would be reported as follows: Collision – 1, Bodily Injury – 2; Property Damage – 1; and Medical Payments – 1. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-26</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-27</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-28</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-29</td>
<td>Number of claims closed during the period, without payment.</td>
</tr>
<tr>
<td>2-30</td>
<td>Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.</td>
</tr>
<tr>
<td>2-31</td>
<td>Number of claims remaining open at the end of the period</td>
</tr>
<tr>
<td>2-32</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-33</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-34</td>
<td>Number of claims closed with payment within 31-60 days</td>
</tr>
<tr>
<td>2-35</td>
<td>Number of claims closed with payment within 61-90 days</td>
</tr>
<tr>
<td>2-36</td>
<td>Number of claims closed with payment within 91-180 days</td>
</tr>
<tr>
<td>2-37</td>
<td>Number of claims closed with payment within 181-365 days</td>
</tr>
<tr>
<td>2-38</td>
<td>Number of claims closed with payment beyond 365 days</td>
</tr>
<tr>
<td>2-39</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
<tr>
<td>2-40</td>
<td>Number of claims closed without payment within 31-60 days</td>
</tr>
<tr>
<td>2-41</td>
<td>Number of claims closed without payment within 61-90 days</td>
</tr>
<tr>
<td>2-42</td>
<td>Number of claims closed without payment within 91-180 days</td>
</tr>
<tr>
<td>2-43</td>
<td>Number of claims closed without payment within 181-365 days</td>
</tr>
<tr>
<td>2-44</td>
<td>Number of claims closed without payment beyond 365 days</td>
</tr>
<tr>
<td>2-45</td>
<td>Number of lawsuits open at beginning of the period</td>
</tr>
<tr>
<td>2-46</td>
<td>Number of lawsuits opened during the period</td>
</tr>
<tr>
<td>2-47</td>
<td>Number of lawsuits closed during the period</td>
</tr>
<tr>
<td>2-48</td>
<td>Number of lawsuits open at end of period</td>
</tr>
<tr>
<td>2-49</td>
<td>Number of lawsuits closed with consideration for the consumer.</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

Schedule 3—Private Passenger Auto Underwriting

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-50</td>
<td>Number of autos which have policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-51</td>
<td>Number of policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-52</td>
<td>Number of new business policies written during the period</td>
</tr>
<tr>
<td>3-53</td>
<td>Dollar amount of direct premium written during the period</td>
</tr>
<tr>
<td>3-54</td>
<td>Number of Company-Initiated non-renewals during the period</td>
</tr>
<tr>
<td>3-55</td>
<td>Number of cancellations for non-pay or non-sufficient funds</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of cancellations at the insured’s request</td>
</tr>
<tr>
<td>3-57</td>
<td>Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-58</td>
<td>Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-59</td>
<td>Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-60</td>
<td>Number of complaints received directly from any person or entity other than the DOI</td>
</tr>
</tbody>
</table>

Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Exclude lender-placed or creditor-placed policies.

Data should be reported for both private passenger automobiles and motorcycles. Exclude antique vehicles and primarily off-road vehicles such as dune buggies or three-wheel ATVs.

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of automobiles insured under the policy.

Report cancellations separately for:
- Policies cancelled for non-payment of premium or non-sufficient funds
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

- These should be reported every time a policy cancels for the above reasons (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted).
  - Policies cancelled at the insured’s request
  - Policies cancelled for underwriting reasons.
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

Exclude:
- Policies cancelled for ‘re-write’ purposes where there is no lapse in coverage.

**Cancellations within the first 59 days** – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

**Cancellations from 60 to 90 days** – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

**Cancellations greater than 90 days** – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ‘underwriting’ period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

**Claim** - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Each claimant/insured reporting a loss is counted separately.
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

Include:
- Both first- and third-party claims.

Exclude:
- An event reported for “information only”.
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also “Date of Final Payment”.

Exclude:
- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Clarifications:
- If a claim is reopened for the sole purpose of refunding the insured’s deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:
- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental
Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also “Date of Final Payment”.

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Complaint – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties.

Coverage - Collision Insurance – Coverage to provide protection against physical contact of an automobile with another inanimate object resulting in damage to the insured automobile.

Clarification:

- Rental/transportation/tow expenses which are paid as a result or part of a collision claim should not be counted as separate claims.
Property & Casualty Market Conduct Annual Statement
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Coverage - Comprehensive/Other than Collision Insurance – Coverage providing protection in the event of physical damage (other than collision), including theft of the insured automobile.

Clarification:
- Rental/transportation/tow expenses which are paid as a result or part of a comprehensive/other than collision claim should not be counted as separate claims.

Coverage - Bodily Injury – Physical damage to one’s person. The purpose of liability (casualty) insurance is to cover bodily injury to a third party resulting from the negligent acts and omissions of an insured.

Coverage - Property Damage Liability Insurance – Coverage in the event that the negligent acts or omissions of an insured result in damage or destruction to another’s property.

Include:
- ‘Property Damage Rental’ coverage (i.e. amounts paid for a third party claimant’s rental car).

Coverage - UMBI – Includes both Uninsured Motorist Coverage and Underinsured Motorists Coverage for bodily injury claims.

- Underinsured Motorist Coverage (UIM) – Provides coverage for bodily injury sustained by an insured who is involved in an accident caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- Uninsured Motorist Coverage (UM) – Provides coverage for bodily injury sustained by an insured involved in an accident caused by an at-fault driver who does not have liability insurance.

Coverage - UMPD – Includes both Uninsured Motorist Property Damage Coverage and Underinsured Motorist Property Damage Coverage.
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

- **Underinsured Motorist Property Damage Coverage** – Provides coverage for property damage to covered property caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Property Damage Coverage** – Provides coverage for property damage to covered property caused by an at-fault driver who does not have liability insurance.

**Coverage - Medical Payments Coverage** – First party coverage for injuries incurred in a motor vehicle accident.

**Coverage - Combined Single Limit** – Bodily injury liability and property damage liability expressed as a single sum of coverage.

**Coverage - Personal Injury Protection (PIP)** – A first party benefit. coverage to pay basic expenses for an insured and his/her family in states with no fault automobile insurance laws. No-fault laws generally require drivers to carry personal injury protection coverage to pay for basic medical needs of the insured, such as medical expenses, in the event of an accident. For the purposes of this project, all PIP coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.

**Date of Final Payment** – The date final payment was issued to the insured/claimant.

Calculation Clarification:
- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claims was received.
- Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:
- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

- The claim would be reported as open in the “00” MCAS submission and closed in the “01” MCAS submission.
- The number of days to final payment would be calculated as 30 days and reported in the “01” MCAS submission.

Date the Claim was Reported – The date an insured or claimant first reported his or her loss to either the company or insurance agent.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarification:
- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for Private Passenger Auto products:
- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Median Days to Final Payment – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:
- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:
- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:
- Subrogation payments should not be included.

Calculation Clarification / Example:
- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company, or the date the request for
supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

**Median** - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

- Consider the following simple example of the number of days it took to settle each of the following seven claims:

<table>
<thead>
<tr>
<th></th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

<table>
<thead>
<tr>
<th></th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
</tbody>
</table>
## Property & Casualty Market Conduct Annual Statement
### Private Passenger Auto Data Call & Definitions

<table>
<thead>
<tr>
<th>Time Interval</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval “61-90 days.” Any reported median that falls outside of this range (i.e., less than 61 or greater than 90) will indicate a data error.

**NAIC Company Code** – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

**NAIC Group Code** – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

**New Business Policy Written** – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:
- Renewals or ‘re-written’ policies unless there was a lapse in coverage.

**Non-Renewals** – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the “non-renewal” clause of the policy.

Include:
- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

Exclude:
- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

**Calculation Clarification**:
- The number of non-renewals should be reported on a policy basis regardless of the number of autos insured under the policy.
Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Private Passenger Auto Insurance – Those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household that are reported on lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement.

Include:
- This covers four-wheel vehicles including station wagons, vans, or pick-up trucks with a gross vehicle weight up to 10,000 pounds or less and not customarily used in the occupation, profession, or business of the insured.
- Vehicles as defined above that are reported on Lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement which meet the definition of private passenger automobiles.
- Motorcycles
- Policies where the insured’s vehicle is titled privately to the insured but is used by the insured for work should be included, unless the coverage is written on a commercial auto form.
- Policies written on a volunteer basis and those written through a residual market mechanism such as assigned risk pools should be included.
- Policies written on RV’s and motor homes are included as they are licensed vehicles that fall under the various states’ Motor Vehicle Responsibility laws.

Exclude:
- Policies written on antiques, collectibles, all-terrain vehicles, snowmobiles, trailers, dune buggies.
- Miscellaneous vehicles written on Inland Marine policies.
- Other vehicles classified by ISO as miscellaneous that do not fall under the various states’ Motor Vehicle Responsibility laws.
- ‘Fleet’ policies are generally considered to be a commercial policy and would not be included unless the premium for these policies is being reported as ‘private passenger auto’ insurance on lines 19.1, 19.2 or 21.1 of the state page of the financial annual statement.
- Non-owned vehicle insurance policies.
- Lender-placed or creditor-placed policies.
- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.
Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

**Telematics and Usage-Based Data** – Data which is collected through devices installed in a vehicle, through mobile applications, or other method. These devices then transmit the data in real time back to insurers. Examples of usage-based data collected via telematics includes - but is not limited to - miles driven, time of day, where the vehicle is driven (Global Positioning System or GPS), rapid acceleration, hard braking, hard cornering and air bag deployment.
**Property & Casualty Market Conduct Annual Statement**

**Lender-Placed Data Call & Definitions**

**Lines of Business:** Lender-Placed Auto and Lender-Placed Homeowners

**Reporting Period:** January 1, 2021 through December 31, 2021

**Filing Deadline:** April 30, 2022

**Contact Information**

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestors</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

**Schedule 1—Interrogatories**

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed auto coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were single-interest lender-placed auto.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-03</td>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed auto coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were dual-interest lender-placed auto.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-05</td>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners hazard coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-06</td>
<td>If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during the period which were single-interest lender-placed homeowners hazard.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-07</td>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners hazard coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Response Options</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>1-08</td>
<td>If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during the period which were dual-interest lender-placed homeowners hazard.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-09</td>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners flood coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-10</td>
<td>If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during the period which were single-interest lender-placed homeowners flood.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-11</td>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners flood coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-12</td>
<td>If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during the period which were dual-interest lender-placed homeowners flood.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-13</td>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners wind-only coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-14</td>
<td>If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued during the period which were single-interest lender-placed homeowners wind-only.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-15</td>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners wind-only coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-16</td>
<td>If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued during the period which were dual-interest lender-placed homeowners wind-only.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-17</td>
<td>Were there policies-in-force during the reporting period that provided blanket vendor single interest auto (vehicle) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-18</td>
<td>Were there policies-in-force during the reporting period that provided blanket vendor single interest home (residential property) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-19</td>
<td>Was the company still actively writing policies/certificates in the state at year end?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-20</td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-21</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>1-22</td>
<td>Has this block of business or part of this block of business been sold, closed or moved to another company during the year?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-23</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-24</td>
<td>How does the company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? For example: Re-open original claim/open new claim</td>
<td>Comment</td>
</tr>
<tr>
<td>1-25</td>
<td>Does the company require third parties it contracts with to forward insurance-related complaints to the company so the company may report the complaints in its complaints logs?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-26</td>
<td>Add additional comment if desired</td>
<td>Comment</td>
</tr>
<tr>
<td>1-27</td>
<td>Does the company monitor third parties it contracts with to ensure insurance complaints are forwarded to the company?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-28</td>
<td>Add additional comment if desired</td>
<td>Comment</td>
</tr>
<tr>
<td>1-29</td>
<td>Claims Comments</td>
<td>Comment (if necessary)</td>
</tr>
<tr>
<td>1-30</td>
<td>Underwriting Comments</td>
<td>Comment (if necessary)</td>
</tr>
</tbody>
</table>

### Coverages

<table>
<thead>
<tr>
<th>Single-Interest Lender-Placed Auto</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual-Interest Lender-Placed Auto</td>
</tr>
<tr>
<td>Single-Interest Lender-Placed Homeowners Hazard</td>
</tr>
<tr>
<td>Dual-Interest Lender-Placed Homeowners Hazard</td>
</tr>
<tr>
<td>Single-Interest Lender-Placed Homeowners Flood</td>
</tr>
<tr>
<td>Dual-Interest Lender-Placed Homeowners Flood</td>
</tr>
<tr>
<td>Single-Interest Lender-Placed Homeowners Wind-Only</td>
</tr>
<tr>
<td>Dual-Interest Lender-Placed Homeowners Wind-Only</td>
</tr>
<tr>
<td><strong>Blanket Vendor Single-Interest Auto (Vehicle)</strong></td>
</tr>
<tr>
<td><strong>Blanket Vendor Single-Interest Home (Residential Property)</strong></td>
</tr>
</tbody>
</table>

**Schedule 2—Lender-Placed Auto and Homeowners and Lender-Placed Blanket Vendor Single-Interest Auto and Home Claims Activity, Counts Reported by Claimant, by Coverage**

Report the number of reserves/lines/features opened for each coverage part per claim.
### Table: Claims and Suits Information

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-31</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-32</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-33</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-34</td>
<td>Number of claims closed during the period, without payment</td>
</tr>
<tr>
<td>2-35</td>
<td>Number of claims remaining open at the end of the period</td>
</tr>
<tr>
<td>2-36</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-37</td>
<td>Number of claims closed with payment within 31-60 days</td>
</tr>
<tr>
<td>2-38</td>
<td>Number of claims closed with payment within 61-90 days</td>
</tr>
<tr>
<td>2-39</td>
<td>Number of claims closed with payment within 91-180 days</td>
</tr>
<tr>
<td>2-40</td>
<td>Number of claims closed with payment within 181-365 days</td>
</tr>
<tr>
<td>2-41</td>
<td>Number of claims closed with payment beyond 365 days</td>
</tr>
<tr>
<td>2-42</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
<tr>
<td>2-43</td>
<td>Number of claims closed without payment within 31-60 days</td>
</tr>
<tr>
<td>2-44</td>
<td>Number of claims closed without payment within 61-90 days</td>
</tr>
<tr>
<td>2-45</td>
<td>Number of claims closed without payment within 91-180 days</td>
</tr>
<tr>
<td>2-46</td>
<td>Number of claims closed without payment within 181-365 days</td>
</tr>
<tr>
<td>2-47</td>
<td>Number of claims closed without payment beyond 365 days</td>
</tr>
<tr>
<td>2-48</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-49</td>
<td>Number of suits open at beginning of the period</td>
</tr>
<tr>
<td>2-50</td>
<td>Number of suits opened during the period</td>
</tr>
<tr>
<td>2-51</td>
<td>Number of suits closed during the period</td>
</tr>
<tr>
<td>2-52</td>
<td>Number of suits closed during the period with consideraton for the borrower</td>
</tr>
<tr>
<td>2-53</td>
<td>Number of suits open at end of the period</td>
</tr>
</tbody>
</table>

### Schedule 3—Lender-Placed Auto and Home Underwriting Elements

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-54</td>
<td>Number of master policies in-force at beginning of the period</td>
</tr>
<tr>
<td>3-55</td>
<td>Number of master policies added during the period</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of master policies canceled for any reason during the period</td>
</tr>
<tr>
<td>3-57</td>
<td>Number of master policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-58</td>
<td>Number of certificates in-force at the beginning of the period</td>
</tr>
<tr>
<td>3-59</td>
<td>Number of certificates written during the period</td>
</tr>
<tr>
<td>3-60</td>
<td>Number of certificates in-force at the end of the period</td>
</tr>
</tbody>
</table>
### Attachment One-F

#### Market Regulation and Consumer Affairs (D) Committee

8/11/20

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-61</td>
<td>Number of certificates flat-cancelled during the period</td>
</tr>
<tr>
<td>3-62</td>
<td>Number of certificates cancelled for reasons other than flat cancellations during the period</td>
</tr>
<tr>
<td>3-63</td>
<td>Number of flat cancellations on certificates within 45 days of placement</td>
</tr>
<tr>
<td>3-64</td>
<td>Number of flat cancellations on certificates within 45-90 days of placement</td>
</tr>
<tr>
<td>3-65</td>
<td>Number of flat cancellations on certificates after 90 days from placement</td>
</tr>
<tr>
<td>3-66</td>
<td>Number of individual policies in-force at the beginning of the period</td>
</tr>
<tr>
<td>3-67</td>
<td>Number of individual policies written during the period</td>
</tr>
<tr>
<td>3-68</td>
<td>Number of individual policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-69</td>
<td>Number of individual policies cancelled for reasons other than flat cancellations during the period</td>
</tr>
<tr>
<td>3-70</td>
<td>Number of individual policies flat-cancelled during the period</td>
</tr>
<tr>
<td>3-71</td>
<td>Number of flat cancellations on individual policies within 45 days of placement</td>
</tr>
<tr>
<td>3-72</td>
<td>Number of flat cancellations on individual policies within 45-90 days of placement</td>
</tr>
<tr>
<td>3-73</td>
<td>Number of flat cancellations on individual policies after 90 days from placement</td>
</tr>
<tr>
<td>3-74</td>
<td>Average gross placement rate during period</td>
</tr>
<tr>
<td>3-75</td>
<td>Dollar amount of gross written premium during the period</td>
</tr>
<tr>
<td>3-76</td>
<td>Dollar amount of net written premium during the period</td>
</tr>
<tr>
<td>3-77</td>
<td>Net written premium during period for policies/certificates for which no separate charge is made to the borrower</td>
</tr>
<tr>
<td>3-78</td>
<td>Dollar amount of premium earned during the period</td>
</tr>
<tr>
<td>3-79</td>
<td>Dollars of claims paid during the period</td>
</tr>
<tr>
<td>3-80</td>
<td>Dollars of claims incurred during the period</td>
</tr>
<tr>
<td>3-81</td>
<td>Number of complaints received directly from the DOI</td>
</tr>
<tr>
<td>3-82</td>
<td>Number of complaints received directly from any person or entity other than the DOI</td>
</tr>
</tbody>
</table>

**Schedule 3—Blanket Vendor Single-Interest Auto and Home Underwriting Elements**

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-54</td>
<td>Number of master policies in-force at beginning of the period</td>
</tr>
<tr>
<td>3-55</td>
<td>Number of master policies added during the period</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of master policies canceled for any reason during the period</td>
</tr>
<tr>
<td>3-57</td>
<td>Number of master policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-75</td>
<td>Dollar amount of gross written premium during the period</td>
</tr>
<tr>
<td>3-76</td>
<td>Dollar amount of net written premium during the period</td>
</tr>
<tr>
<td>3-77</td>
<td>Net written premium during period for policies/certificates for which no separate charge is made to the borrower</td>
</tr>
<tr>
<td>3-78</td>
<td>Dollar amount of premium earned during the period</td>
</tr>
</tbody>
</table>
### Participation Requirements:

All companies licensed and reporting at least $50,000 of lender-placed auto, $50,000 of lender-placed homeowners (hazard, wind-only, and flood collectively), or $50,000 of blanket vendor single-interest auto and home gross premium within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

### Definitions:

Lender-placed insurance has the same meaning as “Creditor-placed insurance” to be reported in the Credit Insurance Experience Exhibit (CIEE) of the Statutory Annual Statement. Lender-placed insurance means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to the property as a result of fire, theft, collision or other risk of loss that would either impair a creditor’s interest or adversely affect the value of collateral.

Except for data element “Net premium written during period for policies/certificates for which no separate charge is made to the borrower,” report experience for lender-placed insurance products for which a separate charge is made to the borrower regardless of whether the charge to the borrower is made at loan origination, periodically while the loan is outstanding or following issuance of coverage under the master policy.

Lender-placed auto has the same meaning as “creditor-placed auto” to be reported in the CIEE. Lender-placed auto means lender-placed insurance on autos, boats or other vehicles.

Lender-placed homeowners has the same means as “creditor-placed homeowners” to be reported in the CIEE. Lender-placed homeowners means lender-placed insurance on homes, mobile homes and other real estate.

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the CIEE. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

Lender-placed homeowners hazard means that portion of lender-placed homeowners required to be reported in the CIEE covering perils other than flood or wind-only (in those states in which insurers may exclude wind coverage).

Lender-placed homeowners flood means that portion of lender-placed homeowners required to be reported in the CIEE covering the peril of flood only.

<table>
<thead>
<tr>
<th>3-79</th>
<th>Dollar of claims paid during the period</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-80</td>
<td>Dollars of claims incurred during the period</td>
</tr>
<tr>
<td>3-81</td>
<td>Number of complaints received directly from the DOI</td>
</tr>
<tr>
<td>3-82</td>
<td>Number of complaints received directly from any person or entity other than the DOI</td>
</tr>
</tbody>
</table>
Lender-placed wind-only means that portion of lender-placed homeowners required to be reported in the CIEE covering the peril of wind only.

Lender-placed blanket vendor means that portion of lender-placed

Single-interest means insurance that protects only the creditor’s interest in the collateral securing the debtor’s credit.

Dual-interest means insurance that protects the creditor’s and the debtor’s interest in the collateral securing the debtor’s credit transaction. Dual-interest includes insurance commonly referred to as limited dual-interest.

Blanket Vendor Single-Interest (VSI), for purposes of reporting experience in this Lender-Placed MCAS, means coverage issued to a lender or servicer to protect a lender’s interest and which:

- Is provided through a blanket policy covering eligible collateral securing loans in the lender/servicer’s portfolio
- Premium charges to the lender/servicer are based on aggregate exposures insured as opposed to any characteristics specific to any individual vehicle or property;
- No individual certificates or policies are issued to borrowers
- Has no ongoing tracking of insurance on borrower’s loans; and
- If there is a charge to the borrower at loan origination, the same charge is made for all borrowers with eligible collateral regardless of insurance status.

Blanket VSI Auto experience and Blanket VSI Home experience is reported separately from Single-Interest Auto, Dual-Interest Auto, Single-Interest Home, and Dual-Interest Home.

**Average Gross Placement Rate** – The total number of coverages placed before cancellations during the reporting period divided by the average number of exposures during the reporting period. Average number of exposures means the average number of vehicles covered by Lender Placed Auto policies or average number of properties covered by Lender Placed Home policies during the reporting period.

**Cancellations** – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage. *See also Flat Cancellation*

**Certificate** – Lender-placed insurance issued under a master policy for an individual vehicle or property, respectively.

Example:

- If the insurer issues 300 certificates under a lender-placed master policy or policies, report 300.

**Claim** – A request or demand for payment of a loss that may be included within the terms of
coverage of an insurance policy/certificate. Each claimant/insured reporting a loss is counted separately.

Include:
- Both first and third party claims.

Exclude:
- An event reported for “information only”.
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

**Claims Closed With Payment** – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also “Date of Final Payment”.

Exclude:
- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Clarifications:
- If a claim is reopened for the sole purpose of refunding the insured’s deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:
- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

**Claims Closed Without Payment** – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was...
closed and the date the claim was reported and/or reopened. See also “Date of Final Payment”.

Include:
- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy/certificate was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured’s deductible.

Complaints Received Directly from any Person or Entity Other than the Department of Insurance – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:
- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties, including, but not limited to, lenders or servicers

Complaints Received Directly from the Department of Insurance – All complaints:
- As identified by the DOI as a complaint.
- Related to LPI or insurance tracking.
- Sent or otherwise forwarded by the DOI to the reporting company.

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:
- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
- Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:
- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
  - The claim would be reported as open in the “00” MCAS submission and closed in the “01” MCAS submission.
The number of days to final payment would be calculated as 30 days and reported in the “01” MCAS submission.

**Date the Claim was Reported** – The date an insured or claimant first reported his or her claim to either the company or insurance agent.

**Dollars of Claims Incurred During Period** – The total dollars incurred for claims for the particular type of lender-placed insurance during the period. Include incurred claim dollars only for lender-placed insurance for which a separate charge is made to the borrower.

**Dollars of Claims Paid During Period** – The total dollars paid for claims for the particular type of lender-placed insurance during the period. Include paid claim dollars only for lender-placed insurance for which a separate charge is made to the borrower.

**Flat Cancellation** – The coverage was cancelled effective the date of coverage with 100% refund of premium.

**Gross Premium Written During Period** – The total premium written before any reductions for refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.

**In-force** – A master policy, individual policy, or certificate in effect during the reporting period.

**Individual Policy** – Lender-placed insurance issued for an individual vehicle or property, respectively.

Example:
- If the insurer issues 300 lender-placed policies for individual vehicles or properties (as opposed to issuing master policies to lenders or servicers), report 300.

**Lawsuit** – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.
For purposes of reporting lawsuits in the MCAS blank:
- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
• Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
• Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

**Lawsuits Closed During the Period with Consideration for the Consumer** – A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.

**Master Policy** – A group policy providing coverage for the vehicles or property serving as collateral for a portfolio of loans. Individual coverage, typically in the form of a certificate, is issued from the Master Policy at the direction of the lender/servicer or automatically at the point in time when the borrower’s required voluntary insurance ceases to be in-force.

**Median Days to Final Payment** – The median value for all claims closed with payment during the period.

Calculation for claims with one final payment date during the reporting period:
• Date the claim was reported to the company to the date of final payment.

Calculation for claims with multiple final payment dates during the reporting period:
• Date the request for supplemental payment was received to the date of final payment (for each different final payment date.)

Exclude:
• Subrogation payments.

**Calculation Clarification / Example:**
• To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the claim was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

**Median** - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:
In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

<table>
<thead>
<tr>
<th>Days to Settle</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval “61-90 days.” Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

**NAIC Company Code** — The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

**NAIC Group Code** — The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

**Net Premium Written During Period** — Gross premium written less refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.
**Net Premium Written During Period for Policies/Certificates for Which No Separate Charge is Made to the Borrower** — Gross premium written less refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which no separate charge is made to the borrower.

**Premiums Earned During Period** — Earned premiums for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 30, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Robin David (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Russell Hamblen (KY); Nathan Strebeck (LA); Dawna Kokosinski (MD); Timothy Schott (ME); Michele Riddering (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Edwin Pugsley (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Peggy Willard-Ross (NV); Larry Wertel (NY); Todd Oberholtzer (OH); Landon Hubbart (OK); Gary Jones (PA); Matt Gendron (RI); Michael Bailes (SC); Tanji Northrup (UT); Melissa Gerachis (VA); and Christine Rouleau (VT). Also participating was: Paul Yuen (HI).

1. **Adopted its March 23 Minutes**

Mr. Haworth said the Working Group met March 23 and took the following action: 1) extend the Market Conduct Annual Statement (MCAS) filing due dates by 60 days due to the COVID-19 crisis; and 2) adopt travel insurance as the next line of business for MCAS.

Ms. Rouleau made a motion, seconded by Mr. Hamblen, to adopt the Working Group’s March 23 minutes (Attachment Two-A). The motion passed unanimously.

2. **Discussed Revisions to the MCAS Best Practices Guide**

Ms. Rebholz said the work on the *MCAS Best Practices Guide* was put on hold while the state departments of insurance (DOIs) and the NAIC concentrated on critical work that was either related to COVID-19 or time sensitive. She said beginning with the Summer National Meeting, the drafting group will re-start the work on editing the *MCAS Best Practices Guide* and other MCAS documents.

Ms. Rebholz said much of the work on the *MCAS Best Practices Guide* was to bring it up to date with the changes to the MCAS since 2014. These changes include new lines of business and changed web page links. The drafting group also created two new appendices to highlight the best practices and provide a list of resources for analysts. Ms. Rebholz said the drafting group expects to finish the edits to the *MCAS Best Practices Guide* during its next meeting.

Ms. Rebholz said editing the *MCAS Best Practices Guide* is only the first piece of a larger project to update all MCAS reference documents with the goal of: 1) identifying “threshold” issues, such as the number of extension requests that a company has made in recent years and the reasons the company cites; 2) specifying the length of the extensions allowed in order to try to bring consistency in the states’ responses to company extension requests; 3) mapping out a generic process the states can use as a template; and 4) developing templates for extension request response letters and orders to be available to the states.

Ms. Rebholz said the materials that the drafting group will be reviewing are: 1) the *MCAS Best Practice Guide*; 2) the MCAS web page; 3) the MCAS Frequently Asked Questions (FAQ); 4) the MCAS Industry User Guide; 5) the MCAS data call letters; and 6) all MCAS training materials.

Ms. Rebholz said the drafting group will also explore what type of extension request report the NAIC can provide on an annual basis to help us determine where threshold issues are triggered. As part of the *State Ahead* strategic plan, the NAIC market regulation staff will be developing a Tableau report that will be able to track historical extension and waiver requests. Our work on the drafting group will provide input into what should be included in this tool and its design.
3. Discussed the Market Analysis Framework

Mr. Haworth said during the Working Group’s March 23 conference call, he asked for volunteers to help draft the revisions to the market analysis chapters. He said Ms. Rebholz, Sarah Crittenden (GA) and Rob McCullough (NE) volunteered, but because of the hiatus on Working Group activities, this group has not met. Mr. Haworth said others still have a chance to volunteer before the group’s first meeting. He encouraged comments or suggestions from anyone who has an interest, but it may not be the time to volunteer.

4. Adopted Scorecard Ratios for the Private Flood MCAS Blank

Mr. Haworth said the Private Flood blank was adopted last year, and the first collection of Private Flood MCAS data will be due on April 30, 2021. He said scorecard ratios are published each year for each line of business in the MCAS. The scorecards are useful to companies because a company can see how their ratios compare to the overall ratios in each state. Mr. Haworth said the aggregate ratios for each MCAS state are public, and they are also available to consumers.

Mr. Haworth said the ratios include a cross section of underwriting and claims data elements, but they are by no means exclusive. He said any number of ratios can be generated using MCAS data, but the scorecard ratios are some of the more useful measurements.

Mr. Haworth said he would like to adopt the scorecards during this meeting to allow NAIC staff to begin programming them into the MCAS for the 2020 data year.

Mr. Haworth said for Private Flood, there will be two sets of ratios—one for first dollar coverage and a second set for excess coverage. He said the two coverages are distinct enough to generate significantly different results.

Mr. Haworth said there are eight proposed ratios. He noted that they track very closely to the homeowners ratios. The first three ratios are the same as the homeowners ratios. However, ratio 3 measures the percentage of claims paid beyond 60 days. Mr. Haworth said flood claims may take longer to settle than the typical automobile or homeowners claim, he and asked if the Working Group wants to consider using a different time period for this ratio, such as 90 or 180 days.

Ms. Ailor said she would like to hear the experience of state insurance regulators or industry representatives prior to deciding on the time period to use. Mr. Hamblen said 60 days seemed to be a quick turnaround for flood claims. He said flood losses are often accompanied by other perils, such as wind, that can take significant time to adjust. He suggested beginning with a ratio using 60 days and adjusting it, if necessary, as the data is received and analyzed. Ms. Ailor suggested beginning with 90 days and adjusting, if necessary. Ms. Rouleau said she was inclined to begin with 60 days and adjust later, if necessary. Mr. Yuen said from his experience with Hawaiian flood claims, 60 days is tight.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she agrees with beginning with a ratio using at least 90 days. Birny Birnbaum (Center for Economic Justice—CEJ) said private flood coverage on homeowners insurance does not face the same multi-peril issues as policies written through the National Flood Insurance Program (NFIP). He said if the ratio was extended to 90 days, there would be a mismatch with the Homeowners MCAS ratios.

Mr. Haworth said ratios 4 and 5 are presented as 4a and 4b and 5a and 5b. He said the Working Group is being asked to decide whether to use 4a and 5a or 4b and 5b rather than all four. He said the Private Flood MCAS blank added a data element asking the company to provide the number of policies in force at the beginning of the reporting period. He said ratios 4a and 5a use this data element in the denominator. He said using this denominator more closely matches with “non-renewals” and “cancellations over 60 days.” He said for non-renewals (ratio 4), flood policies usually have a term of at least one year. He said that means policies only from the prior reporting period would be up for renewal during the reporting period, and policies written during the current reporting period should not be included in the denominator. He said for cancellations greater than 60 days from inception, ratio 5a’s denominator includes both “beginning policies in-force” and “policies written during”, i.e., the entire universe of possible policies that can be cancelled greater than 60 days from inception. Using policies in force at the end of the reporting period excludes policies that were terminated for other reasons during the year, so it does not contain all the possible policies.

Mr. Haworth said the other option is to keep ratios 4 and 5 the same as the ratios used in the Homeowners MCAS scorecard ratios. He said the advantage to this is being able to compare the Private Flood ratios to the Homeowners ratios.
Mr. Hamblen said it is important to be able to compare the Private Flood ratios with the Homeowners ratios.

Mr. Haworth said ratios 6 and 7 duplicate the Homeowners MCAS ratios.

Mr. Haworth said ratio 8 is a new ratio taking advantage of the additional data element asking for the number of lawsuits closed with consideration for the consumer. This is measured against the number of lawsuits closed during the period.

Mr. Hamblen made a motion, seconded by Ms. Vandevoorde, to adopt the Private Flood MCAS ratios (Attachment Two-B), using 60 days for ratio 3 and matching the Homeowners MCAS ratios 4 and 5. The motion passed unanimously.

5. Discussed the MCAS Attestation

Mr. Haworth noted that ever since the MCAS was centralized, the Working Group usually gets a few questions each year regarding the attestation process and requests for clarification or changes to the process. He said a few years back, the Working Group added a second attestation to address who is responsible for the recreation of reported data from the source data. He said one concern recently expressed is whether the attestation can be provided at a more granular level. He said currently, the MCAS tool is designed to collect the attestations at the NAIC company code level even if the same company reports different lines of business in multiple states. He said it is possible, for example, that a Property and Casualty company may also report Health business, and the appropriate people to attest for each would be different.

Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) thanked the Working Group for the MCAS extension for the Health MCAS this year. He said the additional time was appreciated by the carriers.

Mr. Zolecki said the single attestation per NAIC company code is a concern for carriers. He asked for some time for industry to consider this and other issues and come back to the Working Group with a more complete discussion. Mr. Birnbaum said it was not clear what the problem is. Mr. Zolecki said it is important for the governance of a specific line of business to be the ones to attest to the data. They are more likely to understand the data and its sources. Mr. Zolecki said the attestation should be a higher-level rubber stamp of a submission made at a lower level, especially submissions to multiple states on different lines of business. Mr. Birnbaum said a single attessor can attest to the data.

Mr. Haworth said the Working Group will address the issue after industry has an opportunity to consider it more fully.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call March 23, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Jimmy Harris (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Lori Cunningham and Sandra Stumbo (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (NE); Karen McAllister and Douglas Rees (NH); Ralph Boeckman (NJ); Hermoliva Abejar (NV); Larry Wertel (NY); Angela Dingus (OH); Landon Hubbart (OK); Jeffrey Arnold (PA); Matt Gendron and Segun Daramola (RI); Michael Bailes (SC); Tracy Klausmeier (UT); Julie Fairbanks (VA); Christina Rouleau (VT); Theresa Miller (WV).

1. Adopted its Feb. 20 Minutes

The Working Group met Feb. 20 and took the following action: 1) adopted its Jan. 30 minutes; 2) discussed revisions to the MCAS Best Practices Guide; and 3) discussed a proposal to add travel insurance as the next line of business in the Market Conduct Annual Statement (MCAS).

Ms. Kroll made a motion, seconded by Ms. Dingus, to adopt the Working Group’s Feb. 20 minutes (Attachment Two-A1). The motion passed unanimously.

2. Discussed Revisions to the MCAS Best Practices Guide

Ms. Rebholz said the drafting group began work revising the MCAS Best Practices Guide, but it has temporarily stopped meeting. She said the main document has been updated, and the drafting group is identifying the best practices that will be highlighted and added to a separate appendix. She said another appendix will be added to provide links to resources.

3. Extended the MCAS Filing Due Date

Mr. Haworth said most companies have their employees working remotely due to the COVID-19 crisis, and he asked if any members of the Working Group have given thought to an extension of the MCAS due date.

Mr. Hanson suggested polling the companies to see if they need extensions to meet the filing due date. He stated his general agreement with providing an extension to the filing due date. Ms. Ailor said the Arizona Department of Insurance (DOI) has already begun discussions of providing an extension. She thought it was better to meet the need for an extension proactively for all companies instead of handling each company’s extension request individually. Ms. Rebholz said she did not agree with a poll because it would intrude on critical business functions. She agreed with a 60-day or 90-day extension. Mr. Harris said the Arkansas DOI would agree with a 60-day extension. Ms. Rouleau said companies have herculean tasks ahead of them and she favored reasonable accommodations. Ms. Moran also agreed with an extension. Ms. Miller agreed with extending the due date.

Ms. Dingus said she was in favor of an extension only for companies that are required to file on April 30. She said the June 30 due date for the health insurance and disability income insurance MCAS filings could be addressed when we get past April 30. Ms. Abejar agreed with Ms. Dingus. Mr. Arnold said he favored a blanket extension for all lines of business so companies can support essential functions. Mr. Bailes suggested a 90-day extension just for the filings due April 30 and the consideration of other lines of business as the due dates get closer. Ms. Shipp agreed with Mr. Bailes. Mr. Daramola said the Rhode Island DOI supported a 90-day extension.

Michael Lovendusky (American Council of Life Insurers—ACLI) said the ACLI members have said they are pressed with sustaining daily operations, such as claims and underwriting. The companies would be appreciative of an extension to file their MCAS. He said the California DOI has granted 60-day extensions for many of their regulatory filings, and New York is providing 90-day extensions for many of their filings. He said a 60-day or 90-day filing extension seems the most reasonable since no one knows what the COVID-19 situation will look like in 30 days. Lisa Brown (American Property Casualty Insurers Association—APCIA) agreed with Mr. Lovendusky, and she said the majority of APCIA members are working from home.
She said staff normally dedicated to MCAS filings are being used to assist in other critical company functions. Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) said he supported a 60-day extension for all lines of business. He said working remotely slows down the process of cross-validating data.

Birny Birnbaum (Center for Economic Justice—CEJ) said he supports a blanket extension of 60-days for all lines of business. Mr. Lovendusky said he supported a blanket extension of all due dates. He said companies that have a June 30 due date are currently working on gathering data, and an extension of the due date would help them.

Ms. Dingus asked whether the MCAS portal would be open for filings once companies are prepared to file if there was an extension given. Randy Helder (NAIC) said the MCAS portal is open and accepting filings. If companies want to file early, they may.

Mr. Gendron made a motion, seconded by Ms. Rouleau, to extend all 2020 filing due dates by 60 days. The motion passed unanimously.

4. Adopted Travel Insurance as the Next Line of Business in the MCAS

Mr. Haworth said the Working Group has considered travel insurance for the MCAS a couple times. He said it was not adopted the first time because of an ongoing multistate examination, and the Travel Insurance Model Act (#632) was still under consideration. He said Mr. Birnbaum has proposed travel insurance again since the examination has been concluded and Model #632 has been adopted. Mr. Haworth said he is often asked, especially now due to the COVID-19 crisis, about how many travel insurance policies are written and in-force in Washington, and he cannot answer the question because they are not broken out in the financial annual statement.

John P. Fielding (US Travel Insurance Association—UStiA) said the last time travel insurance was proposed as the next line of business in the MCAS, it was not adopted because of the ongoing work of drafting Model #632. He said that even though the Model #632 was adopted, it has only been enacted in eight states. The UStiA is working towards having the Model #632 enacted in all states so there will be a level playing field and uniformity. He said with the differences remaining in the states, it does not make sense to have uniform reporting in the MCAS. He also noted that industry is still being closely monitored by the states since the multistate examination.

Mr. Birnbaum said if travel insurance was adopted for inclusion in the MCAS, the earliest it could be collected would be for 2022 data collected in 2023. He said that in 2023, Mr. Fielding’s concerns would no longer exist. Mr. Birnbaum said travel insurance will continue to grow even more rapidly after the COVID-19 crisis. He said the wide variety in the types of coverage, both medical and non-medical, in travel insurance makes it important to be collected in the MCAS. He said the market is large and growing quickly but he noted that even if the travel insurance market is smaller than many lines of insurance, it makes it more suitable for collection in the MCAS, as that is one of the only tools that would be available to state insurance regulators to monitor the market. He said more competition in a market does not translate to less abuse. He said that was the reason for the multistate examination, and he noted that the Regulatory Settlement Agreement (RSA) monitoring will end by 2023. He also said there does not have to be uniformity in the statutory standards of all the jurisdictions. He noted that states have different standards for many other lines of business, such as private passenger auto. He said the MCAS questions are very high level and generic. They apply to all states regardless of the differing standards.

Mr. Gendron asked what other regulatory scrutiny is occurring other than the Market Actions (D) Working Group multistate examination. Mr. Fielding said he was not aware of any other scrutiny, but he noted that the multistate examination was significant. Mr. Gendron said Rhode Island adopted the Model #632 with the assistance of the UStiA, and he expects more states to adopt it; however, to be most effective, it would help state insurance regulators to know who writes travel insurance and how much they write in their jurisdiction. Because travel insurance is reported within the inland marine line on the financial annual statement, an MCAS filing would be the most efficient way to know who is writing how much travel insurance. He said in is his experience, more consideration is put into the development of an MCAS blank than other data calls.

Ms. Brown agreed with Mr. Fielding that it is too early to consider adding travel insurance to the MCAS. She also asked whether now is the right time to begin creating a new line of business while state insurance regulators and companies are responding to the COVID-19 crisis. Mr. Birnbaum said adopting travel as the next line of business in the MCAS gets it in the queue for creation, but work would not have to begin right away. Ms. Ailor confirmed Mr. Birnbaum’s statement. She said when she chaired the Market Conduct Annual Statement Blanks (D) Working Group, the work was prioritized and did not always begin immediately because of other work being done. Ms. Dingus said the Market Conduct Annual Statement Blanks
(D) Working Group is currently working on a few other issues and likely would not get to travel insurance until later in the year. She said she did not want to delay a vote. Mr. Arnold and Mr. Haworth agreed.

Ms. Rebholz made a motion, seconded by Ms. Moran, to adopt travel insurance as the next line of business in the MCAS. The motion passed unanimously.

5. Discussed Other Matters

Ms. Moran asked if the automatic deletion of the unapproved Market Analysis Review System (MARS) could be put on hold while states respond to the COVID-19 crisis. Mr. Helder said he would look into this. [Note to minutes—the automatic deletion of unapproved MARS reviews and the notification of unapproved reviews was turned off in late 2018.]

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 20, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Ryan James (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Jeffrey Zewe (LA); Dawn Kokosinski (MD); Timothy Schott (ME); Paul Hanson (MN); Stewart Freilich and Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevenoord (NE); Karen McAllister (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Angela Dingus (OH); Landon Hubbard (OK); Jeffrey A. Arnold (PA); Matt Gendron (RI); Michael Bailes (SC); Tracy Klausmeier (UT); Julie Fairbanks (VA); Christina Rouleau (VT); Tom Whitener (WV). Also participating was: Sarah Crittenden (GA).

1. **Adopted its Jan. 30 Minutes**

The Working Group met Jan. 30 and took the following action: 1) adopted its Dec. 8, 2019, minutes; 2) discussed revisions to the *MCAS Best Practices Guide*; and 3) discussed a proposal to add travel insurance as the next line of business in the Market Conduct Annual Statement (MCAS).

Ms. Dingus made a motion, seconded by Mr. James, to adopt the Working Group’s Jan. 30 minutes (Attachment Two-A1a). The motion passed unanimously.

2. **Discussed Revisions to the *MCAS Best Practices Guide***

Ms. Rebholz said the small group began work revising the *MCAS Best Practices Guide*. She said revisions to the *MCAS Best Practices Guide should be complete* by March 4.

3. **Discussed the Market Analysis Framework**

Mr. Haworth asked for volunteers to form a small group to review the NAIC *Market Regulation Handbook* (Handbook) market analysis chapters. Ms. Rebholz agreed that was a good idea. Ms. Crittenden volunteered to be in the group. Mr. Haworth asked anyone who is interested to contact Randy Helder (NAIC).

4. **Discussed New Lines of Business for the MCAS**

Mr. Haworth said a suggestion was received from Birny Birnbaum (Center for Economic Justice—CEJ) to add travel insurance as the next line of business to be added to the MCAS. He said the Market Regulation and Consumer Affairs (D) Committee adopted travel insurance examination standards for the Handbook. He said since there is an examination standard, state insurance regulators need data to determine which companies may need to be examined. Mr. Haworth also noted that pet insurance may be proposed by the Property and Casualty Insurance (C) Committee.

Ms. Ailor said travel insurance needs to be considered for the MCAS because of the growth in the line of business. She said it is important to know who is writing travel insurance and to what degree.

Mr. James said only a few states have adopted the *Travel Insurance Model Act (#632)* and are still promulgating rules. He asked if it is possible to create a travel insurance blank if not all states may define travel insurance the same way. Mr. Haworth said the MCAS asks for items such as policies written and claims paid. The MCAS measures the activity in the state and can help determine what companies are writing in the state.

John Fielding (United States Travel Insurance Association—UStiA) asked if interested parties will be allowed to submit comments. Mr. Haworth said the Working Group would welcome comments.

Mr. Birnbaum said that given the timelines for adopting new lines of business if the travel insurance line of business were adopted at this meeting, the earliest it could possibly be implemented would be for 2022 data reported in 2023. He said if the
rate of growth for the travel insurance line of business continues at the same pace, there will be more than 100 million policies in the market when the MCAS collection begins.

5. Discussed Private Flood Insurance MCAS Scorecard Ratios

Mr. Haworth said the private flood MCAS blank was adopted in 2019, and the initial filing will be April 30, 2021, for the 2020 data year. He said the Working Group is responsible for developing the scorecard ratios for the MCAS lines of business. He said the number of ratios per line of business varies. He asked if there were any thoughts regarding the number of ratios that would be needed for the private flood MCAS blank. Ms. Ailor said it is difficult to say how many scorecard ratios are needed. She suggested that the available data elements need to be examined and that the Working Group needs to know what state insurance regulators need. She said referring to other line of business scorecard ratios would be good idea to see which scorecard ratios have been useful and which have been less useful.

Mr. Haworth said a small group will be formed to begin the process of developing scorecard ratios for the private flood insurance MCAS blank. He said volunteers should contact Mr. Helder. Mr. Helder said the scorecard ratios would need to be developed by September or October 2020.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Market Analysis Procedures (D) Working Group
Conference Call
January 30, 2020

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Jan. 30, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Ryan James (AR); Cheryl Hawley (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Lori Cunningham and Sandra Stumbo (KY); Jeffrey Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Douglas Rees (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Angela Dingus (OH); Joel Sander (OK); Jeffrey A. Arnold (PA); Michael Bailes (SC); Julie Fairbanks (VA); Isabelle Keiser (VT); Desiree Mauller (WV).

1. **Adopted its Dec. 8, 2019, Minutes**

The Working Group met Dec. 8, 2019, and took the following action: 1) adopted its Nov. 21, 2019, minutes; 2) discussed its 2020 charges; 3) discussed a uniform process for addressing Market Conduct Annual Statement (MCAS) extension requests; and 4) discussed concerns arising from its decision to adopt “Other Health” as the next line of business in the MCAS.

Ms. Dingus made a motion, seconded by Mr. Zewe, to adopt the Working Group’s Dec. 8 minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Six). The motion passed unanimously.

2. **Received an Update on the STLD Medical Data Call Template**

Ms. Rebholz said NAIC staff sent the short-term, limited duration (STLD) data filings to all the participating states on Jan. 6. Along with the data, there was another spreadsheet showing all the companies that should have received a call letter. The spreadsheet indicated which companies filed and which companies sent an email advising they do not write STLD business. Ms. Rebholz said each state now needs to decide what to do with the information. She said Wisconsin sent 909 emails to companies that did not report or inform the NAIC they had nothing to report. She said more than 400 responses have been received, and all of them said they did not write STLD. She said the Working Group needs to consider whether it will take any concerted action against the companies that did not respond or leave this to the discretion of each state. She said Jo LeDuc (WI) input the data into Tableau, and Wisconsin has begun analysis. She said Wisconsin is willing to assist any other states.

Ms. Dingus said Ohio has not yet begun its analysis but has noticed a couple groups that indicated they had no business to report but the state has consumer complaints regarding STLD policies written by companies in the group. She said she is not ready to accept the data as complete or accurate and added she would be wary of collectively penalizing the wrong companies. Ms. Rebholz suggested states should share any information they have that indicates a company writes STLD even though they said they do not. Mr. Haworth noted that some companies said the call letter and reminder went to their spam email.

Ms. Rebholz said Wisconsin is willing to share a template of its communication to the companies that did not report to the initial NAIC data call.

3. **Discussed Revisions to the MCAS Best Practices Guide**

Ms. Rebholz said a small group has formed to begin work on needed revisions to the *MCAS Best Practices Guide* and other MCAS materials. She said the other materials are the MCAS web page, the MCAS Frequently Asked Questions (FAQ), the MCAS Users Guide, the MCAS call letter and training materials. She said that the group would begin with the best practices guide to make sure all changes to the guide are reflected in the other materials.

Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) asked if input will be accepted from industry. Mr. Haworth said for now it will be regulator only and will be exposed to interested parties at the Working Group level.
4. **Discussed the Market Analysis Framework**

Mr. Haworth said the current framework used by most market analysts on the state departments is described in Volume 2 of the *NAIC Market Regulation Handbook* which includes Chapters 6 through 8. He reviewed the contents of the chapters with the Working Group. He said the goal would be to identify changes that need to be made or insert additional relevant information and provide the recommended changes to the Market Conduct Examination Standards (D) Working Group.

5. **Discussed New Lines of Business for the MCAS**

Mr. Haworth said a suggestion was received from Birny Birnbaum (Center for Economic Justice—CEJ) to add travel insurance as the next line of business to be added to the MCAS.

Mr. Birnbaum said the travel insurance line of business was considered by the Working Group in 2018 but was declined because the multistate examination was still being finalized and the *Travel Insurance Model Act* (#632) was still being drafted. He said since that time, the examination has been completed, the model act has been adopted and standards for conducting a travel insurance examination are in the *NAIC Market Regulation Handbook*.

Mr. Birnbaum said the travel insurance market is growing rapidly, experiencing a 41% increase in premium from 2016 to 2018. He said 66 million people each year purchase a travel insurance product. He said the number of covered individuals increased 49% from 2016 to 2108, and the number of plans sold increased 36% in the same period. He said this type of growth warrants additional regulatory oversight because it is a fast-growing market with a complex product with many different coverages. He said there is currently no routine monitoring of the travel insurance market.

Mr. Haworth said there are some health products that are marketed with travel insurance but are marketed by both life and disability carriers, as well as property/casualty (P/C) carriers. He said in some states, the coverage is split between P/C and health. He said it is unclear how to track the premium in the financial annual statement. Mr. James asked if the health products should be reported on the “other health” MCAS. Mr. Haworth said that is a valid question and needs to be considered, but “other health” is typically critical illness or fixed indemnity type products. He said no framework for the “other health” blank has been developed yet.

John Fielding (United States Travel Insurance Association—UStiA) said Model #632 was adopted at the end of 2018 and has been adopted in eight states. He said it has provided a uniform approach for filing. He said 49 states require travel insurance to be filed as inland marine, and nine states additionally require it to be filed as health. He said uniformity will increase as Model #632 is adopted in more states. He also noted the multistate action has ended, but implementation and enforcement of the multistate action is continuing.

Mr. Birnbaum said that even if the travel insurance line of business were adopted at this meeting, the earliest it could possibly be implemented would be for 2021 data reported in 2022.

Mr. Haworth said the Working Group will continue to consider the travel insurance line of business.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Property & Casualty (Private Flood)

Same Ratios Apply Separately for First Dollar Coverage (stand-alone plus endorsements) and Excess Coverage (stand-alone plus endorsements)

Ratio 1.  **The number of claims closed without payment compared to the total number of claims closed**

\[
\frac{\text{Number of claims closed during the period, without payment}}{\text{Number of claims closed with payment} + \text{Number of claims closed without payment}}
\]

Ratio 2. **Percentage of claims unprocessed at the end of the period**

\[
\frac{\text{Number of claims open at the beginning of period} + \text{Number of claims opened during period} - \text{Number of claims closed with payment} - \text{Number of claims closed without payment}}{\text{Number of claims open at the beginning of period} + \text{Number of claims opened during the period}}
\]

Ratio 3. **Percentage of claims paid beyond 60 days**

\[
\frac{\text{total number of claims closed with payment beyond 60 days}}{\text{total number of claims closed with payment for all durations}}
\]

Ratio 4. **Company-Initiated Non-renewals to policies in force**

\[
\frac{\text{number of company-initiated non-renewals}}{\text{number of private flood policies or endorsements in force at the end of the reporting period}}
\]

Ratio 5. **Company-Initiated Cancellations over 60 days to policies in force**

\[
\frac{\text{number of company-initiated cancellations that occur 60 days or more after the effective date}}{\text{number of private flood policies or endorsements in force at the end of the reporting period}}
\]
Ratio 6. **Company-Initiated Cancellations under 60 days to new policies issued**

\[
\left( \frac{\text{number of company-initiated cancellations that occur in the first 59 days after effective date}}{\text{number of private flood policies or endorsements written during the reporting period}} \right)
\]

Ratio 7. **Suits opened during the period to claims closed without payment**

\[
\left( \frac{\text{number of lawsuits opened during the period}}{\text{number of claims closed during the reporting period, without payment}} \right)
\]

Ratio 8. **The percentage of lawsuits closed with consideration for the consumer**

\[
\left( \frac{\text{number of lawsuits closed during the period with consideration for the consumer}}{\text{number of lawsuits closed during the period}} \right)
\]
The Market Conduct Annual Statement Blanks (D) Working Group met via conference call July 31, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Sharon P. Clark and Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Todd Oberholtzer (OH); Katie Dzurec (PA); Michael Bailes (SC); and John Haworth (WA).

1. ** Adopted its June 24 Minutes**

The Working Group met June 24 and took the following action: 1) adopted its May 28, May 27, May 21 and May 20 minutes; 2) discussed Market Conduct Annual Statement (MCAS) Data Call and Definitions clarifications needed after adoption of changes to the life, annuity, homeowners and auto MCAS lines of business; and 3) adopted a motion to edit part of the first sentence of the definition for individual indexed variable annuity from “offers some principal protection” to “may offer some principal protection.”

Mr. Haworth made a motion, seconded by Mr. Swan, to adopt the Working Group’s June 24 minutes (Attachment Three-A). The motion passed unanimously.

2. **Discussed Possible Clarifications for Recently Adopted MCAS Updates**

   a. The first item discussed was clarification on how the definitions of the types of insurance (TOIs) are to be used within reporting for the data elements added in the homeowners underwriting section. Four new data elements were added during the June 24 call: 1) the number of dwelling fire policies in force at the end of the period; 2) the number of homeowner policies in force at the end of the period; 3) the number of tenant/renter/condo policies in force at the end of the period; and 4) the number of all other residential property policies in force at the end of the period. Draft language was included in the call materials, and it was posted to the Working Group’s web page for review.

   Ms. Rebholz stated that a note could be added at the beginning of the definitions section of the Data Call and Definitions to clarify how the definitions should be used. There were no comments by Working Group members, interested state insurance regulators or interested parties.

   Any thoughts, suggestions or comments on this topic were requested to be submitted to Teresa Cooper (NAIC) by Aug. 19 for consideration.

3. **Discussed Possible MCAS Updates Previously Tabled**

   a. The first item for discussion was related to the third-party administrator (TPA) and managing general agent (MGA) reporting that was previously adopted for the life, annuity, homeowners and auto interrogatories. For the life and annuity MCAS, an interrogatory was added to ask if the company uses TPAs; if so, it was asked to name each TPA and its function. For the homeowners and auto MCAS, two interrogatories were added. One was to ask if the company uses MGAs; if so, it was asked to name each MGA. The other added interrogatory was to ask if the company uses TPAs; if so, it was asked to name each TPA.

   Ms. Rebholz stated that Ms. Nickel has also suggested adding an interrogatory for the inclusion of the TPA’s and MGA’s national producer number (NPN). Mr. Hanson asked if all TPAs and MGAs would have an NPN. Ms. Nickel stated that she believes they are required to have an NPN. Mr. Haworth stated that some states do not license TPAs, so they may be tracked differently as a result.

   Any thoughts, comments or suggestions on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.
b. The next item discussed was the suggestion from the Center for Economic Justice (CEJ) to add definitions and data elements related to accelerated underwriting to the life MCAS reporting. Comments for this suggestion were included in the meeting materials for the call. The suggested definition is: “accelerated underwriting means underwriting or pricing of life insurance in whole or in part on non-medical data obtained from other than the applicant or policyholder and includes, among other things, facial analytics, social media and consumer credit information.”

Birny Birnbaum (CEJ) stated that the life insurance industry is using non-medical, non-traditional data to develop models that replicate its traditional underwriting. Issues associated with accelerated underwriting may be of interest to market regulators. The proposal includes a definition for accelerated underwriting and three interrogatories. The suggestion would be that some of the data elements would be reported separately for accelerated underwriting related business versus non-accelerated underwriting business. For example, there is currently a data element for the total number of new policies issued by the company during the period; the proposal would suggest separating this into two data elements: one for the total number of policies issued by the company during the period utilizing accelerated underwriting and one for the total number of policies issued by the company during the period utilizing other than accelerated underwriting.

David Leifer (American Council of Life Insurers—ACLI) stated that there is a lot of work going on related to this subject among other NAIC working groups. He does not know if the definition proposed for accelerated underwriting is accurate, and he suggested working with other groups that are discussing this topic before making any final decisions here.

Mr. Birnbaum stated that the CEJ has only proposed this, and if the Working Group decides this is an issue that should be considered as part of the MCAS blanks, the definition of accelerated underwriting will then be developed. He said he does not believe this subject should be delayed, as working on this now means that the earliest reporting would be 2022 data reported in 2023.

Brendan Bridgeland (Center for Insurance Research—CIR) stated support for Mr. Birnbaum’s proposal. He stated that consumers should have some idea of what is going into their rating and underwriting and why they have been denied access. For example, there could be duplicate factors disqualifying someone, such as a credit score in addition to a personal bankruptcy. Mr. Bridgeland stated that it would be useful to track the information proposed by the CEJ.

Commissioner Clark stated that the CEJ’s suggestion holds merit, and she would like the Working Group to consider collecting this data.

Mr. Haworth stated that it is warranted to explore this topic because of the concerns with how different types of consumer information are being used, especially with the current economy. He stated that the Working Group can collaborate with others to create a definition, along with inserting terms for predictive analytics and a couple of others regarding algorithms. Ms. Nickel agreed.

Any thoughts, comments or suggestions on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

c. The next item discussed was related to the placement of lawsuit and complaints data elements within the homeowners and auto MCAS. There is concern that complaint counts are not reported accurately. Previous discussion noted four options. The first option discussed was to create a new reporting section for lawsuits and complaints. The concern with this option is that complaints are currently reported in total in the underwriting section, while lawsuits are reported by coverage in the claims section. Other lines require reporting of complaints by coverage. The second option discussed was to move the complaints questions to the interrogatories. The concern with this option is that it could cause issues when trending past data, and it would be inconsistent with other MCAS lines of business. The third option discussed was to add clarification to the complaint definition. The fourth option was to change the claims section title to be “Claims and Total Complaints.”

Mr. Haworth stated that he does not see a need to make a change here. Ms. Nickel stated that she believes the concern here is that carriers are not reporting this data correctly.
Mr. Haworth stated that he has seen situations in which the company does not have a correct way of tracking what a complaint is, by definition, so the insurance department shows more complaints than the company because of underlying reporting issues within the company.

Mr. Birnbaum stated that one of the concerns that was raised is that the current placement suggests that companies only report certain types of lawsuits or certain types of complaints. By pulling this information out into a section called “complaints and lawsuits,” it would be much clearer to reporting companies that the MCAS is looking for any type of complaint, or any type of lawsuit, regardless of whether it is related to claims, underwriting, or any other matter.

Any thoughts, suggestions or comments on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

d. The next item discussed was the suggestion from the CEJ to break claims data elements for Homeowner Dwelling and Personal Property coverages into Digital Claims Settlements and Other than Digital Claims Settlement. This suggestion is detailed within the CEJ’s May 25 comment letter, which was included in the meeting materials.

Mr. Birnbaum stated that a digital claims settlement, sometimes referred to as “virtual claims handling,” refers to a loss appraisal not involving a human on-site inspection of the property, but it is based on digital information, including photos taken by the insured or claimant, a plane or drone, or information provided by sensors or cameras within or near the property. For some cars, if there is an accident, the car will be able to send information to the insurer, who can run information through an algorithm and almost instantaneously produce a claim settlement proposal for the insured. While there are some great potential benefits, there are also some consumer protection issues, such as whether these digital/virtual claims settlements are fair or significantly different from those that involve a human being.

Because of this change in claim settlements, the CEJ is suggesting that for homeowners and auto, the claim data elements be broken out into digital claims settlement and other than digital claims settlement. Then market analysts can determine whether any significant differences exist by company or by industry in the nature of the timing or the outcomes for digital claims settlements versus other than digital claims settlements. The CEJ proposal included a definition for each category and gave an example of how the two categories might be presented in the MCAS.

Mr. Birnbaum discussed the definitions proposed, and he provided examples. He added that the volume of these types of claims has grown as a result of the pandemic, and it is unlikely that there will be a movement back to fewer digital claims.

Ms. Nickel stated that it would be a good idea to consider this because digital claims will likely increase as time goes on. She stated that considering the effects of underwriting on this topic would be something to think about going forward, as well.

Ms. Cunningham agreed that consideration of digital practices regarding underwriting would be useful.

Mr. Haworth asked if the CEJ proposal applies to homeowners and auto lines. He stated that customers are using applications to submit photos of auto damages, and he pointed out the need to consider how supplements on claims would be addressed. Mr. Birnbaum stated that the proposal does apply to homeowners and auto.

Ms. Rebholz stated that in Wisconsin, auto repair facilities are stating that they see a high number of supplemental claims on digital claims settlements because the initial settlement does not address the full scope of the damage.

Mr. Birnbaum stated that there would be a presentation during the NAIC/Consumer Liaison Committee meeting on Aug. 14 regarding the issue of digital claims settlements for auto if anyone would like to learn more on this issue.

Any thoughts, suggestions or comments on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.
4. Discussed Other Matters

Richard L. Bates (State Farm Insurance) stated that State Farm recently learned that there was an adopted change to the auto MCAS to add a data element for claims closed without payment when the damage is below the deductible. He asked what the purpose of adding this data element is, how the data would be used, and if the industry was consulted on if they could produce this information and the extent to which it would be accurate. He stated that there would be significant costs imposed on carriers, and therefore consumers, in trying to understand the regulatory concern here.

Ms. Nickel stated that it is important for state insurance regulators to know how many claims are being denied, and separating out claims that were closed just because they were below the deductible was a way to better understand the data being presented by carriers and determine if further analysis of a carrier is warranted. She also stated that there were industry representatives present for the discussion on this topic and the call was open to anyone that wanted to participate. She stated that if Mr. Bates could provide an analysis, comments, and any additional feedback from State Farm and/or other carriers by Aug. 19, they would be reviewed and considered. She also stated that if he has any suggestions that would remedy this issue for state insurance regulators and be suitable for insurers, those ideas would be welcome.

Mr. Birnbaum stated that this seems like a useful distinction. He explained that there can be a variety of reasons a claim is closed without payment, and if claims closed without payment due to being below the deductible are separated out, the remaining data on other claims closed without payment is more meaningful. He asked Mr. Bates how much State Farm would have to raise its rates to provide this information to state insurance regulators.

Mr. Bates stated that he did not know and would check on that. He stated that he is looking at the assumption that there is always an ability for insurers to provide the reasons for claims closed without payment, and he suspects that State Farm will be able to satisfy some of that. He explained that there are times when a claim can close without payment below the deductible, and the insurer would not know that is the reason because the policyholder decided not to pursue their claim after filing it, as perhaps the policyholder learned the damages were below the deductible but never shared that with the insurer.

Ms. Rebholz stated that there is a ratio for claims closed without payment compared to the total number of claims closed. She stated that part of the discussion on this issue related to separating out claims closed without payment due to being below the deductible to ensure this ratio accurately reflected the claims that were being closed without payment for other reasons so that a carrier would not appear as an outlier just because they had so many high deductible plans.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call June 24, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Maria Ailor (AZ); Kurt Swan represented by Steve DeAngelis (CT); Scott Woods (FL); Lori Cunningham (KY); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV).

1. **Adopted May 28, May 27, May 21 and May 20 Minutes**

The Working Group met May 28, May 27, May 21 and May 20 and took the following actions: 1) adopted its May 6 minutes; 2) discussed survey results and adopted various changes to the life, annuity, homeowners and private passenger auto (PPA) Market Conduct Annual Statement (MCAS) blanks and Data Call and Definitions; 3) adopted edits to the lender-placed insurance (LPI) MCAS regarding blanket vendor single interest (VSI); and 4) adopted a motion to add an interrogatory for the homeowners and auto MCAS.

Ms. Nickel noted that it appeared that a change needed to be made to the May 28 minutes regarding the motion she made under Section 1, Item E, for reporting claims closed without payment that are below the deductible. Her understanding and intention of the motion was for the data element for claims closed without payment that are below the deductible be its own field.

Ms. Cunningham agreed that she understood the motion to add a data element for reporting claims closed without payment that are below the deductible to be a separate field that would not remove those claims from the total number of claims closed without payment.

Birny Birnbaum (Center for Economic Justice—CEJ) asked if the minutes as they were written just need to have the portion removed that states, “and to remove claims closed because the amount claimed is below the insured’s deductible from the reporting of the claims closed without payment data element.” Ms. Nickel said that was correct.

Ms. Ailor noted that currently the questions on claims closed without payment include those claims that are closed because they were below the deductible. She asked if the proposed change is to collect that data in the same fashion that it has been collected previously, but to add a new data element to only collect claims closed without payment that were closed because they are below the deductible. Ms. Nickel said that was her understanding of the motion.

Ms. Nickel made a motion, seconded by Ms. Cunningham, to correct the May 28 minutes under Section 1, Item E, to read, “Ms. Nickel made a motion, seconded by Ms. Cunningham, to add a data element for reporting claims closed without payment that are below the deductible. The motion passed unanimously.” The motion passed unanimously.

Mr. Haworth made a motion, seconded by Ms. Nickel, to accept the May 28 (Attachment Three-A1), May 27 (Attachment Three-A2), May 21 (Attachment Three-A3) and May 20 minutes (Attachment Three-A4). The motion passed unanimously.

2. **Discussed MCAS Data Call and Definitions Clarifications Needed After Adoption of Changes to the Life, Annuity, Homeowners and Auto MCAS Lines of Business**

   a. The first items discussed were the changes adopted for the Life and Annuity MCAS lines of business. Surrender data elements were added for the number of policies surrendered with a surrender fee and the number of policies surrendered more than 10 years from policy issue. No clarifications were added for these data elements.

   The interrogatory added for the life and annuity MCAS was, “Does the company use third party administrators (TPAs) for purposes of supporting the business being reported? If yes, provide the names and functions of each TPA.” These updates were also added for the Home and Auto lines, but the function is not required for the other lines.
Ms. Nickel suggested that in addition to this interrogatory, the definition of what a TPA is should be added, and it should include the TPA’s National Producer Number (NPN).

Mr. Birnbaum noted that he did not believe this could be presented as clarification, as it appears to be a substantive change and it was not completed by June 1. He also believes a change like this would need to be a data element. After discussion among the Working Group, the decision was made to table this suggestion for next year.

The next item changed in the life and annuity MCAS was replacements. The number of external replacements issued during the period was removed and replaced with the following: 1) number of external replacements of unaffiliated company policies issued during the period; and 2) number of external replacements of affiliated company policies issued during the period. Definitions for external replacement of affiliated company policies and external replacement of unaffiliated company policies were also added.

The final changes discussed on the life and annuity MCAS were the lawsuit data elements and related definitions that were added, as used in the other lines of business.

b. The next items of discussion were the adopted changes for only the annuity MCAS line of business. “Individual Fixed Annuities” was replaced with “Individual Indexed Fixed Annuities and Individual Other Fixed Annuities.” A definition was also added for “Individual Indexed Fixed Annuity.”

“Individual Variable Annuities” was replaced with “Individual Indexed Variable Annuities and Individual Other Variable Annuities.” A definition was also added for “Individual Indexed Variable Annuity.”

Ms. Nickel noted that the definition of “Individual Indexed Variable Annuity” does not specify anything for the variable portion, and she asked if more clarification could be added.

Mr. Birnbaum noted that the definition starts with stating variable annuities and limits the types of variable annuities to those whose accumulation or policy value is linked to an index or indices and offers some principal protection. He believes the variability is adequately covered by starting the definition with a variable annuity. He noted that if you wanted to add the word “may” in the first sentence so that the portion of the definition is “may offer some principal protection” instead of just “offers some principal protection,” he does not believe that harms the definition at all.

Ms. Nickel made a motion, seconded by Mr. Gaines, to edit part of the first sentence of the definition for “Individual Indexed Variable Annuity” from, “offers some principal protection” to, “may offer some principal protection.” The motion passed unanimously.

c. The next set of adopted changes discussed applied to the homeowners and auto MCAS lines of business. The following interrogatories were added: 1) Does the company use TPAs for the purposes of supporting the business being reported? If yes, provide the names of each TPA; and 2) Does the company use managing general agents (MGAs) for the purposes of supporting the business being reported? If yes, provide the names of each MGA. No clarifications were added for this data element. Whether or not the MGA or TPA’s NPN should be included in the reporting is an item that will be tabled and discussed next year.

A data element was also added for lawsuits closed with consideration for the consumer. Suits was updated to lawsuits within the existing lawsuit data elements, and related lawsuit definitions were added from other lines of business to make everything consistent across the blanks.

d. The next set of adopted changes discussed applied only to the homeowners line of business. Updates were made to interrogatory 12 and interrogatory 13, and no clarification was needed.

The underwriting data element for number of homeowners policies in force at the end of the period was replaced with the following: 1) number of dwelling fire policies in force at the end of the period; 2) number of homeowner policies in force at the end of the period; 3) number of tenant/renter/condo policies in force at the end of the period; and 4) number of all other residential property policies in force at the end of the period.
The definition of “Dwelling Fire and Dwelling Liability Policies” was updated to just be “Dwelling Fire Policies.” Homeowners policies were updated to include policies written on HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 policy forms. The definition of “tenant/renter/condo policies” was also added.

Ms. Rebholz noted that the Working Group needs to discuss clarification for renter’s insurance within the “homeowners policy” definition and how to ensure that claims reporting is not altered. Removing renter’s insurance from the definition of “homeowners policy” could cause renter’s insurance data to be left out of the claims reporting.

Ms. Nickel noted that she believes tenant and renter’s policies should be included in the “homeowners policy” definition so they can be reported in claims, cancellations, nonrenewals and other areas, in addition to the dwelling fire.

Mr. Birnbaum discussed his understanding of the adopted change for the renter’s and tenant policies made during the May 27 call.

Mr. Gaines noted that his intent was not to completely break everything down, it was just to be able to capture that information. He said he does not want to make it more difficult on the carriers.

Ms. Rebholz asked if the way the adopted changes are outlined correctly, and Mr. Gaines confirmed they were. After further discussion, Ms. Rebholz suggested that the adopted changes remain as they are written for now, and if issues are seen in collecting these data elements, review and corrections can be made as needed in the future.

e. The next items discussed were the adopted changes to the auto MCAS. Wording was updated in interrogatory 16 and interrogatory 17. No clarification was needed.

The following interrogatory was added: Does the company use telematics or usage-based data? A definition was also added for Telematics and Usage-Based Data. A data element was also added for claims closed without payment because the amount claimed is below the insured’s deductible.

Mr. Haworth noted that the definition of “lawsuit” needs to be corrected under the homeowners Data Call and Definitions, as it indicates it is for life and annuity.

Teresa Cooper (NAIC) confirmed that was a typo that would be corrected. It will also be corrected in the PPA Data Call and Definitions.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
May 28, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 28, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Maria Ailor (AZ); Mark Duffy (CT); Scott Woods (FL); Lori Cunningham (KY); Angela Dingus and Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV).

1. Discussed and Adopted Edits to the PPA MCAS Blanks Data Call and Definitions

Ms. Rebholz said that the survey results and a summary of items in the survey for this discussion are posted on the Working Group’s web page. A summary of the decisions made during the Working Group’s May 27 conference call for the homeowners Market Conduct Annual Statement (MCAS) was provided.

   a. Exclusions

   The first item discussed was to change the granularity of the private passenger auto (PPA) reporting to exclude reporting for uninsured motorist bodily injury (UMBI), uninsured motorist property damage (UMPD), medical payments, combined single limit (CSL) and personal injury protection (PIP). This would mean going forward, the MCAS would focus only on collision, comprehensive, liability and property damage (PD). The Working Group did not express interest in making this change.

   b. Policies in Force

   The next suggestion discussed was to require companies to report the number of policies in force by coverage type within the interrogatories. The Working Group did not express interest in making this change.

   c. Update to Question 16 and Question 17

   The next item of discussion was to make a change to question 18 in the interrogatories to include “last three data years.” It appears the intent was to update question 16 and question 17 similarly to the update suggested for homeowners. The decision made for homeowners was to change the wording in question 12 and question 13 from “Has all or part of this block of business been sold, closed or moved to another company during the year?” to “Has all or part of the this block of business been sold, closed or moved to another company during the reporting period?”

Ms. Nickel made a motion, seconded by Mr. Haworth, to update the wording in question 16 and question 17 of the PPA MCAS to match the reporting for question 12 and question 13 in the homeowners MCAS. The motion passed unanimously.

   d. Telematics or Usage-Based Data

   The next item discussed was the suggestion to add two interrogatories for: “offers a transportation network company (Uber, Lyft) or similar rideshare endorsement” and “offers or uses telematics or usage-based products.” Working Group members, interested state insurance regulators and interested parties discussed the suggestion.

Ms. Nickel made a motion, seconded by Mr. Arnold, to add the interrogatory “Does the company use telematics or usage-based data?” with a “yes” or “no” response. The motion passed unanimously.

   e. Reporting Claims Closed Without Payment That Are Below the Deductible

   The next topic discussed was to add a data element for reporting claims closed without payment that are below the deductible. Ms. Nickel and Ms. Cunningham expressed interest in adding this data element.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said this does not seem to provide information on a company’s market activity and stated a better approach may be redefining claims closed without payment to exclude those
that were closed because the claim was below the deductible. Ms. Nickel said some carriers report these claims incorrectly and explained this could be an indication of a company’s procedural or compliance issue. Further discussion took place.

Ms. Nickel made a motion, seconded by Ms. Cunningham, to add a data element for reporting claims closed without payment that are below the deductible. The motion passed unanimously.

f. **Phantom Claims**

The next suggestion was to edit the claim definition to avoid phantom claims. Mr. Self said an event reported for information only and coverage inquiries are not supposed to be included in claim counts. Ms. Brown said many states have statutes indicating an insurer cannot open a claim file based solely on an inquiry from a policyholder based on the potential of a claim. After discussion among Working Group members, there was no motion to make changes regarding this suggestion.

g. **Claims Closed With Payment Beyond 180 Days**

The next suggestion discussed was to remove data elements for claims closed with payment beyond 180 days. It was explained that removing these data elements removes the ability of NAIC staff to determine if the median days to final payment is reasonable. Mr. Arnold said he thinks these questions should remain due to the long tails that can take place on bodily injury (BI) claims. Ms. Ailor also supported keeping these data elements as PD claims can also last a long time and can be problematic if there are unnecessary delays in paying claims. There was no interest in removing these data elements.

h. **Separate Reporting for Each MGA**

The next suggestion was for reporting to be done separately for each managing general agent (MGA) to allow state insurance regulators to focus more on the MGAs that are potentially causing issues. During the Working Group’s May 27 conference call related to the homeowners MCAS, it was decided to add an interrogatory question to ask if the company uses any MGAs and if so, to list them by name.

Mr. Gaines made a motion, seconded by Ms. Nickel, to add the interrogatory question asking if the company uses any MGAs and if so, to list them by name. The motion passed unanimously.

i. **Company-Initiated Cancellations**

The next suggestion discussed was to break out the reporting of company-initiated cancellations after effective date in the underwriting section, excluding rewrites to a related company, to 0–29 and 30–59 days. Currently, the breakouts for this data element are 0–59 days, 60–90 days and beyond 90 days. This suggestion would add an extra bucket to separate those within the first 59 days. The Working Group did not express interest in making this change.

j. **Reporting of Terminations Triggered by Nonsufficient Funds**

The next suggestion discussed was to separate reporting of terminations triggered by nonsufficient funds and the insured’s request. Ms. Rebholz explained this data is already broken out by number of cancellations for non-pay or nonsufficient funds and number of cancellations at the insured’s request. There was no further discussion raised in making changes here.

k. **MD&A Section**

The next suggestion discussed was to add the submission of a management discussion and analysis (MD&A) section. This was discussed during the Working Group’s May 27 conference call, and the Working Group decided this suggestion would be passed to the Market Analysis Procedures (D) Working Group.

l. **Lawsuits Closed With Consideration for the Consumer**

The next suggestion discussed was to add a data element to reflect lawsuits closed with consideration for the consumer and adjust wording of lawsuits to make it consistent across all lines of business. The decision was made to add a question for lawsuits closed with consideration for the consumer for the homeowners line and to change the wording of lawsuits questions to use “lawsuits” versus “suits” and consistent definitions across the lines of business.
Ms. Nickel made a motion, seconded by Mr. Arnold, to add the “number of lawsuits closed with consideration for the consumer,” to adjust the wording to say “lawsuits” instead of “suits” and to keep the definitions consistent to the other lines of business. The motion passed unanimously.

m. Non-Renewals and Digital Claims

The next topic discussed was the letter received from Birny Birnbaum (Center for Economic Justice—CEJ). Mr. Birnbaum said that the auto and homeowners blanks have data elements for company-initiated non-renewals during the period. He said it would be useful to get more granular information on the cause of non-renewals to see what is driving them and suggested four buckets: 1) non-renewals based in whole or in part on claims history; 2) non-renewals based on catastrophe risk exposure; 3) non-renewals based on changes in credit score other algorithm using non-insurance personal consumer information; and 4) all other company-initiated non-renewals. The proposal has definitions for each bucket to ensure they are mutually exclusive and to avoid overlap.

Ms. Nickel asked the NAIC if this would change any of the current ratios being used. Teresa Cooper (NAIC) said it would not cause any issues with any current ratios.

Ms. Brown said the insurers she communicated with on this suggestion indicated they do not capture this information in their systems. They said they do not code the reasons for non-renewals as outlined in this suggestion. Mr. Birnbaum advised the MCAS timeline is set up the way it is to give companies time to prepare their systems to collect the data being requested in the future. After further discussion among Working Group members and interested parties, it was suggested that this suggestion would be tabled for future discussion and review. There was no motion to make changes here.

Ms. Rebholz advised there was also a suggestion by Mr. Birnbaum regarding breaking claims elements into digital claims versus other than digital claims. Mr. Birnbaum said unless there was a member of the Working Group that has an interest in this, it can also be tabled for future discussion. Ms. Nickel said she likes the idea and agrees it should be reviewed in the future. She expressed interest in knowing about inspections on structures for homes, specifically regarding claims and whether adjusters are looking at the damages. She asked how this would apply to personal property. Mr. Birnbaum advised it would apply in the same way as it would to structural damage—for example, if your home was hit by a hurricane and you sent pictures of the damage, and the claim was settled based on the pictures.

Ms. Brown said that homeowners and auto writers she discussed this with indicated they have a lot of claims that would have aspects of both, where initially they would accept a drone assessment of the policyholder’s loss but then later an adjuster is sent to inspect the damage. The same thing happens with auto claims, where initially the policyholder sends photos and then goes to a body shop, and then subsequent damage is found at the body shop. She said having these things be a part of the future discussion would be appreciated. Ms. Nickel said she sees a lot more of the drone use or use of Google images of homes before they are damaged. Carriers sometimes assess damage based on an older image that was taken years prior to the loss. Mr. Birnbaum said the definitions address some of the issues raised. He also said the National Insurance Crime Bureau (NICB) has a database of aerial photography. The NICB has planes flying over the country taking high-resolution photographs of properties that show resolution within two to three inches of every part of the country. It can use this to show the condition before a hurricane, and then a drone can look at the condition afterwards. This topic was tabled for future discussion.

2. Adopted Edits to the LPI MCAS Regarding Blanket VSI

Ms. Rebholz said that a subject matter expert (SME) group has discussed the lender-placed insurance (LPI) auto and home reporting issue for vendor single interest (VSI) products. The meeting material attachments four and five show redline copies of the LPI blank and data call and definitions that the SME group proposed. The proposal is to add separate reporting for blanket VSI auto and blanket VSI home. Mr. Birnbaum pointed out that the mock-up of the data call and definitions should be updated to have the new interrogatory wording consistent with those added in the blank. Each should say “Blanket Vendor” Single Interest.

Mr. Haworth said several different parties and state insurance regulators have reviewed and provided input on these proposed changes. Ms. Brown said the APCIA supports the proposal. Tom Keepers (Consumer Credit Industry Association—CCIA) said that while the CCIA was a part of the SME group and appreciated the collaboration on defining the data elements and being able to contribute to the process, the CCIA is still not supportive of reporting VSI.
Ms. Nickel made a motion, seconded by Mr. Haworth, to add separate reporting for blanket VSI auto and blanket VSI home, with interrogatory questions to be added for each additional coverage and additional columns to be added for the reporting of data. The motion passed unanimously.

3. **Adopted a Motion to Add an Interrogatory for the Homeowners and Auto MCAS**

Tanya Sherman (INS Companies) said that during the life and annuity conference calls last week, the Working Group agreed that third-party administrators (TPAs) would be added to the interrogatories. She said that during the conference calls today and yesterday, the Working Group agreed to add MGAs for property/casualty (P/C). She asked if also adding TPAs and not just MGAs to the P/C reporting would be appropriate. Ms. Nickel said she does not see a lot of TPA usage in Idaho Mr. Haworth said Washington sees a lot of TPA use, and it has companies that contract out a lot of services either for underwriting or claim handling.

Ms. Nickel made a motion, seconded by Mr. Arnold, to add an interrogatory for the homeowners and auto MCAS asking if the company uses a TPA, and if so, to list the name and function. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 27, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Angela Dingus (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating were: Sarah Crittenden (GA); and Jill Huisken (MI).

1. **Adopted its May 6 Minutes**

The Working Group met May 6 and took the following actions: 1) adopted its Feb. 26 minutes; 2) received an update on existing market conduct annual statement (MCAS) reviews and the other health MCAS development; and 3) adopted a $50,000 premium threshold for the private flood MCAS reporting.

Mr. Gaines made a motion, seconded by Mr. Arnold, to adopt the Working Group’s May 6 minutes (Attachment Three-A2a). The motion passed unanimously.

2. **Discussed and Adopted Edits to the Homeowners MCAS Blanks Data Call and Definitions**

Ms. Rebholz said the Working Group should come to consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. She said some issues may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. She said the survey results and a summary of items in the survey for this discussion are posted on the Working Group web page. The items highlighted in gray are related to the MCAS Market Analysis Prioritization Tool (MAPT). Ms. Rebholz said the Market Analysis Procedures (D) Working Group will forward rankings and ratios to Mr. Haworth for discussion.

   a. **Policies in Force**

The first item discussed was a suggested interrogatory change dealing with policies in force. The suggestion was to add a question to the interrogatories where a company could provide an explanation for any significant difference between the number of policies in force at the end of the prior year and the number reported in force for the beginning of the current reporting period. The other related suggestion is to add a data element to report the number of total, in-force policies by coverage type in the interrogatories. There was no interest expressed to make changes here.

   b. **Renter’s and Tenant Policies**

The next suggestion to the interrogatories was to break out reporting for renter’s and tenant policies. Working Group members discussed this suggestion.

Birny Birnbaum (Center for Economic Justice—CEJ) advised if the Working Groups want to get the information on the number of renter’s policies, it should ask about the number of homeowners policies in force at the end or beginning of the period, how many dwelling fire policies were in force and how many renter/tenant/condo policies grouped together were in force.

Ms. Rebholz said the next suggestion to the interrogatories along this subject is to break out renter’s policies and homeowner coverage separate from dwelling since there is a separate definition within the data call and definitions.

Teresa Cooper (NAIC) said another option is to add the reporting of these values to the underwriting section since data is already collected for policies in force in that section for homeowners, renter’s and dwelling. Mr. Haworth and Mr. Arnold said they agree.
Mr. Birnbaum stated the NAIC Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report) outlines how residential properties groups are categorized. The groups are: 1) dwelling fire, which is HO1; 2) homeowners, which is HO3 and HO5; and 3) renter’s/condo/co-op, which are HO4 and HO6. He suggested using the same three categories if adding them to the underwriting section.

Mr. Gaines made a motion, seconded by Mr. Arnold, to create three additional categories in the underwriting section: 1) dwelling fire; 2) homeowners; and 3) renter’s/condo/co-op. The motion passed unanimously

c. Interrogatories

The next item of discussion was to make a change to question 12 and question 13 in the interrogatories. The question currently asks: “Has all or part of this block of business been sold, closed or moved to another company during the year?” The suggestion is to change the end of the question to ask for information during the “last three data years.”

Ms. Ailor asked if this is data that could be obtained from the dashboard.

Tressa Smith (NAIC) confirmed the interrogatories will be available in the dashboard and that information on a current year would be available, as well as information up to five years back to see how responses have varied over time.

Ms. Crittenden said the three-year question seems to go outside of the MCAS annual reporting for the data year.

Ms. Rebholz asked if it would be better to change the wording to: “Has all or part of this block of business been sold, closed or moved to another company during this reporting period?” with the understanding that the dashboard can provide information three years back. Mr. Haworth supported this idea.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she agrees with Ms. Crittenden and Mr. Haworth in that the companies have been reporting this data for quite a while on an annual basis and if the information can be obtained off the dashboard, the APCIA would support just changing the wording as suggested.

Ms. Nickel made a motion, seconded by Ms. Ailor, to edit the wording in the end of the question from “during the year” to “during this reporting period.” The motion passed unanimously.

d. Private Flood Coverage

The next item discussed was to add an interrogatory asking if the company writes private flood coverage outside the National Flood Insurance Program (NFIP).

Mr. Haworth said if he wants to know this information, he reviews the private flood MCAS. After discussion among Working Group members and interested parties, there was no motion made to make this change.

e. Claims Closed Without Payment

The next topic discussed was to add a data element to the Claims category for reporting claims closed without payment for those that are below the deductible. Currently, claims that are for amounts below the insured’s deductible are reported as claims closed without payment, but they are not separated out from other claims closed without payment. If a data element is added, it might be necessary to exclude these from the current reporting of claims closed without payment.

There was no motion to add this data element.

f. Phantom Claims

The next suggestion was a concern related to phantom claims. The current definition of a claim and the clarification instructing the insurer what to exclude was discussed.

There was no motion to make edits here.
g. **Claims Closed with Payment Beyond 90 Days**

The next suggestion discussed was to remove claims question 26, question 27 and question 28. This would eliminate the reporting of claims closed with payment beyond 90 days. NAIC staff use the numbers reported in lines 23 through 28 to determine if the value reported on line 22 (median days to final payment) is reasonable. If elements 26 through 28 are removed, this check can no longer be done.

After discussion among Working Group members and interested state insurance regulators, there was no motion to make changes here.

h. **Separate Reporting for Each MGA**

The next suggestion discussed was for reporting to be done separately for each managing general agent (MGA) to allow state insurance regulators to focus more attention on the MGAs that are potentially causing issues. During previous life and annuity discussions, the Working Group decided that an interrogatory would be added to ask for a listing of third-party administrators (TPAs) that the company uses and each TPA’s function.

Mr. Gaines said that being able to identify which MGAs a company is using would be helpful.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add an interrogatory to list the names of MGAs that a company is using. The motion passed unanimously.

i. **Complaints Questions in the Underwriting Section**

The next suggestion discussed is to entirely remove the complaints questions in the underwriting section because companies do not seem to report the complaint counts correctly.

Mr. Haworth, Mr. Arnold and Ms. Brown said they do not think it should be removed.

Ms. Ailor said the location of the complaints question being in the underwriting section could be causing confusion.

Mr. Birnbaum advised the complaints data and lawsuit data in other lines of business are broken out in different categories and suggested doing the same here to eliminate confusion that may exist.

Ms. Nickel made a motion to create a new category for complaints and lawsuit information and move the question that currently exists for complaints to that new category.

Ms. Smith pointed out that currently the number of complaints received directly from any person or entity other than the insurance department is under the underwriting section, but that section is not broken out by coverage type. Data for complaints is not collected separately for dwelling, personal property, liability, medical payments and loss of use. Currently, complaints are collected as a whole, and lawsuits are collected by coverage type, so data collected for complaints and lawsuits are collected in different manners.

Ms. Nickel made a motion to move the complaint question out of the underwriting section and to the interrogatory section.

Mr. Haworth asked if the data could still be pulled if the complaints were in the interrogatory section and expressed concern with consistency among other lines.

Mr. Birnbaum said if there is concern about having this question in the interrogatory section in terms of ease of access to the data, it could be kept as a data element. He said a reporting instruction could be added to report all complaints in the dwelling coverage and block out the other coverage boxes for that particular data element.

Ms. Rebholz asked NAIC staff what would be the easiest option and if that was an option.

Ms. Smith advised leaving the question in the underwriting section and said that adding some clarification would be the easiest solution, especially when considering looking at past data. The past data would still be in the underwriting section, and the new
data would be in interrogatories if the question was moved, which is something to be aware of in considering changes here and future analysis.

Ms. Brown asked if it would be easier to change the category name to “Underwriting and Total Complaints.”

Mr. Birnbaum said he believes there is a benefit to pulling out the lawsuits and the complaints data into a separate schedule as it has been done in other categories, so it is clearer that it is all complaints and all lawsuits.

Ms. Nickel made a motion to pull the two elements out for complaints and lawsuits and make one new section for complaints and lawsuits with all related questions into that category. There was no second and no changes or edits were made regarding that suggestion at this time.

Ms. Rebholz advised this can be discussed in the future.

j. Fire Protection Classes

The next suggestion discussed was to add a data element to capture fire protection classes used and to collect information regarding fire protection classes that are used.

Mr. Gaines said the Washington Insurance Examination Bureau conducts exams on companies for this, so Washington would not benefit from this addition.

There was no interest expressed in collecting this information.

k. Terminations Triggered by Nonsufficient Funds and the Insured’s Request

The next suggestion discussed was to separate reporting of terminations triggered by nonsufficient funds and the insured’s request. There is also a suggestion to separate reporting of terminations triggered by nonsufficient funds and the insured’s request. Currently, there are two data elements for this information: 1) the number of cancellations for non-pay or non-sufficient funds; and 2) the number of cancellations at the insured’s request.

There was no interest expressed in making changes here.

l. MD&A Section

The next suggestion discussed is for the addition of a Management Discussion & Analysis (MD&A) section to the MCAS. The suggestion is to add the submission of an MD&A. Insurers currently submit an MD&A document with their financial annual statement filings.

Ms. Nickel said she made this recommendation and explained why she supports this.

Ms. Huiskens asked if this information would be reported on a state-by-state basis. Ms. Nickel said she envisions the reporting would be on a national basis.

Ms. Brown asked if there would be a different MD&A for market versus financial or if it would be a replication of what is done on financial.

Ms. Nickel said it would focus on areas that would primarily affect the market, such as closed books of business and moving/shifting products from indexed annuities to variable products, use of TPAs and other general questions.

Ms. Brown said she thinks this should be a separate market report on a national basis, separate from MCAS reporting since MCAS data is reported by state.

Ms. Rebholz asked if Mr. Haworth could discuss this with the Market Analysis Procedures (D) Working Group to see if there was an interest there. He agreed to do so and said he does not believe it is suitable for MCAS reporting.
m. Lawsuits Closed with Consideration for the Consumer

The next suggestion discussed was to add a fifth data element to reflect lawsuits closed with consideration for the consumer and adjust wording of lawsuits to make it consistent across all lines of business. The MCAS lines of business of long-term care (LTC), disability, private flood and lender-placed have a data element for: “number of lawsuits closed with consideration for the consumer.” These were just added, along with: “number of lawsuits open at the beginning of the period,” “number of lawsuits opened during the period,” “number of lawsuits closed during the period” and “number of lawsuits open at the end of the period.” The current home and auto blanks do not have the “number of lawsuits closed with consideration for the consumer” and also refer to lawsuits as “suits.”

Ms. Brown said companies have indicated that this data is not easily captured. She said they would have to manually look at what offer was made prior to litigation in the settlement, and what payment or other thing of value would need to be added and defined to the claims handling process.

Mr. Birnbaum said that in addition to the data element, the data definitions used in the other blanks should be updated to have consistency with other lines on the data elements and definitions. He also said this information is useful and can eventually be programmed into company systems.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add a data element for “number of lawsuits closed with consideration for the consumer” and to update the language from “suits” to “lawsuits” for consistency purposes. Ms. Cooper asked if the motion includes the definitions for the other lines, and Ms. Nickel said it does. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 6, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Maria Ailor (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Angela Dingus (OH); Katie Dzurec and Jeffrey Arnold (PA); Michael Bailes (SC); John Haworth (WA); and Letha Tate (WV).

1. **Adopted its Feb. 26 Minutes**

The Working Group met Feb. 26 and took the following action: 1) adopted its Dec. 17, 2019, minutes; 2) discussed the review of the life and annuity market conduct annual statement (MCAS); 3) discussed the review of the homeowners (HO) and private passenger auto (PPA) MCAS; 4) discussed vendor single interest (VSI) concerns for the lender-placed MCAS; and 5) discussed the “other health” MCAS data call approved by the Market Analysis Procedures (D) Working Group.

Mr. Haworth made a motion, seconded by Ms. Kroll, to adopt the Working Group’s Feb. 26 minutes (Attachment Three-A2a). The motion passed unanimously.

2. **Received an Update on the Existing MCAS Line of Business Reviews and the Other Health MCAS Development**

Ms. Rebholz noted that due to the COVID-19 situation, the Working Group was previously asked to pause meetings. The Market Regulation and Consumer Affairs (D) Committee has since determined that the work of the Working Group is important and should move forward to avoid delays in the progress of MCAS edits and additions.

The first subject-matter expert (SME) group that will now resume their work is for lender-placed VSI MCAS data reporting. Discussions on this topic will continue May 13. In January, the Consumer Credit Industry Association (CCIA) raised some concerns about the VSI products being collected with the other lender-placed business collected in the MCAS. First, the CCIA said VSI business is commercial business meant to protect only the bank. Second, VSI is written as a blanket policy prior to the consumer transactions. There are no consumer cancellations, claims, or any tracking of insurance. The CCIA also noted that the inclusion of these types of products in the MCAS would skew the numbers because they are not individually underwritten. The Center for Economic Justice (CEJ) agreed with the CCIA on the concerns about including the VSI numbers in the aggregate totals of the lender-placed insurance (LPI) filings. However, Birny Birnbaum (CEJ) made the argument that rather than exclude VSI business, it should be broken out on the MCAS blank as a separate type of LPI coverage.

The LPI VSI subgroup met March 11 and determined that VSI should be broken out and included in the MCAS. Mr. Birnbaum and Tom Keepers (CCIA) submitted recommended edits for the blank, which are posted on the Working Group web page. These will be discussed during the May 13 call. Once the SME group agrees on needed edits, they will then be sent to the Working Group for consideration.

Ms. Rebholz asked if Ms. Dzurec would like to discuss the upcoming call for the “other health” MCAS drafting. Ms. Dzurec noted that the “other health” SME group that is developing the new “other health” MCAS blank and Data Call and Definitions will be meeting tomorrow, May 7. The “other health” drafting group had only one meeting before everyone’s focus was drawn to addressing the COVID-19 crisis. That call was held in regulator-to-regulator session, and it was intended to allow the state insurance regulators to discuss the specifics of the recent short-term limited-duration (STLD) data call and produce a rough draft that could be exposed to a drafting group of state insurance regulators, consumer representatives, and industry representatives. After some discussion at the working group level, a decision was made that all drafting group calls should be open to interested parties.

After two cancellations of the drafting group conference calls, the Working Group was finally given permission to begin its work again. All interested parties who have volunteered to be on the drafting group should have received a notice of the upcoming call. If anyone did not receive the notice and would like to participate, they were advised to contact Randy Helder (NAIC).
Ms. Dzurec also noted that work will begin on the STLD portion of the “other health” MCAS Data Call and Definitions. Consumer representatives were the only stakeholders to submit comments on what was exposed in the past. She advised that if there are others who have comments on this matter, they should also provide them to Mr. Helder.

Ms. Rebholz noted that the SME group discussed life and annuity next. To review the results and suggestions from the life and annuity survey, there will be two Working Group meetings. These meetings will be held May 20 and May 21.

Ms. Nickel noted that a survey was conducted in 2018 asking the states to provide their input regarding needed edits to the life and annuity MCAS blanks and Data Call and Definitions. Since that time, there have been SME group meetings to discuss the results, but no recommendations have been returned to the Working Group. During the last SME group call to discuss the life and annuity MCAS lines of business, the group discussed having each of the SMEs pick the top three issues they would like to address. No feedback from the SME group was received. In addition to the compilation of the 2018 survey results that are currently posted to the Working Group’s web page, a summarized list of issues from the life and annuity MCAS survey will be reviewed at the upcoming Working Group meetings to discuss the life and annuity MCAS lines. Possible additions, revisions and deletions for the life and annuity blanks and Data Call and Definitions will be determined. The meetings to discuss this further will be May 20 and May 21 to determine what the priorities are and move forward from there. Anyone interested in reviewing the survey and providing comments were asked to do so prior to the May 20 call. Comments can be emailed to Tressa Smith (NAIC), Mr. Helder or Ms. Nickel.

Ms. Rebholz noted that two additional meetings will be held to discuss the results from the homeowners and auto MCAS survey and any revisions that should be made for these lines of business. These meetings will be held May 27 and May 28. The homeowners and auto survey results were recently compiled, and they will be distributed prior to the calls. During these calls, the homeowners and auto MCAS survey results will be reviewed, as well as a summarized list of the survey results. As with the life and annuity discussions and possible additions, revisions and deletions for the auto and homeowners MCAS blanks and Data Call and Definitions will be determined.

The meetings for both the life and annuity and the homeowners and auto MCAS data calls will need to move quickly to complete the reviews and determine any needed updates within the allotted times. After completing the series of four calls, the goal is to have approved edits for all four lines of business that will be passed up to the Committee for its approval. If the review and edits are approved by the Working Group within the four calls, the June 1 deadline for proposals from the Working Group will be met. This would allow approved edits to be made applicable to the 2021 MCAS data year reported in 2022.

Materials containing the items to be discussed will be posted on the Working Group’s web page prior to the calls. Meeting notices will be sent soon.

Ms. Nickel asked whether the revisions would go to the Committee or back to the Working Group first after the homeowners and auto SME group meetings. Ms. Rebholz stated that her understanding is that the revisions would go to the Committee.

Ms. Ailor asked if the changes will be exposed for a comment period. Ms. Smith explained that the calls will be at the Working Group level so that they are open, more transparent and documented. The blanket VSI and “other health” lines will still be small group/SME calls, but the other two lines will be at the Working Group level.

3. Considered the Private Flood MCAS Premium Threshold for Reporting

Ms. Rebholz advised that the Working Group needs to determine a reporting threshold for the private flood MCAS. In 2019, the Working Group and the Committee adopted the private flood MCAS blank and Data Call and Definitions; however, no premium reporting threshold was included in the Data Call and Definitions. Mr. Rebholz noted that, to date, all other MCAS lines of business have a $50,000 premium threshold, except long-term care (LTC), which has no threshold.

Mr. Haworth stated that he would be in favor of setting the threshold for the private flood MCAS at $50,000 to be consistent with the other MCAS lines of business. Ms. Dingus agreed.

Mr. Birnbaum stated that the CEJ does not object to the $50,000 threshold, but he would like to clarify that this amount applies to all private flood premium reported in the blank and that it is not $50,000 for each specific coverage, but an aggregate total of $50,000.
Ms. Rebholz confirmed that this was her understanding, noting that if a company writes $50,000 in private flood coverage, it meets the premium threshold and would need to report.

Lisa Brown (American Property Casualty Insurance Association—APCIA) noted that the APCIA would support the $50,000 threshold, and she agreed with Mr. Birnbaum’s suggestion that it should include all individual sublines that were developed for the private flood MCAS blank.

Mr. Haworth made a motion, seconded by Mr. Arnold, to adopt the $50,000 premium threshold for the private flood MCAS. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group Conference Call February 26, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 26, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Jimmy Harris (AR); Maria Ailor (AZ); Scott Woods (FL); Sandra Stumbo (KY); Brent Kabler (MO); Angela Dingus (OH); Katie Dzurec (PA); John Haworth and Ned Gaines (WA); and Letha Tate (WV).

1. **Adopted its Dec. 17, 2019, Minutes**

The Working Group met Dec. 17, 2019, and took the following action: 1) adopted its Nov. 21, 2019, minutes; 2) discussed the review of the life and annuity market conduct annual statement (MCAS); 3) discussed the review of the homeowners (HO) and private passenger auto (PPA) MCAS; 4) discussed vendor single interest (VSI) concerns for the lender-placed MCAS; 5) discussed the other health MCAS data call approved by the Market Analysis Procedures (D) Working Group; and 6) discussed the extraordinary circumstance definition for health extension requests.

Prior to adopting the Dec. 17, 2019, minutes, Tom Keepers (Consumer Credit Industry Association—CCIA) pointed out a word change that needed to be made under item 4, in the first sentence of paragraph 5, regarding fees charged for blanket VSI by lenders. The wording was changed from “carriers” to “lenders” for his response.

Ms. Dingus made a motion, seconded by Ms. Nickel, to adopt the Working Group’s Dec. 17, 2019, minutes (Attachment Three-A2a1A). The motion passed unanimously.

2. **Discussed the Review of the Life and Annuity MCAS**

Ms. Rebholz advised that during the last meeting it was discussed that the life and annuity MCAS review subject-matter expert (SME) group was being reformed to explore changes to the life and annuity MCAS blanks. These changes include not only the definitions and current data elements, but also the possible inclusion of new types of life insurance products beyond just cash value products and non-cash value products.

If interest was previously expressed in being included in this group, individuals should have received an email this week with documentation and a meeting invitation. The meeting is scheduled to take place Wednesday, March 4. Ms. Nickel will lead this effort, with the goal of having recommendations to the Working Group by June 1, if possible, but by the Fall National Meeting at the latest.

Anyone interested in participating in the group that did not receive any communication was advised to send a note to Tressa Smith (NAIC). There was no further discussion on this matter.

3. **Discussed the Review of the HO and PPA MCAS**

Ms. Rebholz said one of the Working Group’s charges for 2020 is to review the MCAS data elements and the data call and definitions for those lines of business that have been in effect for longer than three years and update them as necessary.

Volunteers for this group have come forward, but before review begins, a survey needed to be conducted to see what, if any, appetite there is for changes to the HO and auto lines of business. Market conduct analysis chiefs and MCAS contacts for the states were sent a survey on Feb. 25, 2020. The collection of survey responses will run through March 20 and then survey results will be analyzed. Volunteers will then meet to determine what action needs to be taken with the results of the survey.

The goal is to have recommendations to the Working Group preferably before June 1, if possible, but by the Fall National Meeting at the latest.

Individuals interested in participating in the group that did not receive communication about it, should send a note to Ms. Smith. There was no further discussion on this matter.
4. **Discussed VSI Concerns for the Lender-Placed MCAS**

Ms. Rebholz advised that regarding the questions on the lender-placed insurance MCAS that were discussed during the Dec. 17, 2019, conference call, an SME group has been formed to discuss this. The first discussion will take place March 11, and Ms. Rebholz will be leading the group discussions.

Individuals that expressed interest in participating should have received an email and meeting invitation from Ms. Smith on Feb. 24. Those interested in participating in the group that did not receive communication about it should send a note to Ms. Smith. There was no further discussion of this matter.

5. **Discussed the “Other Health” MCAS Data Call Approved by the Market Analysis Procedures (D) Working Group**

Ms. Dzurec said that state insurance regulators met Feb. 25 to discuss the direction and agenda for a full meeting of the other health MCAS SME group. They will meet next March 6. The “other health” line of business can be separated into short-term limited-duration (STLD) and mini-med-type products like limited benefits and other products that are used to create a federal Affordable Care Act (ACA) look-alike product or that are being marketed in a way that looks like an alternative ACA product. Because of the data collection needs, the SME group recommends separating this data into two separate blanks. The group will move forward with the STLD blank first, with the goal to get it done and forwarded to the Working Group in the next six weeks to meet the deadline for collecting 2021 data year STLD data in 2022, so state insurance regulators can have the information to meet legislative requests and understand their marketplace.

In order to get this done within the next six weeks, comments should be provided by March 4. Comments should be sent to Randy Helder (NAIC). The MCAS blank review for the non-STLD types of products will proceed after the STLD blank review is complete, as this review will take more time.

Tanya Sherman (The INS Companies) indicated that there was nothing in the Working Group web page exposure drafts for interested parties to provide comments on and asked if comments should be based on the previous survey conducted.

Ms. Dzurec explained that creating an exposure draft involves incorporating all considerations, so there is no wording to be considered yet; and all comments are welcome so that as many issues as possible can be factored in, in the context of an MCAS blank. She said the STLD data call that was due Dec. 13, 2019, has information that can be reviewed for relevant information. There is also a memorandum from West Virginia dated July 27, 2018, addressed to Mr. Haworth regarding creating this MCAS blank.

Ms. Ailor said it would be helpful if the data call documents were posted on the Working Group’s web page. Ms. Smith said this information would be posted.

Birny Birnbaum (Center for Economic Justice—CEJ) asked if the SME group has a working definition of STLD products available for review. Ms. Dzurec said there is not and that proposals for this are welcome.

Mr. Birnbaum also asked why the Feb. 25 and March 6 calls being held in regulator-to-regulator session and why interested parties are not being asked to participate.

Ms. Dzurec said the call is to pull together information for an exposure draft on a short timeline, and she explained that there is specific content regarding actual cases that states have experienced being discussed in these calls that are confidential under the state examination laws. She said the information gathered will be provided back to interested parties for feedback because right now this is still in the preparation phase. Interested parties can provide comments in preparation for the March 6 conference call. She said future calls will be open after the draft is created to be sure that all feedback is considered.

Ms. Dingus asked how often other health SME group conference calls would be discussed. Ms. Dzurec said once there is a draft to work from, calls will likely be on a weekly basis, and limited benefit calls will be more spread out.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
December 17, 2019

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Dec. 17, 2019. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Jimmy Harris (AR); Kurt Swan (CT); Scott Woods (FL); October Nickel (ID); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Jeffrey Arnold (PA); Michael Bailes (SC); Ned Gaines (WA); Jo LeDuc (WI); and Letha Tate (WV).

1. **Adopted its Nov. 21 Minutes**

The Working Group met Nov. 21 and took the following action: 1) adopted its Oct. 23 minutes; 2) agreed to change the Market Conduct Annual Statement (MCAS) due dates occurring on weekends and federal holidays to the next business day; and 3) extended the health MCAS filing deadline for 2020, 2021 and 2022 from April 30 to June 30.

Ms. Dingus made a motion, seconded by Mr. Swan, to adopt the Working Group’s Nov. 21 minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Seven). The motion passed.

2. **Discussed the Review of the Life and Annuity MCAS**

Ms. Ailor said that the small group looking into changes to the life and annuity MCAS blanks will be reformed due to continued interest in this topic by some state insurance regulators and consumer representatives. The survey conducted in 2018 indicated most state insurance regulators thought the life MCAS needed to be more granular than just cash value and non-cash value products. Respondents seemed to favor variable and universal life products as the types of products they would like to have more data about. There was also a strong interest in individual pre-need, funeral and final expense life insurance. While most state insurance regulators were satisfied with the current data elements collected, there were still some suggestions for improvements. The responses were similar for the annuity blank but with less interest in more granular level beyond the fixed and variable annuities. More interest was expressed for additional data on equity indexed annuities.

Ms. Ailor asked for volunteers to lead this small group next year with the goal of having recommendations to the Working Group preferably before June 1, 2020, if possible, but no later than the NAIC Fall National Meeting. Those interested in leading or participating in the group are to send a request to Tressa Smith (NAIC).

3. **Discussed the Review of the HO and PPA MCAS**

Ms. Ailor said one of the Working Group’s charges for 2020 is to review the MCAS data elements and the Data Call and Definitions for those lines of business that have been in effect for longer than three years and update them as necessary. In addition to the Life and Annuity lines, she stated the private passenger auto (PPA) and homeowners (HO) lines should be reviewed. She suggested a similar survey as the one done for life and annuity be sent for PPA and HO.

Ms. Ailor asked for volunteers to lead this group next year with the goal of having recommendations to the Working Group preferably before June 1, 2020, but no later than the NAIC Fall National Meeting. Those interested in leading or participating in the group are to let Ms. Smith know.

4. **Discussed Vendor Single Interest Concerns for the Lender-Placed MCAS**

Ms. Ailor said that during the Market Analysis Procedures (D) Working Group meeting on Oct. 31, members heard comments from Tom Keepers (Consumer Credit Industry Association—CCIA) about blanket vendor single interest (VSI) being included in the lender-placed MCAS blank. He expressed concern that due to the way blanket VSI is written and issued, the reporting in the MCAS may be skewed and noted it is a small market with premiums only in the tens of millions nationwide. Birny Birnbaum (Center for Economic Justice—CEJ) said during that same Market Analysis Procedures (D) Working Group meeting that blanket VSI is a lender-placed insurance product that is necessary for state insurance regulators to receive data for and recommended creating a special data call and developing a separate MCAS blank for it. Ms. Ailor said the issue would be
referred to this Working Group for discussion and next steps, and in response received letters from Mr. Keepers and Mr. Birnbaum. The letters were made available to the Working Group for review.

Ms. Ailor asked if Mr. Keepers was on the conference call and would like to comment. Mr. Keepers explained that blanket VSI is a two-party, single-interest commercial insurance policy that protects the lender’s interest in the collateral against damage. He said consumers are not really engaged in the insurance transaction as no coverage is issued at point of sale, they are not a party to the lender-insurer master policy, and they are not issued individual certificates, so consumer cancellations and refunds do not apply. He explained that consumers are engaged in the lending process, not the insurance claims process, as by the time a claim is filed, the consumer has already defaulted on loan payments and the vehicle has been repossessed by the lender, such that the claim is between the lender and the insurer only. He further explained that there is not always a charge to consumers at loan closing and that he does not think the blanket VSI product should be included in the MCAS.

Ms. Ailor asked what kind of fee could be charged for this product, and Mr. Keepers said it generally ranges from $25 to $100 and sometimes higher. She also asked what kind of disclosures are provided to consumers, and he said in the lending documents, consumers are informed of this charge and their option to purchase it separately. He said the fee covers the collateral, and the lender may or may not charge the borrower.

Ms. Nickel said her understanding was that lenders always charged a fee for this type of product, and Mr. Keepers responded that there are plenty of lenders that do not charge fees for blanket VSI. She asked if insurers could track these types of claims, and Mr. Keepers confirmed they can. However, he said that this product is a commercial activity and that while it has fees that may be charged to consumers, it is a commercial product helping lenders mitigate their risks and consumers are not involved. He advised there is no forced placement and that it is just a claim filed to the insurer by the lender and that the only consumer involvement is the one-time fee at the time of the initial loan.

Mr. Birnbaum said one of the things that distinguishes VSI from other types of lender-placed insurance (LPI) is that consumers are charged for force-placed insurance regardless of whether they have a lapse of coverage or not. The other difference is how premium is calculated because rather than being based on an individual vehicle, it is based on the entire portfolio. The third difference is the absence of tracking the borrower’s insurance. He said VSI is a commercial policy issued to the lender and the insurers charge a premium to the lender, not to the borrower. The insurers are not involved in the fee charged by the lender to the borrower. It is a master policy issued to the lender and like traditional LPI, there is no individual lender or property for the underwriting. This puts consumers in a vulnerable position with no market power in the event of damage to the vehicle. Because of the differences in premium calculation and exposure count versus traditional LPI, blanket VSI and traditional LPI comparisons for underwriting, claims and suit data are not compatible and need to be reported separately. The CEJ recommends that VSI be broken out as a separate coverage within the LPI exhibit, which would enable state insurance regulators to address any problems with VSI that are raised by the CCIA.

Ms. Ailor said the Working Group needs to evaluate and decide on how to move forward, whether it be keeping the blank the same and offering further instructions and clarity as to how these products should be reported, adding it as a separate coverage in the blanks or removing it completely. Ms. Ailor asked that everyone review the comments submitted by the CEJ and the CCIA and consider the discussion today and let Ms. Smith know if volunteers are interested in being part of the small group that will review this topic further in 2020.

5. Discussed the Other Health MCAS Data Call Approved by the Market Analysis Procedures (D) Working Group

Ms. Ailor said the Marketing Analysis Procedures (D) Working Group adopted “other health” as the next line of business for MCAS, and the Market Regulation and Consumer Affairs (D) Committee adopted it during the Fall National Meeting. Industry and state insurance regulators expressed concerns with how broad and ambiguous the term “other health” is, and this Working Group must carefully draft the data call so that the data elements, definitions and instructions are detailed and clear and there is no ambiguity about what is reported. Ms. Ailor said an immense amount of experience was gained from the health blank implementation. Data from the short-term, limited duration (STLD) template is available for review as a starting point.

For the “other health” MCAS blank to be successful, industry representatives, individual companies, state insurance regulators and consumer representatives participating in the group will need to be tasked with developing the draft. Ms. Ailor asked that volunteers be on the drafting group, and that those interested in leading or participating in this to notify Ms. Smith.
6. Discussed the Extraordinary Circumstance Definition for Health Extension Requests

Ms. Ailor said the due date for the health MCAS that was extended to June 30 for 2020, 2021 and 2022 will return to April 30 in 2023. Industry representatives made assurances that companies will not ask for individual extensions beyond June 30 except in extraordinary circumstances. Industry representatives have provided a letter with a proposed definition of “extraordinary circumstances,” and the letter has been made available on this Working Group’s web page for review.

Ms. Ailor asked if Joe Zolecki (Blue Cross and Blue Shield Association—BCBSA) would like to address the Working Group to discuss the letter, and Samantha Burns (America’s Health Insurance Plans—AHIP) said Mr. Zolecki was unable to attend the conference call and addressed the Working Group with regard to the letter on behalf of the Health Industry Interested Parties (HIIP) group. Ms. Burns stated the determination for extension request would be at the ultimate discretion and approval of the domestic state. She said the circumstances they consider to be extraordinary and outside of the carrier’s control, among other things, are the following: acts of God, mergers and requisitions, system issues, vendor issues, delayed new or modified federal Centers for Medicare & Medicaid Services (CMS) requirements, and substantive new health MCAS reporting requirements implemented by state insurance regulators.

Mr. Birnbaum stated the list of extraordinary circumstances provided by the HIIP group is far too expansive and that mergers and acquisitions are under the discretion and control of the carrier. System and vendor issues are also subject to the control of the carrier, which reinforces concerns about granting the extension for health MCAS data. He suggested that a list be specified by state insurance regulators for situations that would not qualify as an extraordinary circumstance.

Ms. Burns advised she does not believe carriers have control over the issues that arise stemming from mergers and requisitions and vendor issues and that these items should qualify as extenuating circumstances and be left up to the state to decide.

Mr. Gaines said in Washington, they receive requests extensions the day before the due date, claiming issues with collecting third-party data, even though the carrier just requested data from the vendor. Ms. Burns agreed this type of scenario should not fall under an extraordinary circumstance.

Ms. Ailor explained the extension to June 30 from April 30 has already been granted and that any additional extension is at the discretion of the state, not the domestic state, but the state in which the MCAS must be filed. Requests for extensions are addressed individually, and system issues, vendor issues and the laborious tasks sometimes associated with collecting information from third parties are some of the reasons that the extension to June 30 was granted.

Ms. Burns asked if there would be a vote on this definition, and Ms. Ailor said she does not believe a vote is needed. Randy Helder (NAIC) confirmed a vote is not necessary as the decision to extend beyond June 30 is ultimately up to the state that is receiving the filing.

7. Discussed Any Other Matters Brought Before the Working Group

Ms. Ailor advised she is stepping down as Working Group chair. She said Arizona will still be a member of this Working Group and that anyone interested in learning more about the chair role is asked to contact the NAIC, Mr. Helder, Ms. Smith or Ms. Ailor directly.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group

Conference Call

May 21, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 21, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sara Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Teresa Kroll (MO); Angela Dingus (OH); Katie Dzurec (PA); Michael Bailes and Rachel Moore (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating was: Sarah Crittenden (GA).

1. **Discussed Annuity MCAS Survey Results and Possible Edits to the Blanks and Data Call and Definitions**

Ms. Rebholz noted that the focus of this call is possible edits to the annuity Market Conduct Annual Statement (MCAS) blank and Data Call and Definitions. The results of the 2018 survey results are posted on the Working Group web page. In addition, a summary of items in the survey for this discussion is included in the materials for this call. The items highlighted in gray are related to the MCAS Market Analysis Prioritization Tool (MAPT) rankings and ratios, and they will be discussed by the Market Analysis Procedures (D) Working Group. These items are being passed along to Mr. Haworth for the Market Analysis Procedures (D) Working Group to discuss.

Ms. Rebholz said the Working Group should come to consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. Some issues may not be easily resolved, and they may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. She noted that Ms. Nickel would lead the discussions today, and she explained that time would be allowed for comments on each item discussed.

Ms. Nickel noted that many of the topics discussed yesterday for the life MCAS would also apply to the annuity portion of the MCAS and would be discussed to see if similar changes should be made. The survey results and possible edits specific to the annuity MCAS will then be reviewed.

   a. **Life MCAS Blank**

The first item discussed was to review the changes made to the life MCAS on yesterday’s call and determine if the same changes should apply to the annuity MCAS.

The first change discussed was adding a data element requesting the number of policies surrendered with a surrender fee. Mr. Haworth expressed an interest in making this change. Ms. Crittenden agreed.

Mr. Swan asked if the same 10 year and over methodology would be applied here.

Ms. Nickel explained that the number of policies surrendered greater than 10 years from policy issue date was added to the life MCAS, and she asked if there was also an interest in making this change on the annuity line, explaining that this would be two separate additions. One addition would be for the number of policies surrendered with a surrender fee and one would be for the number of policies surrendered greater than 10 years from the policy issue date.

The next item of discussion was to add an interrogatory asking the company to identify all third-party administrators (TPAs) the company uses and their function.

The next suggestion was to add the following data elements related to lawsuits: 1) the number of lawsuits open at the beginning of the period; 2) the number of lawsuits opened during the period; 3) the number of lawsuits closed during the period; 4) the number of lawsuits closed during the period with consideration for the customer; and 5) the number of lawsuits open at the end of the period.

Ms. Nickel asked if there were any comments regarding the above changes being made to the life MCAS and applying them all to the annuity MCAS.
Birny Birnbaum (Center for Economic Justice—CEJ) asked whether the intent was to add the interrogatory about TPAs for both life interrogatories and annuity interrogatories, or to get one set of interrogatories regarding TPAs.

Randy Helder (NAIC) noted that there would be a TPA question for the life MCAS blank and then a separate TPA question for the annuity MCAS blank in the interrogatories for both.

Mr. Haworth made a motion, seconded by Ms. Nickel, to add the data elements and interrogatory additions discussed here that were added to the life MCAS blank yesterday to the annuity blank. The motion passed unanimously.

b. Internal/External Replacements

The next item discussed was having internal and external replacements further defined, and possibly adding another category for external replacements for those that are replaced by another company within the same group of companies.

Tanya Sherman (INS Companies) asked for clarification on this topic.

Mr. Birnbaum noted that the blank defines internal replacement as being issued by your company and an external replacement as being issued by another company. There probably needs to be some clarification on what “another company” means. It can mean another insurer outside of your group, or it can mean another company within your group if you have multiple companies issuing annuities. Mr. Birnbaum said he would not want to categorize a replacement by another company within the group as an external replacement, as that appears misleading. He noted that it may be helpful to break down external replacements into two data elements; one could be when a policy or annuity is replaced and was issued by a company unaffiliated with your company, and the other could be an external replacement issued by another company that is affiliated with your company. The internal replacement would stand.

Ms. Rebholz noted that one of the suggestions along this line was to add a separate field to report a sister company replacement to help identify if churning may be occurring.

Ms. Nickel asked if anyone wanted to move to add an additional level of detail regarding affiliated or unaffiliated company relationships on replacements.

Mr. Haworth asked whether a motion made here would be consistent for the life MCAS too. Ms. Nickel said that would be appropriate.

Mr. Haworth made a motion, seconded by Mr. Swan, to make the changes as discussed and clarify the external versus internal replacements including affiliated companies.

Mr. Birnbaum noted that the definition for internal replacement is described as a replacement by your company, and the current definition for external replacement is described as being issued by another company. He asked if the proposal is to retain the current definition of internal replacement and then to create two data elements for external replacement where one refers to another company affiliated with your company and then the second definition would be issued by another company unaffiliated with your company.

Mr. Helder noted that his understanding of Mr. Haworth’s motion is to add a separate field to identify external replacements to an affiliated company, and he believes Mr. Birnbaum is asking if there would be a commensurate definition in the data call and definitions.

Mr. Haworth confirmed that the definitions would have to be added, as there is a data field that will need to be explained and clarified.

Ms. Nickel asked for clarification about whether external would be broken out into two separate definitions and internal would remain the same as a replaced policy.

Mr. Helder said that is correct, and one more data element for external replacements would be added for affiliated companies and the definitions would be revised to explain what that means.

Ms. Phelps asked if all companies would understand what the term “affiliated” means.
Mr. Birnbaum noted that the term “affiliated” is standard in the insurance industry, and when companies file their annual financial statement, they complete an organizational chart showing any affiliations. He believes that it is a straightforward term.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add these additional data elements and definition pieces clarifying the external versus internal replacements to the life MCAS blank, as well. The motion passed unanimously.

c. **Granularity of Annuity Reporting**

The next item of discussion was the granularity of annuity reporting. Mr. Gaines expressed an interest in pulling out the variable annuity product data.

Mr. Birnbaum noted that the current MCAS breaks annuities into fixed and variable categories. The fixed category includes immediate fixed, deferred, qualified longevity annuity contract, and indexed annuities. The data includes experiences for different product types sold to different types of consumers, sold by different types of producers in different markets. Variable annuities currently include variable; traditional variable; fixed variable; indexed variable, now called buffered annuities; and contingent deferred annuities. Mr. Birnbaum suggested breaking out the annuities into more granular categories to assist in a more useful and detailed market analysis.

Mr. Haworth noted that it looks like only 10 people responded to this topic on the survey and 22 people did not respond, and he asked if that was correct.

Tressa Smith (NAIC) confirmed that as correct, and she said survey participants were not required to respond to these questions. The first part of the survey had a question that asked if it would be beneficial to have data broken down into a more granular level. Eleven people said “yes,” and 11 people said “no.” Of the 11 people who indicated that they would like more granularity, 10 of those then said they would like more granularity on this category.

Mr. Haworth asked if Working Group members would like more granularity here.

Mr. Gaines noted that he is interested in additional data on the variable side, specifically variable indexed annuities, and not as much on the fixed side.

Mr. Birnbaum suggested categories for variable annuities of indexed variable and all variable annuities other than indexed. Then, the same thing could be done for fixed, having fixed-indexed annuities and all fixed annuities other than fixed-indexed annuities. This would add two additional categories.

After some discussion by the Working Group, Ms. Rebholz asked if there was a motion to make changes here. She explained that currently all fixed annuities are in one bucket and all variable annuities are in the other. The idea is to break out fixed annuities into fixed-indexed and all other fixed annuities, and then break out the all variable bucket into indexed variable and all other variable.

Mr. Haworth made a motion, seconded by Mr. Swan, to add the additional lines as discussed. The motion passed unanimously.

Ms. Nickel asked if there was any interest from the Working Group regarding adding additional levels of granularity here, such as immediate fixed annuities and deferred fixed annuities. There were no comments expressed to make additional changes here.

d. **Other Topics**

The next topic discussed was the suggestion of adding a definition of in-force. There was no interest in making this addition to the annuity MCAS. The next topic discussed was a comment regarding death claims closed with payment that does not fit for annuities, so this was not discussed. The next topic discussed was the suggestion to collect information based on contract state and resident state. There was no interest in making this addition to the annuity MCAS.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 20, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Jimmy Harris (AR); Sara Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Angela Dingus (OH); Jeffrey Arnold (PA); Rachel Moore (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating was: Sarah Crittenden (GA); and Karen McCallister (NH).

1. Discussed Survey Results and Possible Edits to the Life MCAS Blank and Data Call and Definitions

Ms. Rebholz noted that, in 2018, a survey was sent to state market analysis chiefs and Market Conduct Annual Statement (MCAS) contacts to get their input regarding possible updates to the life and annuity MCAS. The results of the survey are posted on the Working Group’s web page. In addition, a summary of the items in the survey for this discussion is included in materials for this call. The items highlighted in gray are related to the MCAS Market Analysis Prioritization Tool (MAPT) rankings and ratios, and they will need to be discussed by the Market Analysis Procedures (D) Working Group. These items are being passed along to Mr. Haworth for the Market Analysis Procedures (D) Working Group to discuss. Tomorrow, the annuity MCAS Blank and Data Call and Definitions will be discussed.

Ms. Rebholz said the Working Group should come to a consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. Some issues discussed today may not be easily resolved, and they may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. Ms. Rebholz noted that Ms. Nickel would lead the discussions today, and she explained that time would be allowed for comments on each item discussed.

Ms. Nickel started by thanking the Center for Economic Justice (CEJ) and the American Council of Life Insurers (ACLI) for the comments submitted to the Working Group. Messages were also received in support of the CEJ comments. These letters of support were from Brendan Bridgeland (Center for Insurance Research—CIR), J. Robert Hunter (Consumer Federation of America—CFA) and Ken Klein (California Western School of Law). Some CEJ comments were related to the frequency of MCAS data submissions. These comments will be shared with the Market Analysis Procedures (D) Working Group chair and vice chair for inclusion in its upcoming meetings. The CEJ, the ACLI and other interested parties will be able to provide input on all edits discussed today.

Ms. Nickel said that during the last subject-matter expert (SME) call, in which possible edits to the life and annuity MCAS were discussed, participants were asked to review the survey responses in detail and bring back their top three selections for changes to the next meeting. In the responses received from Working Group members, there was no consensus regarding the level of granularity needed. There was mention of adding some data elements to the life MCAS blank.

a. Level of Reporting Granularity

The first item discussed was the level of reporting granularity for the life MCAS blank. The meeting materials provided in advance of the call include the survey results related to life granularity. It is a percentage based on each different coverage line. There were comments made for additional areas that were not identified in that coverage by line of business or coverage type. The comments were related to credit and other products with no cash value, preneed, final expense, and funeral contracts. The ACLI provided a basic overview with differences related to those types of products, specifically for final expense and preneed products.

Ms. Nickel asked if Working Group members had an interest in pulling out preneed and final expenses. She noted that the credit line was already rejected by the Market Analysis Procedures (D) Working Group for a new line of business for the Market Conduct Annual Statement Blanks (D) Working Group to work on. Therefore, this will also need to be brought back up with the Market Analysis Procedures (D) Working Group for it to be the Market Conduct Annual Statement Blanks (D) Working Group’s charge to discuss the credit line of business.
Tanya Sherman (INS Companies) noted that it is challenging when conducting analysis when these unique products are mixed in with other lines, and she felt that it would be nice to break these out.

Ms. Nickel asked for clarification about whether Ms. Sherman meant these products should be separated or they could be grouped into one. Ms. Sherman said they could be grouped into one category.

Birny Birnbaum (CEJ) noted that there are two reasons to segregate preneed and final expense. One would be because you have an interest in consumer outcomes for a specific product. The second is that you do not want consumer outcomes in a specific product line to muck up the data for other product lines that you have an interest in. Mr. Birnbaum noted that both instances for preneed and final expense warrant separation from the current overly aggregated categories of cash and non-cash values. He believes that during prior calls, industry stakeholders expressed that preneed was significantly different than final expense, and he felt that these comments should be reviewed so they are not aggregated together.

Ms. Nickel noted that it did not appear that there was a large consensus to make changes here, but it would be beneficial in some respects to pull apart the preneed and final expense. Based on the comments made, there does not appear to be enough interest to make these changes now.

Ms. Rebholz agreed, and she asked if there was a motion from the Working Group members to break out individual preneed and final expense to the life MCAS reporting blanks. There was no motion made.

Mr. Bridgeland noted that he has reviewed this and looked at what information can be gathered by consumers, academics and consumer organizations. It used to be that in the annual statement, you could gather some basic information about generally smaller face value life insurance policies because they fell into the industrial life policy category. Now, however, because of the way it is defined, there is no information reported and industrial life does not exist as its own category. Over the years there have been changes in terms of what information is available about certain types of life insurance products that you used to be able to segregate from the financial data, which you can no longer do because of the way industrial life has been defined and classified over the years.

Mr. Bridgeland noted that there is a gap here because state insurance regulators used to be able to pick up information from annual statement reporting, but it is missing now. He feels that market conduct assessment would help because as a consumer advocate, when he hears from families or funeral service directors, it is commonly related to preneed and burial policies. From a consumer perspective, he believes it is important; and he wants to note that because of changes over the years, there is a gap in data available to state insurance regulators and consumers.

Monica Sole (Lincoln Heritage) noted that one of the problems Lincoln Heritage faces is that there is only one line of business for Lincoln Heritage and it is final expense. Final expense is not defined by the NAIC or any state insurance regulator, and it is not the same as preneed. Ms. Sole asked how bigger companies would report what a is final expense policy is and what is not since it is just a way of marketing a small face policy and there is no definition. She asked if large companies would report differently based on the face value of a policy. She feels that it should be separated from preneed, as it is its own line of business.

Mr. Birnbaum noted that the March 4 letter from the ACLI outlines the difference between final expense and preneed. Final expense is a whole life policy that is marked as final expense, and preneed is a whole life policy used to prepay a funeral on a contingent assignment. Preneed could be easily defined as a contractual relationship. To separate out final expense, you could segregate it as a whole life policy marketed for final expense. He said this would be a straightforward way of doing it, as a company knows if they are marketing something as final expense or not.

Ms. Nickel agreed that companies generally would know what their different product lines are and how to properly file them.

Ms. Rebholz asked if anyone from the Working Group wanted to make a motion to add this endowment coverage to the life MCAS reporting. There was no motion made.

b. Individual Universal Life Insurance and Individual Variable Universal Life Insurance

The next item of discussion was individual universal life insurance and individual variable universal life insurance. There was no interest from the Working Group or any state insurance regulators to segregate universal life products.
Mr. Birnbaum noted that for most of these product lines, there is a different market and a different target population. There have been different types of market problems associated with that. If you look at traditional universal life, there have been problems with companies that promise vanishing premium, and now consumers are being faced with extraordinary premium. With indexed universal life (IUL), there is a different set of issues with unrealistic or misleading illustrations or hidden fees. If you aggregate all of this into cash value products, there is no way to distinguish what is happening with whole life versus universal life versus IUL versus variable life; as a result, the market analysis is ineffective. A company that might be an outlier if you were looking at IUL does not show up as an outlier because that experience is hidden through aggregation with other products.

Mr. Birnbaum said he believes that the pandemic illustrates why there is a problem. People are now being marketed certain products, claiming that they can be protected in the event if a market turndown; yet, there is no way to see what is going on in the marketplace in the aftermath of the pandemic. For those reasons, the CEJ suggests not only a breakout for universal life separate from IUL, but also a break-out for variable life and whole life as part of the cash value breakouts.

Ms. Nickel asked if anyone else has comments to add, and there were none. There was not enough interest here to make changes to universal life.

Ms. Nickel then asked for comments on individual variable universal life.

Mr. Birnbaum noted that he believes there should be a breakout here, as well.

Ms. Sherman noted that she was looking at the survey notes for the life MCAS, and she asked for clarification on the percentages.

Tressa Smith (NAIC) noted that the survey results are on the Working Group’s web page, and they are more than just the summaries for anyone that would like to review them in more detail. There were 32 responses; 19 of those answered that “yes,” they would like additional break outs for more granularity for the life MCAS. The percentages shown are from the 19 people that answered “yes” as to what they would find beneficial.

Mr. Birnbaum further expressed his support for breaking out these lines further to assist with a more detailed market analysis.

Ms. Rebholz encouraged Working Group members to speak up on these matters to have a good understanding of how they feel about making changes to each item as the call progresses. She asked if there was a motion to make any changes to the individual universal life and individual variable universal life, and there were none.

c. Individual Term Life Insurance with no Cash Value and Other Individual Life Insurance with no Cash Value

Ms. Nickel noted that the next topic to discuss is individual term life insurance with no cash value and other individual life insurance with no cash value. She asked if any Working Group members have an opinion or interest to include this as a separate line.

Mr. Gaines noted that he does not believe that this needs to be broken down further. There were no comments by interested state insurance regulators or interested parties made on this topic. There was no motion to make changes here.

d. Individual Equity Indexed Life Insurance

The next topic discussed was individual equity indexed life insurance products. There were no comments from Working Group members, other state insurance regulators, or interested parties with an interest to break this product line out, so no motions were made to make changes here.

e. Individual Whole Life Insurance and Individual Variable Life Insurance

The next item discussed was whether there is an interest in separating individual whole life insurance and individual variable life Insurance.

Mr. Gaines noted that based on the survey, if there is a specific line that has a clear number of states in the majority, the Working Group should consider making changes.
Ms. Nickel noted that the 19 people who indicated that they would like to see changes represented 15 states, which did not seem to represent a significant enough interest from the majority. She explained that in future surveys, it may need to be a requirement for the states to answer these kinds of questions to have a better understanding of all the states.

There were no other comments from Working Group members, other state insurance regulators, or interested parties on this topic, and no motion to make changes was made here.

f. Surrenders

Ms. Nickel noted that the next item of discussion is regarding comments received on surrenders. She asked if any Working Group members want to discuss surrenders being broken out by years and how that would be useful. She asked what the current options are, and Teresa Cooper (NAIC) noted that the options are contracts surrendered under two years of issuance, between two and five years of issuance, and between six and 10 years of issuance. Ms. Nickel asked if there was any interest in modification to these time frames.

Mr. Birnbaum suggested adding an option for 10 years or longer.

Ms. Crittenden noted that she supports adding the option for 10 years or longer, and she expressed interest in knowing about surrender fees.

Ms. Nickel asked if she had a proposal regarding surrender fees.

Ms. Rebholz noted that there was a suggestion in the survey that suggested adding a data element to collect the number of policies surrendered where a surrender fee was applied. She noted that the questions for the Working Group to decide are: 1) whether it would be useful to know how many policies were surrendered; and 2) of those surrendered, how many had a surrender fee applied.

After some discussion among Working Group members, Mr. Haworth made a motion, seconded by Ms. Nickel, to collect the number of policies surrendered where a surrender fee was charged. The motion passed unanimously.

Mr. Haworth asked if adding the option for contracts surrendered past 10 years is going to be discussed further.

After some discussion, Ms. Nickel made a motion, seconded by Mr. Woods, to add the option for contracts surrendered beyond 10 years. The motion passed unanimously.

g. In-Force Contracts and Definitions

Ms. Nickel noted that there was feedback received for in-force contracts and definitions needing more clarity. There was dialogue in the survey regarding policies taken and not taken.

Ms. McCallister noted that she was the one that made this comment, as she had several companies that were not including their non-taken, and she found it odd that some companies are including non-taken while some are not. She said she believes that because it is a formal offer, they should be included, and she is looking for clarity here. There was no interest from other call participants to make changes here, so this subject has been tabled for future discussions if filing discrepancies continue to be a concern.

Ms. McCallister noted that the next matter up for discussion on adding data elements to both individual cash value policies and individual non-cash value policies could be disregarded, as she was referring to the annual financial statement and the comment does not apply here, so there is no need to discuss it.

h. Individual Cash Value Policies Related to Nonforfeiture

Ms. Nickel noted that the next item to discuss is the individual cash value policies related to nonforfeiture. She noted that this relates to the surrender topic discussed earlier on this call, and even though the surrender and nonforfeiture options are different, this could be clearer with the changes being made to the surrender data. She asked if additional separation here is necessary or if the surrender changes agreed on would suffice.
Mr. Haworth agreed that with the changes being made regarding surrender fee data, clarity for nonforfeiture is also gained. There were no additional comments here, so no changes will be made.

i. TPA Information

Ms. Nickel noted that the next topic to discuss is the comment made regarding the life interrogatories and whether it would be valuable information to include third-party administrator (TPA) information. The comment suggested requesting whether the company utilizes a TPA for the line of business, the name(s) of the TPA, and what the TPA does.

Mr. Haworth noted he could see merit with this request because this also came up in the short-term limited-duration (STLD) data call as a topic people wanted to be aware of. He advised it would probably need to be an interrogatory that says whether a TPA is utilized to list the name and for what function.

Mr. Haworth made a motion, seconded by Ms. Nickel, to collect TPA information on an interrogatory and the functions that they carry out. The motion passed unanimously.

Mr. Birnbaum noted that the reporting here is limited to individual coverages, as group coverages are not provided. He asked whether the question about TPAs is intended to relate to the use of TPAs for individual coverages or if it is a broad application question.

Mr. Haworth noted that for this context, it would just be for individual business; however, by being able to track it this way, they can see who these companies work with.

j. Potential Outliers

The next item discussed was for a comment received that stated the following: “We find that most companies do not have comments about being a potential outlier because they do not have any basis for comparison to state and national averages at the time of their filing.”

Ms. Nickel asked if the person who made the comment was on the call and available to elaborate on this. There was no response. Ms. Nickel noted that the score cards are available for everyone to review, including insurance companies and consumers; and even at an individual state level, carriers have the ability to review where they fall and review trends over periods of time to determine what kind of outliers they may have. She asked if anyone else had comments.

Mr. Haworth noted that he believes this is more of an educational comment, as he has had to assist various parties by showing them the tools available to find information on potential outliers. There were no changes to be made here.

k. Illustration Certification Fields

Ms. Nickel noted that the final comment regarding the life MCAS interrogatories supports the incorporation of illustration certification fields. She asked that Working Group members interested in this topic provide further clarification on this request by email to Randy Helder (NAIC) or other NAIC staff to get a better idea of what is being asked for.

l. Resident State vs. Issue State

Ms. Nickel noted that there were some questions on definitions for data being reported by a resident state or an issue state. She advised that this should fall in line with what is used in the annual financial statement. For example, if you issue a policy to a resident of the state of Idaho, then it is an Idaho policy. Ms. Nickel asked that anyone interested in elaborating on this topic further email their comments and feedback to her, Mr. Helder, Ms. Smith or Mr. Haworth.

m. Lawsuits

The next item discussed was the proposal from the CEJ. Mr. Birnbaum has suggested edits to the MCAS related to lawsuit questions that are asked within the life, annuity, home and auto MCAS blanks. His suggestion is to make the lawsuit questions consistent across all lines of business. The current life and annuity lines of business do not contain information related to lawsuits. The other lines of business include the number of lawsuits open as of the end of the period, the number of lawsuits open as of the beginning of the period, the number of lawsuits opened during the period, and the number of lawsuits closed.
during the period in total. With exception of homeowner and private passenger auto, the other lines also include a data element
to collect the number of lawsuits closed during the period with consideration for the consumer. It needs to be determined
whether lawsuit data collection is an addition that should be made to the life MCAS blank.

Mr. Birnbaum noted that all MCAS blank lines have data elements related to lawsuits except life and annuity, and all recent
MCAS blanks have five lawsuit data elements: 1) the number of lawsuits open at the beginning of the period; 2) the number of
lawsuits opened during the period; 3) the number of lawsuits closed during the period; 4) the number of lawsuits closed during
the period with consideration for the consumer; and 5) the number of lawsuits open at the end of the period. He suggested that
these data elements be added to the life MCAS blank.

Ms. Nickel made a motion, seconded by Mr. Arnold, to add these lawsuit elements to the life MCAS. The motion
passed unanimously.

n. Accelerate Underwriting

Ms. Nickel noted that Mr. Birnbaum has also suggested new data elements to address accelerated life underwriting. With
accelerated life underwriting, insurers use credit scores, facial analytics, and other non-medical data to underwrite applicants
and price policies. Mr. Birnbaum has suggested a definition of accelerated underwriting and several interrogatory questions
asking whether a company utilizes accelerated underwriting, on what products, and what data sources and vendors they use, to
replicate the underwriting questions to answer specifically for accelerated underwriting. For example, in addition to asking for
the total number of policies issued, we would also ask for the total policies issued utilizing accelerated underwriting. Ms. Nickel
said she sees the benefits with this.

David Leifer (ACLI) asked if there is a definition of “accelerated underwriting” that would be used.

Mr. Birnbaum stated that they proposed a definition and explained that historically, life insurers have relied on information
provided by consumers and medical information through blood tests, family histories, and things of that nature. In the last five
years, life insurers have started predictive modeling, and they are projecting mortality using non-medical third-party data
sources. The reason the CEJ is making these suggestions is that this is a qualitatively different approach to underwriting and
sales than has been done in the past. In some ways, it is an almost completely digital process as opposed to a traditional, in-
person and hands-on process. There may be different consumer outcomes when there is information being used that the
consumer is not aware of and has no idea how that information is being used. There is not much information that state insurance
regulators have about accelerated underwriting outcomes in the marketplace right now.

The suggestion from the CEJ is that there be some additions to the life blank related to accelerated underwriting, starting with
the definition of accelerated underwriting meaning underwriting and pricing of life insurance in whole or in part on non-medical
data obtained from other than the applicant or policy holder and includes, among other things, facial analytics, social media,
and consumer credit information.

The CEJ also suggests adding interrogatories: 1) whether the company uses accelerated underwriting for life insurance; 2)
whether the company uses accelerated underwriting for life insurance and for what product categories it is used; and 3) whether
the company uses accelerated underwriting for life insurance and a list of the data sources used and vendors supplied, the data,
or the algorithm.

The CEJ also suggests that the specific underwriting data elements have an addition for the total number of new policies issued
by the company during the period utilizing accelerated underwriting, so state insurance regulators could get some sense of how
much accelerated underwriting is being used and what portion of the book of business is developed using accelerated
underwriting.

Mr. Haworth asked if this information could be reviewed as possible data elements to see what this looks like when trying to
capture this information, as he believes that there is some merit to this request.

Ms. Rebholz asked if he was suggesting a mock set of blanks for review. Mr. Haworth confirmed that that is what he is
suggesting. Ms. Rebholz agreed.
Mr. Birnbaum noted that he would provide the mock set of data elements related to accelerated underwriting for review if that would be helpful. Ms. Nickel agreed.

Mr. Leifer noted that insurers are not allowed to change rates after policies are issued, nor do they generally use rating models. He stated that there is no good definition of accelerated underwriting, and life insurance companies have used things like credit and other non-medical information for decades. He believes that this is an extremely complicated topic, and he noted that the NAIC has a working group dedicated to looking at life insurance and accelerated underwriting. He said he believes that this level of granularity could be premature.

Ms. Nickel noted that reviewing the mock set of data elements and then having further discussion about it would be a good place to start, but it may need to be tabled for another year.

Ms. Rebholz agreed and explained that the Working Group already working on this topic may need to be consulted once this is reviewed further.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 23, 2020. The following Working Group members participated: Bruce R. Ramge, Chair, Laura Arp and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair (KY); Mel Heaps and Crystal Phelps (AR); Sarah Borunda and DeLon Price (AZ); Damion Hughes (CO); Kurt Swan (CT); Cheryl Wade (DC); Doug Ommen and Lindsay Bates (IA); Erica Weyhenmeyer (IL); Mary Lou Moran (MA); Jill Huiskes (MI); Paul Hanson (MN); Win Nickens (MO); Tracy Bieln and Teresa Knowles (NC); Maureen Belanger and Edwin Pugsley (NH); Ralph Boeckman (NJ); Laura Baca and Leatrice Geckler (NM); Sylvia Lawson (NY); Nick Stosic and Peggy Willard-Ross (NV); Rodney Beetch, Rick Campbell and Todd Oberholtzer (OH); Landon Hubbart and Shelly Scott (OK); Brian Fordham (OR); Katie Dzurec and Gary Jones (PA); Julie Fairbanks and Bryan Wachtcher (VA); Christina Rouleau (VT); Ned Gaines and John Haworth (WA); and Barbara Belling, Darcy Paskey and Rebecca Rebholz (WI).

1. **Heard Opening Comments**

Director Ramge welcomed returning Working Group members and a new member state, Illinois, represented by Ms. Weyhenmeyer. Changes in Working Group member state representation since the Working Group’s last meeting include New Mexico, represented by Ms. Baca and Ms. Geckler, and Ohio, represented by Mr. Oberholtzer.

Director Ramge said the Working Group has not met since March 4 due to the COVID-19 pandemic and is now resuming scheduled conference calls. He said he would like to keep state insurance regulators’ many commitments related to COVID-19 in mind and to make sure that Working Group members, interested state insurance regulators, subject-matter expert (SME) volunteers and any other parties are not overwhelmed with any workload arising from Working Group calls. Director Ramge asked the Working Group and interested state insurance regulators to reach out to him if that is the case, now, and as the Working Group moves forward on its tasks throughout the year.

2. **Adopted its March 4 Minutes**

The Working Group met March 4 and took the following action: 1) continued discussion on draft limited long-term care insurance (LTCI) examination standards for inclusion in the Market Regulation Handbook (Handbook), which was a carryover item from 2019; 2) began discussion of a new inland marine in force policies standardized data request (SDR) and an inland marine claims SDR for incorporation into the Handbook; and 3) discussed its 2020 charges and potential tasks, which include, but are not limited to, updating SDRs and revising the Handbook with updated examination standards corresponding to recent amendments to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170), the amendments adopted in February to the Suitability in Annuity Transactions Model Regulation (#275) and monitoring the planned activity of the MHPAEA (B) Working Group.

Mr. Haworth made a motion, seconded by Mr. Swan, to adopt the Working Group’s March 4 minutes (Attachment Four-A). The motion passed unanimously.

3. **Adopted the Dec. 11, 2019, Draft of New Limited LTCI Examination Standards Chapter for Inclusion in the Handbook**

Director Ramge said the draft limited LTCI examination standards were developed by state insurance regulator SMEs for the Working Group’s review, discussion and consideration of adoption for inclusion as a new market conduct examination standards chapter in the Handbook. The draft standards were initially exposed Oct. 29, 2019, for public comment and have been discussed during the Working Group’s Nov. 20, 2019, Dec. 18, 2019, and March 4, 2020, meetings.

Director Ramge said the limited LTCI examination standards draft was revised by Ms. Moran and redistributed on Dec. 11, 2019, to Working Group members, interested state insurance regulators and interested parties for the Working Group’s Dec. 18, 2019, meeting. He said Ms. Vandevoorde indicated during that meeting that the revisions made by Ms. Moran addressed the issues raised in Ms. Vandevoorde’s Dec. 3, 2019, comments.
Director Ramge said the Dec. 11, 2019, exam standards draft was discussed during the Working Group’s March 4 meeting, and the Working Group decided not to adopt the draft at that time since it was the first Working Group meeting of 2020. Director Ramge said the draft that was circulated for the July 23, 2020, meeting is identical to the Dec. 11, 2019, draft, except for the attachment numbering and the copyright date.

Mr. Swan made a motion, seconded by Mr. Pyle, to adopt the Dec. 11, 2019, draft “Conducting the Limited Long-Term Care (LTC) Examination” chapter for inclusion in the Handbook (see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Seven). The motion passed unanimously.


Director Ramge said the draft inland marine in force policies SDR and the draft inland marine claims SDR, which were circulated Feb. 24, were developed by state insurance regulator SMEs for the Working Group’s review, discussion and consideration of adoption. Director Ramge said the drafts were discussed for the first time during the Working Group’s March 4 meeting. No comments have been received on the drafts.

Mr. Hamblen made a motion, seconded by Mr. Haworth, to adopt the Feb. 24 draft inland marine in force policies SDR and the inland marine claims SDR for incorporation into the reference documents of the Handbook (see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Eight and Attachment Nine). The motion passed unanimously.

5. Discussed Other Matters

Mr. Hamblen said additional SDRs the Working Group plans to work on in 2020 includes, but are not limited to, LTCI, title insurance and business owners policy (BOP).

Director Ramge said two state insurance regulator volunteers have been tasked with reviewing the Handbook with regard to recent amendments to Model #170, and they will report during the next Working Group meeting on what corresponding changes may need to be made to the applicable chapters of the Handbook.

Director Ramge said that with regard to the February amendments to Model #275, Director Ommen, chair of the Annuity Suitability (A) Working Group, has asked the Market Conduct Examination Standards (D) Working Group to wait before proceeding to update the “Conducting the Life and Annuity Examination” chapter in the Handbook until the Annuity Suitability (A) Working Group has completed its current draft Annuity Suitability Q&A document.

Ms. Arp said the Working Group has drafted a new Mental Health Parity and Addiction Equity Act (MHPAEA) chapter for the Handbook in 2018 (Chapter 24B—Conducting the MHPAEA Related Examination); the chapter was a combined work product resulting from Working Group members, federal agencies that enforce MHPAEA and industry working together to develop numerous revisions during the comment process, and the draft was ultimately adopted by the Working Group, the Market Regulation and Consumer Affairs (D) Committee and the Executive (EX) Committee and Plenary. Ms. Arp said the U. S. Department of Labor (DOL) has included a reference to the Handbook’s MHPAEA chapter in its 2020 revision of its self-compliance tool.

Director Ramge said that with regard to the MHPAEA (B) Working Group’s charge to “provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook,” he will be looking for guidance and support from the Market Regulation and Consumer Affairs (D) Committee and the Health Insurance and Managed Care (B) Committee leadership to see how this Working Group and the MHPAEA (B) Working Group should coordinate their efforts to create additional examiner guidance, as the DOL continues to update its MHPAEA guidance and compliance tools, keeping in mind that the Market Conduct Examination Standards (D) Working Group does not create policy; the Working Group creates examiner guidance to support policy created by DOL.

Ms. Dzurec, chair of the MHPAEA (B) Working Group said she would welcome communication and coordination between the two working groups, because having a clearly defined direction regarding what type of guidance is to be developed by which working group would provide more clarity to MHPAEA examiners, as well as regulated entities.
Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur in late August or early September.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 4, 2020. The following Working Group members participated: Bruce R. Ramge, Chair, (NE); Russell Hamblen, Vice Chair (KY); Jimmy Harris, Mel Heaps and Gwen McClendon (AR); Sarah Borunda and DeLon Price (AZ); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Sarah Crittenden (GA); Jill Huisken (MI); Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger and Edwin Pugsley (NH); Ralph Boeckman (NJ); Hermoliva Abejar, Nick Stosic and Peggy Willard-Ross (NV); Rodney Beetch and Angela Dingus (OH); Kevin Foor and Shelly Scott (OK); Gary Jones and Christopher Monahan (PA); Julie Fairbanks and Yolanda Tennyson (VA); John Haworth and Jeanette Plitt (WA); Barbara Belling, Diane Dambach, Mary Kay Rodriguez, Darcy Paskey and Rebecca Rebholz (WI).

1. Heard Opening Comments

Director Ramge welcomed returning Working Group members and a new member state, North Carolina, represented by Ms. Knowles. Changes in Working Group member state representation in 2020 include Ms Abejar, Landon Hubbard (OK), and Brian Fordham and Tasha Sizemore (OR).

2. Adopted its Dec. 18, 2019, Minutes

The Working Group met Dec. 18, 2019, and took the following action: 1) adopted a new farmowners in force standardized data request and a new farmowners claims standardized data request for inclusion in the reference documents of the Market Regulation Handbook (Handbook); and 2) discussed a new chapter of limited long-term care insurance (LTCI) examination standards for inclusion in the Handbook. The new examiner guidance is based on the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643).

Ms. Plitt made a motion, seconded by Ms. Dingus, to adopt the Working Group’s Dec. 18, 2019, minutes (Attachment Four-A1). The motion passed unanimously.

3. Discussed Potential 2020 Tasks

Director Ramge said the charges of this Working Group, as adopted by the Market Regulation and Consumer Affairs (D) Committee, are to:

- Develop market conduct examination standards and uniform market conduct procedural guidance, as necessary.
- Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models by the Fall National Meeting.
- Develop updated standardized data requests for inclusion in the Market Regulation Handbook by the Fall National Meeting.

Director Ramge said the Working Group will not meet at NAIC national meetings; it will accomplish its assigned tasks via regularly scheduled conference calls, to occur approximately every four to six weeks.

Regarding the adopted 2020 charges, the Working Group plans to continue discussion on draft limited LTCI examination standards, which is a carryover item from 2019. Additional state insurance regulator guidance the Working Group plans to work on in 2020 includes, but is not limited to: 1) updating NAIC standardized data requests; and 2) revising the Handbook with updated examination standards corresponding to recent amendments to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170), the new Guideline on Nonadmitted Accident and Health Coverages (#1860), and the recent amendments to the Suitability in Annuity Transactions Model Regulation (#275).

Director Ramge asked for state insurance regulator volunteers to: 1) review any of the identified adopted models; and 2) report to the Working Group at its next call regarding whether the Handbook needs updating in these subject areas. Ms. Crittenden and Ms. Plitt volunteered to review Model #170. Director Ramge asked for additional volunteers to review Guideline #1860 and Model #275. He indicated that state insurance regulator subject matter expert (SME) volunteers will subsequently be
needed to draft revisions to the examination standards regarding these two models and guideline, and he asked that all
volunteers for these drafting projects contact either himself or Petra Wallace (NAIC).

Current, but not yet completed, NAIC model development activity which the Working Group will be monitoring in 2020—for
the purpose of developing corresponding examination standards in the future—includes, but is not limited to: 1) amendments
to the Unfair Trade Practices Act (#880) currently being considered by the Innovation and Technology (EX) Task Force; 2)
the planned activity of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which will begin drafting a new NAIC
model in 2020 to address certain pharmacy benefit manager (PBM) activities; and 3) the planned activity of the recently formed
MHPAEA (B) Working Group, as one of its charges is “to provide supplemental resources to support documentation and
reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.” Director Ramge asked the Working Group and
interested state insurance regulators to forward any additional areas of focus to himself or Ms. Wallace.

4. **Discussed Dec. 11, 2019, Draft of New Limited LTC Chapter for Inclusion in the Handbook**

Director Ramge said that the draft limited long-term care (LTC) examination standards were developed by state insurance
regulator SMEs for the Working Group’s review, discussion, and consideration of adoption for inclusion as a new market
conduct examination standards chapter in the Handbook. The draft was initially exposed Oct. 29, 2019, for a public comment
and has been discussed during the Working Group’s Nov. 20, 2019, and Dec. 18, 2019, calls.

Director Ramge said that the limited LTC examination standards draft was revised by Ms. Moran and redistributed on Dec. 11,
2019, to Working Group members, interested state insurance regulators, and interested parties for the Dec. 18, 2019, call. He
said that Reva Vandevoorde (NE) indicated during the Dec. 18, 2019, call that the revisions made by Ms. Moran addressed the
issues raised in Ms. Vandevoorde’s Dec. 3, 2019, comments. He said the draft that was forwarded for the March 4, 2020, call
is identical to the Dec. 11, 2019, draft, except for the attachment numbering and the copyright date. He extended the due date
on the draft to April 1, 2020.

5. **Discussed New Draft Inland Marine Standardized Data Requests for Inclusion in the Reference Documents of the
Handbook**

Director Ramge said the new draft inland marine in force standardized data request and the new draft inland marine claims
standardized data request, which were circulated Feb. 24, 2020, were developed by state insurance regulator SMEs for the
Working Group’s review, discussion and consideration of adoption. When the inland marine standardized data requests are
adopted, they will be included in the Handbook reference documents. Director Ramge asked that comments on the inland
marine standardized data requests be submitted by March 25, 2020.

6. **Discussed Other Matters**

Director Ramge asked the Working Group members to participate in as many Working Group conference calls as possible this
year so the Working Group can accomplish the tasks that are planned in 2020.

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is
anticipated to occur in April.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
Market Conduct Examination Standards (D) Working Group
Conference Call
December 18, 2019

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met on Dec. 18, 2019. The following Working Group members participated: Bruce R. Ramge, Chair, and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair (KY); Jimmy Harris (AR); DeLon Price AZ); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Frank Pyle (DE); Sarah Crittenden (GA); Mary Lou Moran (MA); Maureen Belanger (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Rodney Beethe (OH); Kevin Foor, Joel Sander and Shelly Scott (OK); Brian Fordham (OR); Katie Dzurec (PA); Julie Fairbanks and Yolanda Tennyson (VA); John Haworth (WA); Barbara Belling, Diane Dambach, Sue Ezalarab, Darcy Paskey and Rebecca Rebholz (WI); and Desiree Mauller (WV).

1. **Adopted New Farmowners SDRs for Inclusion in the Reference Documents of the Handbook**

Director Ramge said that a new draft farmowners in force standardized data request (SDR) and a new draft farmowners claims SDR were developed by state insurance regulator subject-matter experts (SMEs) for the Working Group’s review, discussion, and consideration of adoption for inclusion in the reference documents of the Market Regulation Handbook (Handbook). The drafts were initially exposed Oct. 29 for a public comment period ending Dec. 2.

Director Ramge said the farmowners in force SDR was subsequently revised and redistributed to Working Group members, interested state insurance regulators, and interested parties on Dec. 11, along with the Oct. 29 farmowners claims SDR, for the Dec. 18 conference call. Mr. Hamblen said the description of the field name CanTerRs (reason for cancellation/termination of coverage) in the Dec. 11 draft farmowners in force SDR was revised so that it would not duplicate the data obtained by field name CanTer (who cancelled the coverage); and the field name CanTer was moved up one row so that it would more logically occur above field name CanTerRs.

Ms. Crittenden made a motion, seconded by Mr. Hamblen, to adopt the Oct. 29 draft farmowners claims SDR (see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment One-A) and the Dec. 11 draft farmowners in force SDR (see NAIC Proceedings – Summer 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment One-B). The motion passed unanimously.

2. **Discussed Dec. 11 Draft of New Limited LTC Chapter for Inclusion in the Handbook**

Director Ramge said that new draft limited long-term care (LTC) exam standards were developed by state insurance regulator SMEs for the Working Group’s review, discussion, and consideration of adoption for inclusion as a new market conduct examination standards chapter in the Handbook. The draft was initially exposed Oct. 29 for a public comment period ending Dec. 2.

Director Ramge said the limited LTC examination standards draft was revised by Ms. Moran and redistributed on Dec. 11 to Working Group members, interested state insurance regulators, and interested parties. Ms. Vandevoorde said that the revisions made by Ms. Moran in the Dec. 11 draft addressed the issues raised in Ms. Vandevoorde’s Dec. 3 comments. Director Ramge extended the due date on the draft to the Dec. 31 conference call and indicated that the work on the draft would continue into 2020.

3. **Discussed Other Matters**

Director Ramge welcomed Mr. Harris to the Working Group, representing Arkansas.

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur early in 2020, after the Working Group is reappointed by the Market Regulation and Consumer Affairs (D) Committee.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 30, 2020. The following Working Group members participated: Cynthia Amann, Chair, and Marjorie Thompson (MO); Ron Kreiter, Vice Chair (OK); Damon Diedrich (CA); Erica Weyhenmeyer (IL); LeAnn Crowe and Brenda Johnson (KS); T.J. Patton and Paul Hanson (MN); Chris Aufenthie and Anders Odegard (ND); Martin Swanson (NE); Tasha Sizemore (OR); Gary Jones (PA); and Don Beatty (VA). Also participating were: Jimmy Harris and Crystal Phelps (AR); Damion Hughes (CO); Evangelina Brooks (FL); Doug Ommen (IA); Kristen Finau and Michele Mackenzie (ID); Kate Kixmiller (IN); Peggy Willard-Ross (NV); Don Layson (OH); Landon Hubbart (OK); Ignatius Wheeler and Carole Cearley (TX); John Haworth (WA); and Barbara Belling (WI).

1. Adopted its May 5 Minutes

Ms. Amann said the Working Group met May 5 and took the following action: 1) adopted its Feb. 19 minutes; 2) heard an update on state and federal privacy legislation; and 3) discussed comments received on the NAIC Insurance Information and Privacy Protection Model Act (#670).

Mr. Kreiter made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group’s May 5 minutes (Attachment Five-A). The motion passed unanimously.

2. Received an Update on State and Federal Privacy Legislation

Jennifer McAdam (NAIC) said a review of the laws about consumer privacy start with data privacy, addressing how data is collected and used by businesses, while data security addresses how data is stored and protected. Ms. McAdam said the NAIC has three model laws governing data privacy: 1) Health Information Privacy Model Act (#55); 2) NAIC Insurance Information and Privacy Protection Model Act (#670); and 3) Privacy of Consumer Financial and Health Information Regulation (#672).

Ms. McAdam said Model #670 was adopted in 1980 to set standards for the collection, use and disclosure of information gathered in connection with insurance transactions. She said it has been enacted by 17 states and addresses how information is collected by insurance institutions, agents and insurance support organizations (ISOs). She said Model #670 balances the need for information by those conducting the business of insurance and the public’s need for fairness; establishes a regulatory mechanism to enable consumers to ascertain what information is being or has been collected about them and to have access to such information so they can verify or dispute its accuracy; limits the disclosure of information collected in connection with insurance transactions; and enables insurance applicants and policyholders to find out the reasons for any adverse underwriting decision. She said Model #670 does this by requiring insurers to provide notice that alerts the individual of the insurer’s information practices and giving consumers the right to request that an insurer: 1) give access to recorded personal information; 2) disclose the identity of the third parties to whom the insurer disclosed the information; 3) provide a right to amend PHI; 4) correct and amend the collected information; 5) amend the personal information; and 6) delete the collected personal information.

Ms. McAdam said the federal Fair Credit Reporting Act (FCRA) was enacted in 1970 to address the fairness, accuracy and privacy of the personal information contained in the files of the consumer reporting agencies and the Federal Privacy Act was enacted in 1974 to govern the collection, maintenance, use, and dissemination of personally identifiable information about individuals that is maintained in systems of records by federal agencies.

Ms. McAdam said following enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the NAIC adopted Model #55 in 1998. She said Model #55 set standards to protect health information from unauthorized collection, use and disclosure by requiring carriers to establish procedures for the treatment of all health information. She said it requires carriers to: 1) create policies and procedures governing health information; 2) notify consumers about those policies and procedures; 3) provide consumers a right to access their protected health information (PHI); 4) provide a right to amend PHI; 5) provide a list of disclosures of consumer PHI; and 6) obtain authorization for collection, use or disclosure of PHI.
Ms. McAdam said the federal Gramm-Leach-Bliley Act (GLBA), enacted in 1999, imposed privacy and security standards on financial institutions and directed state insurance commissioners to adopt certain data privacy and data security regulations.

Ms. McAdam said the NAIC adopted Model #672 in 1999 to: 1) require insurers to provide notice to consumers about their privacy policies and practices; 2) describe the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and 3) provide methods for individuals to prevent a licensee from disclosing that information with “opt out” for financial information and “opt in” for health information. She said Model #672 is intended to be enforced via states’ Unfair Trade Practices Act. She said the provisions governing protection of health information were taken directly from Model #55 and the health information privacy regulations promulgated by U.S. Department of Health and Human Services (HHS) pursuant to HIPAA. She also said the provisions governing protection of financial information are based on privacy regulations promulgated by federal banking agencies. Ms. McAdam said the key difference between the treatment of financial information and health information is that insurers must give consumers the right to “opt out” of the disclosure or sharing of their financial information but insurers must get explicit authorization prior to sharing health information (which is considered “opt in”). She said every state has adopted a version of Model #672.

Ms. McAdam said generally applicable data privacy laws, such as the European Union’s General Data Protection Regulation (GDPR), are not insurer-specific and require companies to obtain explicit consent from consumers to collect their data (“opt in”) with an explanation of how the data will be used. The GDPR also contains standards for safeguarding the data. She said the California Consumer Privacy Act (CCPA) became effective this year and gives consumers the right to request that a business: 1) disclose the categories and specific pieces of personal information collected, the categories of sources the information was collected from, the business purpose for collecting the information, the categories of third parties with whom the information is shared, and the specific pieces of personal information that was shared; 2) delete any personal information; and 3) give consumers the right to opt-out of their information being disclosed to third parties. It also prevents companies from discriminating against consumers who exercise their rights under the law and provides a full exemption for PHI governed by HIPAA and a partial exemption for information subject to the GLBA. However, if the information subject to the GLBA is breached, the consumer can pursue a private civil action against the company.

Ms. McAdam said there has not been much change in the state legislative arena. She said in 2019, 24 states considered some type of data privacy legislation but only three states enacted laws: Illinois; Maine; and Nevada. She said five states—Connecticut, Hawaii, Louisiana, North Dakota and Texas—passed bills establishing task forces to study the issue of data privacy by reviewing laws in other states and making recommendations for what would be appropriate privacy standards. Ms. McAdam said more than 15 states introduced data privacy legislation in 2020 but none of them has been passed. She said many of these bills were fairly comprehensive and similar to the CCPA.

Brooke Stringer (NAIC) said there has not been a lot of activity on the federal level since the last Working Group call. She said for today’s federal update, she would provide: 1) an overview of a new federal data privacy bill from U.S. Sen. Sherrod Brown (D-OH), who serves as the ranking Democrat on the U.S. Senate Committee on Banking, Housing and Urban Affairs; 2) briefly recap the four other bills previously proposed; and 3) conclude with a mention of some COVID-19 data privacy bills that have been introduced.

Ms. Stringer said, as she had mentioned before, the key issues for congressional debate focus on trade-offs regarding the extent of preemption, private rights of action, and the stringency of the standard. She said the most recent draft bill is from Sen. Brown, the “Data Accountability and Transparency Act,” which: 1) establishes a new federal agency to protect individuals’ privacy that would have rulemaking, supervisory and enforcement authority, the ability to issue civil penalties for violations of the act, and an Office of Civil Rights to protect individuals from discrimination; 2) prohibits the use of personal data to discriminate in housing, employment, credit, insurance and public accommodations; 3) requires anyone using decision-making algorithms to provide accountability reports to the new federal agency; 4) does not preempt more protective state laws and provides for enforcement by the state attorneys general; 5) bans the use of facial recognition technology, as well as the collection, usage or sharing of any of that personal data; 6) and contains a private right of action.

Ms. Stringer said, as a recap, she would mention some of the other legislative proposals the Working Group has discussed previously:

- U.S. Senate Committee on Commerce, Science and Transportation Chairman Roger Wicker’s (R-MS) draft bill, the “Consumer Data Privacy Act,” that proposes stringent data privacy standards and preempts all state data privacy and
security laws. She said it has a GLBA carveout, which should protect some state data privacy laws. A technical fix
was proposed to clarify that the bill preserves state laws and regulations developed in accordance with the GLBA. She
said it also provides standards for transparency; consumer rights to access, correct, delete their data; requires
affirmative consent before collecting, processing or transferring data; calls for a Federal Trade Commission (FTC)
study examining the use of algorithms that may violate anti-discrimination laws; and provides enforcement of the
bill’s provisions by the FTC and state attorneys general.

- U.S. Sen. Maria Cantwell (D-WA), the ranking Democrat on the U.S. Senate Committee on Commerce, Science and
Transportation, introduced the “Consumer Online Privacy Rights Act (S. 2968),” which contains standards similar to
the Wicker proposal, but would establish a preemptive floor and allow for a private right of action.
- The U.S. House of Representatives’ Committee on Energy and Commerce’s bipartisan draft proposal would provide
the FTC with significant rulemaking authority to implement standards. Ms. Stringer said the questions surrounding
preemption and private right of action remain subject to negotiation. NAIC staff have had discussions with
congressional staff about the NAIC’s privacy models and efforts to update them.
- U.S. Sen. Jerry Moran’s (R-KS) “Consumer Data Privacy and Security Act (S. 3456)” has concepts like the Wicker
and Cantwell proposals. Ms. Stringer said it preempts state data privacy and security laws but would not supersede
state laws that address financial information held by financial institutions defined in Title V of the GLBA (the GLBA
covers persons providing insurance).

Ms. Stringer said, in addition to comprehensive data privacy proposals, she wanted to mention that there have been several
bills introduced that specifically address COVID-19 data privacy. She said the following proposals would put temporary rules
in place regarding the collection, processing and transfer of data used to combat the spread of COVID-19: 1) Chairman Wicker’s
“COVID-19 Consumer Data Protection Act (S. 3663),” which requires covered entities to obtain affirmative consent before collecting, processing or transferring an individual’s personally identifiable information for the purpose of contact tracing with respect to COVID-19. It preempts state laws and has no private right of action; and
Anna Eshoo (D-CA) requires opt-in consent and data minimization, has a private right of action and does not preempt state
laws. Ms. Stringer noted that the U.S. Congress is struggling with passing the next COVID-19 relief bill, so it is unlikely there
will be any immediate action on the aforementioned COVID-19 bills.

Ms. Stringer said, in terms of future actions on comprehensive data privacy legislation, given the pandemic, the fact that it is
an election year and with the general partisan discord, she said it is unlikely there will be any major congressional movement
before the November elections. She also said it may be the next U.S. Congress that ultimately tackles these issues.

3. Heard a Presentation that Included a Comparative Analysis and Comments Received July 24

Chris Peterson (Arbor Strategies, LLC), representing America’s Health Insurance Plans (AHIP), the Blue Cross and Blue Shield
Association (BCBSA) and the Coalition (an organization that includes Aetna, Anthem, Cigna, Health Care Service Corporation
and UnitedHealthcare), said phase one of any gap analysis by the Working Group should be a side-by-side comparison. He
said the health insurance industry he represents has submitted a side-by-side comparison as a first step in completing a gap
analysis.

Mr. Peterson said this analysis compares various approaches to regulating privacy, which the NAIC would use to determine
whether those gaps are significant and/or relevant to state insurance regulators, insurance consumers and the insurance industry.
He said before conducting this final analysis or final phase of its gap analysis, the Working Group should establish a base for
conducting comparative analysis, as well as determine parameters for conducting analysis and evaluating gaps. Mr. Peterson
agreed with the Working Group that the most logical approach would be to use Model #672 because it reflects the NAIC’s
most current thinking on privacy regulation; it is universally adopted at the state level; and other NAIC models have previously
been rejected as base models by the Working Group during its meetings. He said the parameters for conducting the analysis
should be focused solely on insurance licensees, insurance practices and insurance transactions.

Mr. Peterson said the analysis should not regulate business in general, non-insurance practices or non-insurance transactions.
He said any gaps that are identified should only be filled by concepts that have consensus support at the state level (also known
as the “Walter Bell Rule”) and that the resulting model should be aligned with existing federal laws. Mr. Peterson provided a
comparison of the following aspects of Model #672, HIPAA, Model #670, the CCPA and the GDPR: 1) applicability;
2) definition of “covered or personal information”; 3) privacy notices; 4) opt-in/opt-out rights; and 5) consumer rights.
Lauren Choi (BCBSA) said while she applauds the Working Group’s efforts, she reiterated that updates made to any privacy model would require a deliberative and considered approach based on facts and policy. She said state insurance regulators and the industry together can move forward only if the current landscape of existing federal law in the privacy arena is understood. To assist the Working Group in its efforts, she said the BCBSA and the Coalition has conducted a gap analysis of the specific privacy requirements with which certain insurance licensees must comply, including HIPAA, the CCPA, Model #670, Model #672 and the GDPR.

Ms. Choi said she hopes this material will be helpful to the Working Group to increase the Working Group’s understanding of the existing consumer protections under current regimes. She said the BCBSA and the Coalition have learned that the Working Group has determined it is more beneficial for to focus its efforts on Model #672 instead of Model #670. Ms. Choi said the BCBSA fully supports and appreciates this decision, because, as it compares to Model #670, the newer Model #672 was developed to improve on Model #670; is much more reflective of current regulatory thinking and attitudes; and has been far more widely accepted in the states. She said Model #672 is a viable foundation for the Working Group to review and to determine what changes, if any, are needed to effectively protect consumer interests in the insurance arena.

4. Discussed Plans to Begin a Gap Analysis Discussion by Working Group Members, Interested State Insurance Regulators and Interested Parties Using Model #672 as a Baseline Model

Ms. Amann said the Working Group will begin its gap analysis discussion using Model #672 as a baseline. She said the plan is to break the analysis discussion down into three separate areas: 1) consumer issues; 2) industry obligations; and 3) regulatory enforcement. She said to help the Working Group visualize each of the topics to be discussed, two comparison charts created by Ms. McAdam indicating how Model #670, Model #672, the GLBA, HIPAA and the CCPA address them were posted to the Working Group’s page on the NAIC website prior to this meeting. She said the Working Group would start its discussion at its next meeting with consumer issues such as disclosures, notifications, portability, opt-in/opt-out, changes, deletions, etc.

Having no further business, the Privacy Protections (D) Working Group adjourned.
Privacy Protections (D) Working Group
Conference Call
May 5, 2020

The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 5, 2020. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (OK); Damon Diederich (CA); Erica Weyhenmeyer (IL); LeAnn Crowe (KS); T.J. Patton (MN); Kendall Cotton (MT); Chris Aufenthie (ND); Brian Fordham (OK); and Don Beatty (VA). Also participating were: Jimmy Harris and Crystal Phelps (AR); Damion Hughes (CO); Evangelina Brooks (FL); Doug Ommen (IA); Kristen Finau and Michele Mackenzie (ID); Kate Kixmiller (IN); Brenda Johnson (KS); Paul Hanson (MN); Marjorie Thompson (MO); Anders Odegard (ND); Peggy Willard-Ross (NV); Don Layson (OH); Landon Hubbell (OK); Ignatius Wheeler and Carole Cearley (TX); John Haworth (WA); and Barbara Belling (WI).

1. Heard Opening Remarks

Ms. Amann said this is the Working Group’s second conference call in 2020. She said the Working Group is still in the process of building its membership, as well as forming distribution lists for interested state insurance regulators and interested parties. She asked those interested in joining the Working Group or being added to a distribution list to contact Lois E. Alexander (NAIC). Ms. Amann said the Working Group is charged with addressing the privacy of consumer data. She said data privacy is concerned with how data is collected and used by businesses; however, she said the security of consumer data is concerned with how data is stored and protected. She said data security is not being addressed by this Working Group, but it is being addressed by other working groups. She said NAIC staff support for related working groups are coordinating efforts to ensure that there is no overlap nor duplication of effort. She said the Working Group will continue to track and work closely, as needed, with the other working groups in this arena—the Artificial Intelligence (EX) Working Group, the Accelerated Underwriting (A) Working Group, etc.—as each has its unique set of issues that nevertheless require coordination. She said a significant change going forward is that the Working Group will address health care privacy as it applies to the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672) after more general privacy issues have been reviewed and discussed. She also said the Working Group will have conference calls approximately every six weeks following the Workplan/Briefing document posted on the webpage.

2. Adopted its Feb. 19, 2020, Minutes

Mr. Beatty made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group’s Feb. 19 minutes (Attachment Five-A1). The motion passed unanimously.

3. Heard an Update on State and Federal Privacy Legislation

Jennifer McAdam (NAIC) said there have not been very many state legislative changes since the Working Group’s Feb. 19 call. She said more than 15 states are now considering data privacy legislation. She said regulations for the California Consumer Privacy Act (CCPA) are currently under review and posted to the California Attorney General’s website. She said four research charts updated by NAIC Legal staff on April 20 were posted on the Working Group’s web page prior to today’s call.

Brooke Stringer (NAIC) said there has not been a lot of activity on the federal level since the last Working Group call either. She said there has been one new bill on privacy and security introduced by U.S. Sen. Jerry Moran (R-KS), the “Consumer Data Privacy and Security Act (S. 3456).” She noted that the bill would preempt state data privacy and security laws with exceptions, and it would not supersede state laws that address financial information held by financial institutions as defined in Title V of the Gramm-Leach-Bliley Act, which includes persons providing insurance.

4. Discussed Comments Received on Model #670

Ms. Amann thanked everyone who submitted comments on the exposure draft that the state insurance regulator subject matter expert (SME) group created of key issues. She said all comments received would be discussed by the Working Group on future conference calls. She said sections 14–19 and 22–24 had been referred to NAIC Legal staff for review and an update with similar language from other NAIC models that were adopted recently in the interest of saving time and not recreating the wheel.
She said sections 20 and 21 would require a great deal of discussion, so they will be delayed until later. She said Mr. Kreiter is working on replacing outdated definitions with pertinent standard definitions that were already adopted in other models or taken from the NAIC Market Regulation Handbook or IT Exam Standards Handbook. She asked that the Working Group read the charts prepared by NAIC Legal staff closely, as they provide a very good overview of the CCPA, the European Union’s (EU’s) General Data Protection Regulation (GDPR), and other state legislation. She said the Working Group may decide to update Model #670, Model #672 or both.

Chris Petersen (Arbor Strategies LLC) suggested that the Working Group consider doing a gap analysis of the existing laws first to compare the consumer privacy protection requirements in the current NAIC models to the desired future privacy protection requirements. Ms. McAdam noted that Model #670 is based on the federal Fair Credit Reporting Act (FCRA), so its requirements are closer to those required by the CCPA.

Ms. Amann said the Working Group can have this discussion when this is added to the strikeout version going forward, but it will follow the agenda and walk through Model #670 comments at this time starting with the Preamble. Mr. Hanson suggested replacing the word “institutions” with the word “entities” throughout the document. Ms. Kitt objected to the phrase “natural person,” and she recommended that it be changed. Mr. Diederich said this term was defined in the Fourteenth Amendment to distinguish individuals from a legal entity. Mr. Hanson said it referred to a physical person rather than a corporation, and Mr. Kreiter concurred. Ms. McAdam said she would check to see how this was handled in the recently adopted Insurance Data Security Model Law (#668). Bob Ridgeway (AHIP) said this is an exclusive state standard, and there is only one, not several, set by the Attorney General in each state.

Kate Kiernan (American Council of Life Insurers—ACLI) said the ACLI distinguishes the lines of business separately, and she suggested that the modernized wording from Model #672 be inserted into Model #670. She said this would help all lines of business by having clear instruction about what consumers need to know by the line of business they are considering. She said legal transparency is very important in situations dealing with the privacy protection of insurance consumers.

Ms. Amann said the data that is currently being collected on consumers is very broad and from a multitude of sources, so it is important to use the same consumer privacy protection requirements for all lines of business. Mr. Petersen said it is not separated in Model #668. Mr. Hanson said “institutions” should be changed to “licensee” throughout the document to agree with Model #672 in order to clarify it as not meaning an agent (producer). He said Section D under Scope may not be needed, as it relates to title insurance, or it may need to be cleaned up, as it is unique to title coverage. Elizabeth Blosser (American Land Title Association—ALTA) said language specific to insurance needs to use publicly recognizable terms. Ms. Kiernan said industry finds the Definitions section the most troubling obstacle about areas needing updating. Ms. Amann said the state insurance regulators who are SMEs would refer the Working Group to other models or federal legislation.

Ron Troy (Blue Cross Blue Shield Association—BCBSA) asked what gap the Working Group is trying to fill, and he suggested that the Market Regulation and Consumer Affairs (D) Committee be contacted for clarification of the Working Group’s charges.

Karrol Kitt (The University of Texas at Austin) and Brenda J. Cude (The University of Georgia) said they will submit comments related to the protection of consumer data privacy for the next Working Group call.

Ms. Kiernan said she would send the technical terms she mentioned to the Working Group.

Mr. Petersen said he would send the Model #672 terms to be used in Model #670 to the Working Group.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 19, 2020. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (OK); Damon Diederich (CA); Erica Weyhenmeyer (IL); LeAnn Crowe (KS); T. J. Patton (MN); Kendall Cotton (MT); Bob Harkins (NE); Chris Aufenthie (ND); Brian Fordham (OR); and Don Beatty (VA). Also participating were: Vanessa Darrah (AZ); Michele Mackenzie (ID); Jennifer Demory and Don Layson (OH); John Haworth (WA); Barbara Belling (WI); and Bill Cole (WY).

1. **Heard Opening Remarks**

Ms. Amann said this is the first conference call of the Working Group since its 2020 charges were adopted by the Market Regulation and Consumer Affairs (D) Committee during its Dec. 9, 2019, meeting in Austin, TX. She said the Working Group is still in the process of building its membership, as well as forming distribution lists for interested state insurance regulators and interested parties. She asked those interested in joining the Working Group or being added to a distribution list to contact Lois E. Alexander (NAIC).

2. **Adopted its 2019 Fall National Meeting Minutes**

Mr. Kreiter made a motion, seconded by Ms. Cotton, to adopt the Working Group’s Dec. 8, 2019, minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Ten). The motion passed unanimously.

3. **Heard an Update on State and Federal Privacy Legislation**

Jennifer McAdams (NAIC) said 15 states—i.e., Arizona, Florida, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York, Pennsylvania, South Carolina (applies only to biometric information), Virginia and Washington—have pending data privacy legislation.

Ms. McAdams said many of the bills are comprehensive and like the California Consumer Privacy Act (CCPA). She also said several of the bills contain exemptions for entities or information subject to the Gramm-Leach-Bliley Act (GLBA). She said the New York bill was carried over from 2019, would go further than the CCPA, and would establish a fiduciary duty for companies to act in the consumer’s best interest regarding the consumer’s personal information. However, she said the legislation in South Carolina applied only to biometric information.

Ms. McAdams said updated legal research charts on the Privacy Protections (D) Working Group web page will be posted soon. She said one of the charts lists general state data privacy laws—laws that are applicable to all businesses and not specific to insurers. She said the chart lists the entity responsible for enforcement, exemptions, whether it is “opt-in” or “opt-out,” and consumer notice requirements.

Brooke Stringer (NAIC) said there are three major legislative proposals in the U.S. Congress (Congress) currently, all of which apply to both data security and data privacy. She said some of the key issues focus on trade-offs regarding the extent of preemption, private rights of action, and the stringency of the standard.

Ms. Stringer said the Chairman of the U.S. Senate (Senate) Committee on Commerce, Science, and Transportation, Sen. Roger Wicker (R-MS), has released draft legislation that contains data privacy standards that are very high—higher than California law in several instances according to the committee website. She said it broadly preempts all state laws on data privacy and data security. She said the bill provides standards for transparency and consumer rights to access, correct and delete their data; requires affirmative consent before collecting, processing or transferring data; calls for a Federal Trade Commission (FTC) study examining the use of algorithms that may violate anti-discrimination laws; and provides for the enforcement of the bill’s provisions by the FTC and state Attorney General. She said the legislation currently has a carve out for the GLBA; however, she said the net effect of the proposal would be to preempt all state data privacy or data security laws. She said NAIC staff is
working with the Senate Committee on Commerce, Science, and Transportation to try to clarify the bill language with respect to insurance.

Ms. Stringer said Sen. Maria Cantwell (D-WA), the Ranking Democrat on the Senate Committee on Commerce, Science, and Transportation has introduced her own legislation (S. 2968). She said this legislation contains standards like those in Sen. Wicker’s proposal, but Sen. Cantwell’s proposal allows for a private right of action and would establish a preemptive floor.

Ms. Stringer said the U.S. House of Representatives (House) Committee on Energy and Commerce has released a bipartisan draft proposal that provides the FTC with significant rulemaking authority to implement standards. However, she said questions surrounding preemption and private right of action remain subject to negotiation at this time.

4. Discussed Next Steps

Ms. Amann said it was suggested during the 2019 Fall National Meeting that a public hearing be held to determine how insurers are using the data they collect on consumers. However, she said it was determined that a public hearing will not be necessary since the charges for the Working Group are very clear regarding this issue. She said next steps include the Working Group meeting at 11:00 am on Sunday, March 22, 2020, in Phoenix, AZ at the Spring National Meeting. She said a regulator subject matter expert (SME) group would create a draft of key issues to be exposed to the Working Group for comment prior to the Spring National Meeting. She said all comments received prior to the national meeting will be discussed by the Working Group in Phoenix, AZ.

Having no further business, the Privacy Protections (D) Working group adjourned.
The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 20, 2020. The following Working Group members participated: John Haworth, Chair (WA); Bill Cole, Vice Chair (WY); Lindsay Bates (IA); Erica Weyhenmeyer (IL); Mary Lou Moran (MA); Jason Decker (MD); Paul Hanson (MN); Cynthia Amann (MO); Tracy Biehn (NC); Reva Vandevoorde (NE); Edwin Pugsley (NH); Robert Doucette (NM); Angela Dinges (OH); Landon Hubbart (OK); Brian Fordham (OR); Christopher Monahan (PA); Michael Bailes (SC); Julie Fairbanks (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were: Pam O’Connell (CA); Jill Huisken (MI); and Matt Gendron (RI).

1. **Adopted its Jan. 30 Minutes**

The Working Group met Jan. 30 to discuss the pilot volunteers’ suggested revisions to the Voluntary Market Regulation Certification Program (Program).

Mr. Doucette made a motion, seconded by Ms. Moran, to adopt the Working Group’s Jan. 30 minutes (Attachment Six-A). The motion passed unanimously.

2. **Discussed Comments Concerning Certification Pilot Volunteers’ Suggestions**

Mr. Haworth said one set of comments was received since the Working Group’s Jan. 30 conference call. The comments were from Michael Lovendusky (American Council of Life Insurers—ACLI). Mr. Haworth said the comments recommended requirement 5 include a provision that the department of insurance (DOI) have cybersecurity requirements equal to or more rigorous than those required of regulated entities. He said the comments also discussed requirement 3 for overseeing contractors. Because contractor costs can be very high, the ACLI comment letter recommends companies be allowed to enter into tri-party agreements with contract examiners. Finally, the comment letter said the ACLI cannot support requirement 6 because the Market Actions (D) Working Group policies and procedures are for state insurance regulators only and cannot be viewed by the regulated entities.

Mr. Haworth said the NAIC *Market Regulation Handbook* (Handbook) summarizes the Market Actions (D) Working Group processes. Mr. Lovendusky said there was no understanding by industry of the Market Actions (D) Working Group deliberation processes. He suggested it may be helpful for the Working Group to hold an open meeting with industry to discuss industry concerns.

Ms. Moran said she took issue with Mr. Lovendusky’s comments concerning contractor costs. She said Massachusetts is very careful about keeping costs for examinations down. She said Massachusetts only uses approved contractors and requires and reviews the contractor budgets for every examination. The DOI will conduct an examination if it is too costly. No work is begun until there is direct approval from the DOI. The DOI makes sure that costs are as low as possible. She said most states control the cost of contractors. Mr. Doucette said the New Mexico DOI has a robust procedure for selection and takes Mr. Lovendusky’s charges seriously. Mr. Cole said the Wyoming DOI use contractors frequently because of the DOI’s size and if the cost is exorbitant, the DOI would find another way to address a concern.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said the cost of contractors has been a concern for many years and is beyond the scope of the Working Group’s discussion regarding the certification program revisions. She said she has been told the Market Actions (D) Working Group’s policies and procedures are confidential and cannot be shared with industry. She agreed with Mr. Lovendusky’s comments that the APCIA cannot support requirement 6 for this reason. She suggested that the requirement could reference the Handbook’s description of the Market Actions (D) Working Group’s processes rather than reference its policies and procedures manual. She also asked if a request could be made to the Market Actions (D) Working Group to make their policies and procedures public. Mr. Haworth said that is a consideration for the Market Actions (D) Working Group to take up.
3. Discussed Pass and Fail Metrics

Mr. Haworth said the discussion of the definitions for “unqualified pass” and “provisional pass” in requirement 4 leads to a broader discussion of what the criteria for passing or failing for each requirement should be, as well as the passing and failing of the entire certification program. He noted the terms “unqualified pass” and “provisional pass” are only found in requirement 4. He asked if those measurements should be used for other requirements or not used at all. He noted within requirement 4, it was not clear when a pass would be unqualified or provisional. Mr. Cole said he sees the usefulness of allowing a jurisdiction to pass provisionally if there are conditions outside of their control such as a collective bargaining agreement.

Mr. Haworth suggested possibly using a percentage of positive responses to all the checklist questions to determine whether a jurisdiction passes or fails. For example, if a jurisdiction had a positive response for 70% of the questions, it would pass. He said it would make sense, however, to weight some requirements more than others. He said, for example, if a jurisdiction failed the requirement to be able to maintain confidentiality, the jurisdiction should fail the entire certification program. Mr. Doucette agreed with the importance of weighting more important requirements heavier than the less important requirements. Mr. Cole noted the requirement for participation in the Market Conduct Annual Statement (MCAS) may be weighted less. He said the Working Group would need to determine which requirements are weighted heavier and by how much.

Ms. Amann asked whether each requirement would be rated as “1, 2, 3” or “High, Medium, Low,” and Mr. Haworth said it seemed to be the way the Working Group was leaning. He said in that manner, a jurisdiction would also know which requirements it needs to work on. Ms. Huiskens suggested using the financial accreditation program scoring methodology as a template. Mr. Gendron said he supports a weighted scoring. Ms. Dingus also said a weighted option is appropriate but said she needs some time to consider how each would be weighted.

Ms. O’Connell said it makes sense that some requirements are make or break but others are not so important. A single aggregate score may not be appropriate if they are missing a requirement that must be in place.

Mr. Haworth said that he and Mr. Cole would develop a matrix for scoring based on the discussions.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

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The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Jan. 30, 2020. The following Working Group members participated: John Haworth, Chair (WA); Bill Cole, Vice Chair (WY); Jimmy Harris (AR); Lindsay Bates (IA); Erica Weyhenmeyer (IL); Holly Williams-Lambert (IN); Mary Lou Moran (MA); Jason Decker (MD); Cynthia Aman (MO); Tracy Biehn (NC); Edwina Vandevoorde (NE); Edwin Pugsley (NH); Angela Dingus (OH); Landon Hubbard (OK); Scott Martin (OR); Christopher Monahan (PA); Michael Bailes (SC); Tracy Klausmeier (UT); Isabelle Keiser (VT); and Theresa Miller (WV). Also participating were: Pam O’Connell (CA); and October Nickel (ID).

1. Adopted its Nov. 20, 2019, Minutes

The Working Group met Nov. 20 to discuss the pilot volunteers’ suggested revisions to the Voluntary Market Regulation Certification Program (Program).

Ms. Dingus made a motion, seconded by Ms. Biehn, to adopt the Working Group’s Nov. 20, 2019, minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Nine). The motion passed unanimously.

2. Discussed Comments Concerning Certification Pilot Volunteers’ Suggestions

Ms. O’Connell said the reorganization of the Program is an improvement. She said placing the checklist for each requirement with its corresponding requirement and guidelines makes it clearer to understand, but some of the criteria for what constitutes success on some of the standards is still unclear.

Regarding requirement 1, Ms. O’Connell said the guidelines are not clear as to what standards a jurisdiction must meet in order to pass the requirement. She said the fourth paragraph of the guidelines for this requirement only describes one item as something a jurisdiction must have in order to pass, which is the authority to coordinate with other jurisdictions. The paragraph then says a jurisdiction should have the authority to conduct analysis, examinations and enforcements but does not say it must be able to. She said the paragraph then describes a jurisdiction with the “ability” to conduct analysis, examinations and enforcement, but not the ability to perform continuum actions as marginally passing. She said it is not clear whether the word “ability” is really intended to mean “authority.” She said “authority” seems to be the correct word, or else how would a jurisdiction’s “ability” to do continuums be measured?

Ms. O’Connell said it is not clear how a jurisdiction’s authority or ability to conduct analysis, examinations, enforcement and continuum actions relates to whether the jurisdiction has the authority to collaborate with other states, which is the only specified “must have” according to the guidelines. Ms. O’Connell said the guidelines should be precise with respect to what is required for a jurisdiction to pass this aspect of the requirement.

Ms. O’Connell said while the requirement says part of the evaluation pertains to whether the jurisdiction has adopted or is in the process of adopting key consumer protection laws and the guidelines list a series of key laws a jurisdiction should have, the checklist collects no information regarding the reporting jurisdiction’s consumer protection laws. She said it is unclear how it will be determined whether a jurisdiction meets this portion of the requirement.

Ms. O’Connell said if the items in the second paragraph under the guidelines for requirement 2 are required in order for a jurisdiction to pass this requirement, they should be incorporated into the third paragraph, which begins, “To evaluate whether your jurisdiction passes Requirement 2 ... “.

Ms. O’Connell said that because the checklist for requirement 3 has been modified to create one question about staff examiners and a separate question about contract examiners, the second bullet point in the sixth paragraph of the guidelines needs to be revised to account for the new structure and for the new wording of all of the other questions that follow the current question 3e. She said the original intent of these bullet points, when 3d addressed both staff and contract examiners, was to say if a jurisdiction uses contract examiners for exams and continuums, additional criteria surrounding contractor
hiring practices and oversight must be met in order to pass. She said the second bullet point no longer tracks in this manner due to the changes to lettering.

For checklist item 3c, Ms. O’Connell asked the reasoning behind separating the numbers of companies upon which market analysis is performed during the year between single-state/multistate and L&H/P&C. She said there is not any pass/fail metric tied to the mix of companies analyzed during the review period. She recommended removing the additional layer of detail in order to make the self-reporting for this item less time intensive.

For the newly number questions 3i and 3j, Ms. O’Connell said it is not clear what they are intended to measure and what is meant by “quantitative and subjective measurements” to ascertain whether the Department of Insurance (DOI) is achieving its staffing policies and procedures. She said the Working Group should define these more specifically so jurisdictions will be clear on the standards to which they may be held in the future.

Ms. O’Connell said the narrative for question 3g seems to say the written premium to be entered into the table should be the combined written premium of all entities examined or subject to an action during the calendar year. She said it is not clear how this will demonstrate that the jurisdiction has enough staff to properly oversee its market. For example, she said if state A has total premium writings of $10 billion in its market overall but only did one exam on an insurer with premium writings of $5 million, comparing the $5 million figure with the number of examiners state A has on staff or under contract would provide no perspective on whether that examiner count is reasonable compared to the overall size of state A’s $10 billion market.

Ms. O’Connell said item 3h’s demand for a list of all examiners either on staff or contracted by name, along with specifics about their educational and work history backgrounds, is not relevant to whether the DOI has a properly sized staff or the ability to hire contractors to meet market regulation needs as stated in requirement 3. She noted that item 3g already asks for counts of examiners. She said 3h should be deleted.

Ms. O’Connell said under the requirement 4 structure proposed for unqualified pass and provisional pass for the various subparts of the guidelines, a jurisdiction whose rules for hiring and establishing conditions of employment are subject to collective bargaining and specific civil service rules could only ever attain a provisional pass. In the note to evaluators, it says that for provisional pass items, progress is recommended and expected during successive reviews. She said it is not clear what progress the Working Group expects to see a jurisdiction, bound by collective bargaining, make from year to year when these items are outside the control of the DOI. She said it also is not clear what the consequence would be if a jurisdiction is not able to demonstrate the desired progress.

Ms. O’Connell said the core competencies section of the NAIC Market Regulation Handbook (Handbook) with which, according to requirement 4, a jurisdiction’s methods of ensuring qualifications of staff should be consistent, lists and describes a number of designations and credentials indicative of a high degree of proficiency in market regulation. She said, however, that it also very specifically says the designations listed are not intended to be exhaustive nor is it intended for designations to be required for qualification. She said California is not in favor of the current structure of the guidelines because they set a higher standard for passing than is called for by the language of the requirement and the Handbook. She recommended simplifying this set of guidelines to eliminate the unqualified pass and provisional pass distinctions and instead establish clear criteria to measure whether jurisdictions have hiring processes allowing them to select applicants with appropriate education, work experience, skills and abilities to perform market regulation work regardless of specific designations, and whether the jurisdictions have programs and procedures to encourage and promote professional development of staff.

Ms. O’Connell noted the first line of the second paragraph of the requirement 6 guidelines incorrectly refers to the Market Actions (D) Working Group as the Market Analysis (D) Working Group.

Ms. O’Connell said for requirements 6, 7 and 8 at the bottom of each checklist, there is an unnumbered item that states, “Have there been any changes to your requirements since last year’s review. If “yes,” provide an explanation.” She said it is unclear what the phrase “your requirements” is in reference to. She said the question should be more specific to clarify what the jurisdiction should be reporting in the way of changes during the interim period.

Ms. O’Connell said the requirement 9 guidelines are not clear with respect to expectations for participation in working groups and task forces beyond the Market Analysis Procedures (D) Working Group and Market Conduct Examination Standards (D) Working Group. She said the fourth paragraph of the guidelines, which begins “To evaluate whether your jurisdiction passes Requirement 9,” lists three things the jurisdiction must be able to do at a minimum to pass—1) answer “yes” to 9a and 9b; 2) document who in the department monitors or participates in the Working Groups; and 3) accurately document a list of any other market analysis or market conduct related working groups or task forces the jurisdiction participates in or monitors. She
said the third element conflicts with the last paragraph of the guidelines that says it is at the jurisdiction’s discretion to participate in or monitor the Market Information Systems (D) Task Force or any other working group or task force that reports to the Market Regulation and Consumer Affairs (D) Committee. She said the Working Group should modify the guidelines to eliminate this conflict by either making participation in or monitoring of these other groups mandatory or discussing them in the guidelines as something the jurisdiction should consider being a best practice.

Ms. O’Connell recommended modifying the requirement 11 guidelines and the criteria for what passes this requirement to mirror the current national analysis program process with the recognition that the process could change in the future, in which case the guidelines will be reevaluated and modified. She said the current structure of the national analysis program calls for:

1) a lead state for each line of business that is responsible for the selection process; 2) individual jurisdictions to perform analysis on selected companies; and 3) a summarizing jurisdiction responsible for compiling the results of all individual state analysis for a single company. She said a state currently gets no credit under the certification program for acting as a summarizing jurisdiction. She said the limited number of lead state spots per year will not allow all 56 jurisdictions to have the opportunity be a lead state every other year as needed to pass the requirement. She recommended restructuring the requirement, guidelines and checklist to allow a state to pass the requirement if it reviews national analysis data on an annual basis and on an every other year basis either acts as a lead state responsible for the selection process or acts as a summarizing jurisdiction.

Finally, Ms. O’Connell said the years identified throughout the Proposal for Implementation need to be updated to reflect the current timeline. She said the Working Group should consider a more generic description, such as “two weeks before the Fall National Meeting of the first year following adoption by the membership” since it is not known when the Market Regulation and Consumer Affairs (D) Committee and the Executive (EX) Committee and Plenary will adopt the program. Mr. Decker agreed with updating the implementation dates.

Ms. Nickel said the word “or” needs to be included in the second sentence of the requirement 1 wording. “Additionally, the jurisdiction has adopted, is in the process of adopting, …” to read, “… or is in the process of adopting …”.

Ms. Nickel said the fourth bullet point under section b of the requirement 4 guidelines references “similar organizations.” She said this needs to be defined to specify whether it includes associate or higher-level designations from the Society of Financial Examiners (SOFE) or the Life Office Management Association (LOMA), which are already a requirement in other NAIC standards. She said Ms. O’Connell’s idea to be more general is the best solution.

Ms. Nickel said section d of the requirement 4 guidelines asks if the market regulation section recognizes the licenses and credentials of cybersecurity and information technology (IT) experts. She said this may be duplicative because the financial examinations section of DOIs uses these experts on targeted examinations of domiciled companies where a cyber event occurs. She said this is part of any financial examinations conducted as scheduled by Idaho and is already required by the NAIC financial accreditation standards. Mr. Haworth noted that non-domestic examinations are often left to the market regulation departments to conduct. Ms. Amann noted that the IT Examination (E) Working Group has a charge to work with the Market Conduct Examination Standards (D) Working Group to assist in the development of regulatory oversight policy with respect to cybersecurity examination issues, as requested by the Innovation and Technology (EX) Task Force. She said the guidance from this work may assist smaller states.

Ms. Nickel said the first paragraph of requirement 8 should be rewritten to be more in line with the objective statement and checklist of requirement 8. She suggested (suggested changes in italics): “The department enters data as information is available for sharing into all NAIC systems, including, but not limited to, the Complaint Database System (CDS) and the Regulatory Information Retrieval System (RIRS). Except for immediate concerns as defined in the Market Regulation Handbook, the department enters data into the Market Action Tracking System (MATS) at least 60 days prior to the start of the on-site examination. Additionally, the department enters continuum actions into MATS as appropriate.”

Ms. Nickel said the reporting of continuum actions should be “as appropriate.” She noted the objective statement of requirement 8 indicates the goal is to ensure other jurisdictions are timely informed of market conduct actions that “have occurred, are ongoing, or that are anticipated.” In the checklist, the entry into MATS for on-site examinations are required 60 days prior, but there is no other requirement for continuum activities entry to be 60 days prior. She said that is correct since it would be impossible to enter continuum activities 60 days prior if they were the result of a Market Analysis Review System (MARS) Level 1 or Level 2 recommendation, a referral from the consumer complaints section, a company self-reporting, or if there was an immediate concern.
Ms. Nickel said the checklist item 8c reference to “appropriate databases” is unclear. She said if there are databases other than MATS, she suggested rewording 8c to say: “Does the department enter continuum actions into the other appropriate NAIC database, such as MATS, as recommended and the resulting applicable final status reports or updates (if applicable) at least quarterly?” However, if 8c is intended to be specific to MATS and continuum activities, and there is no quarterly reporting requirement, she suggested rewording 8c to: “Does the department enter continuum actions into MATS including the resulting applicable final status reports or updates as appropriate (or as recommended/required by the Department)?”

Ms. Nickel noted Idaho does not have the resources to continuously update MATS actions quarterly. She said as part of the DOI’s market analysis procedure, MATS actions are entered and updated throughout the course of the continuum activity, which may only be when initially entered and at finalizing the action. She said this may take longer than three months.

Ms. Nickel asked what was necessary to pass certification overall. Do all requirements need to be passed or simply most requirements be passed, or some other number of requirements?

Mr. Decker said he has the same concerns as Ms. O’Connell about needing more objective standards for passing requirement 1. He also noted the same issues with being sure the checklist references are correct for renumbered item numbers.

Mr. Decker asked if any of the pilot program participating states that answered “yes” to requirement 3 checklist items 3i and 3j would share examples of their policies and procedures and the quantitative and subjective measurements that they used in determining if they passed. He said the standards for determining whether a state passed seemed subjective.

For the requirement 8 checklist, Mr. Decker asked if a jurisdiction must be 100% compliant for items 8c and 8e. If not, he suggested incorporating error tolerance rates.

Mr. Decker suggested a metric for measuring success in meeting requirement 9. He said the current measurement is subjective and would be improved by adding a percentage metric similar to the 50% attendance requirement that is used in requirement 10 checklist item 10c.

Mr. Decker said the requirement 10 checklist item 10d does not define how “actively monitor” will be measured. He said a metric should be added for item 10d. He also suggested adding “or their designee” to the individuals who monitor bulletin board discussions.

Lisa Brown (American Property Casualty Insurance Association—APCIA) noted the certification program contains discussion of rating such as “pass,” “unqualified pass,” or “provisional pass” but no discussion on what a “fail” rating would be. She asked if this was because the checklist would only be submitted by jurisdictions that passed each requirement, or because it is intended for each jurisdiction to pass.

Ms. Brown also noted the absence of any requirements to protect insurers, such as requiring states to submit budgets, time frames for review and confidential feedback mechanisms when contract examiners are used.

Ms. Brown said she agrees with Ms. O’Connell regarding requirement 3 checklist item 3j that it is difficult to measure whether a jurisdiction has achieved its policies and procedures for staffing.

Ms. Brown said the use of premium volume of companies examined since it implies jurisdictions will be measured by the premium volume examined. She noted this could skew jurisdictions into examining only large companies rather than companies where potential problems or misconduct exist. Mr. Haworth said it may be more helpful to measurement staffing needs by total market premium rather than the premium of just the examined entities.

Ms. Brown also said requirement 6 asks if a jurisdiction’s policies and procedures are consistent with the Market Actions (D) Working Group’s policies and procedures. She said industry objected to a requirement conditioned on a document to which it has no access.

Michael Lovendusky (American Council of Life Insurers—ACLI) said the ACLI agrees with the comments submitted by the APCIA. In addition, he said he would recommend a new bullet point for requirement 5 that would read: “The department shall have the authority and capability to: Comply with cybersecurity requirements equal or more rigorous than those required of regulated entities.” He said the regulated entities have concerns that government agencies have processes and protections to ensure against cybersecurity breach, especially as they increasingly use contract vendors.

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Mr. Lovendusky said the proposal to delete checklist items pertaining to contract examiners would eliminate critical information about the cost of contract examiners, which is often passed on to the regulated entity.

Mr. Lovendusky agreed with the APCIA’s concern that industry has no access to the Market Actions (D) Working Group’s policies and procedures and said it is more critical if the Market Actions (D) Working Group or a member state relies on contract examiners.

Mr. Haworth said he and Mr. Cole would incorporate the recommended changes and circulate the next version of the certification program prior to the next meeting.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.
Chapter 26A—Conducting the Limited Long-Term Care Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state’s own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter applies to limited long-term care insurance policies. This chapter does not apply to qualified limited long-term care insurance contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement limited long-term care insurance. This chapter also does not apply to life insurance contracts that accelerate benefits in the form of a lump sum payment, in anticipation of death or some other specified occurrence.

This chapter provides a format for conducting limited long-term care insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of limited long-term care insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Appeal of Benefit Trigger Adverse Determination
G. Underwriting and Rating
H. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

IIPRC-Approved Products
When conducting an exam that includes limited long-term care insurance products, rates, advertisements and associated forms approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind the uniform standards, and not state-specific statutes, rules and regulations, are applicable to the content and approval of the product. The IIPRC website is www.insurancecompact.org and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a
compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the IIPRC (including the uniform standards). Under the uniform standards, a limited long-term care insurance product approved by the IIPRC can be used in a compacting state’s partnership program provided the company has obtained the necessary approval from the compacting state or made the necessary certification to the compacting state, as applicable. Please note that the company must still comply with a compacting state’s laws for minimum daily benefit amounts, minimum benefit periods and maximum elimination periods when selling a limited long-term care insurance product approved by the IIPRC.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
STANDARDS
OPERATIONS/MANAGEMENT

<table>
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<th>Standard 1</th>
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<td>The entity files all reports and certifications with the insurance department as required by applicable statutes, rules and regulations.</td>
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Apply to: All limited long-term care companies

Priority: Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations
- Insurance department records of reports and certifications made by the entity

Others Reviewed

- _________________________________________
- _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Each insurer shall file with the insurance commissioner, prior to offering group limited long-term care insurance to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory limited long-term care insurance requirements substantially similar to those adopted in the state of issue (Model #643 Section 20 & Model 642 Section 5). (Note: Section 20 of the Limited Long-Term Care Model Regulation (#643) requires an evidentiary filing only from discretionary groups.

Each insurer should file with the insurance commissioner a copy of any limited long-term care insurance advertising intended for use in the state—whether through written, radio or television medium—for review or approval to the extent required by state law. All advertisements should be retained for at least three years from the date of first use.

Determine if replacement/lapse reporting is submitted by the entity as required. Items to be reported are:

- Top 10 percent of producers with the highest percentage of replacements and lapses; and
- Number of lapsed policies as a percentage of annual sales and policies in force at the end of the previous calendar year.

Determine that the entity complies with filing and certification requirements set forth by statutes, rules and regulations for associations endorsing or selling limited long-term care insurance. Generally, these requirements are imposed on an association group meeting the definition of a professional/trade/occupational association found in Section 4E(2) of the Limited Long-Term Care Insurance Model Act (#642).
Ensure that the insurer has filed all requested advertising with the insurance department regarding association sold or endorsed limited long-term care insurance, as may be requested by the insurance department. Any such advertising must disclose:

- The specific nature and amount of compensation that the association receives from the endorsement or sale of the policy or certificate to its members; and
- A brief description of the process under which the policies and the issuing insurer were selected.

Determine that the entity submits suitability and rescission information as required by applicable statutes, rules and regulations.

Determine the regulated entity has proper procedures in place to ensure its producers are properly trained and that the training meets the minimum standards established by the applicable laws and regulations.

Insurers subject to the Limited Long-Term Care Insurance Model Act (#642) shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A of the Long-Term Care Insurance Model Act (#640) and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of limited long-term care, including Medicaid, in a state. These records shall be maintained in accordance with state record retention requirements and shall be made available to the commissioner upon request. Pursuant to Model#642, Section 9 – Producer Training Requirements are optional.

Most states have a limited long-term care partnership policy forms certification process in order for limited long-term care partnership forms to be sold in their state.
B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
STANDARDS
MARKETING AND SALES

Standard 1
The entity has suitability standards for its products, where required by applicable statutes, rules and regulations.

Apply to: All limited long-term care products
Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ Producer records
_____ Training materials
_____ Procedure manuals
_____ Underwriting/Policy files

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine whether the entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have the entity run a policyholder history to identify the number of policies sold to those individuals.

Determine if entity guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine if the entity has developed and uses suitability standards and procedures to determine whether the purchase or replacement of limited long-term care insurance is appropriate for the needs of the applicant. Suitability standards and procedures should include:

- Consideration of the advantages and disadvantages of insurant to meet the needs of the applicant; and
- Discussion with applicants of how the benefits and costs of limited long-term care insurance compare with long-term care insurance.
- Agent training in its suitability standards and procedures
- Maintain a copy of suitability standards and procedures and make them available for inspection upon request by the commissioner.
If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s intent. Either the applicant’s returned letter or a record of the alternate method of verification shall be made a part of the applicant’s file.

Note: Pursuant to Section 25H of the Limited Long-Term Care Insurance Model Regulation (#643), suitability standards do not apply to life insurance policies or riders that accelerate benefits for limited long-term care as defined in the Limited Long-Term Care Model Act, Section (#642), Section 4(D).

Determine if the insurer is reporting suitability information to the insurance commissioner as required by applicable statutes, rules and regulations.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used by the entity.

Ensure the entity maintains a written statement specifying the standards of suitability used by the insurer and provides the standards to its producers, and that both follow the standards. The standards should specify that no recommendation should be made and/or no policy issued in the absence of reasonable grounds to believe that the purchase of the policy is not unsuitable for the applicant (based on information known to the insurer or producer making the recommendation).
Standard 2
Policy forms provide required disclosure material regarding standards for benefit triggers.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Claim procedure/Underwriting manuals

_____ Claim files

_____ Policy forms

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

*Limited Long-Term Care Insurance Model Act (#642)*
*Limited Long-Term Care Insurance Model Regulation (#643)*

Review Procedures and Criteria

Ensure the policy conditions the payment of benefits on a determination of the insured’s ability to perform activities of daily living (ADLs) and cognitive impairment.

Ensure that the policy contains the definition of ADLs, cognitive impairment and other key terms as required by statutes, rules and regulations.

Determine that the eligibility for payment of benefits is not more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the ADLs or the presence of cognitive impairment. Ensure that payment of benefits is not more restrictive than those allowed by statutes, rules and regulations.

Ensure that the policy contains a clear description of the process for appealing and resolving benefit determinations.
STANDARDS
MARKETING AND SALES

Standard 3
Marketing for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Required reports filed with the insurance department

_____ Marketing materials filed with the insurance department

_____ Underwriting files or other files containing proof of issuance of outline of coverage

_____ Review state statutes, rules and regulations to determine if state limited long-term care requirements apply to annuity products with a limited long-term care element. If so, then the applicable Annuity Disclosure Model Regulation (#245) would apply

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Life Insurance Disclosure Model Regulation (#580)
Life Insurance Illustrations Model Regulation (#582)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity uses applications for limited long-term care insurance policies or certificates containing clear and unambiguous questions designed to ascertain the health condition of the applicant. (In most cases, application forms should have been reviewed by the insurance department’s rates and forms division.)

Verify that the entity complies with right to return/“free look” requirements.

Verify that the outline of coverage is delivered to the applicant at time of initial solicitation through means that prominently directs the attention of the recipient to the document and its purpose.
Verify that at the time of policy delivery the insurer has delivered a policy summary for an individual life insurance policy that provides limited long-term care benefits within the policy or by rider. In the case of direct response solicitations, verify that the insurer has delivered the policy summary upon the applicant’s request, but regardless of request has made delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, ensure that the summary also includes:

- An explanation of how the limited long-term care benefit interacts with other components of the policy;
- Any exclusions, reductions and limitations on benefits of limited long-term care; and
- A statement that any limited long-term care inflation protection option required by the applicable state’s statutes, rules and regulations regarding inflation protection option requirements comparable to Section 13 of the Limited Long-Term Care Insurance Model Regulation (#643) is not available under this policy.

In addition to the above, if applicable to the policy type, ensure that the summary includes the following:

- A disclosure of the effects of exercising other rights under the policy; and
- A disclosure of guarantees related to limited long-term care costs of insurance charges.

The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with the applicable state’s basic illustration requirements comparable to Sections 7 and 8 of the Life Insurance Illustrations Model Regulation (#582) or into the life insurance policy summary, which is required to be delivered in accordance with the applicable state’s life insurance policy summary requirements comparable to Section 5 of the Life Insurance Disclosure Model Regulation (#580).

Verify that the entity complies with records maintenance and reporting requirements:

- Entity must maintain records for each producer of that producer’s amount of replacement sales as a percentage of the producer’s total annual sales and the amount of lapses of limited long-term care insurance policies sold by the producer as a percentage of the producer’s total annual sales;
- Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements;
- Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year; and
- Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year.
STANDARDS
MARKETING AND SALES

| Standard 4 |
| All advertising and sales materials are in compliance with applicable statutes, rules and regulations. |

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for advertisements approved by the IIPRC)
- All company advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials
- Policy forms, including any required buyer’s guides, outline of coverage, limited long-term care insurance personal worksheets and disclosure forms as they coincide with advertising and sales materials
- Producer’s own advertising and sales materials

**Others Reviewed**

- _________________________________________
- _________________________________________

**NAIC Model References**

*Limited Long-Term Care Insurance Model Act (#642)*
*Limited Long-Term Care Insurance Model Regulation (#643)*
*Unfair Trade Practices Act (#880)*

**Review Procedures and Criteria**

Evaluate the company’s system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either at least three years from the date the advertisement was first used or later if required by state statutes, rules and regulations.
Review advertising materials in conjunction with the appropriate policy form. Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead prospective buyers to believe that they are purchasing an investment or savings plan. Problematic terminology may include the following terms: investment, investment plan, founder’s plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences;
- Use terms such as “non-medical” or “no medical examination required,” if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is a fact. Enrollment periods may not be described in terms such as “special” or “limited” when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in the advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact; and
- Misrepresent any policy as being shares of stock.
Materials should:

- Clearly disclose the name and address of the insurer;
- If using a trade name, disclose the name of the insurer, insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to the policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed; and
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact. Any proprietary relationship or payment for the testimonial must be disclosed.

Determine if the company approves producer sales materials and advertising. Ensure that copies of sales material other than company-approved materials, if permitted, are maintained in a central file. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer’s capacity as an insurance producer. Improper terms may include “financial planner,” “investment advisor,” “financial consultant” or “financial counseling,” if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Review the use of the words “free,” “no cost,” “without cost,” “no additional cost,” “at no extra cost” or words of similar import. Those words should not be used with respect to any benefit or service being made available with a policy, unless it is a fact. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a limited long-term care insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

Determine that company procedures and materials relative to limited long-term care products comply with right to return/“free look” requirements.

Review the company and producer’s Internet sites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised products are (or are not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?
For the review of Internet advertisements:

- Run an inquiry with the company’s name;
- Review the company’s home page;
- Identify all lines of business referenced on the company’s home page;
- Research the ability to request more information about a particular product and verify that the information provided is accurate; and
- Review the company’s procedures related to producers’ advertising on the Internet and ensure that the company requires prior approval of the producers’ web pages, if the company name is used.
STANDARDS
MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 5</th>
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<tbody>
<tr>
<td>Company rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.</td>
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</tbody>
</table>

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations
- Replacement register
- Policy/Underwriting file
- Loan and surrender files, if applicable

Others Reviewed

- _________________________________________
- _________________________________________

NAIC Model References

- *Life Insurance and Annuities Replacement Model Regulation* (#613), if applicable
- *Limited Long-Term Care Insurance Model Regulation* (#643)

Review Procedures and Criteria

Review policy/underwriting files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm applicant’s receipt of replacement notice.

Review replacement disclosure forms for completeness and signatures as required.
STANDARDS
MARKETING AND SALES

Standard 6
Company rules pertaining to company requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ Replacement register
_____ Policy/Underwriting file
_____ Agency correspondence file/Agency bulletins
_____ Agency procedural manual
_____ Claim files
_____ Agency sales/Lapse records
_____ Company systems manual

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the company has advised its producers of its replacement policy.

Determine if the company has separate commission schedules for replacement business, pursuant to applicable state statutes, rules and regulations. Note: Some states limit the compensation payable on replacement business to no more than that payable on renewal policies.

Determine if the company has provided timely notice to the existing insurers of the replacement.

Examine the company system of identifying undisclosed replacements for effectiveness.

Determine if the company has the capacity to produce the data required by replacement regulation to assess producer replacement activity.
Determine if the company has issued letters in a timely manner to policyholders advising of the effects of preexisting conditions on covered benefits.

Review policy/underwriting files to determine if the company is retaining required records for required time frames.

Examine company procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the company provides required credit for preexisting conditions or probationary periods on replacements.
D. Producer Licensing

Use the Producer Licensing Standard 2 that is provided in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
STANDARDS
POLICYHOLDER SERVICE

Standard 1
Policy renewals are applied consistently and in accordance with policy provisions.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedure manuals

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Review renewal business to determine if the entity’s procedures for handling renewals are in accordance with applicable statutes, rules and regulations.

Ensure that individual policies or certificates do not contain renewal provisions other than “guaranteed renewable” or “noncancellable,” and that these terms are adequately defined in the policy or certificate.

Review the underwriting/policy file to determine if premium notices were sent in a timely and accurate manner.

Review mailroom records for billings sent by the entity to ensure they were sent in a timely manner.
STANDARDS
POLICYHOLDER SERVICE

Standard 2
Nonforfeiture upon lapse and reinstatement provisions is applied consistently and in accordance with policy provisions.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Administrative files

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the required notification of lapse or termination is sent to the proper addressee(s), within the required time frames and that the required information is provided, per applicable statutes, rules and regulations.

Ensure that the entity receives designation of a person(s), other than the insured, to receive notice of lapse or termination of the policy or certificate for nonpayment of premiums or a written waiver by the insured not to designate an additional person(s) to receive notice.

Ensure that the insurer notifies existing insureds of their right to change their written designation at least once every two years, or as specified by state statutes, rules and regulations.

Verify that nonforfeiture and reinstatement provisions were applied consistently and in a non-discriminatory manner. Nonforfeiture provisions upon lapse and reinstatements should be applied per policy provisions and in accordance with applicable statutes, rules and regulations.

Ensure that the policy includes a provision that provides for reinstatement of coverage in the event of lapse, if the entity has provided evidence that the policyholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option should be made available to the insured for a period of 5 months after the date of termination.
STANDARDS
POLICYHOLDER SERVICE

Standard 3
Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.

Apply to: All limited long-term care products
Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
_____ Underwriting/Administrative file
_____ Entity procedures manual

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the entity offers applicants the opportunity to purchase a limited long-term care policy that includes a nonforfeiture benefit, as required by applicable statutes, rules and regulations.

If the applicant declines the nonforfeiture benefit, ensure that the entity provides a contingent benefit upon lapse of the policy for a specified period following a substantial increase in premium rates, as required and defined by applicable statutes, rules and regulations.

Ensure that a policy offered with nonforfeiture benefits contains the same coverage elements, eligibility, benefit triggers and benefit length as a policy without the nonforfeiture benefit.

Determine if the entity provides notice as required by applicable statutes, rules and regulations prior to the due date of the premium reflecting a substantial premium increase.

Ensure that the entity offers the proper nonforfeiture benefit and nonforfeiture credit, as required by applicable statutes, rules and regulations.

Determine if the policy contains the proper time frames for nonforfeiture benefit and the contingent benefit upon lapse, as required by applicable statutes, rules and regulations.

Determine if the correct nonforfeiture option is provided in case of policy lapse.
Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to nonforfeiture values, refer to applicable statutes, rules and regulations regarding the calculation of nonforfeiture values.

Review the entity’s procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Ensure that the entity notifies policyowners of material changes to any nonforfeiture benefits in accordance with applicable statutes, rules and regulations.
**STANDARDS**

**POLICYHOLDER SERVICE**

<table>
<thead>
<tr>
<th>Standard 4</th>
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<tbody>
<tr>
<td>Policyholder service for limited long-term care products complies with applicable statutes, rules and regulations.</td>
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</tbody>
</table>

**Apply to:**  All limited long-term care products

**Priority:**  Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- Underwriting/Policy file
- Underwriting/Administrative procedures manuals
- Procedure manuals

**Others Reviewed**

- ________________________________
- ________________________________

**NAIC Model References**

- Limited Long-Term Care Insurance Model Act (#642)
- Limited Long-Term Care Insurance Model Regulation (#643)
- Unfair Trade Practices Act (#880)

**Review Procedures and Criteria**

Verify that the entity offers nonforfeiture benefits.
F. Appeal of Benefit Trigger Adverse Determination

Use the standard set forth below.
## STANDARDS

### APPEAL OF BENEFIT TRIGGER ADVERSE DETERMINATION

<table>
<thead>
<tr>
<th>Standard 1</th>
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<tbody>
<tr>
<td>Insurers shall be in compliance with applicable state statutes, rules and regulations regarding appeal of adverse benefit trigger determination.</td>
</tr>
</tbody>
</table>

**Apply to:** All limited long-term care insurers

**Priority:** Essential

**Documents to be Reviewed**

- Company’s written procedures explaining administration of appeals process and template denial letters
- Internal company procedures which describe the appeals process
- Applicable statutes, rules and regulations
- Request copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective

**Others Reviewed**

- _________________________________________
- _________________________________________

**NAIC Model References**

*Limited Long-Term Care Insurance Model Regulation (#643)*

### Review Procedures and Criteria

Ask insurer how it describes its appeal procedures to the insured.

Ask for copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective.

In the event the insurer has determined that the benefit trigger of a limited long-term care insurance policy has not been met, verify that the insurer has provided a clear, written notice to the insured and the insured’s authorized representative, if applicable, of all of the following:

- The reason that the insurer determined that the insured’s benefit trigger had not been met;
- The insured’s right to internal appeal and the right to submit new or additional information relating to the benefit trigger denial with the appeal request within 120 calendar days of receipt of the notice; and
- The insured’s right, after exhaustion of the insurer’s internal appeal process, to have the benefit trigger determination to contact their state insurance department and their State Health Insurance Program (SHIP) office.

Ensure that the individual or individuals making the internal appeal decision are not the same individual or individuals who made the initial benefit determination.

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Verify that the insurer, within 30 calendar days of the insurer’s receipt of all necessary information upon which a final determination can be made, has completed and sent written notice of the internal appeal decision to the insured and the insured’s authorized representative, if applicable.

If the insurer’s original determination is upheld upon internal appeal, ensure that the notice of the internal appeal decision describes any additional internal appeal rights offered by the insurer.

If the insurer’s original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insured has the right to contact their state insurance department and their State Health Insurance Program (SHIP) office, pursuant to applicable state statutes, rules and regulations.

Verify that if any new or additional information not previously provided to the insurer is submitted by the insured or the insured’s authorized representative, the insurer either (1) considers and affirms or (2) overturns its benefit trigger determination.

If the insurer overturns its benefit trigger determination, verify that the insurer has provided notice to the insured and the insured’s authorized representative, if applicable, and the commissioner of its decision.
G. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- Rating practices;
- Underwriting practices;
- Use of correct and properly filed and approved forms and endorsements;
- Termination practices;
- Unfair discrimination;
- Use of proper disclosures, outlines of coverage and delivery receipts;
- Reinsurance; and
- Marketing and sales materials.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Individual and group issued and renewed policy files;
- Policy summaries;
- Replacement and conservation materials;
- Documentation of required disclosures and delivery receipts;
- Individual and group canceled policy files and certificates;
- Documentation of premium refund upon election of “free look” period;
- Recessions occurring prior to a claim;
- Policy forms, endorsements and applications, along with appropriate filings;
- Producer licensing information;
- Producer compensation agreements, where applicable;
- Premium statements and billing statements;
- Group trust arrangements, where applicable;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;
- Reinsurer policies/treaties; and
- Reinsurer guidelines and manuals.

For the purposes of this chapter, “underwriting file” means the file or files containing the new business application, renewal application, certificates or evidences of coverage, including binders, rate calculation sheets, billings, medical information, credit information, inspection or interview reports, all underwriting information obtained or developed, policy summary page, endorsements, cancellation or reinstatement notices, correspondence and any other documentation supporting selection, classification, rating or termination of the policy.
In selecting samples for testing, individual policies should generally not be combined with group policies. Because these two areas are generally not homogeneous, any conclusions or inferences made from the results of sampling may not be valid if combined. The examiner should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies, endorsements and premium statements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice of the examination.

Next, determine the entity’s policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain that the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner’s responses should maximize objectivity; the examiner should avoid replacing examiner judgment for entity judgment.

a. Rating Practices

It is necessary to determine if the entity is in compliance with rating systems that have been filed with and, in some cases, approved by the insurance department. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the entity’s own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by an entity might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that an entity is engaged in unfair competitive practices. Inconsistent application of rates or classifications can result in unfair discrimination.

If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the use of improperly worded, vague or obsolete rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

Occasionally, the examiner may need to review loss statistics to determine if premiums are fair and reasonable in relation to the associated claims experience. When possible, the examination team should make use of audit software to verify the correct application of specific rating components and the consistent use of rates. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

The rating practices for renewal policies and newly issued policies should be reviewed. The examination team should also review premium notices and billing statements. The examiner should ensure the proper application of rate increases or rate decreases.

The examiner should also ensure that the underwriting files contain sufficient information to support the rates that have been developed.
b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the entity’s underwriting manuals, underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and entity minutes that may furnish evidence of anti-competitive behavior may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the entity’s compliance with its own manuals and guidelines. The examiner should confirm that the entity’s underwriters and producers consistently apply the entity guidelines for all business selected or rejected. The examination team should verify that the entity has correctly classified insured individuals.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the entity’s management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of the business. Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each applicable field office.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to the insurance department’s counsel. Ultimately, the information obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Termination Practices

The examination team should review the entity’s policy cancellation and reinstatement practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the entity’s own rules, guidelines and policy provisions.

Cancellation and lapsed policy processing should include a formal notice to the insured, including secondary addressees, where elected by the insured. Adherence to policy provisions for renewal language and for applicable grace periods should be reviewed.

The examination team should verify that premium refunds upon election of “free look” provisions are handled correctly, uniformly and in a timely manner.

The examination team should review reinstatement offers and determine what the entity’s practice is for offering reinstatement. In addition, the examination team should be mindful of billing practices that may encourage policy lapses.
e. Unfair Discrimination

The examination team should be mindful of entity underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional, yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted by the applicable jurisdiction also may prohibit specific underwriting practices.

f. Use of Proper Disclosures, Buyer’s Guides and Outlines of Coverage

The examination team should review the entity’s use of required disclosure forms, buyer’s guides, policy summaries, replacement notices, “free look” periods and outlines of coverage. In addition to the use of such required items, the examiner may wish to verify that the above items contain the correct content and are in the correct format.

g. Reinsurance

Most state statutes include a feature that for many lines of business the entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files.

Adherence to the requirement is easy to test, but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It also may reflect on the care that the entity’s management places on its selection of business, and represent a danger to the financial health of the entity. Errors in this area should be forwarded to the appropriate state financial examiners. Any tests of this type must be coordinated with the state’s financial examiners.

h. Marketing and Sales Materials

It is recommended that a review of all forms and materials be conducted by reviewing the marketing and sales standards simultaneously during the underwriting and rating review.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the entity’s underwriting activities. The sequence of the standards listed here does not indicate priority of the various standards.
<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mandated definitions and requirements for group limited long-term care insurance are followed in accordance with applicable statutes, rules and regulations.</td>
</tr>
</tbody>
</table>

**Apply to:** All group limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- [ ] Applicable statutes, rules and regulations
- [ ] Underwriting files
- [ ] Rating/Quote information provided electronically
- [ ] Marketing materials
- [ ] Correspondence to producers

**Others Reviewed**

- [ ] ____________________________
- [ ] ____________________________

**NAIC Model References**

*Limited Long-Term Care Insurance Model Act (#642)*
*Limited Long-Term Care Insurance Model Regulation (#643)*

**Review Procedures and Criteria**

If a group policy is issued to an employer or labor organization or association, determine if the group meets the required criteria to qualify the association or organization as a bona fide organization established for the benefits of its members.

Determine if all group limited long-term care policies offered in one state and issued in another state comply with applicable extraterritorial jurisdiction statutes, rules and regulations.

Ensure that any group limited long-term care policy standard provisions that are applicable in the examining jurisdiction are incorporated into the group policy. These provisions include, but are not limited to, grace periods, periods of incontestability, required copies of applications, deemers of representations and not warranties, medical or other evidence of insurability, provision for a certificate of insurance and conversion to an individual policy in the event of termination or total disability.
STANDARDS
UNDERWRITING AND RATING

Standard 2
Pertinent information on applications that form a part of the policy is complete and accurate, and applications conform to applicable statutes, rules and regulations.

Apply to: All limited long-term care products
Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All applications

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

Determine if the entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and inflation protection options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Determine if the application complies with applicable statutes, rules and regulations regarding form and content.
STANDARDS
UNDERWRITING AND RATING

Standard 3
The entity complies with specific requirements for AIDS-related concerns in accordance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ Applications and related disclosure and consent forms
_____ Health questionnaires for applicants
_____ Medical underwriting guidelines
_____ Entity guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Ensure the entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional.

Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test, and should be a part of the underwriting file. Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

Questions may ask if the applicant has been diagnosed with AIDS or ARC, if they are designed to establish the existence of the condition, but are not to be used as a proxy to establish sexual orientation of the applicant.
Ensure the entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant’s sexual orientation a factor in the determination of insurability.

Review a sample of underwriting files for denied applications in order to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the entity guidelines (e.g., based on the amount of insurance).

Neither the marital status, the living arrangements, the occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant’s sexual orientation.
## STANDARDS
### UNDERWRITING AND RATING

<table>
<thead>
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<th>Standard 4</th>
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<tr>
<td>Policies, riders, amendments, endorsements, applications and certificates of coverage contain required provisions, definitions and disclosures.</td>
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</tbody>
</table>

**Apply to:** All limited long-term care products  

**Priority:** Essential  

**Documents to be Reviewed**

- [ ] Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)  
- [ ] Underwriting/Administration file  
- [ ] Policies, riders, amendments, endorsements, applications and certificates of coverage  

**Others Reviewed**

- [ ]  
- [ ]  

**NAIC Model References**

- Limited Long-Term Care Insurance Model Act (#642)  
- Limited Long-Term Care Insurance Model Regulation (#643)  

**Review Procedures and Criteria**

Determine if the policy contains the required terms and definition of such terms per applicable statutes, rules and regulations, including, but not limited to:

- Guaranteed renewable and noncancellable;  
- Activities of daily living, acute condition, adult day care, bathing, cognitive impairment, continence, dressing, eating, hands-on assistance, home health care services, Medicare, mental or nervous disorder, personal care, skilled nursing care, toileting and transferring. In addition, coverage specific to limited long-term care benefits may include non-skilled nursing care by providers of service, including but not limited to skilled nursing facility, extended care facility, convalescent nursing home, personal care facility, specialized care providers, assisted living facility, and home care agency; and  
- Reasonable and customary/usual and customary.  

Determine if riders and endorsements added after the original date of issue, at reinstatement or renewal that reduce or eliminate benefits or coverage (except as requested by the insured) require signed acceptance by the insured.  

Ensure that the entity has not established a new waiting period in the event existing coverage is converted or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the individual or group policyholder.
Ensure that the entity does not apply preexisting condition provisions more restrictive than “…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person,” unless the insurance commissioner has extended limitation periods.

A limited long-term care insurance policy or certificate, other than a policy or certificate issued to a defined group, may not exclude coverage for a loss or confinement that is the result of a preexisting condition, unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

A limited long-term care insurance policy or certificate may not exclude or use riders or waivers to exclude, limit or reduce benefits for specifically named or described preexisting conditions or physical conditions beyond the defined waiting period.

Determine if the policy meets the requirements under applicable statutes, rules and regulations with regard to prior hospitalization/institutionalization. The policy may not:

- Condition eligibility of any benefits on a prior hospitalization requirement, or, in the case of benefits provided in an institutional care setting, on the receipt of a higher level of institutional care;
- Condition eligibility for benefits (other than waiver of premium, post-confinement, post-acute care or recuperative benefits) on a prior institutionalization requirement;
- Condition eligibility of non-institutional benefits based on the prior receipt of institutional care on a prior institutional stay of more than 30 days; and
- Condition the receipt of benefits following institutionalization upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge.

A policy or rider containing post-confinement, post-acute care or recuperative benefit shall contain in a separate paragraph titled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.

Determine if the policy contains any limitations regarding preexisting conditions, and, if so, ensure that they are outlined in a separate paragraph titled “Preexisting Condition Limitations.”

Ensure that the policy measures the need for limited long-term care on the activities of daily living (ADLs) and cognitive impairment, and that they are described—along with any additional benefit triggers, benefits and entity-required certification of functional dependency—in a separate paragraph titled “Eligibility for the Payment of Benefits.”

If a limited long-term care policy provides benefits for home health care or community care services, ensure that it meets the required minimum standards required by applicable statutes, rules and regulations.
STANDARDS
UNDERWRITING AND RATING

Standard 5
Underwriting and rating for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All group limited long-term care products

Priority: Essential

Documents to be Reviewed

____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

____ Policy contract

____ Notice of cancellation/nonrenewal

____ Insurance department approval of forms

____ Underwriter’s file or notes on a system log

____ Insured’s request (if applicable)

____ Entity cancellation/nonrenewal guidelines

____ Certificate of mailing

Others Reviewed

____ ___________________________________________

____ ___________________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and applicable statutes, rules and regulations.

Review entity procedures for cancellation/nonrenewal to determine if the entity is following its own guidelines.

Review cancellation and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the forms, if necessary, were approved by the insurance department.
In addition to other applicable review procedures, verify the following:

- The entity has not cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder;
- The entity has not established a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
- The entity does not provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; and
- The entity does not apply preexisting condition provisions more restrictive than “…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person,” unless limitation periods have been extended by the insurance commissioner.

Verify that standards for incontestability periods are no more restrictive than as follows:

- Within 6 months, misrepresentations must be material;
- Within 2 years and more than 6 months, misrepresentation must be material and pertain to the condition for which benefits are sought; and
- After 2 years, benefits are contestable only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured’s health.

Verify that the entity’s underwriting practices reflect minimum requirements related to guaranteed renewability, noncancellability and continuation or conversion.

Replacement of a group limited long-term care policy with another group limited long-term care policy shall offer coverage to all persons covered under the previous group policy on its date of termination, with no preexisting condition exclusions that would have been covered on the prior policy and shall not vary or otherwise depend on the individual’s health or disability status, claim experience or use of limited long-term care services.

Verify that the entity provides notice to the designated person, in addition to the applicant, for termination of a policy or certificate for nonpayment of premium.

Verify that the entity allows for reinstatement of coverage in the event of lapse if provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.

Verify that prior to issuance of a limited long-term care policy or certificate to an applicant age 80 or older, the insurer obtains one of the following:

- A report of a physical examination;
- An assessment of functional capacity;
- An attending physician’s statement; or
- Copies of medical records.

Verify that the entity delivers a copy of the completed application or enrollment form (whichever is applicable) to the insured no later than at the time of delivery of the policy or certificate, unless it was retained by the applicant at the time of application.

Verify that the entity maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated. The entity shall annually furnish this information to the insurance commissioner in the format prescribed by applicable statutes, rules and regulations.

Verify that the premium charged does not increase due to increase of age beyond 65 or the duration the insured has been covered under the policy.
STANDARDS
UNDERWRITING AND RATING

Standard 6
The company’s underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ New business application
_____ All underwriting information obtained
_____ Company underwriting guidelines and bulletins
_____ Declination procedures
_____ Agency agreements and correspondence with producers
_____ Riders or extensions of coverage
_____ Interoffice memoranda and company minutes
_____ Policy specifications page
_____ Underwriter’s file or notes on a system log

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Limited Long-Term Care Insurance Model Act (#642)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on the Basis of Blindness or Partial Blindness (#888)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper
**Review Procedures and Criteria**

Ensure the file documentation adequately supports the decisions made:

- The application should be complete and signed;
- Determine when, and under what conditions the company requires motor vehicle reports, inspection reports, credit reports, Medical Information Bureau (MIB) or other medical physician reports or other underwriting information to confirm exposure or premium basis;
- Determine if the file contains the necessary information to support the classification, rating and selection decision made; and
- Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable statutes, rules and regulations.

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state’s definition of unfair discrimination.

Determine if the company is following its underwriting guidelines, and that the guidelines conform to applicable statutes, rules and regulations, including, but not limited to:

- The insurer shall obtain one of the following prior to issuance of a policy or certificate to an applicant aged 80 or older:
  - A report of physical examination;
  - An assessment of functional capacity;
  - An attending physician’s statement; or
  - Copies of medical records.
- All applications for limited long-term care, except policies issued on a guaranteed-issue basis, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant; and
- If an application for limited long-term care coverage contains a question regarding whether the applicant has had medication prescribed by a physician, the company shall also ask the applicant to list the medication.

Determine if the company underwriting guidelines have been filed, where applicable.

Review interoffice memoranda for evidence of anti-competitive behavior, collusive practices or improper replacement tactics.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each office being examined.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination. Companies may not permit discrimination between individuals of the same class and equal health status.

Ensure that underwriting requirements are not applied in an unfairly discriminatory manner.

Review guaranteed-issue criteria to ensure correct handling.

Review policy provisions for skilled nursing care to ensure that no restrictions are placed on the proper level of care; i.e., the company does not provide only skilled nursing care or does not provide more coverage for skilled care in a facility than coverage for lower levels of care.

Verify that the questions on applications are sufficiently clear and applicable to the coverage being requested.

Verify that Medical Information Bureau (MIB) information is not used as the sole basis for an underwriting decision.
Companies may not refuse to insure, continue to insure or limit coverage based on:

- Sex;
- Marital status;
- Race;
- Religion;
- National origin;
- Physical or mental impairment (except where based on sound actuarial principles or actual or reasonably anticipated experience);
- Blindness or partial blindness only* (however, all other conditions, including the underlying cause of the blindness or partial blindness, are subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person); and
- Abuse status.

*Note: Review individual state statutes, rules and regulations that may provide that an insurer may not refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual solely because of blindness or partial blindness.

Many jurisdictions have enacted legislation regarding subjects of abuse. Examiners should be familiar with their statutes, rules and regulations in this area.

Examine new business applications for the required fraud statement.
H. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
STANDARDS
CLAIMS

<table>
<thead>
<tr>
<th>Standard 1</th>
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<tbody>
<tr>
<td>Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.</td>
</tr>
</tbody>
</table>

Apply to:          All limited long-term care products

Priority:          Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- Company claim procedure manuals
- Claim training manuals
- Internal company claim audit reports
- Insured’s requests (if applicable)
- Claim bulletins and procedure manuals
- Company claim forms manual
- Claim files

Others Reviewed

- _________________________________________
- _________________________________________

NAIC Model References

- Insurance Fraud Prevention Model Act (#680)
- Limited Long-Term Care Insurance Model Act (#642)
- Unfair Claims Settlement Practices Act (#900)
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
- Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether standards comply with state statutes. Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner.

Determine if claim handling meets applicable statutes, rules and regulations, including:

- Correct payees and addresses; and
- Correct benefit amounts.
Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

If a claim under a limited long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

- Provide a written explanation of the reasons for the denial; and
- Make available all information directly related to the denial.

Determine if the insurer is in compliance with proper payment of “clean claims,” as defined in applicable state statutes, rules and regulations. Verify that the insurer pays clean claims within 30 business days after receipt of a clean claim. For claims that do not fall within the category of a clean claim, verify that the insurer has sent a written notice acknowledging the date of receipt of the claim and containing one of the following provisions within 30 business days:

- The insurer has declined to pay all or part of the claim and the specific reason(s) for denial; or
- That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

Verify that the insurer has paid clean claims within 30 business days after receipt of all requested additional information, or has sent a written notice that the insurer has declined to pay all or part of the claim within 30 days. The notice should specify the specific reason(s) for denial.

If, upon review of insurer clean claim payment practices, an examiner determines that an insurer has failed to comply with clean claim requirements, verify that the insurer has paid interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after the receipt of the claim or, in the event the insurer has requested additional information, upon receipt of all requested additional information.

Verify that the insurer has included interest payable in any late reimbursement without requiring the individual who filed the original claim to make any additional claim for such interest.

It is an unfair practice to settle, or attempt to settle, a claim on the basis of an application that was materially altered without the consent of the insured.

Confirm that a monthly report is issued to the policyholder whenever limited long-term care benefits are issued through acceleration of death benefit provisions of a life insurance product.

Confirm that mandatory nonforfeiture benefits are offered.

Determine that eligibility for the payment of benefits is based on a deficiency in the ability to perform not more than 3 of the activities of daily living (ADLs) or the presence of cognitive impairment.

Ensure that determination of deficiency is not more restrictive than:

- Requiring the hands-on assistance of another person to perform the prescribed ADLs; and
- For a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

Ensure that licensed or certified professionals, such as physicians, nurses or social workers, perform assessments of ADLs and cognitive impairment.
POLICY IN FORCE STANDARDIZED DATA REQUEST  
Property/Casualty Line of Business  
Inland Marine

Contents: This file should be downloaded from the company system(s) and contain one record for each inland marine policy issued in [applicable state] which was in force at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of inland marine policies in [applicable state] within the scope of the examination.

- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state (s) licensing information to ensure proper producer licensure

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End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.
CLAIMS STANDARDIZED DATA REQUEST
Property & Casualty Line of Business
Inland Marine

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of inland marine claims within the scope of the examination.
- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper adjuster licensure.

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ANTIFRAUD (D) TASK FORCE

Antifraud (D) Task Force Aug. 3, 2020, Minutes................................................................................................................. 9-182
Antifraud (D) Task Force May 20, 2020, Minutes (Attachment One) .................................................................................. 9-185
The Antifraud (D) Task Force met via conference call Aug. 3, 2020. The following Task Force members participated: Trinidad Navarro, Chair (DE); Jillian Froment, Vice Chair, represented by Michelle Brugh Rafeld (OH); Lori K. Wing-Heier represented by Alex Romero (AK); Alan McClain represented by Paul Keller; Ricardo Lara represented by George Mueller (CA); Michael Conway represented by Damion Hughes (CO); Andrew N. Mais represented by Kurt Swan (CT); Dean L Cameron represented by Randel Pipal (ID); Doug Ommen represented by Scott Rupp (IA); Vicki Schmidt represented by Nicole Turner (KS); Sharon P. Clark (KY); James J. Donelon represented by Matthew Stewart (LA); Kathleen A. Birrane represented by Steve Wright (MD); Anita G. Fox represented by Lee McCallister (MI); Steve Kelley represented by Michael Marben (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Chaney represented by John Hornback (MS); Matthew Rosendale represented by Jeannie Keller (MT); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by JR Arnold (ND); Bruce R. Ramge represented by Martin Swanson and Peg Jas (NE); Marlene Caride represented by Richard Besser (NJ); Russell Toal represented by (NM); Barbara D. Richardson represented by Tim Gahn (NV); Glen Mulready represented by Rick Wagnon (OK); Andrew R. Stolfi represented by Stephanie Noren (OR); Kent Sullivan represented by Christopher Davis and Kyson Johnson (TX); Todd E. Kiser represented by Armand Glick (UT); and Scott A. White represented by Mike Beavers (VA). Also participating was David Altmaier represented by Simon Blank (FL).

1. **Adopted its May 20 Minutes**

Mr. Beavers made a motion, seconded by Mr. Mueller, to adopt the Task Force’s May 20 minutes (Attachment One). The motion passed unanimously.

2. **Discussed State Activity Concerning COVID-19**

Commissioner Navarro said the Task Force has continued to collaborate with the states, industry and antifraud organizations to monitor potential insurance fraud resulting from the COVID-19 pandemic. He said the Task Force met May 20 and took the following action: 1) discussed the COVID-19 pandemic; and 2) heard updates from California, Delaware, Florida, Ohio and antifraud organizations—the Coalition Against Insurance Fraud (CAIF) and the National Insurance Crime Bureau (NICB). He said during this meeting the Task Force will hear updates from California, Florida, Texas, the CAIF and the NICB.

   a. **California DOI**

Mr. Mueller said the California Department of Insurance (DOI) has reached out to 58 counties regarding the COVID-19 pandemic. He said the DOI has sent mailings to approximately 88 contacts in those counties to assist with promoting awareness on potential insurance fraud due to COVID-19. He said these alerts address possible threats of fraudsters scamming the public with different types of fraud, including email phishing. These alerts were sent out in English and Spanish formats to hit a wider range of the public. Mr. Mueller said the DOI’s communications department has been using Twitter and Instagram for social media distribution, which has helped widen its audience. He said the DOI has also used local newspapers to help educate the public. He said the DOI has used the CAIF info-graphic tools on the California website, and it has received great feedback. He said the DOI has put a lot of focus on small businesses, with the purpose to educate them on potential fraud. He said the DOI has utilized public forums to bring awareness, and it has even been on the Dr. Phil show to discuss potential fraud that may be experienced during the pandemic. He said the DOI will continue to monitor fraud trends and bring awareness to the public.

   b. **Texas DOI**

Mr. Johnson said the Texas DOI has made big steps towards public outreach to both consumers and industry. He said the Texas DOI website has been made into a robust source of information concerning potential insurance fraud from COVID-19. He said the DOI has also utilized social media to help educate the public as much as possible about possible fraud schemes.

Mr. Johnson said the DOI has not received many insurance fraud referrals specific to COVID. He said since February, there have been approximately 50 fraud referrals that could be directly related to COVID-19. He said overall, the insurance fraud trends to date have been tracking along about the same as previous years.
c. Florida Office of Insurance Regulation

Mr. Blank said the Florida DOI has seen a decrease in fraud during the COVID-19 pandemic. He said if anything, the past six months have remained consistent with the types of fraud referrals it is receiving; it has just been at a lower rate. He said some of the types of fraud the DOI is witnessing are workers’ compensation and other injuries due to the restrictions of staying at home brought on by COVID-19. He said the DOI has also seen a 25% decrease in health care fraud. He said the expectation was that fraud would increase, but at this time, the DOI is seeing the opposite. He said regarding the fraud that the DOI is beginning to watch more closely, there seems to be a parallel between COVID-19 and substance abuse treatments. The DOI is tracking this area for additional action to be take. Mr. Blank said the DOI is working with partners in the federal arena to continue with cases and arrests. He said the DOI will continue monitoring, and it will be waiting to see how COVID-19 will affect the state in the long term. He said the DOI will continue to collaborate with the Task Force and share any new trends that come about in the future.

d. CAIF

Matthew J. Smith (CAIF) said from what the CAIF has been tracking, all indications show that the insurance fraud cases have remained consistent as in previous years. He said this could be due to a lag in reporting that has been brought on by COVID-19. He said the CAIF is monitoring the fraud trends to see what the long term will bring. He said the CAIF has been reviewing the current pandemic compared to the Great Recession. During this time, there was a significant spike in insurance fraud due to the recession, and that data indicates that we will see the same due to the economic decline caused by COVID-19. Mr. Smith said the CAIF will be rolling out a survey to the fraud directors in effort to collect data from the states concerning fraud during the COVID-19 pandemic. The survey will be issued out to the states’ fraud directors in September, and then the CAIF will follow up six months later. Mr. Smith said the information collected will be confidential and not public information. He said the CAIF is tracking the ability to use artificial intelligence (AI) to track fraud occurrences during the pandemic, and the survey will also collect this information.

3. Received an Update from the Antifraud Education Enhancement (D) Working Group

Ms. Rafeld said during the month of June, with the assistance of Nationwide’s SIU Major Case Director, Steve Bodge, the Antifraud Education Enhancement (D) Working Group updated and finalized the content of the Private Sector Field Safety Course. The webinar will take place Aug. 26. Ms. Rafeld said in addition to the Private Sector Field Safety Course, fraud directors from California, Delaware, Ohio, Oklahoma, Nevada and Utah met via conference call on several occasions over the past two months to revise and finalize the content of the NAIC’s Investigator Safety Training program. The program was initially offered years ago, then it was incorporated as part of the Basic Fraud Investigations Course offered by the NAIC. Ms. Rafeld said the Working Group felt it would be beneficial to offer the course in 2020. The course has been updated to touch on significant safety issues, especially regarding COVID-19. The Working Group believes the new content incorporated into the program will be beneficial to all investigative staff members, regardless of the number of years they have been investigating agent misconduct and insurance fraud. The NAIC Investigator Safety Training Program will be held Sept. 30 at a time to be determined in the future. The Working Group will make sure all members of the Task Force receive the training announcement once it is published by the NAIC Education & Training Department. Ms. Rafeld said the Working Group is also looking to schedule additional investigative courses that would benefit both state and private industry investigators.

4. Received an Update from the Antifraud Technology (D) Working Group

Mr. Glick said the Antifraud Technology (D) Working Group has two projects it has been working on or monitoring. The first is the Online Fraud Reporting System (OFRS) Redesign Project being worked on by NAIC staff. Mr. Glick said the NAIC is finalizing the conversion of the existing system over to the new platform. When finished, the OFRS will be on a new platform with its current level of functionality. Mr. Glick said the Working Group will then have the opportunity to present changes and enhancements to the platform to add increased functionality in the future. He said the NAIC is planning a demo for the new platform at the NAIC Insurance Summit in September. He said the second project is the creation of a single point online repository for insurers to submit their antifraud plans to each state. The Working Group previously decided that it made sense to first evaluate the existing 2011 Antifraud Plan Guideline (#1690) to determine if updates are necessary. Mr. Glick said he, Ms. Rafeld and NAIC staff have been working with a small group of fraud directors to complete a draft revising Guideline #1690. Mr. Glick said the focus has been to reorganize the guideline into a more intuitive order, to eliminate repetitive requirements within the existing guidelines, and add suggestions that will better meet existing requirements for nearly all states. He said they have also tried to incorporate suggestions from industry and other interested parties into these guidelines. The intent of the revision was to not only update the guidelines, but to also better enable the future creation of electronic submission
data fields that insurers can fill out as part of their submission of antifraud plans when the repository is created. Mr. Glick said the draft will be sent out for review, and a comment period will be set for the members to submit their suggestions.

5. Heard Reports from Antifraud Organizations Concerning Insurance Fraud Related to COVID-19

a. CAIF

Mr. Smith said things continue to go well with the CAIF. He said Jim Quiggle, Senior Communications Director, will be retiring, and the CAIF has hired Arinze Ifekauche to step in as the new Communications Director. Mr. Smith said the CAIF has been monitoring state activity, and to date, there have been 26 laws that have passed. He said compared to previous years, that is much lower; however, there is still movement in the right direction. He said, as he mentioned previously, the CAIF will be issuing a survey out to the states that tracks fraud, including the use of AI to fight insurance fraud. This survey will be issued out to fraud directors in September, and additional follow up will take place six months later. Mr. Smith said the legal affairs is working on developing a model act based on the California and Illinois False Claims Acts. The work on this has just started, so it will be next year before it is completed; however, the CAIF welcomes any input from the state fraud directors. Mr. Smith said the CAIF has also been monitoring work by the National Council of Insurance Legislators (NCOIL) to update a model concerning health care sharing ministries (HCSMs). This would subject the same standards that states have in place with health care sharing. Mr. Smith said lastly, he would like to encourage all states to join the CAIF; membership is free, and all the CAIF’s resources would be available for states to utilize.

b. NICB

Alan Haskins (NICB) said the NICB has been monitoring the questionable claims that are coming in, and it is seeing that there is a potential delay for the claims to be filed or potentially not filed at all. He said due to the current nationwide situation with the pandemic, many claims will be paid through the normal insurance process, then they will later be identified as a COVID-19 related claim. He said the NICB is seeing fraudulent activity in the form of organized crime, specific attacks on the elderly regarding identity theft, chiropractic treatment claims, and fraudulent testing sites. He said there has also been a rise on property and auto types of claims, especially with towing and autobody shops. He said towing and autobody shops are charging extra for sanitization of the vehicles due to COVID-19. In addition, due to the economic hardships, which may prohibit some people to make car loan payments, they are seeing a rise in car owner arson. Mr. Haskins said due to the pandemic, the NICB’s National Insurance Crime Training Academy (NICTA), has gone 100% virtual and has fraud courses available. He said moving into the next year, the NICB’s legislative priority will be to assist the states on many fronts, including potential budget cuts in some states due to the pandemic. He said some of the budget cuts may affect state prosecutors, and the NICB will assist to make sure that these areas have the proper funding to continue fighting insurance fraud.

Having no further business, the Antifraud (D) Task Force adjourned.
The Antifraud (D) Task Force met via conference call May 20, 2020. The following Task Force members participated: Trinidad Navarro, Chair (DE); Jillian Froment, Vice Chair, represented by Michelle Brugh Rafeld (OH); Lori K. Wing-Heier represented by Alex Romero (AK); Ricardo Lara represented by George Mueller (CA); Michael Conway represented by Damion Hughes (CO); Andrew N. Mais represented by Kurt Swan (CT); Karinn M. Woods represented by Phil Comstock (DC); John F. King (GA); Vicki Schmidt represented by Dennis Jones (KS); Sharon P. Clark represented by Juan Garrett (KY); Sharon P. Clark represented by Matthew Stewart (LA); Anita G. Fox represented by Lee McCallister (MI); Mike Causey represented by Marty Sumner (NC); Jon Godfread represented by Dale Pittman (ND); Bruce R. Ramge represented by Martin Swanson (NE); Marlene Caride represented by Richard Besser (NJ); Russell Toal and Roberta Baca (NM); Barbara D. Richardson (NV); Eileen Mulready represented by Ron Kreiter (OK); Andrew R. Stolfi represented by Stephanie Noren (OR); Kent Sullivan represented by Leah Gillum and Chris Davis (TX); Todd E. Kiser represented by Armand Glick (UT); and Scott A. White represented by Mike Beavers (VA). Also participating were: Frank Pyle (DE); David Altmaier represented by Evangelina Brooks (FL); and Colin M. Hayashida (HI).

1. **Adopted its 2019 Fall National Meeting Minutes**

Commissioner Richardson made a motion, seconded by Ms. Rafeld, to adopt the Task Force’s Dec. 8, 2019, minutes (see NAIC Proceedings – Fall 2019, Antifraud (D) Task Force). The motion passed unanimously.

2. **Heard Reports from State Fraud Departments Concerning Insurance Fraud Related to COVID-19**

Commissioner Navarro said the Task Force has continued to collaborate with the states, industry and antifraud organizations to monitor potential insurance fraud resulting from the COVID-19 pandemic. He advised that to assist with bringing awareness to insurance fraud, the Task Force has asked the states’ fraud directors and antifraud organizations to provide an update on what they are experiencing.

   a. **California DOI**

Mr. Mueller said the California Department of Insurance (DOI) has been seeing an uptick in insurance fraud claims this quarter compared to previous quarters. He said the DOI currently has an outreach unit, which includes its communication division devoted to insurance fraud related to COVID-19. He said the DOI has contacted its network partners with the California low cost auto program to assist with insurance fraud awareness. The DOI has telephoned 480 community base organizations to bring awareness. Mr. Mueller said the biggest issue the DOI is seeing is with small businesses, and it has formed special outreach teams to assist in this area. He said the DOI conducted a tele-townhall to assist small businesses, which had approximately 1,500 people attend to receive education. He said the DOI has used the Coalition Against Insurance Fraud (CAIF) info-graphic tools to be used on the California website, and it has received great feedback. He said the DOI has also completed a senior fraud outreach for over 1,000 organizations, providing a town hall meeting to provide education. He said this outreach for senior fraud was completed through email and regular mail, which provided to be very successful.

   b. **Delaware DOI**

Mr. Pyle said Delaware has been partnering with federal and state law enforcement, the U.S. Attorney’s Office, the Federal Bureau of Investigation (FBI), and many others to assist with the fight against insurance fraud concerning COVID-19. He said the Delaware DOI created a COVID-19 Antifraud Coalition, which has been invaluable, with many more resources available than other areas. He said the DOI has seen a slight uptick in insurance fraud cases, but nothing specific to COVID-19. He said there are no trends at this time, but the DOI has experienced some cases, including bogus robocalls focused on seniors attempting to get themselves signed up for bogus health plans and bogus assistance offered for individuals that are out of work because of COVID-19. He said Delaware is preparing for upcoming scams concerning fake vaccines for COVID-19. He said there has been some cases that he is aware of concerning the rise in new family pet scams. Due to the rise in families getting new pets because of everyone being stuck at home, these scammers will post potential pets available, request a deposit, and...
then the pet is never delivered. He said Delaware will continue monitoring this, as they expect to see more insurance fraud cases relating to COVID-19 in the future.

c. Ohio DOI

Ms. Rafeld said shortly after the pandemic began, Ohio issued a consumer alert warning consumers about all the various scams resulting from COVID-19. She said the Ohio DOI worked with its communications department to get this alert out through social media and local press. She said the DOI has also worked with senior groups to aid with conducting educational events. She said a call was scheduled with the Ohio industry special investigation units to hear what the industry is witnessing and what can be done to assist with collaboration throughout the state. She said the biggest item the DOI have been witnessing concerning COVID-19 is body shop scams. Body shops have been listing additional cleaning fees for vehicles due to COVID-19. She said some body shops are contracting with towing companies to commit a scam, claiming that a vehicle is being inspected for COVID-19 exposure; this vehicle is then towed even when drivable, which creates an additional expense to the consumer. She said the DOI is working with state and federal organizations to assist on these cases. She said the DOI is also witnessing private chiropractor practices providing COVID-19 prevention methods. She said Ohio is instituting COVID-19 safety precautions for their investigators in the field. She said due to the courts being temporarily closed and prosecutors stuck working from home, the DOI is making efforts to work with these prosecutors regarding potential cases taken to court once reopened.

d. Florida Office of Insurance Regulation

Ms. Brooks said the Florida DOI, as of this morning, received a report that there is a small uptick in COVID-19 cases. She said this could be due to many things, including an increase in testing. She said Florida is seeing some of the same issues as other states. She said the DOI has been tracking insurance fraud specific to COVID-19 since January, but it has seen no specific trends at this time. She said Florida has been discussing the liability for homeowner claims from individuals providing service to someone’s home and claiming that they have contracted COVID-19. She said the DOI is expecting to see personal injury claims on behalf of employees claiming that their employer has not provided proper precautions to protect against COVID-19. She said while the DOI is continuing to monitor all fraud at this time, it is not seeing an uptick in insurance fraud specific to COVID-19.

3. Heard Reports from Antifraud Organizations Concerning Insurance Fraud Related to COVID-19

a. CAIF

Matthew J. Smith (CAIF) said from what the CAIF has been seeing, it looks as though COVID-19 will be the largest spike in insurance fraud in history. He said the CAIF is comparing the pandemic to what was witnessed during the great recession. He said the economic downturn will result in a spike in insurance fraud throughout the country. He said COVID-19 has been considered a worldwide natural disaster that will bring higher than normal cases of insurance fraud. He said the CAIF research found from Google that there was a 125% increase in people searching how to commit arson.

Mr. Smith said during the initial stage of the pandemic, the CAIF partnered with the National Insurance Crime Bureau (NICB) and the International Association of Special Investigation Units (IASIU) to provide a webinar concerning COVID-19. The webinar had approximately 3,000 attendees, which was the largest gathering of antifraud fighters in history. Mr. Smith said COVID-19 has had an impact around the world, and the CAIF has taken part with its international partners to provide 10–12 webinars specific to the pandemic. In addition, the CAIF has partnered with the American Association of Retired Persons (AARP) to fight insurance fraud against the elderly. Mr. Smith said the states have been utilizing the CAIF’s info-graphic tool kit to bring awareness to insurance fraud.

Mr. Smith said the mid-year meeting scheduled for June has been cancelled due to the pandemic, but the CAIF plans to hold the end of year meeting in December as scheduled. He said the CAIF will be conducting a study on artificial intelligence (AI), specifically how companies are using AI to fight COVID-19 insurance fraud.

b. NICB

Alan Haskins (NICB) said the NICB launched an COVID-19 resource center immediately following the pandemic shut down. He said the NICB coordinated with state and trade national fraud groups during the shutdown. He said the NICB has started seeing states like New Jersey and Nevada put together state and federal task forces to investigate insurance fraud due to COVID-19. He said some of the fraudulent claims are unlawful hoarding of medical supplies, price gouging, phishing schemes, and
fake investment opportunities. He said the NICB has been working with the Las Vegas Metro Police Department concerning an increase in vehicle break-ins, specifically against doctors and medical professionals while their car is in parking lot at work. He said thieves are taking information from these cars to locate the individuals’ home addresses and burglarize their homes. He said the NICB has been offering a virtual pandemic safety training course, which is available on its webpage. He said the NICB is holding monthly National Dialog Meetings on COVID-19 concerning fraud claims and insurance fraud trends. He said overall, the NICB has seen a 9% increase in questionable claims, including burglarized vehicles and homes, homeowner claims, and work comprehensive. He said the NICB has witnessed towing and storage claims like what Ms. Rafeld stated that Ohio is experiencing. He said the NICB has also seen tele-medicine schemes, physical therapy, and chiropractor service schemes. Lastly, he said the NICB Geospatial Intelligence Center (GIC), which is its insurance industry global energy provider, has continued to be utilized after natural disasters.

c. **NHCAA**

Leigh McKenna (National Healthcare Antifraud Association—NHCAA) said the NHCAA focuses primarily on education and training regarding health care fraud and the sharing of information. She said one of the NHCAA’s key education and trainings, the annual program focusing on novice fraud investigators, has had to be moved to December due to the pandemic. She said a few of the NHCAA’s educational programs have been moved to a virtual format because of the pandemic. She said the NHCAA’s large annual conference that takes place in November is undetermined at this time as to whether it will be virtual or in-person. She said this conference typically brings 1,300–1,500 health care fraud investigators. She said the NHCAA has been holding monthly information sharing calls for its members and providing webinars for education and information sharing. She said the NHCAA is also holding weekly board member meetings to discuss what is being seen specific to COVID-19. She said the NHCAA has pulled together several valuable resources, which are available on its webpage. She said most of what the NHCAA is seeing is fraudulent COVID-19 testing, the billing of higher hours by providers, and the improper coding of services due to COVID-19. She said the NHCAA continues to monitor and identify schemes quickly so they can be shut down as soon as possible.

d. **HFPP**

Scott Caspall (Healthcare Fraud Prevention Partnership—HFPP) said the HFPP provides two key items: the data analytics to partners and the facilitation of sharing health care fraud intelligence among the partners of the partnership.

Jacob Gray (HFPP) said the HFPP is seeing an increase in health care data, which will add value at the state and federal level. He said the HFPP has increased its support for law enforcement departments, and it has partnered with academic institutions like Stanford to provide useful whitepapers. He said the HFPP has seen a lot of billing for COVID-19, specifically for testing. He said the HFPP ais monitoring known compromised numbers from Medicare and Medicaid, along with stolen identity information, which is used for improper billing. He said the HFPP will be monitoring new providers that are created due to COVID-19.

Having no further business, the Antifraud (D) Task Force adjourned.
The Market Information Systems (D) Task Force met via conference call Aug. 4, 2020. The following Task Force members participated: Lori K. Wing-Heier, Chair (AK); Chlora Lindley-Myers, Vice Chair (MO); Alan McClain represented by Crystal Phelps (AR); Elizabeth Perri (AS); Evan G. Daniels represented by Maria Ailor (AZ); Ricardo Lara represented by Don McKinley and Pam O’Connell (CA); Alan Conway represented by Damion Hughes (CO); Trinidad Navarro represented by Frank Pyle (DE); Doug Ommen (IA); Robert H. Muriel represented by Erica Weyhenmeyer (IL); Vicki Schmidt represented by Tate Flott (KS); Sharon P. Clark represented by Russell Hamblen (KY); Michael Conway represented by Johnny Palsgraaf (ND); Steve Kelley represented by Matthew Vatter (MN); Jon Godfread represented by Jeff Zewe (LA); Marlene Caride represented by Ralph Boeckman (NJ); Barbara D. Richardson represented by Nick Stosic (NV); Jillian Froment represented by Robert Stroup (OH); Kent Sullivan represented by Rachel Cloyd (OK); James A. Dodrill (WV). Also participating: Brent Kabler (MO); and Larry Wertel (NY).

1. **Adopted its 2019 Fall National Meeting Minutes**

   Mr. Haworth made a motion, seconded by Director Lindley-Myers, to adopt the Task Force’s Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Market Information Systems (D) Task Force). The motion passed unanimously.


   Mr. Kabler said the Working Group met July 22 and July 8. These meetings were held in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings.

   Mr. Kabler said the Working Group heard an update on the request to implement the Market Actions Tracking System (MATS) web service in State Based Systems (SBS). He said the requirements for this request have been defined and approved by the interested states. He said this will allow users to open and update actions in the MATS. SBS is in the beginning stages of development.

   Mr. Kabler said the Working Group approved two USER forms to add a subject code of “pandemic” and three coverage codes of “business interruption,” “lender-placed insurance,” and “pet insurance” in the Complaints Database System (CDS). He said the Working Group also approved the USER form to update the Regulatory Information Retrieval System (RIRS) to display data retention policies and terminology related to action dates.

   Mr. Kabler said the Working Group is reviewing the detailed analysis of a USER form to add previously eliminated reason codes in the CDS. The reason codes are to assist in meeting federal reporting requirements under the federal Affordable Care Act (ACA).

   Mr. Kabler said the Working Group is continuing to review RIRS codes through the RIRS Code Review Working Group. The subject matter expert (SME) group is updating its original proposal to address questions from the Working Group.

   Finally, Mr. Kabler said the Working Group began its review of the 2019 MIS Data Analysis Metrics results.

3. **Heard a Report on Outstanding USER Forms**

   Director Wing-Heier said one of the Working Group’s charges is to serve as the business partner to review and prioritize submitted USER forms to ensure an efficient use of available NAIC staffing and resources. She said during the 2019 Summer National Meeting, some concern was expressed about the number of USER forms that have not progressed in the last few years. The Task Force requested that the Working Group take a closer look at the prioritization list to determine which projects should be re-prioritized and identify USER forms that are not active.
Director Wing-Heier said the USER form report has now been split into three major sections: 1) Active USER Forms; 2) USER Forms Being Addressed by State Ahead Project; and 3) USER Forms Pending Detailed Analysis. She said the last section consists of those USER form projects that have not yet begun but that the Working Group would like to keep on the report, so the Working Group does not lose track of them. These USER forms are still important, but they have been prioritized lower than those above them on the report.

Director Wing-Heier said the report on USER forms is informational, but the Task Force will consider adoption of two USER forms concerning CDS coding.

Ginny Ewing (NAIC) said USER form 10051 is a request to implement the MATS web service in SBS. She said when the MATS was developed, services were created that could be used by state back office systems to update the MATS. She said this request eliminates the need for states to dual enter data in back office system as well as the MATS. She said the SBS team worked with interested states to define requirements, and it is currently in the process of implementing the first phase, which will allow users to open an action in SBS and send updates to the MATS.

Ms. Ewing said USER form 10053 is a request to enhance the RIRS. She said the RIRS SME group has reviewed comments received after the Working Group’s review of its proposed changes, and the SME group is planning to submit an updated proposal for the Working Group to consider later this month.

Ms. Ewing said USER form 10069A is a request to enhance CDS codes. She said it requests adding previously eliminated reason and disposition codes and adding new reason codes. She said the results of a detailed analysis were reviewed during the Working Group’s last call, and it will be considered during its next meeting on Aug. 27.

Ms. Ewing said USER form 10080 is a request to update RIRS to provide data retention policies and terminology related to action dates. She said the request includes seven components to provide clarity around the states’ regulatory action data in the RIRS. She said two of those components are related to data definitions and will be assisted by the RIRS SME group, and three components are complete. The completed components are: 1) adding the RIRS Data Retention Policy to iSite+; 2) adding an explanation of the RIRS Custody Date to iSite+; and 3) renaming the “Regulatory Systems Participating State Report” to the “RIRS Participating State Report.”

Ms. Ewing said USER form 10072 is a request to allow companies to file new Market Conduct Annual Statement (MCAS) submissions for prior years. She said the request was completed and released in the first quarter of 2020.

4. **Adopted USER Form 10069B and USER Form 10082**

Ms. Ewing said USER form 10069B is a request to add CDS coverage codes for: 1) Lender-Placed Insurance, consisting of Automobile 2nd Level coverage codes for Lender-Placed, Single Interest and Dual Interest; and Homeowner 2nd Level Coverage codes for Lender-Placed, Dual Interest and Hazard; and 2) Pet Insurance, consisting of a miscellaneous coverage code for Pet Insurance. She said the Lender-Placed Insurance codes will allow for better tracking of complaints specific to lender placed insurance on both auto and homeowners that will align with MCAS data reporting. She said it will also allow for the removal of the MCAS data element that companies must report insurance department complaints. She said the Pet Insurance code will allow for more accurate tracking of Pet Insurance complaints. She said the recommended codes are clearly defined, not duplicative of existing codes, and they will add value. She said states’ back office systems used to collect complaint data will need to be updated to include the new codes. She said testing will be coordinated with SBS and Sircon. She noted that iSite+ and Consumer Insurance Search (CIS) reports are easily updated via metadata. She said the scope of this project includes updates to the CDS in coordination with state back office systems to include the new codes. The level of effort is between 40 hours and 120 hours.

Ms. Ewing said USER form 10082 is a request to add new CDS codes for “business interruption” and “pandemic.” She said the new codes will allow the states to track complaints related to pandemic events, such as COVID-19, and the tracking of complaints related to business interruption, which is a critical coverage in a catastrophic event. She said the “pandemic” code would be added as a subject code that allows tracking complaints related to a specific condition, which leads to a reason for the complaint. She said CDS is currently capturing subject codes; however, it is not displaying them anywhere. The current CDS reports need to be reviewed to determine where subject code can should be added. Ms. Ewing said the states’ back office systems will need to be updated to include the new codes, and NAIC staff will coordinate testing with the vendors.
A new CDS Tableau dashboard is being developed, and it is scheduled to be made available to state insurance regulators this quarter. Since it uses the current metadata, when a new type of coverage code is added, it will be available in the dashboard. Ms. Ewing said the “business interruption” code will be added as a miscellaneous coverage code.

Ms. Ewing said the scope for adding “pandemic” and “business interruption” includes updates to the CDS in coordination with state back office systems to include the new codes and determining what CDS reports and dashboards to update. She said the level of effort is between 40 and 120 hours.

Mr. Flott made a motion, seconded by Director Lindley-Myers, to adopt USER form 10069B (Attachment One) and USER form 10082 (Attachment Two). The motion passed unanimously.

5. **Heard a Presentation on the Use of AI in MIS**

Birny Birnbaum (Center for Economic Justice—CEJ) gave a presentation regarding artificial intelligence (AI), how it used by insurers, the requirements for AI to be effective, and how AI can be used in market regulation. He clarified the distinction between AI and machine learning, noting that AI uses algorithms to mimic human functions, and machine learning takes AI a step further by enabling machines to change the algorithms as they gain more information. He said AI is dependent upon massive amounts of data to be effective. The data must be timely, reliable, granular and sufficient. He noted the current data within NAIC systems is not timely, granular or sufficient enough to be effective in developing algorithms for AI. He outlined two options for using AI in market regulation. One option is to build AI tools for the existing systems, with each AI tool designed to meet a specific purpose. The second option is to determine what the desired outcomes and functionality are and then determine what data is needed to build AI tools to accomplish the functionality.

Having no further business, the Market Information Systems (D) Task Force adjourned.
Complaint Database System (CDS)
Add Codes for LPI and Pet Insurance
Detail Analysis for Request 10069B

Request:

<table>
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<th>ID</th>
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<th>Requestor</th>
<th>Request</th>
<th>NAIC Recommendation</th>
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<td>7/12/2017</td>
<td>Jo LeDuc WI</td>
<td>New CDS Type of Coverage Codes for lender placed insurance and pet insurance.</td>
<td>Proceed to Development</td>
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1) New Lender Placed MCAS Statement is slated to collect data for Lender-Placed insurance for the following eight coverage types:
   - Single-Interest Lender-Placed Auto
   - Dual-Interest Lender-Placed Auto
   - Single-Interest Lender-Placed Homeowners Hazard
   - Dual-Interest Lender-Placed Homeowners Hazard
   - Single-Interest Lender-Placed Homeowners Flood
   - Dual-Interest Lender-Placed Homeowners Flood
   - Single-Interest Lender-Placed Homeowners Wind-Only
   - Dual-Interest Lender-Placed Homeowners Wind-Only

   Recommending the following second level coverage codes be added to allow for complaints to be tracked in a fashion that aligns to the new MCAS statement:

   **Auto (Second Level Coverages):**
   - Lender Placed
   - Single Interest
   - Dual-Interest

   **Homeowners (Second Level Coverages):**
   - Lender Placed
   - Dual-Interest
   - Hazard

2) Recommend adding the following new first level coverage code help states track pet insurance complaints:

   **Miscellaneous (First Level Coverage)**
   - Pet Insurance
Benefits:
Allow for better tracking of complaints specific to lender placed insurance on both auto
and homeowners that will align better with the new MCAS statement, which will also
allow for the removal of the data element whereby companies must report the insurance
department complaints received during the reporting period.

Also allow for more accurate tracking of Pet Insurance complaints.

Preliminary Analysis
(Completed on 7/2/2020 by Brian Whittall)

Preliminary Findings:
- Requested codes can be added to CDS metadata for capture and presentation.

Preliminary Considerations:
- The project size for this request is expected to be medium.
- Outstanding open USER Forms requesting updates to CDS codes (10069A and 10082) could be
  worked concurrently with this request.

Preliminary NAIC Staff Recommendation:
NAIC staff recommends moving forward to detailed analysis.

Detailed Analysis
(Completed on 7/2/2020 by Brian Whittall)

Detailed Analysis Findings:
1) Lender Placed Insurance - Adding the following second level coverage codes will allow for
complaints to be tracked in a fashion that aligns to the new MCAS statement:

Auto (Second Level Coverages):
- Lender Placed
- Single Interest
- Dual-Interest

Homeowners (Second Level Coverages):
- Lender Placed
- Dual-Interest
- Hazard
Auto Coding Explanation
Lender-placed auto insurance complaints would be coded under the appropriate 1st level auto coverage. In addition, the second level coverage code of Lender Placed would be selected. If more detailed information about the contract type is known, the appropriate addition second level coverage code would also be selected.

Auto complaint coding examples:
1. Complaints involving lender placed coverage for a private passenger automobile where it is not known whether it is a single or dual interest contract would be coded as:
   - First Level Coverage Auto
   - Second Level Coverage Lender Placed
2. Complaints involving single-interest lender placed coverage for a private passenger automobile would be coded as:
   - First Level Coverage Auto
   - Second Level Coverage Lender Placed
   - Single Interest
3. Complaints involving dual-interest lender placed coverage for a private passenger automobile would be coded as:
   - First Level Coverage Auto
   - Second Level Coverage Lender Placed
   - Dual Interest

Homeowners Coding Explanation
The following second level coverages for homeowners already exist, so they do not need to be added at this time:
   - Flood
   - Single-Interest
   - Windstorm
Like lender-placed auto insurance complaints, homeowners complaints would be coded under the appropriate 1st level homeowners coverage. In addition, the second level coverage code of Lender Placed would be selected. If more detailed information about the contract is known, the appropriate addition second level coverage code(s) would also be selected.

Homeowners complaint coding examples:
1. Complaints involving lender placed coverage for a homeowners where additional information about the contract is not known would be coded as:
   - First Level Coverage Homeowners
   - Second Level Coverage Lender Placed
2. Complaints involving lender placed single-interest flood coverage for a homeowners would be coded as:
   - First Level Coverage Homeowners
   - Second Level Coverage Lender Placed
3. Complaints involving lender placed hazard coverage for a homeowners but the type of contract (dual vs. single interest) is not known would be coded as:
   - First Level Coverage Homeowners
   - Second Level Coverage Lender Placed
   - Hazard

2) Pet Insurance - Adding a Miscellaneous code for Pet Insurance will help states track pet insurance complaints.

Detailed Analysis Considerations:

1. Recommended Codes
   The recommended codes are clearly defined, not duplicative of existing codes, and would add value for regulators.

2. State Implementation
   States’ back office systems will need to include the requested codes to allow for their submission to the NAIC with each closed complaint. States will need to work with their back-office systems vendor to ensure inclusion of these codes.

3. Reports
   Once added to the NAIC metadata, current CDS reports in iSite+ and in CIS (Consumer Insurance Search) will automatically display the new codes.

4. Other CDS USER Forms
   USER Forms 10069A and 10082 both request additions to complaint codes. USER Form 10069A needs more information regarding (1) the definitions of requested codes and (2) reasons why they should be added back when they were approved for removal by the D Committee in 2008. USER Form 10082 is being submitted with an NAIC staff recommendation to proceed to Development. Should these USER forms be included in the timeline for this USER form?

Scope:
   The scope of this project includes the Complaints Database System, coordination with state back office systems to include the new codes.

Project Size:
   Level of Effort for this request is Medium.
NAIC Staff Recommendation:
NAIC staff recommends moving forward to development as noted:
- Add second level coverage codes for Lender Placed, Single Interest and Dual-Interest to Auto.
- Add second level coverage codes for Lender Placed, Dual-Interest and Hazard to Homeowners.
- Add Miscellaneous type of coverage for Pet Insurance.
- Address USER form 10082 concurrently with this request.

An updated Complaints form, which reflects these recommendations, is attached.
Complaints Database System (CDS)
Add Pandemic Code and Business Interruption Code
Detailed Analysis for Request 10082

Request:

<table>
<thead>
<tr>
<th>ID</th>
<th>Date Received</th>
<th>Requestor</th>
<th>Request</th>
<th>NAIC Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>10082</td>
<td>6/23/2020</td>
<td>Randy Helder</td>
<td>Add Pandemic and Business Interruption codes for complaint tracking and reporting</td>
<td>Proceed to Development</td>
</tr>
</tbody>
</table>

Request Description:
This Request is to add a second level coverage code of Business Interruption to Fire, Allied and CMP or as Miscellaneous coverage.

Track how many complaints state regulators submit to the NAIC due to a “Pandemic.” The “Pandemic” is not a reason but is perhaps a root cause and should be tracked.

Benefits:
This request will allow jurisdictions to track complaints related to pandemic events such as the COVID-19 pandemic. Additionally, in a catastrophic event, business interruption is a critical coverage and may generate many complaints. This request will allow jurisdictions to track business interruption complaints. NAIC will be able to capture and present this information to users of CDS.

Preliminary Analysis
(Completed on 7/2/2020 by Brian Whittall)

Preliminary Findings:
- Requested codes can be added to CDS metadata for capture and presentation.
- Subject Codes are currently captured but not presented. NAIC reports will need to be updated to display Subject codes.

Preliminary Considerations:
- The project size for this request is expected to be medium.
- Outstanding open USER Forms requesting updates to CDS codes (10069A and 10069B) could be worked concurrently with this request.

Preliminary NAIC Staff Recommendation:
NAIC staff recommends moving forward to detailed analysis.
Detailed Analysis Findings:

1. The Complaint Handling and Reporting Standards (D) Working Group, which was formed at NAIC’s 2006 Spring National Meeting, was charged to create uniformity in complaint handling and reporting. (The Group has since dissolved.) In December 2008, the Market Regulation and Consumer Affairs (D) Committee adopted a timeline for implementation of the Working Group’s proposed complaint coding scheme. This scheme included the addition of a subject code to properly track complaint themes and to prevent using reason codes for this purpose. An excerpt from the “CDS Definitions and Basics” document, which was adopted by the D Committee on June 16, 2009, provides additional historic information:

“Prior to the revision, there were 118 Reason codes in the CDS database. The group recommended dropping 43 of these codes as duplicative, unneeded (based on NAIC utilization data), or inappropriate as they did not constitute a “reason” for a complaint but rather identified a subject area of a complaint.

The “reason” for a complaint is the action, or inaction, an insurance entity took which caused the consumer to seek redress. The subject area of the complaint may be a specific condition which led to the “reason.” For example, the proliferation of mold-related complaints led to the inclusion of “mold” as a reason code. However, consumers do not file complaints because of mold per se; rather, they file complaints based on their policy coverage (or lack thereof) for mold remediation, the handling of their mold claims, etc. The action the company took in regard to the consumer’s claim, i.e. denial, delay, unsatisfactory settlement offer, etc. is the “reason” while the “subject” is mold.

Creation of this new “subject” field will permit regulators to track issues of interest such as mold without improperly using a “reason” code to do so.”

2. Although regulators may include a subject code with the submission of closed complaints to the NAIC, and the subject code is captured in the NAIC’s State Producer Licensing Database, that code is not currently displayed in any CDS reports in iSite+ or in CIS (the Consumer Insurance Search) web site.

3. Since subject code was introduced, the following codes have been available for regulators to select when they close a complaint and submit it to the NAIC. There are currently 8 subject codes. However, all subject codes allow users to include free-form text (subject description) to better describe the code being used. This free-form text is primarily used with the OTH (other) code. The counts of subject codes and descriptions are listed below:

<table>
<thead>
<tr>
<th>SUBJECT ID</th>
<th>SUBJECT ID NAME</th>
<th>SUBJECT DESCRIPTION (Count)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 HUR</td>
<td>Hurricane</td>
<td>(11072)</td>
</tr>
<tr>
<td>2 INT</td>
<td>Internet Related</td>
<td>(1186)</td>
</tr>
<tr>
<td>3 LEA</td>
<td>Lead</td>
<td>(8)</td>
</tr>
<tr>
<td>4 MOL</td>
<td>Mold</td>
<td>(180)</td>
</tr>
<tr>
<td>5 OBS</td>
<td>Obesity</td>
<td>(66)</td>
</tr>
</tbody>
</table>
4. Users of CDS should be aware of restrictions currently in place when determining whether to add a first level coverage in the Miscellaneous category or a second level coverage of Business Interruption in the Fire, Allied Lines & Commercial Multi-Peril (CMP). The restrictions are as follows:
   - Type of Coverage is divided into seven mutually exclusive categories: (1) Auto; (2) Fire, Allied Lines & Commercial Multi-Peril (CMP); (3) Homeowners; (4) Life & Annuity; (5) Accident & Health; (6) Liability; and (7) Miscellaneous.
   - Each complaint may have only one major category.
   - All the major categories, except the “Miscellaneous” category, have subcategories of First Level Coverage (of which only one can be selected) and Second Level Coverage, of which up to three can be selected.

5. With the addition of subject and coverage codes, the requested codes must be added to the CDS metadata (decode tables) in order to capture and present this data. States' back office systems will also need to include the requested codes to allow for their submission to the NAIC with each closed complaint. States will need to work with their back-office system vendor to ensure inclusion of these codes.

6. Current CDS reports in iSite+ and in CIS will automatically display a new Business Interruption code, whether it is a second level coverage code in the Fire, Allied Lines & Commercial Multi-Peril (CMP) coverage type or it is a new coverage in the Miscellaneous coverage type.

7. A new CDS Tableau dashboard is in development and tentatively scheduled for release in 3rd Quarter 2020. This dashboard already includes all types of coverage, first level coverage codes, and second level coverage codes. Therefore, a Business Interruption code would be displayed, based on this request. The dashboard could be modified to include subject code in a future iteration.

Detailed Analysis Considerations:

1. Reports
   As noted, the subject code is not displayed anywhere in CDS, although that data is captured from states with the submission of closed complaints. If the subject code can be presented for display in the new CDS Tableau dashboard, NAIC staff, working with regulators will need to determine which CDS reports in iSite+ and in CIS should also display the subject code. There are currently 5 reports in iSite+ for consideration: Closed Complaints Count by Code, Closed Complaints Count by State, Closed Complaint Trend Report, Closed Complaint Index, and the Closed Complaint Record Detail File. All these reports are company specific. There are currently 3 reports in CIS: Complaint Code, Complaint State, Complaint Trend. The reports will automatically display a Business Interruption code once it is added to the CDS metadata because coverage codes are already included in these reports.

   NAIC staff, working with regulators, will also need to determine if a new CDS Summary Report should be developed so that users of CDS can analyze complaint data at more than a company-specific level. The new CDS Tableau dashboard could also be a consideration for this type of analysis, mitigating the need for a new Summary Report in iSite+.
2. Other CDS USER Forms
   USER Forms 10069A and 10069B both request additions to complaint codes. USER Form 10069A needs
   more information regarding (1) the definitions of requested codes and (2) reasons why they should be added
   back when they were approved for removal by the D Committee in 2008. USER Form 10069B has the
   necessary information to consider adding the requested codes to CDS.

3. Business Interruption Code
   The request to add this code could be completed in 2 different ways:
   - Add Business Interruption as a second level coverage code to the Fire, Allied and CMP type of coverage.
   - Add it as a Miscellaneous type of coverage.

   Adding a Miscellaneous code requires less development work and testing than adding a second level
   coverage code. However, if the Working Group approves USER Form 10069B for development, then adding
   second level coverage codes for that request negates the benefit of only adding a first level coverage code.

4. State Implementation
   States' back-office systems will also need to include the requested codes to allow for their submission to the
   NAIC with each closed complaint. States will need to work with their back-office systems vendors to ensure
   inclusion of these codes.

Scope:
The scope of this project includes the Complaints Database System, coordination with state back office systems to
include the new codes, and determining what CDS reports/dashboards to update and when.

Project Size:
Level of effort for this request is Medium.

NAIC Staff Recommendation:
NAIC staff recommends moving forward to development as noted:
- Add subject code for Pandemic.
- Add Miscellaneous type of coverage for Business Interruption.
- Address USER form 10069B concurrently with this request.
- Defer addressing USER form 10069A until required information is available and further analysis is completed.
- Update the CDS dashboard to display Subject code.
- Submit a new USER form to determine where and how to display Subject code in iSite+ and CIS reports, as
  well as consideration for development of a new CDS Summary report.

An updated Complaints form, which reflects these recommendations, is attached.
PRODUCER LICENSING (D) TASK FORCE

Producer Licensing (D) Task Force Aug. 3, 2020, Minutes ................................................................. 9-202
Producer Licensing (D) Task Force May 6, 2020, Minutes (Attachment One)................................. 9-204
The Producer Licensing (D) Task Force met via conference call Aug. 3, 2020. The following Task Force members participated: Larry D. Deiter, Co-Chair (SD); Elizabeth Kelleher Dwyer, Co-Chair (RI); Lori K. Wing-Heier represented by Chris Murray (AK); Jim L. Ridling (AL); Alan McClain represented by Crystal Phelps (AR); Ricardo Lara represented by Charlene Ferguson (CA); David Altmaier represented by Matt Guy (FL); Doug Ommen represented by Jackie Russo (IA); Vicki Schmidt represented by Nancy Strasburg (KS); Sharon P. Clark (KY); James J. Donelon represented by Patrick Bell (LA); Anita G. Fox represented Michele Riddering (MI); Chlora Lindley-Myers (MO); Mike Kreidler represented by Jeff Baughman (WA); and James A. Dodrill represented by Robert Grishaher (WV). Also participating was: Colleen Draper (NY).

1. **Adopted its May 6 Minutes**

Commissioner Clark made a motion, seconded by Director Lindley-Myers, to adopt the Task Force’s May 6 minutes (Attachment One). The motion passed unanimously.

2. **Discussed Producer Licensing Issues Arising from the COVID-19 Crisis**

Superintendent Dwyer said Washington was the only state offering online, proctored examinations when the pandemic began, and she said the Task Force will receive updates from states, industry representatives and examination vendors on the state implementation of online examinations.

Ms. Draper said New York recently implemented remote testing as a permanent way to deliver examinations. She said New York has administered 4,000 remote exams and remote testing accounts for 60% of examinations administered. She said there has not been a negative impact on pass rates, and remote testing is very helpful to candidates who live in rural areas of the state.

Mr. Baughman said Washington made all examinations available through remote testing on March 1. He said Washington administered over 200 remote exams in March. He said his biggest concern was security, but very few incidents have been identified, such as a candidate having a cell phone or materials in sight, or background communication heard that might indicate that someone is assisting a candidate with answers. He said approximately 60% of Washington’s exams are administered through the remote platform. He said the pass rate in Washington has increased a little with remote testing.

Superintendent Dwyer said Rhode Island will begin offering remote exams on Aug. 11. Mr. Beavers said Virginia began offering remote testing on June 1, and approximately 60% of Virginia’s exams are administered through the remote platform. He said Virginia administers approximately 1,200 exams per month, and it did not issue temporary licenses. Ms. Anderson said Oregon began offering remote testing two weeks ago, and the implementation process was very smooth. Ms. Hatchell said North Carolina offered temporary licenses to address the closure of examination centers and a lack of fingerprinting, which is administered through the Federal Bureau of Investigation (FBI) in North Carolina. She said North Carolina is working to implement remote testing.

Douglas Wheeler (New York Life Insurance Company) said New York Life has captive agents, and it set a goal in 2020 of investing upwards of $500 million on recruiting and training new agents. He said COVID-19 and the closure of examination centers disrupted this goal. He said the issuance of temporary licenses was helpful, and he encouraged states to implement remote testing. He said remote testing allows candidates to take exams in a safe and secure environment.

Bill Johnson (Fidelity Investments Life Insurance) said New York Life helps Fidelity meet the security needs of its customers. He said the need for financial advice has increased during the pandemic, and Fidelity has seen an increase in the purchase of new annuities compared to this time last year. He said Fidelity needs 4,000 new associates to meet the demand, and the limited availability of examinations has hindered Fidelity’s ability to meet client demands and provide employment opportunities for
new associates. He said the issue of temporary licenses has helped and encouraged states to implement remote testing. He said there are protocols to ensure that remote exams are secure and that states that have implemented remote testing have had a positive experience.

Brad Burd (GoHealth) said GoHealth said the closure of exam centers creates a backlog of exam availability, and access to fingerprinting was also a challenge. He said he agrees with prior comments and the direction to implement remote testing. He said insurance and financial security becomes very important to consumers, especially for health insurance and seniors. He said GoHealth would like to see further implementation of remote testing, and he suggested the creation of a best practice checklist for states to conduct a self-review of the state examination process. He said the issue of temporary licenses was helpful, but individuals holding a temporary license were unable to obtain appointments with companies. He encouraged states to explore additional options available for fingerprinting beyond exclusive contracts with examination vendors.

David Leifer (American Council of Life Insurers—ACLI) said the ACLI appreciates the states’ issuance of temporary licenses and the progress of implementing remote exams. Julie Mix McPeak (Greenberg Traurig) requested that states be deliberative in unwinding their emergency regulations, and she asked for communication and transparency with stakeholders.

Brad Erickson (Prometric) said Prometric will implement remote testing in its ninth state. He said Prometric worked with the Financial Industry Regulatory Authority (FINRA) on its implementation of remote testing, and it can implement a state with remote testing as quickly as one week. He said the pass rate for remote tests is within 1% of traditional examinations. He said Prometric also facilitates fingerprints, but a paper fingerprint requirement is a challenge with social distancing guidelines.

Jason McCartney (PSI Services) said PSI worked with Washington, and approximately 50–60% of exams administered in Washington are administered via a remote testing platform. He said PSI can implement remote testing in a state within 60 days. He said PSI implemented remote testing in Washington in October, in New York in June, and in Pennsylvania and Oregon in July. Mr. He said PSI will implement remote testing in South Carolina and Michigan in August and in New Jersey in September. Paula Sisneros (Pearson VUE) said Pearson VUE implemented remote testing in Colorado and Rhode Island in August. She said approximately 30% of the exams in Colorado are scheduled as remote exams.

3. Received an Update from the Producer Licensing Uniformity (D) Working Group and the Uniform Education (D) Working Group

Mr. Murray said the Producer Licensing Uniformity (D) Working Group has not met because of COVID-19. He said the Working Group remains ready to assist the Task Force, and it will be reviewing its charges and holding a call in the coming months. Superintendent Dwyer provided the Uniform Education (D) Working Group update on behalf of Rachel Chester (RI), chair of the Working Group. Superintendent Dwyer said the Working Group will be monitoring state implementation of the Continuing Education Reciprocity (CER) Agreement. She said the Working Group has not met because of COVID-19, but it will also review its charges in the coming months. She said the Working Group will review the course guidelines for classroom webinar delivery.

4. Received a Report from the NIPR Board of Directors

Director Deiter said 48 states have issued over 100 separate bulletins regarding producer licensing since the onset of the COVID-19 pandemic. Thirty-three bulletins specifically address license renewal extensions, and 30 states issued bulletins offering temporary licensing. These bulletins and state changes required the National Insurance Producer Registry (NIPR) to complete significant coding work to move the states’ license expiration dates and provide an electronic solution for a new temporary producer license class through NIPR. Director Deiter said NIPR has also been developing enhancements to its Attachment Warehouse product, which allows insurance producers and other licensees to upload licensing related documents for review by state insurance regulators.

Having no further business, the Producer Licensing (D) Task Force adjourned.
The Producer Licensing (D) Task Force met via conference call May 6, 2020. The following Task Force members participated:

Larry D. Deiter, Co-Chair (SD); Elizabeth Kelleher Dwyer, Co-Chair (RI); Lori K. Wing-Heier represented by Chris Murray (AK); Jim L. Ridling represented by Jimmy Gunn, Antwione Dunklin, Reyn Norman and William Rodgers (AL); Alan McClain (AR); Ricardo Lara represented by Charlene Ferguson and Tyler McKinney (CA); Trinidad Navarro represented by Stacy Washburn (DE); David Altmair represented by Matt Guy (FL); Doug Ommen (IA); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Lorie Gasior (LA); Anita G. Fox represented by Jill Huusken, Paige McCully, Leslie Page and Michele Riddering (MI); Chloria Lindley-Myers (MO); Mike Causey represented by Angela Hatchell and Teresa Knowles (NC); Jon Godfread represented by Stephanie Butz (ND); Bruce R. Ramge represented by Kevin Schlautman (NE); Marlene Caride represented by Joe McDougal (NJ); John Godfread represented by John Arnold (ND); Jillian Froment represented by Tynesia Dorsey and Karen Vourvopoulos (OH); Glen Mulready (OK); Andrew R. Stolfi represented by Kirsten Anderson and Carol Ruda (OR); Jessica K. Altman represented by Adriane Force and Christopher Monahan (PA); Raymond G. Farmer represented by Andrea Bourgoin and (SC); Kent Sullivan represented by Rachel Cloyd, Randall Evans and Chris Herrick (TX); Todd E. Kiser represented by Randy Overstreet (UT); Scott A. White represented by Pat Murray (VA); Mike Kreidler represented by Jeff Baughman (WA); and James A. Dodrill represented by Greg Elam (WV). Also participating was Christina Rouleau (VT).

1. Adopted its 2019 Fall National Meeting Minutes

The Task Force met Dec. 7, 2019, and took the following action: 1) adopted revisions to the NAIC State Licensing Handbook; 2) adopted the 2019 Continuing Education Reciprocity (CER) Agreement; 3) adopted the report of the Producer Licensing Uniformity (D) Working Group; 4) adopted the report of the Uniform Education (D) Working Group; 5) discussed the Surplus Lines (C) Task Force request to consider whether the requirement of a resident producer to hold underlying property/casualty (P/C) licenses before a surplus lines license is issued should be expanded to permit an accident and health (A&H) license to fulfill this requirement; 6) heard a report from the National Insurance Producer Registry (NIPR) Board of Directors.

Superintendent Dwyer made a motion, seconded by Commissioner Schmidt, to adopt its Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Producer Licensing (D) Task Force). The motion passed unanimously.

2. Discussed Producer Licensing Issues Arising from the COVID-19 Crisis

In response to industry representatives requesting regulatory relief for the onboarding of new producers and the state issuance of bulletins on temporary licenses, Director Deiter said he and Superintendent Dwyer worked with NAIC and NIPR staff to develop a list of best practices and a template bulletin to assist the states wanting to implement temporary licenses without requiring an examination or fingerprinting applicants. He said they did this in their capacity as co-chairs of the Task Force and leadership roles on the NIPR Board; however, the documents did not go through the Task Force, as each state needs to make its own policy determination on how best to respond to the closure of examination centers. These documents were distributed to the NAIC members and state producer licensing directors on April 17. Director Deiter said 29 jurisdictions have issued bulletins on temporary licenses. Some common provisions among the states, which were incorporated into the template bulletin, include the following:

- A Temporary Producer License automatically expires (insert appropriate timeframe) days after a State of Emergency is lifted by the Governor and examinations and background check services are available.
- A Temporary Insurance Producer License shall not exceed 180 days from the date of issue.
- A Temporary Insurance Producer License is not renewable.
- A Temporary Insurance Producer License allows the producer to operate only as a resident temporary producer. Temporary producers are not eligible for non-resident licenses in other states.
- An insurer or responsible license producer must assume responsibility for all acts of a Temporary Insurance Producer.

Director Deiter said two states in the process of rescinding temporary producer license orders and testing sites are beginning to reopen. In response to Director Deiter’s request for an update from NIPR, Laurie Wolf (NIPR) said NIPR added a COVID-19
resource center to the NIPR website where all state bulletins regarding producer licensing are available. Ms. Wolf said 33 jurisdictions have issued bulletins on the extension of license renewals and continuing education (CE) compliance, and 29 jurisdictions have issued bulletins on the issuance of temporary licenses. A total of 47 jurisdictions have issued producer licensing related bulletins. Ms. Wolf said NIPR is processing temporary licenses for Arizona, Rhode Island, South Carolina, and Tennessee, and it is working with Mississippi, New Jersey and North Carolina.

Commissioner Schmidt said Kansas has been fully operational with their examination vendor, Pearson VUE, since April 16. She said the Kansas Department of Insurance (DOI) made a video to explain how applicants can take fingerprints and submit them for licensure. She said Kansas has not had issues with the availability of examinations due to social distancing requirements, but she said the examination centers are serving people on a first-come-first-serve basis and operating at a reduced capacity.

Director Deiter asked if the states are implementing remote, proctored examinations. Mr. Baughman said Washington has had online, proctored exams available since October 2019 through PSI, its examination vendor. He said Washington had administered over 200 online, proctored examinations since the middle of March. He said examination sites have also remained open, and Washington has not seen any disruption in the availability of examinations. Ms. Ruder said Michigan has had 400 applications for temporary licenses, and its examination centers opened on May 1. She said there have been problems finding proctors to monitor examination centers. Ms. Ferguson said California exam centers are open, but close to 40% of individuals who register to take an examination do not show up. Mr. Herrick said Texas issues a temporary license bulletin on March 22, and it has had 4,500 individuals apply for a temporary license. He said Texas contracts with Pearson VUE, and it has 3,000 exams for permanent licenses scheduled in May.

Superintendent Dwyer said she spoke with the three examination vendors. Based on these discussions, she thinks remote, proctored examinations will be available in June. Mr. Arnold said North Dakota contracts with Prometric as its examination vendor, and Prometric has been offering remote, proctored exams for the past two weeks. He said applicants can schedule the exam and take it within two days to a week. Ms. Rouleau said Vermont contracts with Prometric, and it was told remote testing will not be available in Vermont until July or August. Mr. Schlautman said Nebraska contracts with Prometric, and it has had remote testing available since April 17. Mr. Overstreet said Utah contracts with Prometric, but it has not been administering producer examinations because digital fingerprinting is not available. Mr. Arnold said applicants can get fingerprints elsewhere and submit hard copy fingerprints to the DOI. Mr. Baughman said applicants in Washington usually facilitate their fingerprints somewhere else other than the examination center. Ms. Ferguson said California exam centers are open, but close to 40% of applicants who register to take an examination do not show up. Mr. Herrick said Texas issues a temporary license bulletin on March 22, and it has had 4,500 individuals apply for a temporary license. He said Texas contracts with Pearson VUE, and it has 3,000 exams for permanent licenses scheduled in May.

David Leifer (American Council of Life Insurers—ACLI) said the members of the ACLI appreciate the work of state insurance departments, but he said he has heard of exam availability in some states. Because of this, he requested that the states keep temporary licenses in place until any backlog on the availability of examinations for permanent licenses is resolved. He said the ACLI supports the use of remote, proctored exams, and he stated that the Task Force might develop a white paper on the best practices for the use of remote, proctored examinations.

Wes Bissett (Independent Insurance Agents and Brokers of America—IIABA) said he thinks the NAIC template bulletin for temporary licenses is written from a company-centric view, which presents a problem for independent insurance producers. He said the states should permit either an insurer or a responsible licensed producer to assume responsibility for the acts of a temporary license.

Kristy Croushore (Fidelity Investments) said her company has been working with the Financial Industry Regulatory Authority (FINRA) on remote, proctored exams, and FINRA is making remote, proctored exams available to all broker/dealers by the end of May. She said allowing a temporary licensee to be appointed to one carrier limits Fidelity Investments’ ability to offer the best recommendations to clients. She said limiting a temporary license to resident states also limits the ability of a Fidelity Investments associate to serve all the needs of a client. She said Fidelity Investments is hiring 2,000 associates in the coming weeks, and it wants to make sure the best services are available to clients.

Mr. Dunklin said Alabama issued temporary licenses prior to the COVID-19 crisis, and it requires oversight of a licensed insurer. He said Alabama experienced an increase in improper activity when this requirement was not in place.
3. **Discussed Licensing for Independent Adjusters**

Superintendent Dwyer said a priority for the NAIC members in 2020 is improving licensing uniformity and reciprocity for independent adjuster licensing. Before discussing these broader policy issues, she asked if there were any immediate market access and consumer protection issues arising from the COVID-19 crisis. She did not hear any comments, but she said Rhode Island is looking at both remote, proctored exams for both producer and independent adjusters. David Farber (King & Spalding), representing the Association of Claims Professionals (ACP), asked the states to extend COVID-19 bulletins issued for insurance producers to independent adjusters.

Mr. Farber discussed the broader policy issues regarding independent adjuster licensing. He said 34 of the 50 states license independent adjusters, and the average independent adjuster holds eight to 12 licenses. He said the lack of uniformity and reciprocity negatively affects consumers. For example, he said an independent adjuster who misses a license renewal date must refer his/her clients to another adjuster. He said it would also be better to have an ample number of adjusters licensed prior to a catastrophe rather than trying to process license applications after a catastrophe.

Mr. Farber said the issue of licensing is a process issue and not a substantive licensing issue. He said he does not expect all states to immediately adopt identical laws and regulations, but he suggested that administrative changes could be accomplished very quickly. For example, he said the states could use a uniform application and have uniform license renewal dates. He said the ACP looks forward to working with the states to implement changes, and he believes that taking small steps to change administrative processes can lead to greater uniformity and reciprocity across the states.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she supports the efforts of the ACP, and she said the same issues that apply to independent adjusters also apply to company adjusters. Superintendent Dwyer agreed with this from a licensing perspective, and she said she would work to address uniformity and reciprocal licensing issues for both independent adjusters and company adjusters.

Having no further business, the Producer Licensing (D) Task Force adjourned.
The Financial Condition (E) Committee met via conference call Aug. 11, 2020. The following Committee members participated: Scott A. White, Chair (VA); Eric A. Cioppa, Vice Chair (ME); Michael Conway (CO); David Altmaier (FL); Robert H. Muriel (IL); Stephen W. Robertson (IN); Steve Kelley represented by Kathleen Orth (MN); Mike Chaney represented by David Browning (MS); Marlene Caride (NJ); Russell Toal (NM); Raymond G. Farmer (SC); Kent Sullivan represented by Doug Slape (TX); James A. Dodrill (WV); and Jeff Rude represented by Linda Johnson (WY).

1. **Adopted its July 1, June 12, May 15 and March 26 Minutes**

Commissioner White said the Committee met July 1, June 12, May 15 and March 26. During its July 1 meeting, the Committee adopted its Feb. 27 and Dec. 9, 2019, minutes. During its Feb. 27 meeting, the Committee took the following action: 1) adopted a Request for NAIC Model Law Development from the Receivership and Insolvency (E) Task Force and a separate Request for NAIC Model Law Development from the Financial Stability (EX) Task Force; and 2) adopted a request for extension from the Mortgage Guaranty Insurance (E) Working Group regarding ongoing work on an NAIC model. During its July 1 meeting, the Committee also took the following action: 1) adopted technical revisions to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) and acknowledged similar technical revisions made to Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48) by the Life Insurance and Annuities (A) Committee; and 2) adopted actions from the Capital Adequacy (E) Task Force, the Valuation of Securities (E) Task Force, and the Accounting Practices and Procedures (E) Task Force, with the exception of Interpretation (INT) 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends, which was rejected and sent back to the Accounting Practices and Procedures (E) Task Force. During its June 12 meeting, the Committee took the following action: 1) adopted a memorandum from the Committee to all commissioners regarding the treatment of the London Interbank Offered Rate (LIBOR) under state investment laws; and 2) adopted an extension of mortgage forbearance previously adopted by the Committee through Sept. 30, 2019. During its March 26 meeting, the Committee adopted mortgage forbearance through June 30. The Committee’s May 15 meeting was an educational session on LIBOR.

Commissioner Caride made a motion, seconded by Commissioner Dodrill, to adopt the Committee’s July 1 (Attachment One), June 12 (Attachment Two), May 15 (Attachment Three) and March 26 (Attachment Four) minutes. The motion passed unanimously.

2. **Adopted INT 20-08**

Commissioner White reminded the Committee that on July 1, the Committee rejected a previous version of a proposed interpretation on this topic and gave direction to the Accounting Practices and Procedures (E) Task Force to revise it, with a strong recommendation to add more flexibility. Since then the Task Force has revised and adopted, with only one no vote, a new interpretation that notes that premium treatment is the default methodology, but it also provides the flexibility requested to allow underwriting expense treatment as a limited-time exception. The limited-time exception addresses the concern voiced by industry regarding permitted practices, as it allows reporting entities to apply the limited-time exception without having to seek a permitted practice. This flexibility only applies to Property and Casualty products to avoid the potential negative implications to the medical loss ratio (MLR) for underwriting expense reporting on health products. All payment types will be disclosed, and for those that apply the limited exception, the interpretation provides the transparency needed through disclosure in Note 1 in a similar manner as a prescribed practice. This will assist the states in analyzing the impact compared to the default method if such flexibility is not chosen. Director Farmer made a motion, seconded by Commissioner Caride, to adopt the revised interpretation (Attachment Seven). The motion passed unanimously.

3. **Adopted the Reports of its Task Forces and Working Groups**

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

Commissioner Robertson made a motion, seconded by Superintendent Cioppa, to adopt the following task force and working group reports: the Accounting Practices and Procedures (E) Task Force, the Capital Adequacy (E) Task Force, the Receivership and Insolvency (E) Task Force, the Reinsurance (E) Task Force, the Valuation of Securities (E) Task Force, the Group Capital Calculation (E) Working Group (Attachment Five), and the Group Solvency Issues (E) Working Group (Attachment Six). The motion passed unanimously.

The Financial Analysis (E) Working Group met July 15, June 17, May 13, May 12, May 6 and May 5 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses related to second-quarter 2019 financial results. Additionally, the Valuation Analysis (E) Working Group met in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.

Having no further business, the Financial Condition (E) Committee adjourned.

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Financial Condition (E) Committee
Conference Call
July 1, 2020

The Financial Condition (E) Committee met via conference call July 1, 2020. The following Committee members participated:
Scott A. White, Chair, Doug Stolte and David Smith (VA); Eric A. Cioppa, Vice Chair (ME); Michael Conway (CO);
David Altmaier (FL); Robert H. Muriel represented by Kevin Fry (IL); Stephen W. Robertson and Roy Eft (IN); Steve Kelley
represented by Kathleen Orth (MN); Mike Chaney represented by David Browning (MS); Marlene Caride (NJ); Russell Toal
(NM); Raymond G. Farmer (SC); Kent Sullivan represented by Doug Slape and Jamie Walker (TX); James A. Dodrill
represented by Jamie Taylor (WV); and Jeff Rude (WY). Also participating were: Trinidad Navarro (DE); Chlora Lindley-
Myers (MO); and Jillian Froment (OH).

1. **Adopted its Feb. 27, 2020, and 2019 Fall National Meeting Minutes**

Commissioner White said the agenda for the conference call is focused on considering actions taken by the Committee’s
technical groups that provide annual updates to various solvency-related publications. He said, before doing that, the Committee
should consider adoption of the Committee’s minutes from the 2019 Fall National Meeting and the Feb. 27, 2020, conference
call in which the Committee adopted two model law development requests and an extension to the Mortgage Guaranty
Insurance (E) Working Group, which has been working on its own model law changes for mortgage insurers.

Commissioner Toal made a motion, seconded by Commissioner Caride, to adopt the Committee’s Feb. 27, 2020
(Attachment One-A) and Dec. 9, 2019 (see NAIC Proceedings – Fall 2019, Financial Condition (E) Committee) minutes. The
motion passed unanimously.

2. **Adopted Technical Edits to Model #787**

Commissioner White said the next item is to consider adoption of technical edits to the *Term and Universal Life Insurance
Reserve Financing Model Regulation* (#787). He noted how NAIC staff identified a small number of purely editorial items
during a Jan. 29 conference call of the Reinsurance (E) Task Force, where these were adopted. He said similar technical edits
were also being made by the Life Insurance and Annuities (A) Committee to *Actuarial Guideline XLVIII—Actuarial Opinion
and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC
Valuation of Life Insurance Policies Model Regulation* (AG 48), noting that both Model #787 and AG 48 will be presented to
the Executive (EX) Committee and Plenary for consideration at the Summer National Meeting.

Commissioner Caride made a motion, seconded by Commissioner Toal, to adopt the technical edits to Model #787
(Attachment One-B). The motion passed unanimously.

3. **Adopted Reports from Select Task Forces**

Commissioner White said the Committee received summary reports from the Accounting Practices and Procedures (E) Task
Force (which met June 22), the Capital Adequacy (E) Task Force (which met June 3) and the Valuation of Securities (E) Task
Force (which met May 14), noting that—with the exception of INT 20-08: *COVID-19 Premium Refunds, Rate Reductions and
Policyholder Dividends* (INT 20-08), which would be considered separately—the intent is to adopt each Task Force’s actions
and include such items that are technical, non-controversial and/or considered to be of a routine nature in maintaining the
insurance financial solvency framework in a Financial Condition (E) Committee Technical Changes Report sent to all NAIC
members. He noted that, under the process previously adopted by the Plenary, NAIC members will have 10 days to comment;
otherwise, the technical changes will be considered adopted by the NAIC membership and effective immediately.

Commissioner Robertson made a motion, seconded by Ms. Orth, to adopt the actions taken by the Accounting Practices and
Procedures (E) Task Force, the Capital Adequacy (E) Task Force and the Valuation of Securities (E) Task Force, with the
exception of INT 20-08. The motion passed unanimously.
4. Discussed INT 20-08

Commissioner White said the last item is to consider INT 20-08, which was adopted by the Accounting Practices and Procedures (E) Task Force during its June 22 conference call, with more than 75% of the Task Force voting in favor of the adoption. Under this interpretation, the refunds and rate reductions that have been issued by many property/casualty insurers and some health insurers in response to COVID-19 and decreased exposure are treated as a reduction of premium.

Commissioner White said he participated on the Task Force’s June 22 conference call, and described how there was a lot of debate and not total agreement on the issue, as some of the regulators believed it would more be appropriate to treat these refunds as an underwriting expense. He stated that the interpretation as adopted utilizes the same accounting approach that has existed for years on premium refunds, which is a reduction of premium. He also noted the opinions of consumer representatives, who had emphasized the substance of these refunds being economically the equivalent of a return of premium, because it was due to a reduction in exposure and not an expense to the company.

Commissioner White described how the reduction also comes up in discussing the concerns of others related to the impact on premium taxes, because, in many cases, the tax law on premium taxes may be reduced for premiums returned. He explained that, in Virginia, matters dealing with premium taxes are outside of the insurance code and noted that, for Virginia, it really does not matter what guidance the NAIC issues for solvency purposes; Virginia taxes are determined by state taxation laws and paragraph 24 of the interpretation makes this point.

Commissioner White described how the interpretation retains the fundamental concepts of consistency and comparability, and specifically allows the use of prescribed and permitted practices to be issued by any insurance commissioner, with disclosure of that difference in Note 1. By doing so, non-domestic regulators can consider such accounting practice in their review of such insurers’ financial statements and will know that the loss ratios for those companies would be understated. He said he believes all of these points are what played into why the Task Force adopted the interpretation with 75% of the states voting in favor. For this reason, and due to the underlying policies of the Statutory Accounting Principles (E) Working Group, this guidance is actually considered adopted unless overturned by the Task Force with a two-thirds vote in opposition; however, only nine states dissented, so it was passed easily over what was required. He concluded by noting that this policy exists specifically to allow the NAIC membership to issue accounting interpretations quickly, noting how that same policy has already allowed the NAIC membership to provide guidance to many insurers on various COVID-19 issues.

Commissioner Robertson asked if the Committee could prevent this interpretation from moving forward if the Committee were to vote in opposition to INT 20-08. Commissioner White said this is a good question, because there would be no available accounting for the issue for the second quarter statements coming due. He described how, if that is the result, it would be best if the Committee sends the issue back to the Task Force to come to a decision supported by two-thirds of the members of that Task Force, because the current interpretation was adopted by more than two-thirds of the states.

Dan Daveline (NAIC) indicated that the Committee has the authority to overrule the issue. Commissioner White noted that the intent is to take a vote and, if the interpretation is not adopted, it would go back to the Task Force. Commissioner Robertson asked how many members are needed to overturn the Task Force’s adoption; specifically, if a two-thirds vote or a majority vote is required. Mr. Daveline responded that a majority vote would be sufficient to send the issue back to the Task Force.

Commissioner Robertson noted that a letter was distributed to the members of the Committee from the American Property Casualty Insurance Association (APCIA), which requests flexibility in accounting for the monies returned or credited to policyholders. He stated his preference that no company be allowed to use this as a reduction of premium and described how, in Indiana, the state would lose $1,250,000, which would equate to 20 jobs, or 20 people who would lose their jobs to make up that amount of money. He noted that while the Task Force emphasized comparability, he believes the Committee has a different duty, noting that the members have never experienced anything like this. He suggested that the Committee use more flexibility and not be so rigid and bureaucratic, and he warned against listening to the industry that the states regulate, noting that he believes the APCIA’s request is reasonable. He said he is not willing to tell his governor that he lost $1,250,000 in revenue due to a technicality vote that he does not think is necessary. He said each member must make their own decision, but the 28 people who voted not to honor the request of the APCIA will likely all have safe jobs, and a lot of people will lose their jobs if this goes through as-is. He described the need to take advantage of every opportunity to collect revenue for the state. He encouraged those voting to take a “bigger picture” perspective.

Commissioner Robertson made a motion to adopt the position of the APCIA as the method to treat the funds.
Commissioner White clarified that flexibility is allowed within the interpretation and simply needs to be disclosed in Note 1 of the financial statements. Commissioner Robertson asked if he only has authority over domestic companies or all companies doing business in Indiana. Commissioner White responded that his authority would only cover domestic insurers. Mr. Daveline agreed but noted that the commissioner may also have authority to prescribe certain tax treatment. Mr. Stolte said the Commissioner could issue a prescribed practice for all licensed companies. Commissioner Robertson stated his appreciation for Mr. Stolte’s comment but will make his motion later.

Commissioner Caride said it is her understanding that it only takes one state to not grant the same prescribed or permitted practice for the entire situation to be stalled. She said all states have been impacted by COVID-19, noting that New Jersey has asked its insurance companies to be flexible with consumers and give them the benefit of the doubt, even if it should not have been given. She described how New Jersey’s companies have worked with the state and taken its request to heart with regard to consumers in New Jersey and have worked to put consumers first at a time when there is high unemployment, health issues, health insurance being cancelled, and little money to pay rent, let alone car insurance. She said the industry has shown good faith, noting that the companies have been good corporate citizens and agree that the NAIC should show some flexibility during this period. She said this is something we have never seen before in our lifetime. She described the benefits of using consistent accounting but noted at the same time this is not a normal, everyday event; therefore, flexibility is needed. She said the accounting may not be pretty in terms of how the companies have to account for this, but her understanding from her carriers is that if they do it according to the interpretation, they would have to go back and deal with commissions paid and other issues. She said the least that can be done right now is to show flexibility. She said she abstained during the Task Force’s vote on the interpretation, but would vote against it if the Committee were to consider its adoption today.

Director Farmer expressed his appreciation for the work of the Task Force, but he could not say it any better than Commissioner Caride. He said regulators have asked companies to go outside of their comfort zone to give forbearance, and companies have made decisions to give refunds or dividends or whatever method they choose, noting that the companies have done this on their own. He said this was commendable and because we had asked them to be flexible, we should be as well. He noted that the states have not been down this road before and all states have had to be flexible on a number of issues.

Director Farmer made a motion to send the issue back to the Task Force and to provide flexibility to regulators and insurers.

Director Froment agreed with what has been said by the other Committee members, noting that Ohio has concerns with the interpretation. She discussed how Ohio worked with companies to provide relief and every company did something different in their offerings as a means to get monies into the hands of consumers, even though each company crafted things differently compared to the next. She described that in Ohio, not in one instance was a rate filing required; therefore, Ohio did not approve a reduction of premium but, rather, allowed the companies to offer relief. She said little upfront guidance was provided. She said Ohio would not be following the interpretation and will be providing flexibility to Ohio domestics, but she also has concerns about things not being done uniformly nationwide.

Director Lindley-Myers expressed her support for the positions taken by Ohio, South Carolina and New Jersey. She said she agrees that companies have sprung into action to do the best they could during this pandemic, and she wants to make sure Missouri is as flexible as possible to the companies.

Commissioner Conway said he would like to make sure he understands why the states do not want to provide the flexibility. He asked if there was something to consider besides consistency.

Commissioner White said one thing he hears often is the need for transparency, so that a non-domestic can look at Note 1. He said he believes there is flexibility through permitted and prescribed practices. He stated there is also concern that this could create a bad precedent. He noted that while everyone agrees with the way the industry has handled the issue, 28 “yes” votes at the Task Force was based on the principles of consistency and comparability, and using the same methodology that has been used in the past through Note 1 disclosure.

Commissioner Toal complimented the chair for explaining this appropriately. He described that he voted for INT 20-08 at the Task Force and would support it today. He said if he believed the states were not granted flexibility, he would not support it.

Commissioner Conway asked for a greater explanation of the permitted practices.
Superintendent Cioppa agreed with that request because Maine voted in favor of INT 20-08, but if, at the end of the day, another step is needed to get where things are desired, he is somewhat concerned. He stated that for that reason he is in favor of hearing more.

Mr. Stolte described the historical work completed by the Statutory Accounting Principles (E) Working Group to develop an accounting model that works and emphasized how it was never meant to overrule a state’s authority, and that is how prescribed and permitted practices were created. Footnote 1 shows both the state’s basis used in the financial statements and the NAIC’s basis to allow comparability, which has served its purpose for a long period of time. He said he does not understand the stigma or problem with the prescribed or permitted practices.

Commissioner White said he believes the question is the extra burden on the companies and the states, noting that the concern is more with the prescribed practices as it pertains to non-domestic companies. Mr. Stolte described that if a state issues a prescribed practice for all licensed companies, then that is the manner in which the item would have to be reported in all companies’ financial statements for the business in Virginia.

Robin Marcotte (NAIC) read from the Accounting Practices and Procedures Manual (AP&P Manual) and, more specifically, Question and Answer #2, which describes a permitted practice as an accounting practice requested by an individual insurer that departs from statutory accounting principles and has received approval from the domestic state. She said the AP&P Manual defines a prescribed practice as an accounting practice that is incorporated directly by state law, regulation or general administrative rule applicable to all applicable insurers. She said the AP&P Manual is not intended to preempt a state’s legislative and regulatory authority. In a prescribed practice, a state could tell all its licensed companies to follow a particular practice. She explained that it is possible for two states to decide to tax these refunds differently and it would apply to all carriers licensed in their respective state. She said, for example, Virginia could have a different practice for filing premium taxes than Missouri, and both would be disclosed in Note 1 if either differed from the accounting practice outlined in the AP&P Manual.

Commissioner Conway asked Ms. Marcotte if the non-domiciliary state issues a prescribed practice that disagrees with the domestic state, would the same result be the case. Ms. Marcotte said the company files the annual financial statement in accordance with its domiciliary state requirements. Ms. Marcotte noted that the distinction she made is related to premium and related premium taxes because those are driven by state law; therefore, domestic companies are required to follow all the rules in that state. So, for example, Virginia does not control premium and premium taxes for companies domiciled in Missouri.

Commissioner White asked if Colorado wants it to be treated as an expense for Colorado-licensed companies, if that would be allowed. Ms. Marcotte noted that for purposes of premium and related premium taxes, all Colorado licensed companies would be required to follow Colorado law.

Mr. Slape said he would like to make the distinction on the interpretation related to accounting and transparency through disclosure, noting that the accounting could have an impact on loss ratios but that is a completely different conversation than taxes. He stated that no matter what the NAIC says, it has no impact on how this is handled for premium taxes; he stated this needs to be clear because that is controlled by state law on how premium tax is determined. He noted that the state statute may define the terms generally, noting for example, in Texas, the Department of Insurance is not the premium tax agent; it is the comptroller. He said the members of the Committee should not think this has any impact on premium for premium tax purposes.

Commissioner White agreed with Mr. Slape, noting that paragraph 24 of the interpretation makes this same point.

Mr. Fry discussed the negative moniker that comes with permitted practices and how, for this particular interpretation, comes with an additional degree of administrative duties. He noted that the states need flexibility, given the transparency is also built in with the disclosure and, therefore, supports such flexibility.

Mr. Navarro said he believes Indiana made a motion and either a second must be made or the motion must be withdrawn, or at least that is normally the case.

Commissioner White said he believes a couple of motions were made, one by Commissioner Robertson and another by Director Farmer, noting that he would like to receive comments first.

Commissioner Robertson said he would withdraw his motion and instead second Director Farmer’s motion.
Commissioner White said Director Farmer’s motion was to send the issue back to the Task Force. Commissioner White asked if Director Farmer would like to proceed with the motion and take a vote at this time or if Director Farmer is supportive of hearing from the industry and interested parties, and then returning back to the motion to take a vote. Director Farmer said he is supportive of hearing further discussion and then returning back to the motion.

Philip Carson (APCIA) said the commissioners have raised the APCIA’s issues, noting that what the APCIA offered was a compromise that many of the commissioners seem to support. He said flexibility and fairness to policyholders was requested and the APCIA believes the commissioners should do the same thing. He stated that the discussion related to permitted and prescribed practices is one that creates a lot of confusion, noting that there would be a lot of burden on permitted practices, especially for those companies that operate in multiple states. He said there would be confusion if the states adopt different positions on the request for permitted practices, which would add a complication, stating that if the interpretation is adopted as it reads now, the companies would have no recourse if they were not allowed to obtain permitted practices in all the states in which they operate. He said the APCIA’s proposal harms no one, respects the good faith effort the companies put forth, and would be the fairest and cleanest way to proceed with the issue.

Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC) echoed the comments made by the APCIA and noted the unprecedented times. He described how the discussion on permitted and prescribed practices demonstrates the complexity of the issue and noted how flexibility seemed to be the preference of the Committee, noting that it is just a matter of how that flexibility is granted. He said NAMIC believes the transparency exists with the APCIA’s proposal, regardless of whether it is recorded as a reduction of premium or as an expense.

Keith Bell (Travelers) said Travelers went through this issue and initially determined it was properly accounted for as a return of premium, even though companies have filed amendments to change their policies. Staff at Travelers wondered if they had missed something but when they went back and reviewed the guidance, it confirmed that they believe it is more properly reported as a return of premium, as it does not meet the definition of an expense and actually violates the Level 5 guidance in the Preamble of the AP&P Manual. Mr. Bell noted, however, in stepping back and looking at it, the amount charged to customers as premiums is one of the most important measures to insurer companies because it is a measure of risk and is used in several leverage ratios, but other financial measures used by insurers. Additionally, because the payments being made back to policyholders are the result of reduced possibility of loss, Travelers believes it should be recorded as a reduction of premium, because premium should represent the amount charged to take on the risk. He said he does not believe the accounting is that difficult when treated as a contra-revenue, recording the original premium and then the return premium would be reported separately as a contra amount, allowing the company to track the original premium so that they could pay agents and brokers on the appropriate original amount, but would also allow the track of the gross and net amount so they can pay the correct premium tax based on the differences in state law or state requirements. He said Travelers’ lead state is having its Department of Revenue issue a bulletin to apply the premium tax to the gross amount and not the net amount on this matter.

Commissioner White thanked everyone for their comments, noting that there was not consensus, either among the industry or among regulators. He returned to the motion by Director Farmer to send the issue back to the Task Force to have INT 20-08 revised in a way that is still supported by two-thirds of the Task Force members. Director Farmer concurred that was his motion but added that he strongly urges the Task Force to incorporate flexibility so that the permitted practice burden does not have to be utilized. The motion was seconded by Commissioner Robertson. The motion passed, with New Mexico dissenting.

Having no further business, the Financial Condition (E) Committee adjourned.
1. **Adopted a Request for NAIC Model Law Development from the Receivership and Insolvency (E) Task Force**

Commissioner White made the Committee aware that the Executive (EX) Committee approved a Request for NAIC Model Law Development from the Group Capital Calculation (E) Working Group with respect to the *Insurance Holding Company System Regulatory Act* (Model #440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (Model #450), which could have implications for this new request from the Receivership and Insolvency (E) Task Force related to the same models.

Commissioner White stated that while the two items are unrelated, it is important for the Committee to understand whether this new work could slow down the work of the Group Capital Calculation (E) Working Group. More specifically, the goal is for the group capital calculation (GCC) to be adopted by the Working Group at the Summer National Meeting so the states can begin introducing it in early 2021. With that as a backdrop, Commissioner White requested that Mr. Baldwin provide a summary of the Task Force’s request.

Mr. Baldwin stated that on Jan. 8, the Receivership and Insolvency (E) Task Force adopted a request to the Committee. He stated that the background for the Task Force’s request is a common issue that can arise in a receivership of an insurance company where affiliated entities provide essential services through inter-company agreements. The continuation of these services can be critical to the operation of the receivership, particularly when all staffing and information technology (IT) functions are outsourced. This issue is specific to agreements with affiliated entities that are formed for the sole purpose of providing services to the insurance company. For example, affiliated entities may handle all the insurance company’s administrative functions (e.g., handling, underwriting, statutory accounting and premium collection), but provide no services to entities outside of the group.

Mr. Baldwin said that when an insurance company is placed in receivership, the unilateral termination of services by an affiliate can lead to delay, waste, and significant expense to the receivership estate. An interruption in obtaining data can also impede a guaranty association’s ability to pay claims. Mr. Baldwin stated that the Task Force recognizes that there are some existing protections under the current Model #440, specifically the requirement for prior approval of affiliate transactions, which can afford state insurance regulators an opportunity to identify problematic agreements in advance of a receivership. There are also provisions in Model #450 that restrict such agreements from including unilateral or automatic terminations if an insurer is placed in receivership. Mr. Baldwin noted that a receiver can file legal action against an affiliated service provider that refuses to continue essential services under a contract or seek a court order requiring the affiliate to provide records. However, protracted litigation can result in delays and additional costs. Additionally, when the affiliate is in another jurisdiction, these efforts can be challenging.

Mr. Baldwin stated that in some cases the insurance company and an affiliate are inextricably intertwined. He stated that if the operations and records of the entities are commingled, it is difficult to handle the receivership without the affiliate’s cooperation. Sometimes it is necessary to place an affiliate in receivership and administer it with the insurance company. However, if the affiliate does not consent, the ensuing litigation will involve further time and expense.

Mr. Baldwin stated that one potential solution that the Task Force identified is to consider revisions to Model #440 by modifying the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to an insurer. While the Task Force recognizes that there are significant issues to be worked through, including potential conflicts with other laws, the Task Force would endeavor to address those and any other issues as part of the work in developing a solution within Model #440 and Model #450.
Commissioner Caride made a motion, seconded by Mr. Kaumann, to adopt the Request for NAIC Model Law Development to amend Model #440 and Model #450 to develop revisions to address issues with continuity of essential services (Attachment One-A1). The motion passed unanimously.

2. **Adopted a Request for Extension from the Mortgage Guaranty Insurance (E) Working Group**

Commissioner White reminded Committee members that the NAIC requires model law requests, such as the one adopted from the Receivership and Insolvency Task Force, to be adopted as NAIC model laws or model law changes within one year of the original request to the Executive (EX) Committee. He stated that to the extent that a model change is not completed within one year from the date approved by the Executive (EX) Committee, an extension must be requested and approved.

With respect to the specific request from the Mortgage Guaranty Insurance (E) Working Group, Commissioner White stated that while this work has been ongoing for a significant period, this was a project that he supported being completed, and he supported the request. He stated that the ongoing work has largely been the product of its technical nature and need for the NAIC to hire consultants and then modifications based upon the consultant’s work. He stated he was encouraged to hear that the Working Group does now appear to be close on finalizing this work, as they have now exposed a new loan level capital model for these mortgage insurers; all of the states on this Working Group are supportive of the direction.

Superintendent Toal made a motion, seconded by Commissioner Caride, to adopt the request by the Mortgage Guaranty Insurance (E) Working Group for an extension its Request for NAIC Model Law Development to amend the Mortgage Guaranty Insurance Model Act (#630) (Attachment One-A2). The motion passed unanimously.

3. **Adopted a Request for NAIC Model Law Development from the Financial Stability (EX) Task Force**

Commissioner White stated that the Committee had received an additional Request for NAIC Model Law Development from the Financial Stability (EX) Task Force on Feb. 26, and it relates to a liquidity stress test that has been in the process of being developed for some time. He stated that while the actual stress test is not yet completed, it is like the GCC in that the primary purpose of any type of legislative change is to provide the necessary confidentiality protections. He stated that, similar to the request from the Receivership and Insolvency (E) Task Force, it is too early to know whether the completion of this work could affect the GCC, but the idea is to make all three of the different legislative changes to Model #440 and Model #450 at the same time, assuming that all are ultimately supported and adopted.

Commissioner White stated that during the Feb. 26 conference call of the Financial Stability (EX) Task Force, one comment letter on this item was received from the American Council of Life Insurers (ACLI), and the general response on adopting the request was that while Model #440 and Model #450 might not ultimately be chosen as the ideal placement for holding this tool confidential, if it is, it makes sense that all three of the items be addressed at the same time. He described how far fewer companies were likely be impacted by this liquidity stress test than the GCC, with as few as 23 for this test.

Commissioner Robertson and Mr. Eft expressed support for the confidentiality aspect of this request, but they expressed concern about one of the provisions that limits and decides what stress test gets used in a liquidation because it seems to reduce the states’ right to choose the stress.

Commissioner Caride stated that work is ongoing, and all comments are welcome.

Commissioner Robertson asked what was being voted on and whether the issue of what stress test is being used is still open for consideration.

Commissioner White responded that the issue before the Committee is not adoption of the actual stress test, but rather the request to work on changes to Model #440 and Model #450 that would provide the authority and confidentiality protections of the liquidity stress test, but the stress test itself is still being developed.

Commissioner Caride agreed that the item on the table was only to consider if the model is the appropriate venue. She stated that she would be happy to reach out to Commissioner Robertson subsequent to the conference call to better understand his concern regarding the actual stress test.
Commissioner Robertson stated that he would like it to be clear in the minutes that the action contemplated is only requesting the authority for the Task Force to work on the changes to Model #440 and Model #450 and not the actual stress test to be required.

Commissioner White stated that was the case, and he stated that Commissioner Robertson’s concern would be noted in the minutes.

Commissioner Caride made a motion, seconded by Superintendent Cioppa, to adopt the Request for NAIC Model Law Development from the Financial Stability (EX) Task Force to amend Model #440 and Model #450 (Attachment One-A3). The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.
To: Financial Condition (E) Committee

From: Receivership and Insolvency (E) Task Force

Date: January 8, 2020

RE: Model Law Request for Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

The Receivership and Insolvency (E) Task Force requests the Committee consider opening the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to consider revisions to address issues with continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company, specifically agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

The Task Force is cognizant of other unrelated revisions being considered for Models 440 and 450 under an existing open Model Law Request and understands the sensitivity of the timing of that work. Work related to the continuation of essential services is not intended to delay or impede any other revisions; however, the Task Force feels it may be efficient to conduct its review and drafting concurrently with that work.

Background and Rationale

In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Financial Stability Board’s (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The
Task Force identified the following authority and remedies available within the US regime related to these international standards:

- The *Insurance Holding Company System Model Act* (#440) requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The *Insurance Holding Company System Model Regulation* (#450), Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.

- The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

One potential solution is to revise the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.

The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

**Scope of the Proposed Revisions to Models 440 and 450**

The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed draft Models 440 and 450 revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450. Consistency with any revisions to Model 440

Any questions about this memorandum may be directed to NAIC staff, Jane Koenigsman (jkoenigsman@naic.org, 816-783-8145).
To: Commissioner Scott White (VA), Chair, Financial Condition (E) Committee

From: Kevin Conley (NC), Chair, Mortgage Guaranty Insurance (E) Working Group

Date: February 7, 2020

Re: Updated Request for Extension

The Mortgage Guaranty Insurance (E) Working Group is in the process of fulfilling its charge to update the Mortgage Guaranty Insurance Model Act (Model #630). The Working Group anticipated completion of its Charge by the 2020 Spring National Meeting. As chair, I would like to update that request to the Financial Condition (E) Committee in accordance with NAIC procedures.

As background, the NAIC engaged Milliman to assist the Working Group in finalizing a Mortgage Guaranty Insurance Capital Model that will become the new capital standard for mortgage insurers. Following some delays due to a shift in focus directed by the Working Group, Milliman’s work was completed in early December of last year. Subsequent to discussion at the Fall National Meeting, the Working Group exposed the Draft Mortgage Guaranty Insurance Capital Model, Mortgage Guaranty Insurance Model Act (#630), Mortgage Guaranty Insurance Standards Manual, and a proposed Mortgage Guaranty Insurance Exhibit. The Working Group will discuss and address comments received on the exposure and send a referral to the Blanks (E) Working Group regarding the proposed exhibit during the next several months.

At this time, we believe we can complete this work by the 2020 Fall National Meeting. The request for additional time is to allow the necessary time to address comments regarding the above referenced documents and ensure that a comprehensive regulatory framework is in place to effectively regulate these complex insurance entities. We are aware that we have been unable to complete our work within the one-year time period expected under the NAIC model law process and request an extension until the 2020 Fall National Meeting in order to finalize a product that can be adopted by the domestic states of the mortgage insurers, as well as any other state also wishing to adopt the same.
To: Financial Condition (E) Committee  
From: Financial Stability (EX) Task Force  
Date: February 26, 2020  
RE: Model Law Request for Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

The Financial Stability (EX) Task Force requests the Financial Condition (E) Committee consider opening the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to consider revisions to establish regulatory authority to require liquidity stress testing processes and confidentiality protections for the data reported from the liquidity stress tests.

The Task Force is cognizant of other unrelated revisions being considered for Models 440 and 450 under an existing open Model Law Request and understands the sensitivity of the timing of that work. Work related to liquidity stress testing is not intended to delay or impede any other revisions; however, the Task Force feels it may be efficient to conduct its review and drafting concurrently with that work.

Background and Rationale

In the Task Force’s recent exposure of the 2019 Liquidity Stress Test, the regulatory authority and confidentiality rely upon the specific lead state’s examination laws and supporting processes (e.g., confidentiality agreements). For the ongoing liquidity stress tests performed in future years, a specific provision needs to be made in state statutes and/or regulations to provide more consistency in this authority and confidentiality protection.

Scope of the Proposed Revisions to Models 440 and 450

The scope of the request is limited to addressing the issue of establishing regulatory authority to require stress testing and disclosures related to liquidity risk and to establish in statute the confidentiality of those disclosures as appropriate. The Financial Stability (EX) Task Force would complete the review and recommend proposed draft Models 440 and 450 revisions. It is anticipated that these revisions will need to reference Liquidity Stress Testing Framework documents that will need to be able to be modified annually without opening up the models themselves (e.g., directions regarding the liquidity stress test, reporting templates, stress scenarios). Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 8: Confidential Treatment
- Model 450. Consistency with any revisions to Model 440

Any questions about this memorandum may be directed to NAIC staff, Todd Sells (tsells@naic.org, 816-783-8403).
TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

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Section 1. Authority

This regulation is adopted and promulgated by [title of supervisory authority] pursuant to [insert provision of state law equivalent to section 5B of the Credit for Reinsurance Model Law] of the [name of state] Insurance Code.

Section 2. Purpose and Intent

The purpose and intent of this regulation is to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees; and to ensure that, with respect to each such financing arrangement, funds consisting of Primary Security and Other Security, as defined in Section 5, are held by or on behalf of ceding insurers in the forms and amounts required herein. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer (1) are issued by the ceding insurer or its affiliates; or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any if its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).

Section 3. Applicability

This regulation shall apply to reinsurance treaties that cede liabilities pertaining to Covered Policies, as that term is defined in Section 5B, issued by any life insurance company domiciled in this state. This regulation and [insert provision of state law equivalent to the Credit for Reinsurance Model Regulation] shall both apply to such reinsurance treaties; provided, that in the event of a direct conflict between the provisions of this regulation and [insert provision of state law equivalent to the Credit for Reinsurance Model Regulation], the provisions of this regulation shall apply, but only to the extent of the conflict.

Section 4. Exemptions from this Regulation

This regulation does not apply to the situations described in Subsections A through F.

A. Reinsurance of:

(1) Policies that satisfy the criteria for exemption set forth in [insert provision of state law equivalent to Section 6F of the Valuation of Life Insurance Policies Model Regulation] or [insert provision of state law equivalent to Section 6G of the Valuation of Life Insurance Policies Model Regulation]; and which are issued before the later of:
(a) The effective date of this regulation, and
(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than Jan 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in [insert provision of state law equivalent to Section 6E of the Valuation of Life Insurance Policies Model Regulation] and which are issued before the later of:
(a) The effective date of this regulation, and
(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than Jan. 1, 2020;

(3) Any universal life policy that meets all of the following requirements:
(a) Secondary guarantee period, if any, is five (5) years or less;
(b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Commissioners Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and
(c) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period;

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; nor

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

B. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provision of state law equivalent to Section 2D of the Credit for Reinsurance Model Law]; or

C. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provisions of state law equivalent to Sections 2A, 2B or 2C, of the Credit for Reinsurance Model Law], and that, in addition:

(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer’s reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1 (“SSAP 1”); and

(2) Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in [insert provision of state law equivalent to the Risk-Based Capital (RBC) for Insurers Model Act] when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or

D. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provisions of state law equivalent to Sections 2A, 2B or 2C, of the Credit for Reinsurance Model Law], and that, in addition:
(1) Is not an affiliate, as that term is defined in [insert provision of state law equivalent to Section 1A of the Insurance Holding Company System Regulatory Model Act], of:

(a) The insurer ceding the business to the assuming insurer; or

(b) Any insurer that directly or indirectly ceded the business to that ceding insurer;

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

(3) Is both:

(a) Licensed or accredited in at least 10 states (including its state of domicile), and

(b) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in [insert provision of state law equivalent to the Risk-Based Capital (RBC) for Insurers Model Act] when its Risk-Based Capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer’s reported surplus; or

E. Reinsurance ceded to an assuming insurer that meets the requirements of either [insert provision of state law equivalent to Section 5B(4)(a) of the Credit for Reinsurance Model Law, pertaining to certain certified reinsurers] or [insert provision of state law equivalent to Section 5B(4)(b) of the Credit for Reinsurance Model Law, pertaining to reinsurers meeting certain threshold size and licensing requirements]; or

Drafting Note: A state may satisfy the requirements of Section 4E above by either adopting Section 5B(4) of the Credit for Reinsurance Model Law (#785), or it may include the specific provisions of Section 5B(4) of the Credit for Reinsurance Model Law (#785) directly into its adoption of this regulation, Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

E.F. Reinsurance not otherwise exempt under Subsections A through E if the commissioner, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this regulation (as described in Section 2 above);

(2) The risks are included within the scope of this regulation only as a technicality; and

(3) The application of this regulation to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall publicly disclose any decision made pursuant to this Section 4F to exempt a reinsurance treaty from this regulation, as well as the general basis therefor (including a summary description of the treaty).

Drafting Note: The exemption set forth in Section 4F was added to address the possibility of unforeseen or unique transactions. This exemption exists because the NAIC recognizes that foreseeing every conceivable type of reinsurance transaction is impossible; that in rare instances unanticipated transactions might get caught up in this regulation purely as a technicality; and that regulatory relief in those instances may be appropriate. The example that was given at the time this exemption was developed pertained to bulk reinsurance treaties where the ceding insurer was exiting the type of business ceded. The exemption should not be used with respect to so-called “normal course” reinsurance transactions; rather, such transactions should either fit within one of the standard exemptions set forth in Sections 4A, B, C, D, or E or meet the substantive requirements of this regulation.
Section 5. Definitions

A. “Actuarial Method” means the methodology used to determine the Required Level of Primary Security, as described in Section 6.

B. “Covered Policies” means the following: Subject to the exemptions described in Section 4, Covered Policies are those policies, other than Grandfathered Policies, of the following policy types:

1. Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or,

2. Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

C. “Grandfathered Policies” means policies of the types described in Subsections B1 and B2 above that were:

1. Issued prior to January 1, 2015; and

2. Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in Section 4 had that section then been in effect.

D. “Non-Covered Policies” means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.

E. “Required Level of Primary Security” means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.

F. “Primary Security” means the following forms of security:

1. Cash meeting the requirements of [insert provision of state law equivalent to Section 3A of the Credit for Reinsurance Model Law];

2. Securities listed by the Securities Valuation Office meeting the requirements of [insert provision of state law equivalent to Section 3B of the Credit for Reinsurance Model Law], but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

3. For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

   a. Commercial loans in good standing of CM3 quality and higher;

   b. Policy Loans; and

   c. Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

G. “Other Security” means any security acceptable to the commissioner other than security meeting the definition of Primary Security.

H. “Valuation Manual” means the valuation manual adopted by the NAIC as described in Section 11B(1) of the Standard Valuation Law, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

Drafting Note: Section 5H presumes that each state is permitted under its state laws to directly reference the Valuation Manual adopted by the NAIC. If a state is required by its state laws to reference a state law or regulation, it should modify Section 5H as appropriate to do so.

Drafting Note: Sections 5H and I presume that each state is permitted under its state laws to “adopt” the Valuation Manual in a manner similar to how the Accounting Practices and Procedures Manual becomes effective in many states, without a separate regulatory process such as adoption by regulation. It is desirable that all states adopt the Valuation Manual requirements and that such adoption be achieved without a separate state regulatory process in order to achieve uniformity of reserve standards in all states. However, to the extent that a state may need to adopt the valuation manual through a formal state regulatory process, these sections may be amended to reflect any state’s need to adopt the Valuation Manual through regulation or otherwise.

Section 6. The Actuarial Method

A. Actuarial Method

The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

(1) For Covered Policies described in Section 5B(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in Section 5B(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

(2) For Covered Policies described in Section 5B(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

(3) Except as provided in Paragraph (4) below, the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.

(4) If the reinsurance treaty cedes less than one hundred percent (100%) of the risk with respect to the Covered Policies then the Required Level of Primary Security may be reduced as follows:

(a) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under Subparagraph (c) below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

(b) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(c) If a portion of the Covered Policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be
(d) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security.

It is possible for any combination of Subparagraphs (a), (b), (c), and (d) above to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than one hundred percent (100%) of the risk.

The Adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

(5) In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

(6) If the ceding insurer cedes risks with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this Regulation, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this Regulation;

(7) If a reinsurance treaty subject to this Regulation cedes risk on both Covered and Non-Covered Policies, credit for the ceded reserves shall be determined as follows:

(a) The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies, and Section 7 shall be used to determine the reinsurance credit for the Covered Policy reserves; and

(b) Credit for the Non-Covered Policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of Subparagraph (a), is held by or on behalf of the ceding insurer in accordance with [cite the state’s version of Sections 2 and 3 of the Credit for Reinsurance Model Law]. Any Primary Security used to meet the requirements of this Subparagraph may not be used to satisfy the Required Level of Primary Security for the Covered Policies.

B. Valuation used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

(1) For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer’s general account and without taking into consideration the effect of any prescribed or permitted practices; and

(2) For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the
Section 7. Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation

A. Requirements

Subject to the exemptions described in Section 4 and the provisions of Section 7B, credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to Covered Policies pursuant to [insert provisions of state law equivalent to Sections 2 or 3 of the Credit for Reinsurance Model Law] if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

1. The ceding insurer’s statutory policy reserves with respect to the Covered Policies are established in full and in accordance with the applicable requirements of [insert provisions of state law equivalent to the Standard Valuation Law] and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this regulation does not exceed the proportionate share of those reserves ceded under the contract; and

2. The ceding insurer determines the Required Level of Primary Security with respect to each reinsurance treaty subject to this regulation and provides support for its calculation as determined to be acceptable to the commissioner; and

3. Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of [insert provision of state law equivalent to Section 3 of the Credit for Reinsurance Model Law], on a funds withheld, trust, or modified coinsurance basis; and

4. Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (3) above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of [insert provision of state law equivalent to Section 3 of the Credit for Reinsurance Model Law]; and

5. Any trust used to satisfy the requirements of this Section 7 shall comply with all of the conditions and qualifications of [insert provision of state law equivalent to Section 124 of the Credit for Reinsurance Model Regulation], except that:

a. Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in Section 6B, be valued according to the valuation rules set forth in Section 6B, as applicable; and

b. There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of Section 7A(3); and

c. The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by Section 7A(3)) below 102% of the level required by Section 7A(3) at the time of the withdrawal or substitution; and

(d) The determination of reserve credit under [insert provision of state law equivalent to Section 124E of the Credit for Reinsurance Model Regulation] shall be determined according to the valuation rules set forth in Section 6B, as applicable; and

NAIC’s Life Actuarial (A) Task Force no later than the Dec. 31st on or immediately preceding the valuation date for which the Required Level of Primary Security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.
The reinsurance treaty has been approved by the commissioner.

B. Requirements at Inception Date and on an On-going Basis; Remediation

1. The requirements of Section 7A must be satisfied as of the date that risks under Covered Policies are ceded (if such date is on or after the effective date of this regulation) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under Section 7A(3) or 7A(4) with respect to any reinsurance treaty under which Covered Policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

2. Prior to the due date of each Quarterly or Annual Statement, each life insurance company that has ceded reinsurance within the scope of Section 3 shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which Covered Policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of Sections 7A(3) and 7A(4) were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to Section 7A(3), unless either:

   a. The requirements of Section 7A(3) and 7A(4) were fully satisfied as of the valuation date as to such reinsurance treaty; or

   b. Any deficiency has been eliminated before the due date of the Quarterly or Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of Section 7A(3) and 7A(4) to be fully satisfied as of the valuation date.

3. Nothing in Section 7B(2) shall be construed to allow a ceding company to maintain any deficiency under Section 7A(3) or 7A(4) for any period of time longer than is reasonably necessary to eliminate it.

Section 8.   Severability

If any provision of this regulation is held invalid, the remainder shall not be affected.

Section 9.   Prohibition against Avoidance

No insurer that has Covered Policies as to which this regulation applies (as set forth in Section 3) shall take any action or series of actions, or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of such action, transaction or arrangement or series thereof is to avoid the requirements of this regulation, or to circumvent its purpose and intent, as set forth in Section 2.

Section 10.   Effective Date

This regulation shall become effective [insert date] and shall pertain to all Covered Policies in force as of and after that date.
Commissioner White reminded the Committee of a May 15 educational session on the topic of the London Interbank Offered Rate (LIBOR) in which the Committee took no action on a proposal from the American Council of Life Insurers (ACLI).

Commissioner White said the ACLI proposal requests two things: 1) a safe harbor to address the fact that all state laws essentially limit the type of derivatives insurers can engage in; and 2) deem these types of derivatives as effective hedges. He said the proposal was received, but action was deferred because it was an educational-focused conference call. He said that under the LIBOR transition, insurance companies will be receiving certain swaps that do not easily fit into those allowable categories. He noted that the only way an insurance company would not be forced to sell these swaps the day they were received, and potentially incur losses, would be to receive a clarification issued by the insurance commissioner that allows these as permissible investments.

Commissioner White said he believes that issuance of such a clarification is appropriate because the issue is not something the insurers have any control over and when coupled with the potential for an insurer losing what he would consider policyholder money from this LIBOR transition, it is the correct position to take in his state. He stated for that reason, and because he did not hear any pushback from the Committee members during the May 15 conference call, he prepared a memorandum that summarizes his views on this issue.

Mr. Smith recommended that the word “forbearance” in the subject line of the memorandum be replaced with the word “clarification.” Commissioner White agreed, and so did the other Committee members.

Commissioner White said issuing a clarification on state law is an issue each individual commissioner would have to decide. He stated that the accounting issue embedded in the original request from the ACLI should be referred to the Statutory Accounting Principles (E) Working Group.

Michael Lovendusky (ACLI) stated the ACLI appreciates the action from the Committee and supports the clarification that these should be permissible. However, he said the ACLI questioned the referral. He stated the ACLI did discuss the issue briefly and did not believe the issue needed to be addressed by the Statutory Accounting Principles (E) Working Group.

Commissioner White reiterated his previous views regarding the accounting issue and said it is appropriate to break out the accounting issue separately.

Commissioner Toal made a motion, seconded by Superintendent Cioppa, to adopt the draft memorandum and refer the accounting issue to the Statutory Accounting Principles (E) Working Group (Attachment Two-A). The motion passed unanimously.

2. **Adopted an Extension on Mortgage Forbearance**

Commissioner White directed the Committee to the previously issued March 27 guidance from the Committee on this issue, and the question was whether this guidance should be extended.

Bruce Oliver (Mortgage Bankers Association—MBA) said there were several moving parts, including the MBA’s most recent letter to the Committee, being considered at this time. He referenced the previously issued guidance that lasts until the end of June and referenced subsequent clarifications. He said the MBA has since sent a letter to the Life Risk-Based Capital (E)
Working Group requesting specific changes to the guidance for year-end, including addressing various issues it identified in a previous letter. Mr. Oliver then introduced John Waldeck (Pacific Life Insurance Company), speaking on behalf of the ACLI.

Mr. Waldeck stated that members of the ACLI have been working with borrowers regarding possible loan modifications without knowing how long things would last and when things may begin to reopen. He said that many decisions have been made by insurance companies on this forbearance issue in a prudent manner. He said some insurers may decide that such agreements should be extended. Therefore, working with guidance in the federal Coronavirus Aid, Relief and Economic Security (CARES) Act or to the banks, they still need time to work with borrowers since reopening is just beginning to occur. He said the request to the Life Risk-Based Capital (E) Working Group had been until the end of the year and for year-end and, therefore, the request is for an extension until such time, or at least until September.

Mr. Waldeck said the request to the Life Risk-Based Capital (E) Working Group issues are broader, but the extension issue before the Committee is the most pressing issue at this time. He said the intent of this request was not to forestall impairments but rather prudently work with borrows, and he noted that the ACLI believes the extension is appropriate.

Commissioner White noted the Committee believes the original guidance is appropriate to help in addressing this broader issue for borrowers throughout the country when done so prudently. He stated that he supports the Life Risk-Based Capital (E) Working Group discussing the broader guidance before the Committee takes any further action after today, but that extending this guidance until the end of September seems appropriate.

Commissioner Robertson made a motion, seconded by Commissioner Dodrill, to extend the original forbearance guidance until Sept. 30 and update the guidance posted to the NAIC website (Attachment Two-B and Attachment Two-C). The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.
MEMORANDUM

TO: Commissioners, Directors and Superintendents

FROM: Commissioner Scott A. White (VA)
Chair of the Financial Condition (E) Committee

DATE: June 12, 2020

RE: Support for Commissioner Clarification Regarding State Law on Derivatives

Background Information
The London Interbank Offered Rate (LIBOR) is a set of reference rates based on average rates for short-term interbank unsecured loans quoted by London banks, and it is not expected to be available as a financial reference rate after 2021. As part of a market-wide transition away from LIBOR and toward the Secured Overnight Financing Rate (SOFR), U.S. central clearing counterparties (CCPs) will shift their discounting rate from the Effective Federal Funds Rate (EFFR) to the SOFR using a one-time special valuation cycle. This is expected to occur once on Oct. 16. As part of this unique market event, the CCPs will revalue existing cleared swaps and issue basis swaps on a mandatory basis to all parties that clear swaps on the CCPs to restore a counterparty’s original risk profile. Insurance companies use derivatives, such as interest rate swaps and credit default swaps, primarily for hedging purposes, including to manage risks associated with matching an insurer’s projected liabilities with large bond portfolios and protect an insurer’s exposure to various cash instruments and market conditions.

When using derivatives, insurance companies are required to abide by investment guidelines and legal and regulatory constraints established by the commissioner for their general account assets in a state. Most state laws limit insurers’ derivative use to activities such as hedging, replication, and certain income-generation activities. Life insurance companies have asked for clarification that the basis swaps they will receive as part of CCP’s transition to the SOFR discounting and certain transactions entered into in connection with receipt of those basis swaps will be deemed effective hedges under the uses of derivatives allowed by regulation in a state and under any derivative use plan required to be submitted under state insurance law.

Support for Commissioner Clarification
Due to the above circumstances and the fact that insurers have no control over the distribution of such basis swaps to them, and recognizing that insurers may be disadvantaged if required to dispose of such basis swaps upon receipt or a time thereafter, the Financial Condition (E) Committee is issuing this memorandum to make commissioners, directors and superintendents aware of this issue and offering support for those who issue bulletins on this issue.
The Committee, however, has not concluded that the basis swaps should be deemed effective hedges, but rather, they should be deemed “permissible derivative investments.” Therefore, the Committee supports that for the purposes of applicable state law, any basis swap (or group thereof) incurred by an insurer in connection with a clearinghouse’s shift in discounting from the EFFR to the SOFR (CCP Cutover) shall be deemed a permissible derivative investment for up to one year past the date of the CCP Cutover. We recognize that a commissioner’s decision to provide clarification on a state law set forth by state legislatures is an individual one, and we would respect that some commissioners may wish to perform further due diligence with their own domestic insurers before issuing a bulletin offering such clarification.
To: All Insurers  
RE: June 12 Question & Answer on Guidance for Mortgages for March 31 - September 30 Statutory Financial Statements and Related Interim Risk-Based Capital Filings

**Background Information**

On March 27 and June 12, the Financial Condition (E) Committee issued guidance to encourage insurers to work with borrowers who are unable to, or may become unable to meet their contractual payment obligations because of the effects of COVID-19. Nothing in that guidance supersedes the requirement or authority of any state, particularly any state that has separately issued COVID-19 orders, directives or other guidance the impact of which may lead to debt becoming troubled and/or needing to be restructured.

**Original Questions**

**Q1** Is the June 12 guidance also intended to apply to insurers that are not required to report risk-based capital calculations to their domestic regulator or the NAIC for March 31, June 30 and September 30?

A1 - Yes. The guidance applies to all U.S. insurers filing and is not specific only to insurers that are required to report quarterly risk-based capital calculations. The reference to risk-based capital calculations prepared by insurers for March 31, June 30 and September 30 is intended to provide guidance for periodic internal reporting and reporting to policyholders, the public, and rating agencies that is not otherwise a prohibited announcement under state law.

**Q2** Is this guidance intended to apply to all COVID-19 loan modifications that occur through September 30, 2020, so that an insurer that modifies a loan in accordance with the parameters of the guidance within that period is not required to adjust the origination date, valued date, or property value as of the modification date (as required under current RBC rules for loan restructures) for current or future RBC reporting periods?

A2 - Yes. The intent of the guidance is to encourage insurers to make prudent loan modifications for borrowers who are temporarily unable to meet their contractual payment obligations because of the effects of COVID-19 and is not intended to have long-term negative impacts under current RBC rules. Consistent with this intent, if an insurer modifies a loan in accordance with the parameters of the guidance, the insurer is not required to adjust the origination date, valued date, or property value for current or future RBC reporting periods. In addition, an insurer is not required to reclassify to a different RBC category (such as within CM categories (e.g., CM1 to CM2) or within standing categories (e.g., In Good Standing, Overdue, Not in Process, In Process of Foreclosure)) for March 31, June 30 and September 30. The expectation is that further, more deliberative discussion is expected to occur in the future through the Life Risk-Based Capital (E) Working Group, regarding these loans for future reporting periods.

**Q3** Some construction projects are not allowed to operate because of government imposed stay-at-home orders. Current RBC rules specify that a loan with “construction loan issues” (e.g., abandoned) is required to have a CM5 rating. Is the guidance that loans are not required to be reclassified to a different RBC category as a result of government-mandated delays in any required principal and interest payments in the first and second quarters of 2020 also intended not to require reclassification of construction loans in cases of government-mandated delays in construction?

A3 - Yes. No RBC category change is required to be changed for March 31, June 30 and September 30 as a result of government-mandated construction delays in the first, second and third quarters of 2020. The expectation is that
further, more deliberative discussion is expected to occur in the future through the Life Risk-Based Capital (E) Working Group, regarding these loans for future reporting periods.

**Q4**—Many properties for which borrowers are not requesting relief may be impacted by valuation and NOI changes resulting from the COVID-19 pandemic. What will be the risk-based capital treatment of these loans?

**A4**—The expectation is that further, more deliberative discussion on valuation, NOI impacts and other impacts COVID-19 may cause will occur in the future through the Life Risk-Based Capital (E) Working Group.

**Additional Questions**

**Q1**—The guidance indicates support for loan modifications as a result of COVID-19 but seems to restrict to only those loans that are troubled debt restructures, was this intentional?

**A1**—No, the guidance was intending to apply to all loan modifications made as a result of COVID-19 before September 30 even if they would otherwise be categorized a troubled debt restructure; setting forth a safe harbor for all such changes made as a result of COVID-19 during that time period with the intent of the Life RBC Working Group developing more explicit and detailed RBC guidance for both 4Q and beyond, as well as how loan modifications made subsequent to the September 30 date would be treated. While such a safe harbor was intending to encourage loan modifications that are prudent so that there was no long-term impact on policyholders asset values, the view was that guidance on things such as operating income or other considerations within the RBC formula that attempt to measure the future risk of loans would be better addressed by the Life RBC Working Group. (Modifications of loan terms do not automatically result in TDRs. According to U.S. GAAP, a restructuring of a debt constitutes a TDR if the creditor, for economic or legal reasons related to the debtor’s financial difficulties, grants a concession to the debtor that it would not otherwise consider. Short-term modifications made on a good faith basis in response to COVID-19 to borrowers who were current prior to any relief, are not TDRs. This includes short-term (e.g., six months) modifications such as payment deferrals, fee waivers, extensions of repayment terms, or other delays in payment that are insignificant. Borrowers considered current are those that are less than 30 days past due on their contractual payments at the time a modification program is implemented. Working with borrowers that are current on existing loans, either individually or as part of a program for creditworthy borrowers who are experiencing short-term financial or operational problems as a result of COVID-19, generally would not be considered TDRs.)

**Additional Questions**

**Q1**—Is the guidance expected to be updated in the future for 4Q financial statements and if so how?

**A1**—The June 12 guidance developed was intended issued to provide immediate guidance and the expectation is that further, more deliberative discussion is expected to occur in the future through the Life Risk-Based Capital (E) Working Group.

**Q2**—The guidance indicates that delays in any required principal and interest payments in accordance with the defined parameters are not required to be reclassified to a different RBC category, does this include reclassification either within CM categories (e.g. CM1 to CM2) or within other categories (e.g. In Good Standing, Overdue, Not in Process, In Process of Foreclosure, or both?)

**A2**—The guidance is meant to apply to both situations, the CM categories and the standing categories.
To: All Insurers  
From: Financial Condition (E) Committee  
Date: June 12, 2020  
RE: Guidance for Troubled Debt Restructurings for March 31 - September 30 Statutory Financial Statements and Related Interim Risk-Based Capital Filings (where required)

**Background Information**
This guidance is being issued by the Financial Condition (E) Committee to all U.S. insurers filing with the NAIC in an effort to encourage insurers to work with borrowers who are unable to, or may become unable to meet their contractual payment obligations because of the effects of COVID-19. The Committee, which is the NAIC parent committee of all the solvency policy making task forces and working groups of the NAIC, supports the use of prudent loan modifications that can mitigate the impact of COVID-19.

**Parameters of Guidance**
This guidance applies to a troubled debt restructuring issued as a result of COVID-19 and is applicable to the term of the loan modification, but solely with respect to a modification, including a forbearance arrangement, an interest rate modification, a repayment plan, and any other similar arrangement that defers or delays the payment of principal or interest, which occurs during the applicable reporting period for a loan that was not more than 30 days past due as of December 31, 2019. Nothing in this guidance supersedes the requirement or authority of any state, particularly any state that has separately issued COVID-19 orders, directives or other guidance the impact of which may lead to debt becoming troubled and/or needing to be restructured.

**Direct Mortgage Loans & Schedule BA Mortgages**
For purposes of any risk-based capital calculations prepared by insurers for March 31, June 30 and September 30, all direct mortgages and Schedule BA mortgages for which the insurer chooses, or is government mandated, to allow delays in any required principal and interest payments in accordance with the above parameters are not required to be reclassified to a different RBC category (e.g. will not affect the origination date, valued date, and net operating income or be treated as delinquent) than was utilized during the December 31, 2019 RBC filing and which may have otherwise required a higher capital charge for such a mortgage.

**RMBS and CMBS Securities**
For purposes of the reporting of NAIC designations in the financial statements prepared for March 31, June 30, and September 30 or any risk-based capital calculations prepared by insurers for March 31, June 30 and September 30, all RMBS and CMBS securities which were modeled by the NAIC for year-end 2019 and for which any required principal and interest payments have been deferred in accordance with the above parameters are not required to receive an updated NAIC designation despite the fact that payments may have been deferred as previously described.

**Related Accounting Guidance & Updates**
Please see the following for both related accounting guidance and updates to this guidance via Q&A.  
https://content.naic.org/cmte_e_app_blanks.htm  
(Please see related documents tab)

**Questions**
Any questions on this guidance should be directed to Dan Daveline by e-mail at ddaveline@naic.org
The Financial Condition (E) Committee met via conference call May 15, 2020. The following Committee members participated: Scott A. White, Chair, and Doug Stolte and David Smith (VA); Eric A. Cioppa, Vice Chair (ME); Michael Conway represented by Rolf Kaumann (CO); David Altmaier, Carolyn Morgan and Virginia Christy (FL); Robert H. Muriel represented by Kevin Fry, Shannon Whalen and Susan Berry (IL); Stephen W. Robertson represented by Roy Eft (IN); Steve Kelley represented by Constance Peterson (MN); Mike Chaney represented by David Browning (MS); Marlene Caride and John Sirovetz (NJ); Russell Toal represented by Mark Jordon (NM); Raymond G. Farmer and Daniel Morris (SC); Kent Sullivan represented by Jamie Walker (TX); and Jeff Rude represented by Linda Johnson (WY).

1. **Heard an Educational Session on LIBOR**

Commissioner White described that the purpose of the conference call is educational on the topic of the London Interbank Offered Rate (LIBOR), which will no longer be supported past 2021. He described how insurance companies would be affected as early as October 2020 and the reason for a proposal from the industry to alleviate the potential adverse impact away from LIBOR. He described how the core issue is ultimately how some of the derivatives that are delivered to insurers may not be in conformance with state law since derivatives are usually only allowed to be one of one of three types—hedging, income generation and replication—and that those derivatives that derived from the LIBOR exchange may not fit into one of those three buckets.

Michael Lovendusky (American Council of Life Insurers—ACLI) introduced member companies that would collectively facilitate the educational session. The presenters included Kathleen O'Neill, Associate General Counsel at New York Life Insurance Company and Vice Chairwoman of the ACLI Derivatives Policy Working Group; Joseph J. Demetrick, Managing Director, Derivatives & Liquid Markets at MetLife Investment Management and Chairman of the ACLI Derivatives Policy Working Group; and Chris McAlister, Managing Director at Prudential Financial. Ms. O'Neill presented most of the information in the written presentation (Attachment Three-A). During the presentation, she emphasized how as the clearinghouse, which is a large financial player, changes its valuation rate, it is expected to generate a lot of liquidity across the Secured Overnight Financing Rate (SOFR) term structure, which is expected to facilitate the transition of new transactions away from LIBOR. She describes this as a technical move that had a large impact, and she referenced how the mechanics were described in the appendix of the written presentation. Essentially, the clearinghouses will make a one-time move to change their valuation process on a single day on Oct. 16. Ms. O'Neill described how there are two steps involved in this process. First, the clearinghouses will conduct a standard end-of-day valuation cycle using federal funds, just like any other day, and the clearinghouses will run a special valuation cycle on the same positions using the SOFR. The two sets of data will be compared, and they will make a one-time adjustment that includes a cash component that adjusts each account that offsets the value transfer as a result of these discounting changes. Second, the clearinghouses book mandatory federal funds SOFR basis swaps that have one leg in federal funds and then one leg in the SOFR. This will restore the accounts’ original risk profile. These accounts will have the same risk profile at the end of the day as the beginning of the day by having these derivatives distributed to them on a mandatory basis. This is where the tension with state insurance law occurs since in many states, insurers can only enter for hedging, replication or income generation, and it is not clear where these would fit into those categories. Ms. O'Neill pointed out that the clearinghouses are planning to put in an auction process for those that do not want to hold the basis swaps, but those processes have not been finalized; therefore, it creates further issues. She also noted that it is not possible for insurers to move away from clearinghouses since under the federal Dodd Frank Wall Street Reform and Consumer Protection Act, many of these are mandated to be cleared under these clearinghouses.

Ms. Berry asked about the duration of these swaps. Mr. McAlister responded how the proposals from the clearinghouses are to give swaps across several durations—two, five, seven, 10, 20 and 30-year swaps—so that it is across a wide number of durations. Commissioner White asked why the clearinghouses used 2020 given that LIBOR does not go away until 2021. Mr. Demetrick stated that part of this is designed to create additional SOFR liquidity and activate transition portfolios. He stated that this will help liquidity to build in the SOFR. Commissioner White asked if state law was considered in determining this approach. Mr. McAlister indicated that he was not sure that it was considered, but he noted that banks used federal funds across their franchise and manage it holistically. This is just part of their federal funds risk, and they are concerned that what is at these clearinghouses will offset something else they have in their franchise, and banks requested that these basis swaps be granted. Mr. McAlister indicated that Prudential voiced that this is not something they preferred, but he implied that the banks...
are more influential in the clearinghouses. Mr. Demetrick added that it is important to know that the clearinghouses have to remain in a balanced risk position; therefore, if they are going to offer basis swaps to one party, they automatically have to deliver them to the people on the other side of the transaction. Otherwise, they would be taken on market risk by the clearinghouse itself. Commissioner White asked hypothetically if insurers were not allowed a full year to dispose of these basis swaps what would occur. Mr. Demetrick described how this was a one-off event and that the differential between the LIBOR and SOFR rates are close, but if insurers are required to unwind early, that could drive a technical widening and therefore disadvantage life insurers. Dan Daveline (NAIC) requested information on the rationale behind the derivatives being effective hedges and whether they could be classified as something else. Ms. O'Neill stated that while state laws differ, her understanding is that under New York state law, the insurer is required to show that the hedge is effective; therefore, it is hard to understand how the effectiveness testing would operate. Consequently, the ACLI is looking for clarification on whether it is both a hedge and an effective hedge so that insurers would not have to make that determination. Ms. O'Neill stated that she would like to think through this more, but she noted that having a hedge would be helpful, but the effective hedge aspect of this could be worked around.

Having no further business, the Financial Condition (E) Committee adjourned.
Executive Summary

- Availability of LIBOR is not assured past 2021
- As part of the transition to SOFR, Central Clearing Parties (CCP) for cleared swaps plan to switch their discounting rate from Fed Funds to SOFR in October 2020
- As part of this switch, parties that trade on the CCP will be compelled to receive basis swaps
- We request that state regulators clarify that derivatives entered into directly in connection with the CCP discounting change are categorized as hedging transactions

LIBOR Transition and Insurance Companies – General Considerations

- Insurance companies experience LIBOR exposure across a wide array of markets, requiring a flexible approach across asset classes that may be coalescing around different approaches, such as for floating rate notes, CLIs, securitized products, private placements, real estate and derivatives
- Within derivatives, there are different issues posed by over-the-counter derivatives and cleared derivatives
- The specific issue we will discuss today arises from a planned change at CCPs, who will shift their discounting rate on uncleared swaps from Fed Funds to SOFR, affecting life insurers’ cleared derivatives
CCP Transition to SOFR

- The cleared derivatives market in the US is expected to shift to SOFR via a staged approach, in line with the ARRC’s Paced Transition Plan.
- This will entail both a shift in discounting (planned for October 2020) and ultimately a shift in reference index (from LIBOR to SOFR).
- The first step is a migration of the calculation of discounting and price alignment interest for cleared USD interest rate swap products from the daily Effective Federal Funds Rate (EFFR) to SOFR.
- This move at the CCPs is seen as a key step in generating liquidity across the SOFR term structure. This will facilitate transitioning new transactions away from LIBOR.

CCP Transition to SOFR – mechanics

- The switch from EFFR discounting to SOFR discounting will be undertaken in two steps, occurring on October 16, 2020:
  - **Step 1 – Valuation**: the CCP will conduct a standard end-of-day valuation cycle based on EFFR and then it will run a “special valuation cycle” on the same positions, using SOFR as the discounting rate.
  - **Step 2 – Adjustment**: the CCP will (1) make a cash adjustment to each account to offset the value transfer arising from the discounting change and (2) book mandatory EFFR/SOFR basis swaps to each account to restore the account’s original risk profile.

- As a result, all CCP participants, including life insurers, will be allocated basis swaps on a mandatory basis.
- CCPs are contemplating an “auction” process for participants that do not want to hold the basis swaps, but the feasibility of these auctions and their mechanics have not been finalized.

Proposed Relief

- **Proposal**: we are requesting a bulletin/circular letter from state insurance regulators providing a safe harbor for derivatives entered into in connection with the CCPs’ transition from EFFR to SOFR discounting.
- "For the purposes of [applicable state law], any basis swap (or group thereof) incurred by a life insurer with the purpose of mitigating risk in connection with a clearinghouse’s shift in discounting from the federal funds effective rate to the secured overnight financing rate (a “CCP Cutover”) shall be deemed an effective hedging transaction notwithstanding any other provision of [applicable state law] or such life insurer’s derivatives use plan, so long as the life insurer has documented the fact that it has engaged in such basis swap (or group thereof) with the express purpose of mitigating risk in connection with a CCP Cutover. This would apply for a period up to 1 year past the date of the CCP Cutover.”

Appendix

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The World’s Most Important Number

Libor & Its Impact

Source: ISDA, IBOR Global Benchmark Survey 2018 Transition Roadmap, February 2018; Goldman Sachs (data as of 2014)

Current Libor Setting Methodology

Most Libor submissions not based on observable transactions
Market Transactions Underlying LIBOR Have Decreased Significantly

Funding Volumes of G-SIBs

Source: FR2420 Report of Selected Money Market Rates and DTCC. Federal Reserve staff calculations based on daily volumes aggregated across fed funds, Eurodollar, certificates of deposit, and unsecured commercial paper transactions of the 30 global systematically important banks with tenors between 25 and 35 calendar days (for one-month) 80 and 100 calendar days (three-month), or 150 and 210 calendar days (six-month) over the period October 15, 2016 to June 30, 2017.

Key Dates in LIBOR Phase Out

- 2014: International Organization of Securities Commissions (“IOSCO”) establishes Principles for Financial Benchmarks by Administrators of EURIBOR, LIBOR and TIBOR.
  - Principles indicate that reference rates should be transitioned to “rates that are anchored in observable transactions.”
- 2014: International Regulators begin work on establishing alternative reference rates.
- US Fed establishes the Alternate Reference Rates Committee (“ARRC”) to identify alternative, transaction-based reference rate to replace LIBOR.
- June 2017: ARRC identifies Secured Overnight Financing Rate (“SOFR”) - a broad overnight rate based on Reps financing rates – as alternative to USD LIBOR.
- July 2017: UK Financial Conduct Authority (“FCA”) announces that it will no longer compel or persuade banks to submit to LIBOR panels after the end of 2021.
- October 2017: ARRC adopts its Paced Transition Plan, including a switch to SOFR discounting/PAI at CCPs.
- November 2017: FCA announces voluntary agreement with all IBOR panel banks to sustain LIBOR until the end of 2021.

IOSCO Summary of Principles

- Governance - intended to ensure that Administrators have appropriate governance arrangements in place to protect the integrity of the Benchmark determination process and to address conflicts of interest.
- Benchmark quality - intended to promote the quality and integrity of Benchmark determinations through the application of design features that result in a Benchmark that reflects a credible market for the interest rate measured by that Benchmark.
- Data sufficiency - intended to promote the quality and integrity of Methodologies by setting out minimum information that should be addressed within a Methodology. The Principles require that information be Published or Made Available so that Stakeholders may understand and make their own judgments concerning the overall credibility of a Benchmark. They also require that the Methodology address the need for procedures that control when material changes are planned, as a means of alerting Stakeholders to these changes that might affect their positions, financial instruments or contracts.
- Accountability - require that Administrators establish complaints processes, documentation standards and audit reviews intended to provide evidence of compliance by the Administrator with its quality standards, as defined by the Principles and its own policies. The Principles also addressed making this information available to relevant Market Authorities.

What is SOFR?

- Secured Overnight Financing Rate (“SOFR”)
- Overnight, nearly “risk free” rate that is correlated with other money market rates
- Fully transaction based, reflecting broad measure of overnight US Treasury repos (“Repos”) financing transactions
- Encompasses robust underlying market with over $500 billion in daily transactions
- FRBNY proposes to use an adjusted volume weighted median as the measure for SOFR
- FRBNY began publishing SOFR and its summary statistics in April of 2018
LIBOR vs SOFR: Key Features & Differences

<table>
<thead>
<tr>
<th>Feature</th>
<th>LIBOR</th>
<th>SOFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Interbank Offered Rate (LIBOR)</td>
<td>Average interest rate for short-term, inter-bank unsecured loans</td>
<td>Secured Overnight Financing Rate (SOFR) secured overnight repo rate based on US Treasury repo transactions</td>
</tr>
<tr>
<td>Term (O/N, 1-mo, 3-mo, 6-mo, 12-mo)</td>
<td>Overnight (compounded)</td>
<td>Daily Fixing</td>
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<tr>
<td>Incorporates credit risk premium</td>
<td>No credit risk premium</td>
<td>Based on observable market transactions</td>
</tr>
<tr>
<td>Forward looking</td>
<td>Daily Fixing</td>
<td>Liquid, deep, and transparent</td>
</tr>
<tr>
<td>Reflects Banks’ cost of funds</td>
<td>Reflects cost of borrowing against Treasuries</td>
<td>Source: ICE Benchmark Administration</td>
</tr>
</tbody>
</table>

SOFR-linked Transaction Growth

SOFR Daily Trading Volumes Dwarf Alternatives

IBOR Replacements

<table>
<thead>
<tr>
<th>Country / Region</th>
<th>IBOR Index</th>
<th>Proposed Replacement</th>
<th>Underlying Transactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
<td>EUR-LIBOR</td>
<td>ESTER</td>
<td>Overnight borrowings; secured overnight transactions between lenders</td>
</tr>
<tr>
<td>Japan</td>
<td>JPY-LIBOR</td>
<td>TONAR</td>
<td>Secured transactions in the unsecured overnight call rate market</td>
</tr>
<tr>
<td>Switzerland</td>
<td>TOIS</td>
<td>SARON</td>
<td>Secured transactions in the unsecured overnight repo market</td>
</tr>
</tbody>
</table>
| United Kingdom   | UK-LIBOR   | SONIA                | Secured overnight LIBOR transactions;
| United States    | USD-LIBOR  | SOFR                 | Broad measure of overnight US Treasury Repo financing transactions |
LIBOR Cessation—Documentation Issues for Life Insurers

- Across asset classes (securitizations, floating rate notes, derivatives, repo, etc.), no consistency regarding mechanics to replace LIBOR
- The “missing mechanics” are known as “fallback triggers” and “fallback rates”
- “Fallback Triggers” are events that cause a switch from one floating rate to another (trigger can be general (e.g., “LIBOR ceases to be published” or “LIBOR is no longer representative”) or bespoke (e.g., “50% or more of collateral assets in a securitization switch from LIBOR”)
- “Fallback Rates” replace LIBOR following a Fallback Trigger; either hardwired into a document (e.g., “term SOFR”) or left to negotiation (e.g., “as reasonably determined by the Calculation Agent”)
- The market has not converged on a single mechanism and asset classes will diverge (e.g., derivatives versus cash products); these differences can give rise to basis risk both within deals (e.g., securitizations) and across deals (hedges vs. hedged positions)

LIBOR Cessation—Derivatives Issues for Life Insurers (cleared swaps)

- Cleared OTC derivatives incorporate by reference ISDA definitions that do not provide Fallback Rates to replace LIBOR
- US cleared market will shift to SOFR via a staged approach that entails first a shift in discounting (planned for Fall 2020) and ultimately a shift in reference index (from LIBOR to SOFR)
- Basis swaps will be allocated to insurance companies during the cleared swap discounting shift on a mandatory basis
- Regulators (e.g., CFTC, Fed, OCC, etc.) and standard-setting bodies (e.g., FASB, IASB) have been releasing rules and guidance providing “flexibility” so that changes to terms of existing transactions relating to LIBOR cessation do not trigger undesirable accounting, tax and regulatory consequences
- State insurance regulators should follow suit to assure life insurers’ compliance with their regulatory schema

LIBOR Cessation—Derivatives Issues for Life Insurers (uncleared swaps)

- Over-the-counter (“OTC”) uncleared derivatives typically incorporate ISDA definitions that do not provide a Fallback Rate to replace LIBOR
- US uncleared market will adopt compounded-in-arrears SOFR; for new trades via updated ISDA definitions (currently being finalized) and for existing trades via an optional “protocol” to retroactively apply the new ISDA definitions to existing transactions
- Some insurers and their counterparties may negotiate bilateral terms for swap transactions as needed
- Regulators (e.g., CFTC, Fed, OCC, etc.) and standard-setting bodies (e.g., FASB, IASB) have issued rules and guidance providing “flexibility” so that changes to terms of existing transactions relating to LIBOR cessation do not trigger undesirable accounting, tax and regulatory consequences
Financial Condition (E) Committee
E-Vote
March 26, 2020

The Financial Condition (E) Committee conducted an e-vote that concluded March 26, 2020. The following Committee members participated: Scott A. White, Chair (VA); Eric A. Cioppa, Vice Chair, (ME); Michael Conway represented by Rolf Kaumann (CO); David Altmaier (FL); Robert H. Muriel represented by Kevin Fry and Kevin Baldwin (IL); Stephen W. Robertson and Roy Eft (IN); Steve Kelley represented by Fred Andersen (MN); Mike Chaney represented by David Browning (MS); Raymond G. Farmer (SC); Kent Sullivan represented by Doug Slape and Jamie Walker (TX); and Jeff Rude (WY).


The Financial Condition (E) Committee conducted an e-vote to consider adoption of the guidance. A majority of the members voted in favor of adopting the guidance (Attachment Four-A). The motion passed.

Having no further business, the Financial Condition (E) Committee adjourned.
To: All Insurers  
From: Financial Condition (E) Committee  
Date: March 27, 2020  
RE: Guidance for Troubled Debt Restructurings for March 31-June 30 Statutory Financial Statements and Related Interim Risk-Based Capital Filings (where required)

Background Information  
This guidance is being issued by the Financial Condition (E) Committee to all U.S. insurers filing with the NAIC in an effort to encourage insurers to work with borrowers who are unable to, or may become unable to meet their contractual payment obligations because of the effects of COVID-19. The Committee, which is the NAIC parent committee of all the solvency policy making task forces and working groups of the NAIC, supports the use of prudent loan modifications that can mitigate the impact of COVID-19.

Parameters of Guidance  
This guidance applies to a troubled debt restructuring issued as a result of COVID-19 and is applicable to the term of the loan modification, but solely with respect to a modification, including a forbearance arrangement, an interest rate modification, a repayment plan, and any other similar arrangement that defers or delays the payment of principal or interest, which occurs during the applicable reporting period for a loan that was not more than 30 days past due as of December 31, 2019. Nothing in this guidance supersedes the requirement or authority of any state, particularly any state that has separately issued COVID-19 orders, directives or other guidance the impact of which may lead to debt becoming troubled and/or needing to be restructured.

Direct Mortgage Loans & Schedule BA Mortgages  
For purposes of any risk-based capital calculations prepared by insurers for March 31 and June 30, all direct mortgages and Schedule BA mortgages for which the insurer chooses, or is government mandated, to allow delays in any required principal and interest payments in accordance with the above parameters are not required to be reclassified to a different RBC category (e.g. will not affect the origination date, valued date, and net operating income or be treated as delinquent) than was utilized during the December 31, 2019 RBC filing and which may have otherwise required a higher capital charge for such a mortgage.

RMBS and CMBS Securities  
For purposes of the reporting of NAIC designations in the financial statements prepared for March 31 and June 30 or any risk-based capital calculations prepared by insurers for March 31 and June 30, all RMBS and CMBS securities which were modeled by the NAIC for year-end 2019 and for which any required principal and interest payments have been deferred in accordance with the above parameters may be reported with the same NAIC designation as used for year-end 2019 and are not required to receive an updated NAIC designation despite the fact that payments may have been deferred as previously described.

Related Accounting Guidance & Updates  
Please see the following for both related accounting guidance and updates to this guidance via Q&A.  
https://content.naic.org/cmte_e_app_blanks.htm  
(Please see related documents tab)

Questions  
Any questions on this guidance should be directed to Dan Daveline by e-mail at ddaveline@naic.org
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met via conference call July 29, 2020. The following Working Group members participated: David Altmaier, Chair (FL); Kathy Belfi, Vice Chair, (CT); Susan Bernard (CA); Philip Barlow (DC); Carrie Mears and Mike Yanacheak (IA); Kevin Fry (IL); Roy Eft (IN); John Turchi (MA); Judy Weaver (MI); Kathleen Orth (MN); John Rehagen (MO); Jackie Obusek (NC); Justin Schrader (NE); Dave Wolf and Diana Sherman (NJ); Victor Agbu (NY); Dale Bruggeman and Tim Biler (OH); Greg Lathrop (OR); Joe DiMemmo (PA); Trey Hancock (TN); Doug Slape (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. **Adopted its July 21, June 2 and May 19 Minutes**

Commissioner Altmaier said the Working Group met July 21, June 2 and May 19. During its July 21 and June 2 meetings, the Working Group discussed proposed changes to the *Insurance Holding Company System Regulatory Act* (Model #440). During its May 19 meeting, the Working Group discussed the results of the Group Capital Calculation (GCC) field testing.

Ms. Belfi made a motion, seconded by Mr. Wolf, to adopt the Working Group’s July 21 (Attachment Five-A), June 2 (Attachment Five-B) and May 19 (Attachment Five-C) minutes. The motion passed unanimously.

2. **Considered Comments Received on Exposed Revised Template and Instructions**

Commissioner Altmaier expressed his appreciation for the comments received (Attachment Five-D) on the previously exposed template and instructions, noting that they were extensive and thoughtful. He described how NAIC staff had divided the comments into 12 core issues (Attachment Five-E) and developed a recommended course of action, and the purpose of the meeting was for the Working Group to determine if it supported such a recommendation or preferred a different approach.

   a. **Use of the GCC**

Mr. Felice described how this issue was related to some of the wording of how the analyst would use the GCC in a draft of the analyst guidance included in the June 2 conference call materials. He stated that the wording in that document is consistent with other tools with which you are trying to direct some action from the analyst under certain conditions, and he suggested that it was best that those issues be dealt with separately. Mariana Gomez-Vock (American Council of Life Insurers—ACLI) stated that the ACLI appreciated the inclusion of the interested parties developing the draft *Financial Analysis Handbook* guidance, and it seemed important and should be exposed for comment, particularly considering that it includes a threshold within it. Ms. Weaver stated that as chair of the NAIC group overseeing the *Financial Analysis Handbook*, if the guidance is exposed at this Working Group and any changes are made, we would have a shorter exposure at the group she chairs, but ultimately it will be exposed for comment.

Mr. Felice said the second part of this issue deals with the filing of the GCC. He stated that NAIC staff believed this was already being handled and the GCC would be filed in the changes to Model #440, where currently there will be strong confidentiality geared towards filing with the lead state regulator and sharing of some of the information in regulatory communication. Jim Braue (UnitedHealth Group—UHG) stated that it had two main points: 1) the GCC should be a tool for the lead state and can certainly share information with other domestic regulators within the group, but not more broadly; 2) emphasis on a tool, not a standard, and could take action using the GCC. Ms. Belfi stated that as they go through developing guidance for the *Financial Analysis Handbook*, they will make sure to sync that up with the instructions.

   b. **Calibration Level**

Mr. Felice described how the calibration level determines the strength the GCC is set at, with it currently being set at 300% of Authorized Control Level (ACL) risk-based capital (RBC). Comments suggested that it be lowered to 200% ACL, and another suggested that it could go even lower. Mr. Felice noted that a number of other issues should be addressed first, such as how financials entities are defined and the definition of material risk for non-financial entities. However, he stated that NAIC staff
supported the current proposed level from an analytical level as opposed to a lower threshold where action at the individual company level may be imminent. He stated that other comments suggested that the use of trend test terminology was an issue, for which staff does not oppose modifying. Ms. Gomez-Vock stated that the ACLI’s concern was causing confusion since 200% ACL is what is referred to publicly, and she also noted its concern with unintended potential market perceptions. David Neve (Global Atlantic) stated that Global Atlantic is concerned about the confusion, and it prefers it to be consistent with the widely held use of 200% ACL. Mr. Braue stated that UHG had a few points, one of which is that the 300% calibration is in congruence with a group with its ultimate controlling person (UCP) an insurer; the filer would look fine for RBC, but yet fall below the threshold for the GCC, unless the suggestion is that RBC is not set at the appropriate level. He stated that from an analysis standpoint, looking at some level above that is reasonable; and he said such a level had already been developed for the Financial Analysis Handbook for the calibration of the ratio. The other point, discussed early on, is that a ratio equivalent to Company Action Level RBC is appropriate for a legal entity, and there is a lot of diversification benefit within a group; therefore, this should be taken into account, which has not been done. Ian Adamczyk (Prudential Financial) added that Prudential Financial’s key point is the linkage that Ms. Belfi discussed. Mr. Bruggeman noted that he does not have a problem with a calibration different than 300%, but he thought the reason this was utilized was that was the first point when regulatory action could be triggered that puts the company in a situation where they have to do specified items. He emphasized that this does not mean any action would be taken; this is a tool, and for that reason, it is not a major deal. Therefore, he stated that he was confused by the interested parties’ comments that it was not an action level when it is, along with other items. Ms. Belfi agreed with Mr. Bruggeman, but some of the comments seem to be suggesting that it is more punitive than if one was looking at an individual company. She stated that she was not sure if it was a potential something, but rather that it was a chance for the state insurance regulator to look at the risks of the group to cause the calibration level to hit that level. She stated that it was more of an awareness, and what risks are causing the drops needs to be determined. Mr. Rehagen stated that the Reinsurance (E) Task Force did a great deal of work with this, where 300% is utilized for comparison to other countries. He said for him, it is less confusing to use 300% RBC and not more confusing. Mr. Felice described what would happen if 300% was retained, which assists in a number of ways and can be messaged clearly, and an additional threshold above the 300% level might not be necessary in the Financial Analysis Handbook threshold.

c. Scope of Application

Mr. Felice described how some of the comments were focused on the ability to potentially exclude financial entities. He stated that NAIC staff believe that once financial entities are more clearly defined and agreeable to all, those entities should not be excluded, as they tend to have a little bit more risk. He stated that the original definition of financial entities was a bit more activities focused, and he would recommend improving the definition. He stated that other comments deal with the information required for entities from the calculation. Bob Ridgeway (America’s Health Insurance Plans—AHIP) stated that the instructions should specifically exclude nonmaterial entities, regardless of being financial, noting that financial entities generally do not pose a risk. He stated that the staff recommendation to focus on activities was a good suggestion, and AHIP would be happy to work with staff to accomplish this. Stephen Broadie (American Property Casualty Insurance Association—APCIA) agreed with AHIP that changes to the definition of financial would be helpful, but he suggested the removal of nonmaterial entities. Chuck Finer (State Farm) suggested the elimination of information already provided to the lead state insurance regulator from the inventory tab, specifically noting how Schedule Y already contains information on all entities, and inclusion of information on each entity is duplicative. He questioned why the exclusion of non-financial entities should not apply to financial entities, including insurance companies.


Mr. Felice described how he was hearing a number of related comments from issues four, six and seven, and he noted that he would discuss them together. The definition of material risk was an area in which NAIC staff was supportive of either principle-based or quantitative-based; although, the group has not been able to agree to such. Therefore, they would determine if the principle-based ideas could be considered in detail. Mr. Felice noted that there is also room for improvement on the definition of financial entities. Therefore, inclusion of some of the affiliates that are more related to the performance of the policy should be reconsidered in favor of a more activities-based definition. Mr. Felice stated that once an agreeable definition is developed, NAIC staff are not in favor of applying a diversification benefit or excluding it. Rather, past financial crisis suggests that a properly defined financial entity is subject to risks that are independent of the insurance company. Mr. Felice stated that NAIC staff also believe that quantitative data in the GCC is complimentary to other filings to state insurance regulators. He described comments on the charge for financial entities, and he said all financial entities should be treated the same. Currently, an
operational risk type charge is applied to revenue. Mr. Felice state that the approaches considered now generally are consistent; although, one considers three years average revenue, while another considers just one year.

Mr. Felice described how the Working Group could make a referral back to the Capital Adequacy (E) Task Force in cases where the treatment of an entity type is different from RBC, but this should not be a prerequisite to finalizing the GCC. He described how if the Working Group sticks to the original 300% calibration, a 15% factor should be considered since that is what is considered internationally. Mr. Ridgeway stated that AHIP looked forward to working with NAIC staff, but it continues to consider how these are considered together, since the process should consider existing things already considered by state insurance regulators to determine materiality. He discussed how a number of issues being contemplated are already subject to regulatory review (affiliated transactions). He emphasized the need to look at the activity itself, and he hopes AHIP can work through this issue with state insurance regulators. Mr. Broadie agreed with working with staff on a better definition of financial entity, and he also noted the need for a high-level principle definition of materiality; he had made recommendations in this area. The APCIA has also proposed a list of criteria that a lead state and a company should look at, but it is happy to work with NAIC staff. Mr. Finer stated that he too looks forward to working on a definition. Mr. Braue stated that if financial entity is redefined to be more like banks and securities traders, it would eliminate UHG’s concerns, noting that affiliates that provide services to the insurer are less risky and already subject to review by the state insurance regulator. Mr. Adamczyk stated that Prudential Financial was the party that recommended that a simple approach be taken, as it views the key goal of providing insight into the nonregulated entity, but it does not believe different factors will make a material difference. The APCIA believes that ultimately, the inventory approach will facilitate the conversation and serve as a point for further discussion by the state insurance regulator, as well as other tools beyond the GCC.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.

W:\National Meetings\2020\Summer\Cmte\E\GCCWG\Attachment A-July 29 GCC min.docx
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met via conference call July 21, 2020. The following Working Group members participated: David Altmaier, Chair (FL); Kathy Belfi, Vice Chair (CT); Kim Hudson (CA); Philip Barlow (DC); Carrie Mears, Mike Yanacheak and Kim Cross (IA); Shannon Whalen (IL); Roy Eft (IN); Christopher Joyce (MA); Judy Weaver (MI); Fred Anderson (MN); John Rehagen (MO); Jackie Obusek (NC); Justin Schrader and Lindsay Crawford (NE); Dave Wolf (NJ); Edward Kiffel and Bob Kasinow (NY); Dale Bruggeman (OH); Joe DiMemmo (PA); Trey Hancock (TN); Doug Slape and Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. **Discussed Further Modifications to Exposed Exemptions**

Commissioner Altmaier stated his appreciation for the comments received (Attachment Five-A1) on the Working Group’s previously exposed proposed changes to the Insurance Holding Company System Regulatory Act (#440). He said that NAIC staff had developed a revised Model #440, which incorporates changes to address many of the comments, and that this conference call will be specifically focused on those comments that either did not have specific language or would represent a change from the Working Group’s previously developed intent. He stated those comments for which the Working Group believed further changes should be made would be incorporated in the revised Model #440 and re-exposed. He asked Dan Daveline (NAIC) to summarize each of the comments along with a recommendation disposition, and then allow the Working Group to decide on each.

   a. **Specificity of Exemptions**

Mr. Daveline said that Texas recommended in its comment that the Working Group consider giving the insurance commissioner the authority to provide exemptions by rule and moving some of the more detailed exemptions that may be adjusted in the future into a regulation. He said the exemption criteria, and in particular those where commissioner discretion is allowed, is very detailed and that moving such to a model regulation seemed reasonable. Ms. Walker said how the request would be particularly helpful in this time of regulatory fatigue, particularly knowing that some of these changes would require quick adoption, especially in her state where the legislature does not meet annually. Commissioner Altmaier stated he does not oppose the movement of some of the items highlighted and shared some of the concerns of Texas. Mr. Hudson noted how this was consistent with other models and said that California is not opposed to the change. No Working Group members disagreed with the change.

   b. **Additional Discretion to Waive Schedule 1**

Mr. Daveline said that this comment relates to a request for the insurance commissioner to be able to waive the Schedule 1 filing if he or she does not believe it provided value. Mr. Daveline noted that NAIC staff appreciated that with some small groups, the Schedule 1 may not provide the state insurance regulator the value desired, and for that reason proposed language that could be used in the revised Model #440 to provide this discretion. Commissioner Altmaier asked Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC) if the proposed resolution addressed their issue. Mr. Rodgers stated the language seemed reasonable but added that he would like to consider the language more closely during the comment period. However, he said he believes it was positive toward addressing their comment. No Working Group members disagreed with the change.

   c. **Development of a Process for Recognizing and Accepting the GCC by Another Jurisdiction**

Mr. Daveline said that the comments on this issue were extensive. He noted that NAIC staff agreed with the concept of the comment and more specifically the need to develop a process and an NAIC Working Group responsible for maintaining a list of jurisdictions deemed to have recognized and accepted the group capital calculation (GCC), although there was no specific action that needed to be taken at this time. Mariana Gomez-Vock (American Council of Life Insurers—ACLI) emphasized the need for a transparent process in terms of how decisions are made and asked if this issue would be fleshed out in the regulation. Commissioner Altmaier stated he appreciates the need for such a process and referenced the work done on reinsurance as a possible blueprint to follow for consistency sake. No Working Group members disagreed.
d. **Initial Filing of the GCC**

Mr. Daveline said that the comment seemed to question the need for an initial filing of the GCC before the insurance commissioner has the discretion to exempt a group going forward. He noted that he believes the Working Group’s rational for the initial filing to suggest obtaining one filing would enable the state insurance regulator to better assess on an individual company basis whether the calculation would provide information that was of value, thus making it more easy for the state insurance regulator to more confidently exempt the group going forward. Tom Finnell (America’s Health Insurance Plans—AHIP) stated he was seeking clarity and having received that, AHIP has no further comments. No Working Group members were opposed to not making any further changes for this issue.

e. **Exemption for Non-U.S. Groups**

Mr. Daveline said he believes one of the comments was addressed through incorporation of proposed language from another commenter that was incorporated into the revised Model #440. Jeff Johnson (John Hancock) stated the language incorporated into a revised Model #440 aligns with the concepts John Hancock was attempting to address and at this point, they have no further comments. No Working Group members were opposed to not making any further changes for this issue.

f. **Broad Definition of Financial Entity**

Mr. Daveline said this comment was focused on the broad definition of a financial entity within the GCC instructions. He noted, however, that the exemption limitation is very narrow and only applies to financial entities that are subject to a specified regulatory capital framework. He stated NAIC staff did not suggest incorporating further specificity and did not believe any further changes were needed. Mr. Finnell stated the concern was that the broad definition may somehow prevent a group from availing themselves of an exemption, but after looking at the language further along with the description, he said AHIP had no further comments at this time. No Working Group members were opposed to not making any further changes for this issue.

g. **Limit Sharing of the GCC Information**

Mr. Daveline said this was an informal comment made during the course of communicating with various parties on the confidentiality language. He said the comment suggested the GCC could only be shared with members of a supervisory college. Mr. Daveline said that while he is not certain the GCC itself will actually be shared by the lead state with other domestic states, information from the GCC definition will through the Group Profile Summary. As a result, the suggestion to limit the sharing seems problematic, and he noted that NAIC staff believe existing state confidentiality language around the examination and analysis process should be sufficient for such sharing. Commissioner Altmaier reinforced that while the Working Group is very supportive of confidentiality protections, this does seem to be too limiting. Michael Gugig (Transamerica), representing the Coalition, stated the Coalition appreciates the points and have no further comments on this issue. No Working Group members were opposed to not making any further changes for this issue.

h. **Expand Exemptions**

Mr. Daveline said this comment suggested adding an additional exemption for companies with premium thresholds of $100 million. He said the current exemptions already allow groups of this size to be exempted if further conditions are met, and also noted NAIC staff had some concern with further modifications that could create a conflict with the covered agreement. Mr. Rodgers stated that given the previous additional flexibility added, he has no further comments given that seemed to address the very small mutual insurance companies that this comment was also directed at. No Working Group members were opposed to not making any further changes for this issue.

i. **Confidentiality Language**

Mr. Daveline said this issue was related to a very small part of the confidentiality language at the end originally developed by the Coalition. He said he believes the existing language that described the GCC as a regulatory tool for assessing group risk is accurate, even though he appreciated the fact that the tool is then used to evaluate the impact on the insurer. Mr. Rodgers noted NAMIC believed it was another tool to be used for evaluating solvency on the insurers’ risk given legal entity regulation is what drives the GCC but stated he had no further points. No Working Group members were opposed to not making any further changes for this issue.
j. Commissioner Authority for Further Exemptions

Stephen Broadie (American Property Casualty Insurance Association—APCIA) said the APCIA recommends the Working Group incorporate more broad discretion for unique circumstances similar to language in the Risk Management and Own Risk and Solvency Assessment Model Act (#505). He mentioned an example where there was one insurer above the $1 billion premium threshold, but only had one other affiliate that had de minimis business. Mr. Daveline noted NAIC staff were concerned about a potential conflict with the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement). Mr. Finnell noted AHIP’s position is different from ACPLA’s but could be used as regulatory guidance in further considering exemptions under the specific thresholds. No Working Group members expressed an interest in considering incorporation of the language from Model #505. However, Commissioner Altmaier stated he is willing to further consider the comments and, to the extent agreeable, consider further changes to the revised proposed Model #440.

k. Deleting Language from Section 8 That Applies to Rest of Model #440

Mr. Daveline said that during the course of communicating with various interested parties in the interim on the confidentiality language, it was noted that some parties recommended deletion of language that already pertains to other aspects of Model #440 and how NAIC staff had always sought out not making any changes to the existing confidentiality protections. Therefore, NAIC staff recommended no further changes as suggested by some that may remove such protections. He noted that this did not mean some of the language could not be applied specifically to the GCC and that perhaps such consideration could be given by parties in the forthcoming re-exposure of Model #440. Mr. Ridgeway agreed with Mr. Daveline’s characterization of the process under which NAIC staff worked with various parties to try to simplify the confidentiality language where “less is more” when it comes to state legislatures that would be asked to consider the model. He described how Model #505 had become the gold standard in terms of confidentiality protections and that the NAIC would be wise to consider some of those same provisions for other sections. He stated during the re-exposure, he would continue to review the language and work with NAIC staff to continue to improve. No Working Group members disagreed with making no changes.

l. Reciprocity Issue

Mr. Daveline directed the Working Group to language proposed by Reinsurance Group of America (RGA), which was exposed since it incorporates the aspect of reciprocity as discussed during the Working Group’s June 2 conference call. He said that the proposed language modifies the language dealing with exemptions for non-U.S. groups by specifying those exemptions shall not apply if the non-U.S. groupwide supervisor requires subgroup reporting. He indicated the Working Group has discussed subgroup reporting in the past and that it was not intended for the GCC in that it would not provide value. However, this language indicates subgroup reporting only comes into play if the non-U.S. group reporting requires subgroup reporting.

Michael Demuth (Allianz) stated Allianz is supportive of efforts to reduce regulatory burden. However, he said the proposal has a series of practical issues that Allianz believes should be taken into consideration before making a final decision since it could create practical and legal challenges, which could create problems both for Allianz and the entire industry.

Mr. Broadie stated the APCIA had two goals: 1) It strongly believes each insurance group should be subject to only one GCC and that should be a parent level and none should be applied at the subgroup level; and 2) it strongly supports reciprocity and the concept of mutual recognition and a level playing field. He stated the APCIA does not support the language and if it was included in the model, language would have to be developed for clarity. He stated the NAIC can develop a transparent process for determination if reciprocity does not exist at the subgroup level and should include coordination with international colleagues with the intent of supporting mutual recognition to get to a place that each group is only submitting one GCC, whether a U.S. group or non-U.S. group.

Matthew Wulf (Swiss Reinsurance Group) stated Swiss Reinsurance Group believes these questions of reciprocity should be asked and discussed with state insurance regulators. He said they understand the goal of the GCC and the insurance capital standard (ICS) and that there are broader goals. He noted there is a great deal more that needs to be laid out and determined but should not be included due to the legislative fatigue. He said he is not sure what the current proposed language means. He said this does not apply to troubled companies and that there are so many reasons why this is not practical and is too cumbersome.

Joseph Sieverling (Reinsurance Association of America—RAA) agreed with the previous commenters on the practical concerns. He said the RAA supports one group capital at the group level, but one thing that is unclear are the facts on the ground—whether many, or some or lot, or one jurisdiction actually report subgroup reporting for U.S. groups. Ultimately, he
said it comes down to the supervisory purpose, and there really is no supervisory purpose of subgroup reporting. He said putting subgroup reporting into the model to try to get reciprocity is just the wrong way to approach this issue.

Ms. Gomez-Vock said the ACLI worked very hard with its members to try to reach an agreement that was actually unanimously agreed upon. She said this includes one group capital at the group level and that subgroup regulation is undesirable. However, the ACLI ultimately came back with supporting the reciprocity provision as long as it is supported by a transparent process and equitable to insurers in all jurisdictions. She said this issue went all the way up to the chief executive officers (CEOs), where it was still unanimously supported.

Ian Adamczyk (Prudential Financial) said Prudential Financial fully supports the concept of mutual recognition across supervisory regimes, but as internationally active insurance groups (IAIGs), that should include recognition and accepting the GCC as part of that support. He stated this should be included in the model act because: 1) it would further the objective of mutual recognition; 2) it is an overarching concept that sets an expectation; and 3) it would help promote consistency across the states. He stated Prudential Financial acknowledges there are some practical considerations, but there are solutions that could be implemented for all parties. Commissioner Altmaier stated the language was included in the draft as a means to generate discussion. He stated he expects further discussion but that timing would be dependent upon other factors.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.
Comments on Exposure

This document is intended to serve as a detail agenda for considering the comments received.

The following does NOT attempt to address all of the specific comments related to each of the issues, but rather a summary, and points the reader to the specific comments for further review.

<table>
<thead>
<tr>
<th>Core Issue</th>
<th>Summary of Comment</th>
<th>Party Making Comments</th>
<th>Page Number in Attachment D (All comments)</th>
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<tbody>
<tr>
<td>Issue 1-Specificity of Exemptions</td>
<td>We recommend Model 440 give authority for the commissioner to provide exemptions by rule and moving some of the more detailed exemptions that may be adjusted in the future to Model Regulation 450.</td>
<td>Texas</td>
<td>7</td>
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**Staff Summary of the Issue:**
During the June 2 call, direction was given to draft exemptions for 1) small county mutual insurers; 2) a group filing the BBA with the Federal Reserve, provided the BBA has to be filed with the lead state; 3) a group whose group-wide supervisor is an located in a reciprocal jurisdiction; 4) non-US groups that provide sufficient information to the lead state and either accepts the GCC in their jurisdiction for US groups or accepts the GCC as an acceptable ICS and indicates as such to the IAIS.

In addition, the direction given was the commissioner should have discretion to exempt other groups that are under the $1 billion ORSA premium threshold; don’t have insurers in another country and don’t have a bank with a capital requirements within the group. However, this exemption can only be granted after the group has filed one GCC with the lead state and the state has determined the group has de minimis affiliated transactions and de minimis risky entities within its holding company. This criteria is intended to give specificity as requested by RAA and APCIA and at the same time make sure the commissioner can require the GCC on a group where the group has material affiliated transactions (for which the GCC would be helpful) or has other noninsurers in the group which could cause material risk (for which the GCC may be helpful). Finally, paragraph (g) allows all of these entities that meet the exemption criteria just noted to instead only have to complete an annual Schedule 1 (from the GCC and related trending of that information) and also grants this Schedule 1 allowance to other entities (mutual or other entities whose UCP is a US insurance company that files RBC).

**Recommended Action:**
NAIC Staff recommends the Working Group further discuss the Texas proposal. This may be a reasonable suggestion as it relates to some of the very detailed exemption requirements. More specifically, the language discussed in the preceding paragraph (or paragraphs (f) and (g) in the exposed model) which provide the additional “flexibility” might be reasonable for inclusion in a model regulation instead of the model act since its exceptionally detailed. A model regulation may also be helpful in addressing other more detailed items suggested by Met Life/Prudential/RGA, if the Working Group decides to include the subgroup reciprocity paragraphs.
Comments on Exposure

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<tr>
<td>Issue #2- Combine Exemption Discretion and Schedule 1 Discretion</td>
<td>Our second section would be to combine and modify Section 4L(2)(f) and 4L(2)(g) to not require the Schedule 1 at the Commissioners discretion.</td>
<td>NAMIC</td>
<td>69</td>
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**Staff Summary of the Issue:**
NAMIC notes that the purpose of this recommendation is so the lead state commissioner has the discretion to waive the GCC and Schedule 1 if the regulator does not feel it adds any value. We strongly feel if the ultimate controlling parent is an RBC filer, the GCC results would be substantially similar, therefore, we think the commissioner should have the authority to waive the GCC and other components.

**Recommended Action:**
NAIC Staff notes that while we are not opposed to combining these two sections, there are complications in doing so in that section 4L(2)(g) specifically allows mutuals to be exempt from the GCC and only file the Schedule 1 since RBC produces substantially the same results as the GCC. NAIC staff can appreciate the reason why the Schedule 1 may not provide value to a regulator for some small groups and would support the following modified language to allow such:

*The lead-state commissioner has the discretion to either require or exempt the ultimate controlling person from filing a limited group filing or report on an annual basis if either of the following are met:*

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<td>Issue #3- Development of Process for “Recognizes and Accepts the GCC”</td>
<td>“As 4L(2)(d) is written, the non-U.S. group wide supervisor must “recognize and accept” the U.S. GCC for non-U.S. groups to qualify for an exemption from the GCC.” “…the phrase “recognizes and accepts” will need to be clarified by establishing a transparent process in an accompanying regulation or regulator guidance.” “It could for example, be defined to allow supervisory regimes to demonstrate reciprocity through regulatory action.</td>
<td>ACLI</td>
<td>33</td>
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**Staff Summary of the Issue:**
This comment letter provides greater detail on potential item to be addressed, although NAIC staff has already incorporated one of the identified items (recognizes and accepts if another jurisdiction does not require a US group to complete a GCC) including the NAIC acting as a central body to establish and maintain a record of jurisdictions that “recognize and accept” the GCC.
Comments on Exposure

Recommended Action:
NAIC agrees that it will be necessary to create a list of jurisdictions that recognize the GCC and to have an NAIC group responsible for developing such a process and possibly even codifying such a listing, unless other more streamlined processes can be recommended (e.g. inclusion on the listing may be dependent upon identification from a member of the industry operating in that jurisdiction and NAIC staff confirming with such jurisdiction).

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<tr>
<td>Issue #4- Initial Filing Requirement</td>
<td>In some cases, for which exemption is apparently provided in the draft HCA text, the group must nonetheless make an initial filing of the GCC with the Lead State, and only subsequent to that could the commissioner grant the exemption. It is not clear why an initial filing would be required, and which would seem to contradict the notion of an exemption.</td>
<td>AHIP</td>
<td>48</td>
</tr>
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Staff Summary of the Issue:
The comment is directed at the Working Group’s previous decision to require an initial filing to determine the benefits of the calculation for the applicable groups.

Recommended Action:
NAIC staff understood the Working Group’s rational for the initial filing to suggest that obtaining one filing would enable the regulator to better assess on an individual company basis whether the calculation would provide collective information or individual information that was of value; if not the regulator would more confidently be able to exempt the group going forward. Therefore rejection of this comment appears appropriate.

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<td>Issue #5- Exemption for non-US Groups</td>
<td>The draft Act does not include language similar to Section 6(D) of the ORSA Model Act, which allows regulators to grant an ORSA exemption “based upon unique circumstances.” APCIA recommends including similar language in Sections 4(L)(2)(f) and (g) of the draft Act.</td>
<td>John Hancock</td>
<td>25</td>
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Staff Summary of the Issue:
While the comment letter provides a great deal of backdrop, ultimately the comment recommends the following changes:

c. An insurance holding company:
   (i) That has provided information to the accredited lead state, either directly or indirectly through the group-wide supervisor, who has determined such
Comments on Exposure

information is satisfactory to allow the lead-state to comply with the NAIC principles of group supervision as detailed in the NAIC Financial Analysis Handbook, and the lead state has determined that because of this the group capital calculation is not required to be filed; and

(ii) Whose non-U.S. group-wide supervisor, as determined in accordance with the principles of section 7.1, meets either of the following requirements:

a. Where a non-U.S. jurisdiction does not apply its own group capital reporting requirements to U.S. groups or the parent of a U.S. subsidiary operating in that jurisdiction, then the U.S. would not require insurance groups or their parent company domiciled outside the U.S. to file the group capital calculation Recognizes and accepts the group capital calculation for U.S. insurance groups who operate in the jurisdiction of that group-wide supervisor; or

Drafting Note: The phase “Recognizes and accepts” does not require the non-U.S. group-wide supervisor to require the U.S. insurance groups to actually file the group capital calculation with the non-U.S. supervisor but rather does not require its own version of a group capital filing.

b. For jurisdictions where no U.S. insurance groups operate, recognizes the group capital calculation as an acceptable international capital standard by indicating such formally in writing to the lead state with a copy to the International Association of Insurance Supervisor. The requirement to file the group capital calculation is at the discretion of the U.S. designated group-wide supervisor for the internationally active insurance group.

Recommended Action:
As it relates to the recommended changes to (iv)(a), NAIC staff believes that the concept embedded in the recommended change to (iv)(a) was intended to be addressed in the drafting note. For that reason, NAIC staff has incorporated language from other comment letters that likely address this. As it relates to the recommended changes to (iv)(b), it’s not clear why the NAIC should not encourage, through other jurisdictions, the acceptance of the GCC where the result would be the same (such non-US group is exempt from the GCC). Meaning, if the discretion exists, it’s likely the state would do so. With existing language, the jurisdiction need only to make the recommendation to the IAIS as a means to support more mutual recognition through the use of different methodologies.

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<tr>
<td>Issue #6- Broad Definition of Financial Entity</td>
<td>Affiliates that are integral to the performance of the insurance contract or provision of the insurance or financial products or services to policyholder, members or depositors will be treated as financial entities. AHIP suggests that the reference to “specified regulatory capital framework within is holding company structure be clarified to refer to the capital remine of the other sectoral regulators (e.g. federal or state banking agencies).</td>
<td>AHIP</td>
<td>48</td>
</tr>
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Comments on Exposure

**Staff Summary of the Issue:**
The comment is referring to the following requirement that must be met in order for an exemption to be granted.

“The holding company includes no banking, depository or other financial entity that is subject to a specified regulatory capital framework.”

**Recommended Action:**
NAIC staff believes the language is clear that this criteria only exists for financial entities that have a capital requirement, we hesitate to add too much specificity which may undermine the concept of believing its reasonable of not allowing a group that has a non-insurer within its group that is subject to a capital requirements to be exempt given the state may receive some pressure of being able to share group information with that capital regulator.

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<tr>
<td>Issue #7- Add Language limiting sharing through a supervisory college</td>
<td>Add language to limit sharing</td>
<td>Coalition</td>
<td>N/A-Informal comments</td>
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**Staff Summary of the Issue:**
Some have recommended adding the following additional provision to 8(c)2:

Notwithstanding paragraph (1) above, the commissioner may only share confidential and privileged documents, material, or information reported under Section 4L(2) with commissioners of states that are members of the subject insurer’s supervisory college, and whose states have statutes or regulations substantially similar to Subsection A and who have agreed in writing not to disclose such information.

**Recommended Action:**
NAIC staff find this language problematic as this would only permit the GCC to be shared with commissioners who are part of the supervisory college. Staff noted that lead states need to be able to share key figures of the information from the GCC with all domestic regulators of companies that are part of that group and have examination and/or analysis statutes that protect such information. We believe existing confidentiality requirements are sufficient to do so.

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<tr>
<td>Issue #8 Reciprocity Those Opposed</td>
<td>The comment letter suggests a significant number of issues would need to be addressed before reciprocity paragraphs are appropriate</td>
<td>Allianz / Transamerica</td>
<td>1</td>
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## Comments on Exposure

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<tr>
<th>Opposed</th>
<th>“Hardwiring one solution into the Act or state law is not, in our opinion, the appropriate way to proceed.” “Instead the NAIC should develop a process....” “...this process should involve consultation and coordination with U.S. regulators’ international colleagues, and it should be made clear that the purpose of this process is to support mutual recognition and a level regulatory playing field.”</th>
<th>APCIA</th>
<th>11</th>
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<tr>
<td>Opposed</td>
<td>While Swiss Re agrees with the premise that a country’s group capital calculation should not apply at the subgroup level, we do not support including this language in the model act.</td>
<td>Swiss Re</td>
<td>41</td>
</tr>
<tr>
<td>Opposed</td>
<td>We cannot support the revised language proposed in subsections 4.L.(2)d. and e. and the drafting note, which would require a U.S. subgroup capital calculation for a non-U.S. group if the group-wide supervisor of that non-U.S. insurance group does not treat subgroups of U.S. groups in a similar manner (i.e. reciprocal treatment).</td>
<td>RAA</td>
<td>61</td>
</tr>
<tr>
<td>Support</td>
<td>The ACLI supports the inclusion of a reciprocity provision, such as subsection 4L(2)(e) in the Model Holding Company Act. We believe that the phrase “recognizing and accepts” will need to be clarified upon implementation, perhaps in an accompanying regulation, or by a process that is transparent on how reciprocity is determined in practice, and equitable to insurers based in all jurisdictions.</td>
<td>ACLI</td>
<td>34</td>
</tr>
<tr>
<td>Support</td>
<td>We support the inclusion of Section 4L(2)(e) to clarify that reciprocal treatment applies at the subgroup level as well as the groupwide level.</td>
<td>Met/PRU/RG A</td>
<td>73</td>
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Comments on Exposure

Staff Summary of the Issue:
During 2019, the Working Group discussed the idea of “subgroup reporting” of the GCC, or more specifically whether the GCC should be required for the US operations (e.g. US insurers) of non-US groups and generally concluded they were not interested in this concept, noting that the GCC was not designed for this purpose. During the June 2 conference call of the Working Group, one of the commenters (RGA) discussed the concern that many companies have relative to Subgroup reporting, and more specifically that some jurisdictions could potentially require this for US groups with insurers in such jurisdictions, but that reciprocity was important to help prevent this from becoming a widespread practice that could eventually disadvantage US insurers. Responses from two regulators indicated a desire to discuss reciprocity more and as a result, language from RGA that incorporates the reciprocity was incorporated into the exposed draft to assist in such a discussion. More specifically, the language in (e) below was included to indicate that non-US groups otherwise exempt under either (c) or (d) below would NOT be exempt if the other jurisdiction required “subgroup reporting for a US group in that jurisdiction”, and would actually require the non-US group to file a “US subgroup GCC.” Note, subgroup reporting is ONLY required if done so first by another jurisdiction.

d. An insurance holding company whose non-U.S. group-wide supervisor, as determined in accordance with the principles of section 7.1, is located within a Reciprocal Jurisdiction [insert cross-reference to appropriate section of Credit for Reinsurance Law].

e. An insurance holding company:

(iii) That has provided information to the accredited lead state, either directly or indirectly through the group-wide supervisor, who has determined such information is satisfactory to allow the lead-state to comply with the NAIC principles of group supervision as detailed in the NAIC Financial Analysis Handbook, and the lead state has determined that because of this the group capital calculation is not required to be filed; and

(iv) Whose non-U.S. group-wide supervisor, as determined in accordance with the principles of section 7.1, meets either of the following requirements:

a. Recognizes and accepts the group capital calculation for U.S. insurance groups who operate in the jurisdiction of that group-wide supervisor; or

Drafting Note: The phrase “Recognizes and accepts” does not require the non-U.S. group-wide supervisor to require the U.S. insurance groups to actually file the group capital calculation with the non-U.S. supervisor but rather does not require its own version of a group capital filing.

b. For jurisdictions where no U.S. insurance groups operate, recognizes the group capital calculation as an acceptable international capital standard by indicating such formally in writing to the lead state with a copy to the International Association of Insurance Supervisor.

f. The exemptions in Sections 4L(2)(c) and 4L(2)(d) shall not apply to the U.S. operations of a non-U.S. insurance holding company if its group-wide supervisor does not recognize and accept the group capital calculation for any U.S. insurance group’s operations in that group-wide supervisor’s jurisdiction.

Recommended Action:
NAIC staff recommends the Working Group further discuss if they support the subgroup reporting/RGA reciprocity concept. Even if the Working Group decides against retaining the language, further guidance will still need to be developed around a process of listing jurisdictions the NAIC considers having shown reciprocity to the GCC. If the Working Group decides for reciprocity, the language proposed by Met Life/Prudential/could serve as a possible language to be included in a model language that describes such a process. Doing so may also limit the need for incorporation of the specific language in the model act, but rather including in the model regulation that defines reciprocity in more detail, although all other reciprocity language included in the revised proposed draft could be retained in the Model Act. In summary, the model regulation could house this detail on reciprocity as well as the commissioner’s discretion to grant exemptions for groups below the ORSA thresholds, which is very detailed.
Comments on Exposure

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<tr>
<td>Issue #9- Expand Exemptions</td>
<td>Our suggestion is to expand the exemption criteria in Section 4L(2)(a) to include holding company groups with direction premiums less than $100,000,000.</td>
<td>NAMIC</td>
<td>68</td>
</tr>
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Staff Summary of the Issue:
Some have recommended adding the following additional provision to 8(c):2:

Notwithstanding paragraph (1) above, the commissioner may only share confidential and privileged documents, material, or information reported under Section 4L(2) with commissioners of states that are members of the subject insurer’s supervisory college, and whose states have statutes or regulations substantially similar to Subsection A and who have agreed in writing not to disclose such information.

Recommended Action:
NAIC staff notes that under the current exposure, all mutual insurance companies are exempt from filing the GCC since their ultimate controlling person is a U.S. regulated insurer that already completes an annual RBC filing and only need file the Schedule 1 and related analytics. NAIC staff further notes insurers with less than $1 billion in premium (which would include those with less than $100 million) can be exempted from the GCC if other limited requirements are met. Finally, NAIC staff notes that insurers that are not in a holding company structure (e.g. no other affiliates) would not be subject to the GCC as they are not subject to the Holding Company Act.

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<td>Issue #10- Confidentiality Language</td>
<td>We would request on minor change to Section 8 to reflect the intent of the GCC but also acknowledge the GCC not a tool to assess group risk, but rather as an additional tool to assess and insurer’s risk.</td>
<td>NAMIC</td>
<td>72</td>
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Staff Summary of the Issue:
They recommend the following change:

It is the judgement of the legislature that the group capital calculation and resulting group capital ratio required under Section 4L(2) is a regulatory tool for assessing group insurer’s risks and capital adequacy, and is not intended as a means to rank insurers or insurance holding company systems generally.

Recommended Action:
NAIC staff disagrees, noting that the original language proposed from the Coalition accurately captures that the GCC is a tool for assessing group risk, even though we agree that the purpose of determining group risk is to evaluate its potential impact on the insurer. However, we believe the proposed language is inaccurate.
## Comments on Exposure

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<td>Issue #11- Commissioner Authority for Further Exemptions</td>
<td>The draft Act does not include language similar to Section 6(D) of the ORSA Model Act, which allows regulators to grant an ORSA exemption “based upon unique circumstances.” APCIA recommends including similar language in Sections 4(L)(2)(f) and (g) of the draft Act.</td>
<td>APCIA &amp; AHIP</td>
<td>12 &amp; 48</td>
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**Staff Summary of the Issue:**
This comment recommends the following additional exception authority be added:

*An insurer that does not qualify for exemption pursuant to subsections (e) and (f) may apply to the commissioner for a waiver from the requirements of this Act based upon unique circumstances. In deciding whether to grant the insurer’s request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer’s request for a waiver.*

**Recommended Action:**
This issue has not been discussed previously although NAIC staff has some concerns with this suggestion, specifically that a group that does business in a covered agreement jurisdiction could be exempted, creating an issue.

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<tr>
<td>Issue #12- Deleting Language from Section 8A which applies to rest of Act</td>
<td>ORSA Model 505 does not contain this language</td>
<td>AHIP</td>
<td>57</td>
</tr>
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**Staff Summary of the Issue:**
The language in reference is as follows but is currently part of the Form F and other existing HCA authorities for the Commissioner:

*The Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines the that the interest of policyholder, shareholder or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.*
Comments on Exposure

Recommended Action:
Some comments suggest deleting the language to mirror the Confidentiality of the Risk Management and Own Risk and Solvency Assessment Model Act (#505) with respect to ORSA Summary Report. However, this language is applicable to more than just the Group Capital Calculation, and consideration needs to be given to whether it is necessary to retain this authority for other aspects of this section. NAIC recommends this language not be deleted for this reason. NAIC staff is not opposed to AHIP proposing language that would specify this language is not applicable to the GCC.
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met via conference call on June 2, 2020. The following Working Group members participated: David Altmaier, Chair (FL); Kathy Belfi, Vice Chair (CT); Kim Hudson (CA); Philip Barlow (DC); Carrie Mears, Mike Yanacheak and Kim Cross (IA); Susan Berry and Vincent Tsang (IL); Roy Eft (IN); John Turchi and Christopher Joyce (MA); Judy Weaver (MI); John Rehagen (MO); Jackie Obusek (NC); Justin Schrader and Lindsay Crawford (NE); Edward Kiffel (NV); Dale Bruggeman and Tim Biler (OH); Greg Lathrop (OR); Kimberly Rankin (PA); Trey Hancock (TN); Mike Boerner and Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Discussed Further Modifications to Exposed Exemptions

Commissioner Altmaier stated that the purpose of this conference call is for the Working Group to consider whether further modifications are needed to the previously exposed exemptions on who would be required to file the group capital calculation (GCC). He described how the Working Group had received quite a bit of feedback on those exposed exemptions in the form of comments letters (Attachment Five-B1) and that the intent is to work through the comments based upon themes, where he will seek input from Working Group members on their views of each of the themes.

   a. Size Threshold

Commissioner Altmaier stated that the previously exposed exemptions did not include the concept of a size threshold, be that the comments overwhelming support the concept of a size threshold like that contained within the Risk Management and Own Risk and Solvency Assessment Model Act (#505). Commissioner Altmaier stated that he believes most of the state insurance regulators were of the opinion that the GCC would be a tool that would be helpful for analysts for any group regardless of its size or where it writes its business, but that the Working Group should think about its characteristics and when it would be most helpful. He noted that the Working Group may determine that it may not be most useful for all groups and that care should be taken with the approach. He stated he believes that groups that do not meet the size exemptions of the Own Risk and Solvency Assessment (ORSA) or have international business are the types where state insurance regulators would want the GCC to be completed. He stated, however, that beyond that, he would be open to a proposal that authorized state insurance regulator discretion for groups that did not meet such a threshold. He stated that while there are some individuals that may be concerned with that type of discretion without any guiding principles or criteria, it would be important for the Working Group to consider how best to effectuate.

Mr. Schrader stated he thinks this is an important issue and that regardless of what approach the Working Group takes, either all groups filing or some type of threshold, he believes it is important to have regulatory discretion to either include or exclude those that are outside of the normal given the unique groups that exist. He stated he thinks the ORSA threshold may be a bit high because there were many groups under that threshold that were fairly complex, but that he is in favor of getting for all groups since analysts are expected to perform holding company analysis on all groups. However, if the analyst or state insurance regulators feel there is no value for that company, then they should have the authority to waive them. He stated with commissioner discretion, there is a potential for either a lot of companies to be exempted or no companies exempted. Commissioner Altmaier stated that was a reasonable viewpoint, particularly in the early years, until a determination can be made on how helpful the GCC was.

Mr. Eft stated he is in support of an ORSA exemption, but authority to exempt others if deemed necessary, but not cast as wide of an approach as suggested by Nebraska. Ms. Berry stated that Illinois was of the view that they wanted a threshold closer to the ORSA along with making sure companies with international business would still be captured, but they also see value in an exception where smaller companies are allowed to just file a listing out the companies and some of the other related information, but not the actual GCC itself. Commissioner Altmaier stated that could be helpful in developing a compromise position. Ms. Belfi stated that after listening to Mr. Schrader and others, what she would really like to do as a regulator is eventually let her largest entities to be completing the GCC only and originally was in the camp of the ORSA threshold. However, after thinking about what Mr. Schrader said, she said she does not think it would be a bad idea to cast a wide net to take a one-time look at their group and learn about the risks of the group. Ms. Belfi stated the fact these groups do not complete an ORSA may be a reason to obtain the GCC at least once. Then going forward, if the GCC is not particularly helpful, they could be exempted.
Commissioner Altmaier stated there appears to be a consensus at least for those that provided their views, and while he expects discussions will need to continue, it would be helpful to first receive a written proposal. He requested NAIC staff to draft language where initially everyone should file the GCC, but lead states should have the discretion to exempt groups below the ORSA and international threshold, but for those that are exempted requiring a filing of the information from the inventory tab of the GCC. He stated ideally, information could be obtained on the number of groups affected, recognizing states’ resources are important. He stated future discussion on guardrails would be helpful as well. Stephen Broadie (American Property Casualty Insurance Association—APCIA) stated the APCIA supports an ORSA threshold and will continue to do so and listen with interest. He suggested the Working Group note that it would be difficult to revise the exemptions given the Working Group is considering putting the exemptions in the *Insurance Holding Company System Regulatory Act* (#440). Commissioner Altmaier agreed and noted they would be sensitive to that fact.

b. **Accept the RBC Ratio as the GCC for a Top-Tiered RBC Filer**

Commissioner Altmaier noted that for this issue, there was dovetail with the GCC Instructions. Therefore, he said he would like to postpone this discussion until after the exposure period on the GCC Instructions ends in the second half of July.

c. **Accept the RBC Ratio as the GCC for a Top-Tiered RBC Filer**

Commissioner Altmaier stated the Working Group has discussed this issue in the past and has generally stated it would not be in favor of any duplicative regulatory requirements and be open to not requiring the GCC for groups that are required to complete the building block approach (BAA) and file with the Federal Reserve. He stated that if states can obtain a copy of the BBA, he recalls this being the past position. Mr. Boerner agreed with the statements by Commissioner Altmaier. Mr. Schrader stated that until state insurance regulators see what the BBA looks like, there may still be some value of obtaining a listing of entities and related financial information for these groups like the recommendation made for smaller groups as previously made by Ms. Berry. Mariana Gomez-Vock (American Council of Life Insurers—ACLI) stated the ACLI strongly supports this recommendation. She stated the BBA has a similar schedule as the Inventory and other Federal Reserve forms and was quite extensive. Dale Berry (TIAA) indicated the TIAA supports the recommendation and stated he does not believe there is much daylight between the GCC and the BBA. Ms. Belfi stated that it might be helpful for NAIC staff to provide a comparison between the GCC and the BBA.

d. **Reciprocal or Qualified Jurisdictions**

Joseph Sieverling (Reinsurance Association of America—RAA) stated that the RAA supports this exemption because it supports the premise that groups should be subject to a single group capital measure per their group-wide supervisor. Andrew Vedder (Northwestern Mutual) stated that Northwestern Mutual, along with New York Life and Travelers, are generally supportive of this exemption but had some nuances—specifically, looking at the ORSA allowance to make available comparable information that is available to the insurance group to make sure the lead state has the relevant information, which is consistent with the approach being taken by the Working Group on the BBA. He stated under 4(L)2C, the definition of a reciprocal jurisdiction currently does not exempt U.S. groups, and this could be fixed by inserting non-U.S. before group-wide supervisor. Ian Adamczyk (Prudential Financial) stated Prudential Financial’s position is nuanced. He said while it supports the one group and one group standard, Prudential Financial views that from the perspective of applying that exemption at the worldwide level and does not believe the exemption should extend to U.S. subgroups of foreign-based insurers with U.S. subgroups. He summarized the points from Prudential Financial’s comment letter on this subgroup. Kim Welch (Reinsurance Group of America—RGA) stated RGA agrees with the principle of one group capital measure per one group-wide supervisor but that it disagrees with the concept of subgroup reporting. She stated that while the issue is hypothetical now, RGA sees it as a real possibility, and it is concerned that the current wording does not allow a determination of reciprocity. She discussed the need for U.S. regulators to have leverage to encourage reciprocity. She also stated RGA has concerns with the reciprocity in the qualified jurisdictions being limited to reinsurance and, therefore, the exemption should be limited to reciprocal jurisdictions. Matthew Wulf (Swiss Reinsurance Group) stated Swiss Reinsurance Group does not agree with Prudential and whether those concerns come into play, not to mention the difficulty of drawing a box around companies for U.S. subgroups.
Mr. Rehagen stated he believes reciprocity is a very important issue and thinks this is something the Working Group should consider.

e. **Unintended Exemptions**

Ms. Gomez-Vock stated she believes the conversation, as well as the current draft, may have addressed this issue. She did, however, describe how at some point in time it might be helpful to have a memorandum that describes each of the exemptions and the rationale for each.

f. **Commissioner Discretion Concern**

Commissioner Altmaier noted that this issue may have already been raised and asked if there were additional issues that required further discussion at this time. Mr. Sieverling stated he believes Commissioner Altmaier already covered this but noted that if the focus was on either scoping groups out of the calculation, that would make things easier but certainly being more specific on the criteria is what would be needed. Mr. Broadie agreed with Mr. Sieverling.

g. **Commissioner Discretion Concern**

Commissioner Altmaier discussed the importance of this issue and how it is a driving force behind embedding the GCC into a model law. He stated one comment suggested the need to address the confidentiality of the BBA if filed with the lead state, and he said he believes this is a fair comment. He asked Ms. Gomez-Vock if the ACLI could send language to NAIC staff for further consideration. He noted America’s Health Insurance Plans (AHIP) seemed to suggest the current language seems to allow the sharing of the GCC with the International Association of Insurance Supervisors (IAIS). It was noted this would be taken up on a future conference call. Commissioner Altmaier also noted Prudential made some comments. Mr. Adamczyk summarized some of Prudential’s concerns taken from its comment letter. There was no reaction from Working Group members on these comments.

2. **Discussed Other Matters**

Commissioner Altmaier indicated NAIC staff had drafted a Frequently Asked Questions (FAQ) document and for individuals to be aware it will be posted. He also indicated that NAIC staff was intending to hold a webinar to those wishing to participate in understanding how the GCC is intended to work; it would not be an official meeting of the Working Group.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.
Via Electronic Delivery

Commissioner David Altmaier
Florida Office of Insurance Regulation
Attention: Mr. Dan Daveline
J. Edwin Larson Building
200 E. Gaines Street, Room 101A
Tallahassee, Florida 32399

RE: Draft Memorandum from the Chair of the Group Capital Calculation (E) Working Group to the Chair of the Group Solvency Issues (E) Working Group

Commissioner Altmaier:

State Farm Mutual® Automobile Insurance Company and its affiliates ("State Farm"), appreciate the opportunity to submit these comments concerning the Draft Memorandum ("Draft Memo") from the Group Capital Calculation (E) Working Group (the "Working Group") to the Chair of the Group Solvency Issues (E) Working Group ("GSI"), Mr. Justin Schrader (NE). The Working Group is charged with constructing a U.S. group capital calculation (the "GCC") using a risk-based capital ("RBC") aggregation approach.

The stated purpose of the Draft Memo is to seek assistance from the GSI in drafting changes to existing National Association of Insurance Commissioners ("NAIC") model laws. The noted needed changes are to create a requirement that the GCC be completed annually and that confidentiality be provided. To that end the Draft Memo makes the following suggested changes to two different sections of NAIC’s Holding Company Act, Model #440:

Section 4

- Require a new item “M” that requires submission of an annual GCC to the lead state regulator (like Item L Enterprise Risk Filing) through a new Form G filing required by the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450).

- Specify the following entities as being exempt from the GCC:
  - Small mutual insurance companies (similar to the exemption in the Annual Financial Reporting Model Regulation (#205)).
  - Groups required to file with the U.S. Federal Reserve, but separately require that such groups provide a copy of the filing with the Federal Reserve to file to the lead state.
  - Groups for which the group-wide supervisor is a reciprocal or qualified jurisdiction per the Credit for Reinsurance Model Law (#785).
• Group not considered a reciprocal or qualified jurisdiction but for which the group-wide supervisor: i) accepts the GCC for any U.S. insurance group; or ii) recognizes the GCC as an acceptable international capital standard to the International Association of Insurance Supervisors (IAIS); and iii) has been sponsored by an accredited lead-state.

• With respect to the exemptions, the model should provide the lead state commissioner the authority to require the GCC of any group otherwise determined to be exempt, like the language in the Own Risk and Solvency Assessment (ORSA). Also, with respect to a company previously exempt, the model should provide appropriate transition guidance.

Section 8.1
• Confidentiality language consistent with that recommended by a comment letter directed to the Working Group from the Coalition (see attached) which, among other things, prohibits the filing of the report with the NAIC unless supported by a confidentiality agreement (similar to the Risk Management and Own Risk and Solvency Assessment Model Act [#505]).

State Farm appreciates the effort and transparency the Working Group has utilized in developing the GCC. State Farm participated as a volunteer group and provided feedback as to the GCC calculation and its supporting informational elements during its development. State Farm understands that the GCC provides an evaluation tool for domestic regulators to consider along with various other risk information provided by groups such as the ORSA Report filing.

However, State Farm is concerned that the Draft Memo should include additional exemptions and recognitions. As noted above, State Farm participated as a volunteer company with the development of the GCC, but it also participated in the Qualitative Impact Study (“QIS”) on the U.S. Federal Reserve Notice of Proposed Rulemaking (“NPR”) concerning its development of group capital calculation and corresponding capital requirements. State Farm notes that the calculation of the NPR is very similar to the GCC and both generated very similar results for State Farm. This similarly was by design as noted by the NAIC President’s opening remarks at the Fall 2019 meeting.1

State Farm noted that the similarity in results is due to the basis of the calculations that start with an aggregation method based on the Risk Based Capital (“RBC”) calculation for insurers, the assets and liabilities being measured are predominately derived by the business of insurance and the parent of the holding company is itself a regulated insurance entity. In fact, the NPR, GCC, as well as the RBC, generate substantially the same ratio results. State Farm asserts if the

Working Group is suggesting that groups filing with the Federal Reserve or other equivalent regulatory schemes should be exempt, that a similar exemption should be included for groups when the expected results of the GCC are similar to the RBC for a regulated insurer parent of a group that predominately derives its assets and liabilities from the business of insurance as it is another equivalent regulatory framework used by regulators.

State Farm appreciates the Working Group recognizing the duplicative effort and willingness to utilize other equivalent regulatory processes and information. In the case of State Farm, and other similarly situated groups, it should be recognized that State Farm Mutual Automobile Insurance Company’s (“State Farm Mutual”) RBC provides equivalent regulatory information that should be accepted in lieu of the GCC. State Farm Mutual’s RBC rolls up the assets and liabilities of its affiliates and subsidiaries utilizing the same aggregate approach after which the GCC is modeled, with only those non-insurance entities receiving a slightly different scaled calculation in the GCC that makes up less than a few percentage points of State Farm’s overall assets and liabilities. As a result of the assets and liabilities being so heavily based on the business of insurance, the results of the GCC are not significantly different than the RBC. The result was expected by the Working Group and State Farm, and unsurprisingly, the Federal Reserve also expected the NPR, under the similar aggregation method, would produce near the same result as the RBC for State Farm Mutual.

The domestic regulator that manages the solvency of the entities that make up such a group, which receives an abundance of financial information such as receiving quarterly and annual financial statements, holding company filings, ORSA, Form F and individual legal entity RBC calculations, is in the best position to determine if such exemption is appropriate. This is especially true when the group is predominately conducting the business of insurance. Furthermore, as proposed in the Draft Memo, the domestic regulator will have the ability to require a group to complete the GCC regardless of the exemption. Groups should not be required to complete the GCC for the sake of uniformity especially when the proposal is already exempting groups for the various stated reasons and when completion of the GCC does not provide any additional insight to the domestic regulator who is charged with the responsibility to regulate solvency.

The GCC is requesting information that the domestic regulator already receives or has access to if the domestic regulator deems it necessary to evaluate the risk of the group. State Farm is not aware of any specific information contained in the GCC that is not already available to its domestic regulators and does not believe that the GCC needs to apply to State Farm, or any other group, for that purpose. The domestic regulator has information on financial institutions it does not regulate, such as State Farm Bank, as a result of Supervisory Colleges and through the provisions of the Holding Company Act.
Since the Working Group is willing to exempt a group on the basis of its filing with the Federal Reserve presumably being deemed equivalent to the GCC as well as the other stated exemptions, the Working Group should not argue against an exemption for a group, such as State Farm, for the reason that the GCC provides new information. There is no new information provided in the GCC that is not already provided to the domestic regulator and, if there is any information not already provided, it most likely pertains to an immaterial aspect of the group that is mainly an insurance business.

State Farm is concerned that the GCC may be needlessly applied to State Farm and other similarly situated insurers for the purported purpose of satisfying an international regulatory standard and Covered Agreement. State Farm does not believe that uniform application of the GCC is necessary when such groups are not internationally active and there is an equivalent regulatory tool. A group like State Farm should not have to pass along the costs to its policyholders as a result of a uniform application of the GCC so that internationally active groups are not confronted with dual regulation. The presumed driver of this is the Covered Agreement, however, State Farm is not aware that the Covered Agreement requires the uniform application and suggests that for those internationally active groups that desire to be regulated under a single regulator that those groups can opt into completing the GCC.

State Farm urges the Working Group to include a stated exemption for a group when that group’s parent is a regulated insurance company that files under the Risk Based Capital provisions with an accredited lead state by amending the Draft Memo to include the following language in the suggested changes to Section 4 of Model #440:

Specify the following entities as being exempt from the GCC:

Groups required to file with the U.S. Federal Reserve an equivalent group solvency calculation, but separately require that such groups provide a copy of the filing with the Federal Reserve to file to the lead state; or a group when that group’s parent is regulated insurance company that files under the Risk Based Capital provisions with an accredited lead state.

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As an alternative to an explicit exemption as suggested above, State Farm requests that the Working Group amend the Draft Memo to include generic authority to exempt a group from filing the GCC similar to the ORSA provision of Model #505 which provides:

D. An insurer that does not qualify for exemption pursuant to subsection A may apply to the commissioner for a waiver from the requirements of this Act based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

This would allow the domestic regulator to determine the need for a group to complete the GCC on a case by case basis and for any number of reasons. Adding such a provision also is balanced in that the Working Group in the Draft Memo is already suggesting that Section 4 include the ORSA provision to require a group to complete the GCC regardless of whether that group otherwise is exempted.

Finally, State Farm would like to take this opportunity to comment on the GCC calculation process. State Farm urges the Working Group to limit the “destacking” of entities within the GCC when entities are subsidiaries of RBC filing insurance companies. This dramatically reduces the burden in completing the GCC, especially for more streamlined organizations. In addition, State Farm requests that the Working Group consider a materiality threshold in the requirements to reduce the burden of including entities that do not impact the overall GCC result.

If the GSI proposes amendments to the NAIC’s Holding Company Act, Model #440, State Farm will comment more fully on the language of that proposal.

Thank you for your time and consideration in this project and to our comments. If there are any questions concerning the comments, please contact me.

Sincerely,

Chuck Feinen
State Farm Mutual Automobile Insurance Company
February 13, 2020

Dan Daveline  
Director, Financial Regulatory Services  
NAIC  
Submitted via Email

Re: Draft Letter to Chair of the Group Solvency Issues (E) Working Group  
Regarding Confidentiality of Group Capital Calculation

Dear Mr. Daveline:

Teachers Insurance and Annuity Association of America (“TIAA”) appreciates the opportunity to submit the following comments in response to the draft letter (the “Draft Letter”) from the Chair of the National Association of Insurance Commissioners’ (“NAIC”) Group Capital Calculation (E) Working Group (the “GCC Working Group”) to the Chair of the NAIC Group Solvency Issues (E) Working Group regarding the confidentiality of the proposed group capital calculation (“GCC”).¹ Below, we provide our thoughts in response to certain sections of the Draft Letter. We hope that our ideas and suggestions will assist the NAIC as it considers revising its Insurance Holding Company System Regulatory Act (#440) (“Model #440”).

About TIAA

Founded in 1918, TIAA is a life insurance company and the leading provider of retirement and financial services for those in academic, research, medical, and cultural fields. Over our century-long history, TIAA’s mission has always been to aid and strengthen the institutions and participants we serve and to provide life insurance and other financial products that meet their needs. To carry out this mission, we have evolved to include a range of financial services, including asset management and retail services. Today, TIAA manages over $1

trillion in assets, and our investment model and long-term approach aim to benefit the five million retirement plan participants we serve across more than 15,000 institutions. With our strong nonprofit heritage, we remain committed to the mission we embarked on in 1918 of serving the financial needs of those who serve the greater good.

**TIAA supports the proposed exemption for groups required to file with the Federal Reserve.**

The Draft Letter proposes that groups required to file with the Board of Governors of the Federal Reserve System (the “Federal Reserve”) be exempt from the requirement to file an annual GCC (as a prospective Form G or other filing), so long as they are separately required to provide a copy of their Federal Reserve capital requirement filings to their lead state regulator. TIAA strongly supports this proposed exemption. TIAA is subject to regulation and supervision by the Federal Reserve as a savings-and-loan holding company significantly engaged in the business of insurance (an “Insurance SLHC”). As the NAIC is aware, the Federal Reserve recently proposed capital requirements that are designed specifically for Insurance SLHCs, which we expect will be finalized later this year. The Federal Reserve’s proposed approach would construct “building blocks,” or groups of entities in the Insurance SLHC’s organization that are covered under the same capital framework, to calculate an entity’s combined, enterprise-level available capital and capital requirement. The Federal Reserve has also proposed a capital conservation buffer that Insurance SLHCs must meet to avoid certain restrictions in addition to the minimum capital requirement.

We believe the Federal Reserve’s proposed approach is not only appropriately tailored to the unique business model of insurers but also generally consistent with the approach and requirements of the GCC. As such, we think it is appropriate for Insurance SLHCs like TIAA and other groups required to file with the Federal Reserve to be exempt from the annual GCC filing requirement, so long as such entities provide a copy of their Federal Reserve capital requirement submission to their lead state regulator. This approach would ensure that Federal Reserve-supervised insurance companies are covered under a sufficiently stringent enterprise-wise capital framework (with sufficient line of sight for their state regulators), but are not subject to a needlessly duplicative regulatory regime under the GCC.

**TIAA supports the proposed addition of confidentiality language to Model #440.**

The Draft Letter proposes to include in Model #440 GCC-specific confidentiality language consistent with the NAIC’s Own Risk and Solvency Assessment (“ORSA”) confidentiality language, as set forth in the *Risk Management and Own Risk & Solvency Assessment*

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2 Data are as of September 30, 2019.
Model Act ("Model #505"). This proposal echoes a recommendation made in a comment letter regarding GCC confidentiality directed to the GCC Working Group from a coalition of ten companies. TIAA supports the addition of the proposed confidentiality language. We believe entities’ GCC information, including any Federal Reserve capital requirement submissions to lead state regulators, should receive the highest level of confidential treatment, and should not be disclosed by the NAIC or any other entity for any non-regulatory purpose. For this reason, we believe that adding broad confidentiality provisions to Model #440, including provisions that would prevent public disclosure of any entity’s GCC filings, would be appropriate. We encourage the NAIC to adopt the approach recommended by the Coalition to ensure that sensitive GCC information is adequately protected.

Conclusion

TIAA commends the GCC Working Group for its focus on these issues, and we appreciate the opportunity to comment on the Draft Letter. We hope our suggestions above prove helpful as the NAIC continues working to formulate a robust GCC framework. We would welcome the opportunity to engage further on any aspects of this letter.

Sincerely,

Bret C. Hester

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Via Electronic Mail

Commissioner David Altmaier, Chair  
NAIC Group Capital Calculation Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Mr. Dan Daveline  
Director, Financial Regulatory Services  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

RE: Comments on Group Capital Calculation Referral Letter

Dear Messrs. Altmaier and Daveline:

The Reinsurance Association of America (RAA), headquartered in Washington, D.C., is the leading trade association of property and casualty reinsurers doing business in the United States. The RAA is committed to promoting a regulatory environment that ensures the industry remains globally competitive and financially robust. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross border basis.

The RAA appreciates the opportunity to comment on the draft Group Capital Calculation (GCC) referral letter to the Group Solvency Issues Working Group regarding the scope of application of the GCC, confidentiality protections and establishing the regulatory authority to require annual GCC filings. We agree that the insurance holding company act and regulation (NAIC Models 440 and 450) are the appropriate locations to incorporate the regulatory authority and guidance for annual GCC reporting.

Scope Exemptions:  
The RAA’s longstanding position on group capital measures is centered on the premise that insurance groups should only be subject to a single group capital measure and only be subject to group supervision administered by their global group-wide supervisor. An important corollary to this position is that insurance groups should not be subject to multiple group capital measures and related requirements applied extraterritorially, whether they involve U.S. based multinational insurance groups or Non-U.S. groups with operations in the United States. This position appears broadly held as it was a central theme in the coalition of U.S. insurance trades’ comments on the NAIC’s August 7, 2018 Scope of Group Testing Memorandum.
Viewed through this prism, the RAA supports the scope exemption proposals outlined in the draft referral letter, subject to the following suggestions or clarifications:

- We support an exemption for small groups but believe the $1M annual premium threshold referenced from NAIC model #205 is too low. While it is important that nearly all insurance entities have annual statutory audits, requiring a GCC for all these groups appears unnecessary and overly burdensome. The coalition of trades suggested in 2018 that a better exemption threshold would be the ORSA standard, which is $1B in annual premium. The RAA still supports an ORSA based threshold, but if the NAIC determines that this threshold is too high, we suggest it consider adopting a threshold such as the $500M threshold used in section 17 of model #205 regarding Management’s Report of Internal Control over Financial Reporting. The NAIC/AICPA working group annually monitors this threshold, which currently encompasses over 93% of U.S. gross premium.

- We support the proposed exemption for groups regulated by the Federal Reserve because it would avoid duplicative group capital filing requirements.

- We support the proposed exemptions for groups domiciled in a reciprocal or qualified jurisdiction under the Credit for Reinsurance Model Law and for groups supervised by jurisdictions that recognize the GCC as an acceptable international capital standard comparable with the ICS. This proposal is essentially identical to the industry position outlined in the August 2018 trade coalition letter on scope issues.

**Commissioner Discretion:**

The RAA is concerned that the proposal to grant commissioner discretion to require the GCC for insurance groups otherwise exempt could be too broad. The language in the referral letter refers to ORSA guidance, but that guidance is expansive. The ORSA guidance manual lists several very general factors as examples that could justify an otherwise exempt entity having to file an ORSA, but the judgment ultimately depends on “unique circumstances” that are undefined. The ORSA model #505, provides better and more specific examples such as triggering an RBC action level or being deemed to be in hazardous financial condition, but these are only examples used within a context of broad commissioner discretion.

The RAA believes that any provision for commissioner discretion to disregard the scope exceptions to the GCC described above should be both distinct and limited. The exercise of broad commissioner discretion in this regard could violate the terms of the US/EU Covered Agreement, which provides relatively narrow exceptions for Host supervisors to impose group solvency requirements on Home party insurance or reinsurance groups. Recognizing that the discretion granted in the covered agreement applies to both parties, it follows that states should prefer provisions that limit any potential application of multiple capital requirements to insurance groups, since they would affect U.S. based groups as well.

Except for narrow circumstances relating to identifiable solvency concerns, each insurance group should be subject to only one group capital requirement and only the single group-wide supervisor should require a group capital measurement. Foreign supervised insurance groups should generally be exempt from the GCC and U.S.-based insurance groups should be accorded reciprocal treatment in non-U.S. jurisdictions.
Confidentiality:
The RAA supports strong confidentiality protections to prevent disclosure of GCC results. Such protections should be both explicit and robust and should preclude disclosure of any group’s GCC outside the regulatory community, whether by regulators, their consultants or by insurance groups themselves. We reviewed the July 30, 2019 “confidentiality coalition” letter referenced in the referral memorandum and broadly agree with their recommended revisions to Section 8 of NAIC Model #440.

Thank you for the opportunity to provide these comments. We look forward to continued discussion of these issues at future working group meetings.

Sincerely,

[Signature]

Joseph B. Sieverling
Senior Vice President
February 17, 2020

Commissioner David Altmaier
Florida Office of Insurance Regulation
Chairman, NAIC Group Capital Calculation (E) Working Group
via email to Dan Daveline ddaveline@naic.org

Re: “Confidentiality of Group Capital Calculation” Memorandum

Dear Commissioner Altmaier:

A coalition of 16 companies (Athene Holding Ltd., Brighthouse Financial, CNO Financial, Genworth Financial, Global Atlantic Financial Group, Hannover Life Reassurance Company of America, Jackson National Life Insurance, Lincoln Financial Group, National Life Group, Ohio National, Principal Financial Group, Protective Life, Reinsurance Group of America, Sammons Financial Group, Standard Insurance Company/StanCorp Financial Group, and Transamerica; collectively, the “Coalition”) appreciates the opportunity to respond to the memorandum (the “Memorandum”) from the Chair of the Group Capital Calculation (GCC) Working Group (GCCWG) to the Chair of the Group Solvency Issues Working Group (GSIWG), regarding “Confidentiality of Group Capital Calculation.” The Coalition’s primary purpose is to advocate for the creation of a GCC that is faithful to domestic state legal entity rules.

In its Memorandum, the GCCWG states that it seeks assistance from the GSIWG to open the Insurance Holding Company System Regulatory Act (#440) (the “Holding Company Act”) so that “confidentiality protection and other legal authorities needed for the GCC” can be incorporated into the Holding Company Act. The Coalition agrees that statutory authority is necessary to govern the confidentiality and scope (and potentially other facets) of the GCC, and that the use of the Holding Company Act is appropriate for this purpose.

The Coalition does not have a collective view on issues relating to scope, but scope is of interest to many Coalition companies, and individual companies may separately provide comments on the topic. Regarding confidentiality, we appreciate that Commissioner Altmaier’s Memorandum suggests to the GSIWG that the starting point for GCC confidentiality-related Holding Company Act amendments be the Coalition letter of July 30, 2019. As set forth in that letter, the Coalition believes that individual group GCCs be subject to the most robust confidentiality protection allowed by law. This would include prohibiting companies from disclosing their own GCC results, because doing so will help alleviate some of the competitive playing field issues that the GCC could create. We refer the GCCWG to the Coalition letter of July 30 for a comprehensive discussion of why such a high level of confidentiality would be needed for GCC results and for suggested amendments to the Holding Company Act to cover the confidentiality issue.

We also note that the NAIC’s accreditation standards require states to adopt the Holding Company Act in substantially similar form to the Model itself. Thus, in amending the Holding Company Act, the Coalition urges the NAIC to ensure that all of the due process
protections surrounding the adoption of accreditation standards are applied to GCC-related Holding Company Act changes.

Finally, the Coalition would oppose any effort to amend the Holding Company Act such that the GCC would be permitted to deviate from state legal entity rules, particularly with respect to the issue of “on-top adjustments” to statutory capital where such capital is included in an insurance company’s RBC. It is the Coalition’s firm belief that it would be inappropriate for the GCC to deviate from legal entity rules, when such rules have been considered and passed by the NAIC with all necessary due process protections, and relied upon by many insurance companies in making now virtually irreversible capital deployment decisions. Our objection to permitting the GCC to deviate from legal entity rules includes not only to draft model law/model regulation language, but also to any guidance manual or similar NAIC document that would instruct groups as to how to complete the GCC.

The Coalition thanks the GCCWG for permitting us to comment on the Memorandum, and remains available to answer any questions that the GCCWG may have.

Regards,

Athene Holding Ltd.
Brighthouse Financial
CNO Financial
Genworth Financial
Global Atlantic Financial Group
Hannover Life Reassurance Company of America
Jackson National Life Insurance
Lincoln Financial Group
National Life Group
Ohio National
Principal Financial Group
Protective Life
Reinsurance Group of America
Sammons Financial Group
Standard Insurance Company/StanCorp Financial Group
Transamerica
February 17, 2020

Via Electronic Delivery

Commissioner David Altmaier
Florida Office of Insurance Regulation
J. Edwin Larson Building
200 E. Gaines Street, Room 101A
Tallahassee, Florida 32399

Attention: Dan Daveline

Re: GCC - Draft Memo on Confidentiality and Exemptions

Commissioner Altmaier:

We appreciate the opportunity to comment on your draft memo (the “Memo”) on behalf of the Group Capital Calculation (E) Working Group (“GCCWG”) addressed to the Chair of the Group Solvency Issues (E) Working Group regarding potential exemptions from the GCC requirement and confidentiality of GCC reporting.

We continue to support the NAIC’s development of a group capital calculation (“GCC”). We believe that the calculation, if designed appropriately, will provide a useful supervisory tool to assist lead states in analyzing the financial condition of insurance groups by complementing entity-based solvency requirements.

Our primary purpose in writing today is to address the Memo’s proposal on how to identify insurance groups that will be exempt from the GCC (i.e., those that will be outside the “scope of application” of the GCC). As we have observed in prior comments, the scope of application should be a function of the purpose that the GCC is expected to serve. The NAIC’s GCC proposal document as of December 7, 2019, references the need to provide a consistent and coherent analytical framework to better understand an insurance group’s financial risk profile for the purpose of enhancing protection of policyholders. The scope of application should be sufficiently broad such that this need is met, while at the same time avoiding unnecessary burdens for groups for which this perspective would not provide a supervisory benefit or would be duplicative of tools already available to state insurance regulators.

As we have previously commented, to the extent limits are placed on the scope of application, we believe these should align with other risk focused regulatory tools such as the Own Risk and Solvency Assessment (the “ORSA”). Doing so would ensure consistency across risk focused regulatory tools, provide enhanced insight into risk across a material portion of the U.S.
insurance market rather than a narrow subset of it, and maintain a level regulatory playing field for the industry.

With that background, we are generally supportive of the exemptions proposed in the Memo. We believe the exemptions could be improved, however, through better alignment with the concepts embodied in the Risk Management and Own Risk and Solvency Assessment Model Act (#505) and in the NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual. First, the ORSA exemption for small companies sets a higher size threshold than that proposed in the Memo. The ORSA threshold may strike a better baseline balance between cost and benefit for the use of available state insurance regulatory and insurer resources. Second, ORSA provides that an insurer may comply with the reporting requirement by submitting a report including comparable information that is submitted to a supervisor or regulator of a foreign jurisdiction. This concept may be implied within the third and fourth bullets of the GCC exemption mechanism, but it may be desirable to fully articulate this in order to ensure that state insurance regulators have access to relevant group capital results applicable to the insurers that they regulate. Lastly, we support the provision in the Memo that gives the lead state commissioner the authority to require the GCC reporting of any group otherwise determined to be exempt, the same as the provision in the ORSA requirement.

We also note that the definition of “Reciprocal Jurisdiction” per the Credit for Reinsurance Model Law (#785) includes a U.S. jurisdiction that meets NAIC accreditation standards. We believe this reference is unintentional and would not be the basis for an exemption from the GCC; however, if it was intended to be included, additional explanation is needed to better understand the intent.

On the secondary issue, i.e., confidentiality of GCC reporting, now that the mechanism for establishing the GCC requirement has been confirmed, we do not object to the confidentiality treatment proposed by the Memo. That said, if it is desirable from a regulatory perspective for the NAIC to align the GCC confidentiality language to better match the terms of existing confidentiality language, our first preference would be the language used within the ORSA requirement and secondarily, the Holding Company Model Law.

* * *
We are grateful for your time and attention to our comments. If you would like to discuss this letter with us, please let us know.

Sincerely,

Douglas A. Wheeler  
Senior Vice President  
Office of Governmental Affairs  
New York Life Insurance Company

Andrew T. Vedder  
Vice President - Solvency Policy & Risk Management  
The Northwestern Mutual Life Insurance Company

D. Keith Bell  
Senior Vice President  
Corporate Finance  
The Travelers Companies, Inc.
February 13, 2020

Commissioner David Altmaier
Chair, Group Capital Calculation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

VIA Email Transmission: ddaveline@naic.org; lfelice@naic.org

RE: NAMIC Comments on Draft Memorandum to the Group Solvency Issues (E) Working Group from the Group Capital Calculation (E) Working Group Requesting Assistance on Drafting and Adopting Changes to NAIC Models

Dear Mr. Altmaier:

The following comments are submitted on behalf of the member companies of the National Association of Mutual Insurance Companies regarding the draft memorandum to the Group Solvency Issues Working Group that was made public on January 8. The memorandum serves as a request for assistance from the GSIWG in drafting and adopting needed changes to the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation (#450). We appreciate the opportunity to provide comments and to participate in discussions that will ultimately lead to the development and adoption of an insurance group capital assessment tool.

The changes currently contemplated and communicated in the memorandum would be to both Model #440 and #450, including adding a new filing requirement - an annual GCC report – to be filed by the ultimate controlling parent with the lead state regulator. This change will involve a similar process to what the NAIC did in 2010 when they added the annual enterprise risk report; that required a change to both Models, including adding a new filing form to Model #450. In this case, the memorandum recommends the addition of a Form G to collect GCC information. Additional changes contemplated by the working group to Model #440 include adding exemption criteria to determine who is required to file the GCC and amending the confidentiality section so that it is similar to the language included in the Risk Management and Own Risk and Solvency Assessment Model Act (#505).

1 NAMIC is the largest property/casualty insurance trade association in the country, with more than 1,400-member companies representing 39 percent of the total market. NAMIC supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies serve more than 170 million policyholders and write more than $230 billion in annual premiums. Our members account for 54 percent of homeowners, 43 percent of automobile, and 32 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
NAMIC members are supportive of amending both Model #440 and #450 as a means to provide exemptions based on certain criteria and to include strong confidentiality protection for documents, communications, and workpapers (created or received by regulators) used for the production of the GCC. However, we have significant concerns with the exemption criteria recommendation and suggest amending the memorandum before it is sent to the GSIWG. While we appreciate the thought given to exempting companies that may have to comply with more than one capital aggregation approach and companies of the very smallest size, NAMIC would suggest, as we have from the beginning of this project, for the NAIC to take a more proportional and principled approach to exemption criteria, similar to how other NAIC solvency models have incorporated these concepts. In addition to a size-threshold exemption similar to ORSA and the Model Audit Rule, NAMIC recommends that the lead-state regulator be allowed to accept the RBC results of a top-tier insurance regulated entity domiciled in their state if those results are substantially similar to expected GCC results. The remainder of our letter will go into more detail regarding our rational for these recommendations and will also provide other suggestions for the working group to consider.

Size-Related Exemption from Group Capital Calculation Reports

NAMIC recommends that small insurers – including those with less than $500 million in direct written premium – should be exempted from the proposed Group Capital Calculation Report (Form G) filing requirement. There is precedent for exempting small companies from the provisions of other NAIC models:

- The Risk Management Own Risk and Solvency Assessment model act exempts small companies (i.e., premium threshold of $500 million for individual insurers or $1 billion for an insurance group).

- The Model Audit Rule exempts insurers with less than $500 million of annual direct written and assumed premium from the requirement that they file a Management Report of Internal Control over Financial Reporting.

Small insurers are being treated to one-size fits all regulatory requirements related to many different NAIC models. The ERR (Form F) is just one of the many requirements that does not balance the cost vs. the benefit for small insurers. Further, the Corporate Governance Annual Disclosure provides no distinction to the size of insurer and requires corporate governance information for companies of all sizes. Each new requirement, filing, or report adds to the expense of providing insurance products. This added expense impacts small companies disproportionately. Mutual insurers feel a particular responsibility to their customers to do everything they can to make policymakers aware of the expense impact of each new requirement. Both the ERR and CGAD, along with RBC, help regulators assess the risk within an organization. Adding a new GCC filing form on top of the existing Form F will be viewed as duplicative for these smaller groups and others, as the purpose of both tools is to help regulators assess the risks coming from other non-insurance organizations within a groups’ structure.

It is important to understand that while any new requirement presents potential concerns and uncertainty for all companies, larger companies employ full-time legal, internal audit, accounting, finance, and enterprise risk management staff. There will
still be a cost for these large companies as there is for any new form requirement, but without a doubt, the cost of compliance and accuracy is a higher percentage of annual revenue for small companies. NAMIC strongly feels that proportionality needs to be part of the discussion when deciding on exemption criteria. Given that, NAMIC recommends modifying the second bullet in the draft memorandum regarding Section 4 to read:

Small mutual insurance companies that have annual direct written and unaffiliated assumed premiums of less than $500,000,000 for individual insurers or $1 billion for an insurance group (excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program) (similar to the exemption in the Annual Financial Reporting Model Regulation (#505)).

Accept Ultimate Controlling Parent RBC if GCC Expected Results are Similar

The primary purpose of the GCC is to help regulators understand large and complex groups. NAMIC members have long held the view that where the ultimate controlling parent is an underwriting company that directly or indirectly owns or controls all of the other entities within the group, that the annual RBC report of the UCP should be an acceptable alternative to reporting a GCC. NAMIC members that have participated in field-testing exercises where the top-tier entity is an insurance underwriter that files RBC have concluded that annual RBC is substantially similar to the expected results of the GCC.

As we’ve stated in our comment letter to the Federal Reserve on their Building Block Approach to group capital, U.S. RBC for a top-tier insurance underwriting holding company is a proxy for consolidation. For a top-tier insurance underwriting holding company, all the activities and investments made, including in any subsidiary insurers are rolled up into the parent’s insurance RBC calculation. The existing insurance RBC formula already incorporates necessary adjustments for inter-affiliate transactions, such as capital invested in a subsidiary by the parent; thus, the top-tier insurance underwriting holding company RBC is, in effect a consolidated view of the group’s capital position. For these reasons, NAMIC believes the draft memorandum should be amended to include language that would exempt an UCP that is an RBC filer from having to file an annual GCC report. In lieu of requiring an annual GCC report, the lead-state regulator would accept the group’s annual RBC, as these results would be substantially similar to the expected results of a GCC.

In consideration of including language around exempting an UCP that is an RBC filer, NAMIC recommends that an additional bullet be added to the list of entities exempt from the GCC in the draft memorandum:

The model should provide flexibility to accept annual RBC where the ultimate controlling parent is an underwriting company, as the expected results of the GCC would be substantially similar to RBC in lieu of requiring an annual GCC report.
Confidentiality

NAMIC is supportive of modifying the confidentiality provisions within the HCA to mirror the language included in the ORSA model. Of particular importance is including language about documents, communications, and workpapers that have been created by or received by other regulators as part of the analysis of the GCC. Because the information that will be submitted to regulators will be used to analyze various stress scenarios and testing options, protecting any information that would be created by regulators and subsequently shared with other regulators in order to complete their analysis of the GCC is of utmost importance to NAMIC members.

Thank you for your consideration of these comments on this matter of importance to NAMIC, its member companies and their policyholders. If there are any questions, please feel free to contact me at 317-876-4206.

Sincerely,

Jonathan Rodgers
Director of Financial and Tax Policy
National Association of Mutual Insurance Companies
February 17, 2020

Commissioner David Altmaier, Chair
Group Capital Calculation (E) Working Group
National Association of Insurance Commissioners

Re: Referral Memorandum on Changes to the Insurance Holding Company Regulatory Act (#440)

Dear Commissioner Altmaier:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to comment on the Group Capital Calculation (E) Working Group’s referral memorandum regarding amendments to the Insurance Holding Company Regulatory Model Act (#440) to incorporate the Group Capital Calculation (GCC). APCIA is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

Exemption for Groups Subject to Another Group-Wide Capital Assessment

The referral memorandum specifies four classifications of groups to be exempt from the GCC. However, the memo also recommends that lead state commissioners have the authority to require the GCC of any group otherwise determined to be exempt. APCIA is concerned with the recommendation to grant commissioners the authority to require the GCC from exempt groups—particularly for groups that are already subject to a group-wide capital assessment. Insurers should not be required to comply with more than one group-wide capital measure. Groups subject to the Federal Reserve’s Building Block Approach (BBA), as well as insurers with a group-wide supervisor in a Reciprocal Jurisdiction outside the United States, should be, without exception, exempt from the GCC.

For groups required to file with the Federal Reserve, the exemption contemplated in the referral memorandum would require a copy to be filed with the lead state. Similarly, for insurers where the group-wide supervisor is a Reciprocal Jurisdiction under the Credit for Reinsurance Model Law, paragraph 10 of the August 2, 2019 GCC Field Testing Instructions specified conditions for a potential GCC exemption, including access to information for lead state regulators. Specifically, paragraph 10 of the field-test instructions provides the following:
After field testing a determination will be made as to whether a non-U.S. based group (a group with a non-U.S. group-wide supervisor) may be exempt from the GCC based on the following:

i. The non-U.S. based group is based in a Reciprocal Jurisdiction that recognizes the U.S. regulatory regime and accepts the GCC from U.S. based groups to satisfy the Reciprocal Jurisdiction’s group capital requirement;

ii. The non-U.S. Group-Wide Supervisor’s home jurisdiction requires a group capital calculation be applied at a level that includes the same (or substantially similar) Scope of Application as would otherwise be determined by the Lead State Regulator in the absence of this exemption; and

iii. The Lead State Regulator can obtain information from the foreign group’s Group-Wide Supervisor either through a Supervisory College or otherwise, that allows the Lead State Regulator to understand the financial condition of the group and complete the expectations of other states in its Group Profile Summary (GPS).

With the assurance that lead state regulators have access to group-wide information through the conditions provided above, or through BBA filings, an exception to the GCC exemptions is not necessary. Therefore, APCIA believes that groups subject to the BBA, as well as insurers with a group-wide supervisor in a Reciprocal Jurisdiction outside the United States, should be exempt from the GCC without exception.

**Exemption for Insurers Not Required to File an ORSA**

Furthermore, APCIA also recommends adding an exemption from the GCC for insurers that are not required to file an Own Risk and Solvency Assessment (ORSA). The referral memorandum only recommends an exemption for small mutual insurers, which is expected to be similar to the exemption for small insurers in the Annual Financial Reporting Model Regulation, with an annual threshold of $1 million in premium. However, we believe the exemption criteria set forth in the model law for the filing of an ORSA is more relevant in the context of the GCC, as the purpose of both the GCC and an ORSA is to provide a group-level perspective on insurers’ capital and risk. An exemption for insurers that do not file an ORSA would recognize proportionality in the application of supervisory measures, and it would allow regulators to focus resources on companies and the areas within companies that pose the most risk. Therefore, we recommend an exemption from the GCC for insurers that fall below the premium thresholds (i.e., less than $500 million of direct written premium by the insurer and less than $1 billion of direct written premium by the insurer’s group) in Section 6(A) of the Risk Management and Own Risk and Solvency Assessment Model Act as well as an exemption like that in Section 6(D), which can be granted by a commissioner “based upon unique circumstances.”

**Process for Considering GCC Design Decisions**

While the Working Group’s memorandum is in the form of a referral to the Group Solvency Issues (E) Working Group, it appears to contain some preliminary decisions on GCC design (such as the scope issues mentioned above). In September 2018, APCIA’s predecessor associations and four other industry associations (Joint Trades) filed a comment letter with the Working Group in which we discussed our recommendations on a number of open design issues. Other interested parties did the same. Rather than engage in public discussion and resolution of those comments at that time, the Working Group decided to leave them open during 2019 field testing. While we
understand the rationale for that decision, there has still been no public discussion of these issues, yet apparently some of them have been decided, at least on a tentative basis. We look forward to an opportunity to engage in more thorough discussion of these issues before further decisions are made about the final design of the GCC.

Thank you for considering the points addressed in this letter, and we continue to support NAIC staff and the Working Group in their successful development of the Group Capital Calculation.

Sincerely,

Stephen W. Broadie
Vice President, Financial & Counsel
February 17, 2020

Commissioner David Altmaier, Chair
Group Capital Calculation (E) Working Group
National Association of Insurance Commissioners

By e-mail to: Dan Daveline, NAIC, at ddaveline@naic.org

Re: Group Capital Calculation (E) Working Group Exposure

Dear Commissioner Altmaier:

America’s Health Insurance Plans (AHIP) is pleased to comment on the Draft Memorandum that you propose to send in your capacity as Chair of the NAIC’s Group Capital Calculation (E) Working Group (GCCWG) to the chair of the NAIC’s Group Solvency Issues (E) Working Group. The Draft Memorandum concerns suggested amendments to the Insurance Holding Company Regulatory Model Act (#440) proposed by the GCCWG to implement the Group Capital Calculation (GCC).

AHIP’s comments pertain to several aspects of the suggestions in the Draft Memorandum, i.e., regarding confidentiality, exemptions, and process.

Confidentiality:

The Draft Memorandum suggests that “Confidentiality language consistent with that recommended by a comment letter directed to the Working Group from the Coalition which, among other things, prohibits the filing of the report with the NAIC unless supported by a confidentiality agreement (similar to the Risk Management and Own Risk and Solvency Assessment [ORSA] Model Act [#505]).” The Coalition’s letter of July 30, 2019 includes a redline of the confidentiality provisions in Section 8 of Model #440, and AHIP generally supports these redline changes. However, two additional adjustments are in order.

First, the language in Section 8.C(1) which appears to allow a group’s GCC to be shared with “international regulatory agencies” should be modified to prohibit sharing with the IAIS unless the group or insurer grants its consent.
Second, language should be added to the end of Section 8.C(4)(iii) as follows: “…and require the NAIC or third-party consultant to provide certification or other proof satisfactory to the insurer or group that all such materials are no longer stored and have been destroyed, deleted, returned, or otherwise rendered inaccessible.”

**Exemptions:**

The Draft Memorandum suggests several situations for which it is suggested that a group be exempt from filing the GCC with its lead state regulator. Some of those situations parallel recommendations made in the September 20, 2018 letter submitted to the GCCWG by AHIP together with the American Insurance Association and the Property Casualty Insurers Association of America (now merged as the American Property Casualty Insurance Association), Blue Cross Blue Shield Association, the National Association of Mutual Insurance Companies, and the Reinsurance Association of America (the “Joint Trade Letter”). However, there are some variances from the Joint Trade Letter as well. These similarities and differences are presented below, as they serve to frame AHIP’s current comments on the related text in the Draft Memorandum:

1. Group size exemption: The Joint Trade Letter supported exemption of a U.S.-based group from filing a GCC if the group is not required to file an ORSA with its Lead State Regulator, i.e., if the insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than $1 billion. The Draft Memorandum suggests an exemption only for small mutual insurance companies, citing the exemption in the Annual Financial Reporting Model Regulation (#205), which has a threshold of $1 million in such premiums.

AHIP is concerned about the apparent wide chasm between the views of many in industry as expressed in the Joint Trade Letter and of GCCWG members as to the apparent value to the regulatory process that could be gained by requiring a large number of small(er) insurance groups to file the GCC. AHIP again suggests that the GCCWG consider the ORSA-like threshold and, after gaining experience with the utility of the GCC from its experience with larger groups that are subject to ORSA, that the threshold might then be lowered to a level (but likely much greater than $1 million in annual premiums) to include more groups but nonetheless balances the cost and benefit/utility of the GCC to groups and regulators alike.

2. Mutual company exemption: The Joint Trade Letter proposed an exemption for U.S. groups where the Ultimate Controlling Party (UCP) is an underwriting company that directly or indirectly owns all of the other entities within the Broader Group. In such a situation the UCP could provide its Annual RBC report as an acceptable alternative to the GCC. This suggestion has apparently not been considered for inclusion in the Draft
Memorandum, and AHIP would like to understand the basis for that exclusion (see “Process”, below). AHIP notes that the suggested exemption, if permitted, would not only pertain to many mutual insurance companies, but also to other types of entities such as non-profit health plans, both of which are among AHIP’s membership.

3. Groups regulated by the Federal Reserve Board (FRB): The Draft Memorandum suggests that groups required to file with the FRB be exempt from filing the GCC with their lead state regulator, but that those groups be required to provide a copy of the filing with the FRB to the lead state. AHIP appreciates this suggestion, which is consistent with the Joint Trade Letter.

4. Foreign-based groups: The Draft Memorandum provides two situations for which it is suggested that a foreign-based group be exempt from filing the GCC:
   a. If it is a reciprocal or qualified jurisdiction per the Credit for Reinsurance Model Law (#785);
   b. Other groups for which the group-wide supervisor otherwise accepts the GCC for any U.S. insurance group or recognizes the GCC as an acceptable international capital standard to the International Association of Insurance Supervisors (IAIS), and has been sponsored by an accredited lead-state.

While this seems somewhat consistent with the Joint Trade Letter, there are some nuanced variances for which AHIP would appreciate a better understanding, e.g., the concept of being “sponsored by an accredited lead state” (see “Process”, below).

Process:

As mentioned previously, the Joint Trade Letter was submitted September 20, 2018, and was part of a series of exposures and comments from interested parties in 2018 leading up to the launch of GCC field testing in 2019. Despite the input sought by the GCCWG in 2018, and the numerous recommendations offered by Interested Parties, the GCCWG did not act to either adopt or reject many of those recommendations. Rather, the decision was made to leave those aspects open as options to be explored through field testing. With the 2019 field test exercise now completed, the open dialogue that might otherwise have occurred back in 2018 has still not occurred. However, the GCCWG Draft Memorandum appears to represent decisions (at least proposed decisions) that have since been made by the GCCWG in the absence of any related open dialogue with Interested Parties. In other written and oral submissions, recommendations were made on issues other than exemptions as well. This explains why AHIP looks forward to further policy-based discussions between regulators and Interested Parties before moving ahead with the memo to the GSIWG or other unresolved questions related to the GCC. We suggest those discussions could happen during the GCCWG meeting in Phoenix in March, and in subsequent conference calls as needed, but we would urge the Working Group to begin those discussions with an open exchange and inventory of pending issues, and an analysis of which can be answered now, and which must be further postponed due to lack of available information or other reasons.

* * * * *
AHIP appreciates this opportunity to comment and would be glad to address any questions you or other GCCWG members may have at your convenience.

Sincerely,

America’s Health Insurance Plans

Bob Ridgeway
Bridgeway@AHIP.org
501-333-2621
Commissioner David Altmaier
Florida Office of Insurance Regulation
Chair, NAIC Group Capital Calculation (E) Working Group
[via-email: ddaveline@naic.org]

February 12, 2020

Re: Exposure Memorandum addressing confidentiality and scope of the Group Capital Calculation

Dear Commissioner Altmaier,

The American Council of Life Insurers\(^1\) appreciates the opportunity to share our views on the NAIC Group Capital Calculation (E) Working Group’s exposed draft memorandum to the Group Solvency Issues (E) Working Group. The memo recommends updating the Insurance Holding Company System Regulatory Act (#440) to create the legal filing mechanism and confidentiality protections for the Group Capital Calculation (“GCC”).

i. Confidentiality

As noted in many of our past comments on the GCC, ACLI strongly supports robust confidentiality protections to guard against disclosure of GCC results. The NAIC has historically acknowledged and recognized the potential for the misuse of certain regulatory filings like non-public RBC reports or plans by limiting the ability of companies or state insurance regulators to disclose these reports. The GCC, as contemplated by the NAIC, will be a regulatory tool that helps state insurance regulators “better understand an insurance group’s financial risk profile for the purpose of enhancing policyholder protections.” A high degree of regulatory acumen will likely be necessary to ensure that the results, and the nuances contained within them, are understood in the appropriate context. As such, we appreciate the NAIC’s apparent commitment to strong confidentiality protections for GCC data and results.

One area that may require additional consideration is protecting the confidentiality of reports and results submitted by holding companies regulated by the Federal Reserve Board (the “Board”). Nonpublic information submitted to the Board must be subject to similar confidentiality protections as GCC data and results.

ii. “Small mutual holding company” exemption

ACLI supports an exemption for small companies and groups, but we believe the Working Group should increase the proposed threshold. The memo proposes an exemption for “small mutual insurance companies” with less than $1,000,000 in annual premium and fewer than 1,000 policy or contract holders. We believe that a GCC small-company/group exemption level that mirrors the thresholds used in the Own Risk and Solvency Assessment (“ORSA”) Act would be more appropriate.

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\(^1\) The ACLI advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. 90 million American families depend on our members for life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, dental and vision and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

**American Council of Life Insurers**
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and a better use of supervisory resources. Further, given that the NAIC plans to use the GCC as a tool, not a standard or requirement, to “complement existing group supervisory tools already available to state insurance supervisors” including the Own Risk and Solvency Assessment Summary Report, Form F and Form B filings, we think it makes sense to align the threshold with ORSA. ACLI believes that requiring these small groups to perform the calculation would burden them and their regulators without providing any additional insight into the group as their structures are typically less complex and not difficult to understand. As such, we recommend increasing the exemption threshold to a requirement that will allow states to focus their resources on groups where additional transparency into the group and non-insurance financial entities may provide the most benefit to regulators and policyholders.

iii. Groups regulated by the Federal Reserve Board

ACLI supports the proposed exemption for groups that are regulated by the Federal Reserve Board (“Board”) who provide a copy of their Board filings to their lead state regulator. We believe this is appropriate and avoids duplicative requirements of having to file two group capital assessments at the world-wide parent level for Board-regulated insurance holding companies. To the extent those filings include non-public information, they must be protected by express confidentiality protections in section 8.

iv. Placement of the GCC within section 4 of the Insurance Holding Company System Regulatory Act (#440)

The placement of the GCC within section 4 of the Insurance Holding Company System Regulatory Act (hereafter the “Holding Company Act”) appears to create an implicit exemption that was not expressly discussed in the memo. As noted in the memo, the NAIC Group Capital Calculation Working Group recommends placing the regulatory authority for the GCC in section 4 of the Holding Company Act, which governs registration and reporting requirements for insurance companies who are part of an insurance holding company system. With that in mind, it appears that companies who do not file registration reports under section 4 of the Holding Company Act, are also exempt from filing the GCC, regardless of whether they exceed the proposed exemption for “small mutual insurance companies” or any of the other proposed exemptions. Additional clarification on this issue, as well as more fulsome analysis and rationale for each exemption and the scope of application, would benefit all stakeholders and permit stakeholders to provide input on those issues.

Conclusion

We look forward to continuing these discussions and appreciate the Working Group’s attention to scope of application. We look forward to continuing to engage on these important topics as more information becomes available on these or other topics required to implement an effective GCC. We encourage the NAIC GCCWG to release a proposed mark-up of section 4 and 8, which would help our

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2 With some exceptions, insurers are exempt from ORSA if the insurer’s annual premiums are less than $500 million and they belong to a group with fewer than $1 billion in annual written/assumed premiums. ORSA also preserves supervisory discretion to exempt or apply ORSA to firms.

3 NAIC GCCWG Request for Model Law Development (October 30, 2019).

4 Section 1 of the NAIC Insurance Holding Company System Regulatory Act (#440) defines an insurance holding company system as two (2) or more affiliated persons, one or more of which is an insurer. An affiliate is defined as “a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.”

5 Id. at 1.
members evaluate the proposed exemptions and confidentiality protections with greater certainty, and thus provide more detailed feedback.

Regards,

Mariana Gomez-Vock
Associate General Counsel
Marianagomez-vock@acili.com (202) 624-2313

Patrick Reeder
VP & Deputy General Counsel
patrickreeder@acili.com (202) 624-2195

David Leifer
VP & Associate General Counsel
davidleifer@acili.com (202) 624-2128
Re: Comments on Group Capital Calculation Working Group Referral Memorandum

Dear Commissioner Altmaier:

Reinsurance Group of America, Incorporated (RGA) is a global life and health reinsurer headquartered in the United States. RGA appreciates the opportunity to comment on the NAIC Group Capital Calculation (E) Working Group’s exposed draft referral memorandum to the Group Solvency Issues (E) Working Group.

RGA supports amending the Insurance Holding Company System Regulatory Act (#440) to ensure confidentiality, appropriate scope, and legal authority for the Group Capital Calculation (GCC). We are writing specifically to request clarification with respect to the third and fourth proposed exemptions to the GCC to ensure that there is reciprocity for U.S. groups as intended:

- Groups for which the group-wide supervisor is a reciprocal or qualified jurisdiction per the Credit for Reinsurance Model Law (#785).

- Group not considered a reciprocal or qualified jurisdiction but for which the group-wide supervisor: i) accepts the GCC for any U.S. insurance group; or ii) recognizes the GCC as an acceptable international capital standard to the International Association of Insurance Supervisors (IAIS); and iii) has been sponsored by an accredited lead-state.

RGA supports the position that insurance and reinsurance groups should be subject to only one group capital calculation, standard or requirement (measure), which should be administered only by the group’s own group-wide supervisor. As such, we support excluding certain non-U.S. groups described in exemptions 3 and 4 from the Group Capital Calculation (GCC) requirement at the level of their worldwide group so long as those exemptions are conditioned on U.S. groups being accorded reciprocal treatment in those non-U.S. jurisdictions. We recommend that this reciprocity requirement be clearly stated in the exemptions.
We also request clarification on reciprocal treatment with respect to subgroup reporting, as opposed to reporting at the level of the worldwide group. As currently written, it appears that the GCC exemptions would apply to a group from a non-U.S. jurisdiction that imposes a group capital measure on a U.S. group’s subgroup located in that non-U.S. jurisdiction.

While we do not object to the NAIC exempting U.S. subgroups of non-U.S. groups from the GCC requirement, such exemption should be conditioned on that non-U.S. group’s home jurisdiction likewise abstaining from requiring a U.S. group to file a group capital measure at the subgroup level in that jurisdiction. Otherwise, the reciprocity principle as adopted in the U.S. will inadvertently disadvantage U.S. groups.

We note that the EU-U.S. and UK-U.S. Covered Agreements and the Credit for Reinsurance Model provisions on reciprocal or qualified jurisdictions do not appear to resolve the subgroup issue. While Article 4(b) of the EU-U.S. Covered Agreement generally prohibits a “Host” supervisory authority from exercising group supervision, including capital, at the worldwide group level, it does not prohibit the host supervisor from exercising group supervision over the “Home” group at the subgroup level, i.e., “at the level of the parent undertaking in the territory of the Host Party”. Article 4(b) further provides that “Host supervisory authorities do not otherwise exercise worldwide group supervision with regard to a Home Party insurance or reinsurance group, without prejudice to group supervision of the insurance or reinsurance group at the level of the parent undertaking in the territory of the Host Party.” (Emphasis added.)

Article 4(h) addresses group capital specifically and provides that with respect to a group capital assessment that fulfills certain criteria, “the Host supervisory authority does not impose a group capital assessment or requirement at the level of the worldwide parent undertaking of the insurance or reinsurance group according to the applicable law in its territory.” (Emphasis added.) Thus, the prohibition on the Host supervisor’s imposition of a group capital measure appears to be limited to the worldwide parent, and not the subgroup in that jurisdiction. Similarly, Sections 9(B)(1) and 9(B)(3) of the Credit for Reinsurance Model Regulation on reciprocal jurisdictions appear to address worldwide, but not subgroup, reporting.

RGA requests that the referral memorandum’s third and fourth exemptions be amended to clarify that reciprocity is required not only at the worldwide group level but at the subgroup level as well. Thank you for the opportunity to provide these comments. We would be happy to discuss this issue further.

Sincerely,

Michael L. Emerson
EVP & Head of U.S. and L/S Markets

16600 Swingley Ridge Road, Chesterfield, Missouri 63017 (t) 612 217-6101  memerson@rgare.com
February 20, 2020

Via Electronic Delivery

Commissioner David Altmaier
Florida Office of Insurance Regulation
Chairman, NAIC Group Capital Calculation (E) Working Group
Via email to Dan Daveline (ddaveline@naic.org)

Re: The National Association of Insurance Commissioners ("NAIC's") Draft Confidentiality of Group Capital Calculation Memorandum ("the draft memorandum")

Dear Commissioner Altmaier:

Prudential Financial, Inc. ("we") thank the Group Capital Calculation Working Group ("Working Group") for continuing to seek input on key elements of the Group Capital Calculation ("GCC"). We support the development of supervisory tools that enhance state regulators’ ability to protect policyholders and insurance markets.

We believe determining the companies to which the GCC applies should be a function of its overarching objective. The May 29, 2019 NAIC Proposed GCC document provided the following context on why the NAIC is developing the GCC and the objective it is intended to achieve:

“The GCC is a natural extension of work state insurance regulators had begun, in part driven by lessons learned from the most recent financial crisis, to better understand an insurance group’s financial risk profile for the purpose of enhancing policyholder protections. State insurance regulators already exercise their legal powers to obtain any information regarding the capital positions of affiliated business entities. However, there has not been a consistent or coherent analytical framework for evaluating such information and monitoring trends. As such, the GCC is designed to meet this need, delivering financial solvency regulators a panoramic, transparent view of the interconnectedness, business activities, and underlying capital support for an insurance group.”

We support the stated objectives and to achieve them, we believe the GCC should broadly apply to insurers operating in the U.S. with limited exceptions. Such an approach would ensure that policyholders benefit equally from the insights the GCC may provide, and that the panoramic view of the U.S. insurance market state regulators and the NAIC are pursuing is not subject to significant gaps. That said, we recognize the importance of exercising proportionality to avoid instances where application of a regulatory tool would introduce an undue burden on an insurer/insurance group. With these considerations in mind, we believe the following exemptions from completing the GCC would be appropriate:

1. Small insurance companies/groups
Rationale – We believe it is appropriate to extend existing exemptions from various risk related reporting requirements to the GCC.

2. Groups required to file with the U.S. Federal Reserve System ("the Fed"), but separately require that such a group provide a copy of the Fed filing to its lead state regulator.

Rationale – We believe insurance groups – at the worldwide parent level – should be subject to only one group capital calculation or requirement. While the GCC is intended to serve as an analytical tool, the framework the Fed imposes will be a binding requirement. Given this difference as well as the concerted efforts of the NAIC and Fed to align their respective frameworks to enhance regulatory consistency in the U.S., we believe it would be appropriate for the lead state to accept a copy of the filing with the Fed in lieu of requiring completion of the GCC.

3. Foreign-based insurance groups that are subject to a group capital calculation or requirement provided:
   i) The group-wide supervisor accepts the GCC for any U.S. insurance group; and
   ii) The group-wide supervisor shares relevant information with the lead state upon request

Rationale – As noted above, we believe insurance groups – at the worldwide parent level – should be subject to only one group capital calculation or requirement. Thus, in the case of foreign-based insurance groups, we believe the lead state should respect the sovereignty of the insurance regulator in the jurisdiction of the worldwide parent and not require the completion of a second group capital calculation. Similar deference should be provided by the insurance regulator of the foreign jurisdiction for U.S. companies operating in their respective market. Such an approach would be consistent with Article 1, Objectives (c) of the Bilateral Agreement between the U.S. and the EU on Prudential Measures Regarding Insurance and Reinsurance (“the Covered Agreement”), which outlines expectations for Host and Home supervisory authorities:

   “the role of the Host and Home supervisory authorities with respect to prudential group supervision of an insurance or reinsurance group whose worldwide parent undertaking is in the Home Party, including, under specified conditions, (i) the elimination at the level of the worldwide parent undertaking of Host Party prudential insurance solvency and capital, governance, and reporting requirements, and (ii) establishing that the Home supervisory authority, and not the Host supervisory authority, will exercise worldwide prudential insurance group supervision, without prejudice to group supervision by the Host Party of the insurance or reinsurance group at the level of the parent undertaking in its territory;

While we support an exemption from the GCC for the worldwide parent of foreign-based insurance groups, we believe the lead state should require submission of the GCC for its U.S. operations ("U.S. sub-group"). Requiring U.S. sub-group compliance with the GCC is appropriate and important for several reasons, including:

- Making sure policyholders receive the benefit of equal prudential oversight from state regulators;
- Securing a sufficiently panoramic view of the U.S. insurance market, which would better enable lead states and the NAIC to identify trends and emerging risks and position the GCC as a complement to tools being developed under the Macroprudential Initiative ("MPI");
• Avoiding an unlevel playing field – although the GCC has been framed as a tool rather than a requirement, we believe supervisors would feel compelled to act if presented with a concerning GCC ratio; and

• Aligning with practices and/or requirements in foreign markets, which have already determined there is value in receiving such information

More broadly, we believe language in the Covered Agreement does not preclude application of prudential tools at the sub-group level; rather, section (ii) of objective (c) implicitly recognizes that supervisors may feel the need to apply tools that encompass all operations within their jurisdiction.

Finally, we are generally supportive of the suggested edits to the Insurance Holding Company System Regulatory Act (#440) text to address confidentiality protections for the GCC. However, we believe the text would be improved through the following changes:

Section 8.A. – “.... However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties, but notwithstanding the foregoing, the commissioner shall seek to maintain the confidentiality of the group capital calculation and Group Capital Ratio, including in such documents during the course of any such regulatory or legal action. With respect to all other documents, materials or other information covered by this paragraph, the commissioner ....”

Rationale – We believe the proposed edits would better align the text with the NAIC’ intention for the GCC to serve as additional tool for identifying potential risks within the group rather than a minimum standard or requirement that triggers regulatory or legal action if breached.

Section 8.G. – “It is the judgment of the legislature that the group capital calculation and resulting Group Capital Ratio is a regulatory tool for assessing group risks and capital adequacy, and is not intended as a means to rank insurers or insurer groups generally. Therefore, except as otherwise may be required under the provisions of this Act or as may be customary for engagement with investors, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine, website or other publication, or in the form of a notice, circular, pamphlet, letter or postcard, e-mail, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the group capital calculation or Group Capital Ratio of any insurer or any insurer group, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the group capital calculation or resulting Group Capital Ratio or an inappropriate comparison of any other amount to an insurer’s or insurance group’s group capital calculation or resulting Group Capital Ratio is published in any written or electronic publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written or electronic publication if the sole purpose of the announcement is to rebut the materially false statement.”
Rationale – We believe the proposed edits would appropriately carve out the current market practice of sharing solvency related information with the investor community and modernize the disclosure to account for potential publication via electronic means.

We again thank the Working Group for seeking stakeholder input on key elements of the GCC and would welcome the opportunity to discuss the information included in this response should the Working Group or NAIC staff engaged in the GCC project wish to do so.

Sincerely,

Ann Kappler
Senior Vice President, Deputy General Counsel and Head of External Affairs
Prudential Financial, Inc.
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met via conference call on May 19, 2020. The following Working Group members participated: David Altmaier, Chair, and Ray Spudeck (FL); Kathy Belfi, Vice Chair (CT); Laura Clements (CA); Philip Barlow (DC); Carrie Mears, Mike Yanacheak and Kim Cross (IA); Susan Berry and Vincent Tsang (IL); Roy Eft (IN); Christopher Joyce (MA); Judy Weaver (MI); Constance Peterson and Barbara Carey (MN); John Rehagen and Karen Milster (MO); Jackie Obusek (NC); Justin Schrader (NE); Dave Wolf (NJ); Edward Kiffel and Mark McLeod (NY); Dale Bruggeman and Tim Biler (OH); Greg Lathrop (OR); Joe DiMemmo (PA); Trey Hancock and Hui Wattanaskolpant (TN); Mike Boerner and Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm and Levi Olson (WI).

1. Adopted of its 2019 Fall National Meeting Minutes

Ms. Belfi made a motion, seconded by Mr. Bruggeman, to adopt the Working Group’s Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Financial Condition (E) Committee, Attachment Three). The motion passed unanimously.

2. Exposed the NAIC Staff Post-Field Test Recap of the GCC and Initial Suggested GCC Revisions

Commissioner Altmaier stated that NAIC staff would be presenting a PowerPoint (Attachment Five-C1) summarizing preliminary input and revisions resulting in adjustments to the draft revised group capital calculation (GCC) instructions and a revised GCC template. He stated that the goal was to expose the documents for a 60-day public comment period, and the bulk of questions and comments should be handled via the comment period. He asked Lou Felice (NAIC) to begin the presentation.

Mr. Felice opened by saying that the bulk of the presentation would focus on the PowerPoint with some references to the instructions. He stated that the template will operationalize what is in the instructions, so the template was provided more for information and descriptive purposes. He pointed out that the materials were developed to be agnostic to pending decisions as to what groups would be required to submit a GCC template. He highlighted directional adjustments to the instructions and template, which include the following:

- Expanded language on possible entities that could be excluded from the GCC scope of application.
- Expanded opportunities for the grouping of non-financial entities and narrowing capital calculation options to two.
- An equity-based factor in the base capital calculation for non-financial entities and non-operating holding companies.
- Addition of a two-step approach to establishing an allowance for senior and hybrid debt as additional capital, including the reporting of paid-in and contributed capital.
- Selection of proxy allowance for senior debt (30%) and hybrid debt (15%).
- A potential course for removal of an informational sensitivity analysis for XXX/AXXX captives.
- Selection of a single scalar option for certain jurisdictions based on the Pure Relative Ratio Approach.
- Additional sensitivity analysis items and the retention of others.
- Expanded collection of “other information” useful for lead-state analysis or to inform future GCC enhancements.
- Added, deleted and relocated data entries on Schedule 1, the Inventory Tab, and in other areas of the instructions/template, including the addition of an attestation.

Commissioner Altmaier expanded on the XXX/AXXX slide, stating that those who wish to comment on this issue should bear in mind that once another group is identified and takes up a charge to conduct further review of XXX/AXXX captives, the informational sensitivity analysis for those captives will be removed from the template.

Mr. Felice also pointed out some areas where feedback is specifically requested. These include, but are not limited to:

- Adding principals and guidance criteria for excluding entities from the GCC scope of application.
- Clarifying modifying the definitions for what is a financial vs. non-financial entity.
- Including greater granularity in applying a capital calculation to non-financial entities.
• Adding criteria for “tracked down streamed’ debt and whether that category should be dropped from the template in favor of relying on “paid-in and contributed capital.”
• Limiting the allowance of additional capital from debt to 50% of total adjusted carrying value.
• Proposals for alternatives for scalars and for the treatment of jurisdictions with less developed capital requirements.
• Collecting information on the source of foreign currency conversion.

Commissioner Altmaier reinforced that there are several areas where the Working Group is actively seeking feedback on the materials. He asked state insurance regulators and interested parties if there are any initial questions.

Stephen Broadie (American Property Casualty Insurance Association—APCIA) asked whether options presented are for Working Group discussion and decision or choices for the group filing the template to pick from when completing the template. Commissioner Altmaier agreed that there is some optionality on the scope of application based on lead-state interaction with the group, while other options are directional, presented with the goal of ultimately agreeing on a common treatment in the template. Mr. Felice agreed, stating that there are directional items and those in which specific feedback could influence the inputs or methodologies included in the GCC template.

Tom Finnell (America’s Health Insurance Plans—AHIP) noted that there is an opportunity for differences in the scope of application across groups based on the application of criteria by lead-states. Commissioner Altmaier stated that the Working Group is trying to balance useful information to the state insurance regulator with comparability between groups. He added that the lead-state has the last word on what is included in the template, and there are opportunities, such as the supervisory colleges, to provide information to other involved state insurance regulators.

Patrick C. Reeder (American Council of Life Insurers—ACLI) asked about the longer-term workplan for the rest of the year beyond the 60-day exposure. Commissioner Altmaier stated that the Working Group will be conducting parallel discussions on the analytics and the proposed revisions to the Insurance Holding Company System Regulatory Act (#440). He added that the agenda for the Working Group beyond the comment period would depend on the comments received during the comment period. The goal is to adopt the template and instructions at some point after the exposure period. Commissioner Altmaier offered the possibility of a mid-exposure webinar if interested parties felt it was useful to address initial technical questions or provide further information on the changes. The materials were exposed for a 60-day public comment period without objection.

3. Formed a Drafting Group to Review and Improve Staff Developed Guidance for How GCC Will Be Used

Commissioner Altmaier stated that as an analytical tool, enhancing group-wide analysis for state insurance regulators is the main purpose for the GCC. He noted that NAIC staff have developed an initial guidance and metrics document that could eventually be passed along for inclusion in the Financial Analysis Handbook or to the Group Solvency Issues (E) Working Group. He added that it was the intent to advance the development via a small drafting group made up of state insurance regulators and interested parties and bring the result of the drafting group’s work back to the Group Capital Calculation (E) Working Group. There were no objections to that course of action. Commissioner Altmaier asked those wishing to volunteer for the drafting group to contact Dan Daveline (NAIC).

Mr. Daveline said the document is laid out in a manner generally consistent with the way risk-based capital (RBC) is used in the Financial Analysis Handbook for looking at trends and thresholds and then drilling down into the root causes and underlying data behind the trends. He added that feedback from the drafting group is needed on whether the data elements collected in the GCC template are sufficient to support the analytics.

4. Discussed Other Matters

Commissioner Altmaier stated that one or two open Working Group calls would be scheduled in June to address comments and further discuss the proposed revisions to Model #440 related to adding the GCC and any updates on the analytics guidance.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.
Key Decisions

- Scope of Application and Calibration
- Grouping and De-stacking of Financial and Non-financial Subsidiaries
- Treatment of Financial Entities without Regulatory Capital Requirements
- Treatment of Non-insurance / Non-financial Entities
  - Schedules A and BA
- Allowance for Capital Instruments as Additional Capital
- XXX / AXXX
- Choice of Scalars
- Applying Sensitivity Analysis

Scope of Application (Instructions pages 6-9, 15-16)

- Unchanged: Starting Point is the Ultimate Controlling Party and all Entities Within the Group (Schedule Y) in Alignment with the HCA
- Staff supports the following:
  - A consistent set of principles for establishing the scope of application of the GCC ratio based on evaluation of all entities within the group
- Working with the lead-state regulator, a reduction or limit on the scope of entities to be included may be accomplished in most instances via request by the Group to exclude certain non-financial entities that do not pose material risk
  - The lead-State may accept the request for all or some entities while rejecting it for others
  - In some cases of large decentralized groups, a reduction in scope of application upfront may be requested
- It is preferable that the regulatory evaluation of such requests is based on established guidance (Examples include materiality of risk, structural separation, no history of cross subsidies, or other criteria supporting regulatory judgment)
- Group requests for reducing the scope of application of the base GCC should be based on defined criteria documented and applied by the Group
- Rationale for lead-State acceptance of the request should be documented with information on excluded entities made available upon request of the regulator

Scope (cont.) and Calibration Level

- Scope – Cont.
  - Collecting information on criteria and rationale are important to support future improvements to the Base GCC
  - No single suggestion for a threshold for materiality had consensus from the field test volunteers
- Suggested Base Calibration Level:
  - All RBC filers capital calculations will be included in the Base GCC ratio at 300% x ACL RBC (Trend Test Level)
  - Capital calculations for all entities that are subject to scaling based on RBC levels will use the trend test RBC Level

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Grouping and De-Stacking (Instructions Pages 14-15)

- Unchanged: Continue to Allow Grouping of Financial Entities without a Regulatory Capital Requirement Using Current Criteria
  - Same business type
  - Same accounting basis
- Suggested Change: Allow grouping for Non-insurance / Non-financial Entities Not Owned by RBC Filers or Financial Entities with a Regulatory Capital Requirement for those Entities
- Suggested Change: Do Not Require De-Stacking of Non-insurance / Non-financial Entities Owned by Either RBC Filers or Financial Entities with a Regulatory Capital Requirement that Includes a Capital Charge
- Suggested Change: Use RBC of UCP Mutual Insurer at 300% x ACL RBC Calibration with Only Financial Affiliates De-stacked
  - If no financial entities in the group, then TAC and RBC of top mutual is all that is required in the Inventory Tab
  - Data for other schedules still required for each grouping or entity as applicable

Capital Calculation For Financial Entities (Instructions pages 8, 29-30)

- Staff Suggestion is That all Financial Entities within the Larger Group should be Included in the GCC
  - Subject to further discussion / discretion based on the breadth of definition of a financial entity
- Suggested Changes: Options for Financial Entities Without Regulatory Capital Requirements Reduced to 2
  - Retain Basel op risk type charge applied to 3 years average gross revenue
    - Current charge is 12% but Basel moving to 15%
  - Option: Scaled version of the charge based on Average RBC ratios
    - Currently 4%, but could increase to close to 5% based on 15% full Basel charge
- Suggested Change: Consider treating all financial entities without regulatory the same (incl. asset managers)
  - Decision on full vs. scaled charge may be dependent on the breadth of entity types that are classified as financial entities
  - Impact: Minor since field test Base Ratio used 12% and Tested scaled charge with scaled version also tested

Capital Calculation For Non-Financial Entities (Page 30)

- Suggested Change: Capital charges for Non-insurance / Non-financial Entities Reduced to 2 Approaches (one in Base GCC and another for information)
  - Consider applying a 7% equity charge (based on average post covariance charge on this entity type in RBC) or tailor the equity factor by insurer type
  - Alternate Option: Apply a 3 - 5% risk charge to reporting year gross revenue or tailor the factor by industry type
  - Note: The two alternatives above only apply to non-financial entities not owned by RBC filers or by financial entities with a regulatory capital requirement
  - Impact: The equity charge is lower than what was used in the field test base ratio and the revenue charge is not significantly different from what was tested
- Suggested Change: Consider treating all non-insurance / non-financial entities the same
  - Option: Apply either the equity or revenue charge based on the nature of the non-financial entity operating activities

- Non-operating Hold Cos:
  - Suggested Change: Apply same equity charge used for other non-insurance / non-financial entities (7% or tailored)
  - Discuss positive value only vs. netting (also consider for non-financial entities)
  - Impact: More than the zero-value used in field test base ratio, but less than alternative equity charge of 22.5% applied in field test. Netting decreases the impact further.

Capital Instruments (Instructions pages 35-37)

- Suggested Change: All Capital Instruments to be Reported in this Tab and Adjusted for GCC Allowance Purposes
  - No longer reported in Schedule 1
- Suggested Change: Include Allowance for Additional Capital in Base GCC Adjusted for any Double Counting
  - Exception: No allowance should be calculated where the lead-State accepts a GCC submission that excludes the UCP issuer of the debt
- Question: Should HC values reported be adjusted for debt allowance for purposes of a capital calculation?
  - Two Step Approach
    - Step 1 - Down-streamed comparison (Similar to what was used in field test)
      1. Tracked based on criteria (New - Criteria to be Suggested)
      2. Total paid-in and contributed capital and surplus from insurer annual statements (New item in Template)
      3. Largely of two items above is carried into step 1
Capital Instruments – Cont. (Instructions page 37)

- Two Step Approach
  - Step 2 - Proxy Allowance (Recommended selection from field test Options)
    1. Qualifying Senior Debt @ 30% x (Total Adjusted Carrying Value from Inventory B + Outstanding Senior and Hybrid Debt)
    2. Qualifying Hybrid Debt @15% x (Total Adjusted Carrying Value from Inventory B + Outstanding Senior and Hybrid Debt)
- Larger of Step 1 or Step 2 Becomes Additional Capital Allowance (Subject to Max = 100% of Outstanding Senior and Hybrid Debt – Same as field test)
- Suggested Limits on Allowance:
  - Overall additional allowance can be no more than 50% of total adjusted carrying value in Inventory B (field test applied limit of 100%)
- Impact: Of 24 Volunteers that Reported Senior and / or Hybrid Debt, 6 Could Not Include 100% of Their Qualifying Debt as Additional Capital. 3 of the 6 could not include more than 10% of their outstanding senior and hybrid debt (11% - 27%)

XXX / AXXX Assets and Liabilities

- Suggested Change: Provisionally Exclude Sensitivity Analysis for XXX / AXXX Captives from the GCC Template upon referral to an E Committee Group or Subgroup for Further Risk Assessment / Data Collection Associated with Implementation of Economic Reserves and Recognition of non-SAP assets as available capital
  - With particular focus on review of grandfathered XXX / AXXX captives
- Sensitivity Analysis (Based on Field Test Method 3) to be Removed from the GCC Template Once the Appropriate E Committee Group or Subgroup is Identified and an Agenda is Adopted

Scalars (Instructions pared to reflect the selected method)

- Suggested Change: Apply Pure Relative Ratio Option at 300% RBC Calibration in Base GCC for Jurisdictions Where Data is Available
  - Separated UK from EU and added new jurisdictions
- Other Jurisdictions
  - Use 100% of the capital requirement at PCR level in Base GCC
- Treatment for regimes without capital requirements
  - For discussion: Suggestions during field test made to set calc capital of between 50% and 100% of available capital in Base GCC
- Continue to Explore Other Potential Methods for Scaling (in conjunction with similar work for ICS – AM)
- Impact: Any Current Scalar (except Japan) Increases the GCC Ratio Compared to the Base Ratio in the Field Test which used 100% Values
  - Any new options would need to be evaluated as to impact on the GCC ratio
Suggested Change: Sensitivity Analysis Tab Added

Instructions pages 38-39

- Sensitivity Analysis is Available on an Informational Only Basis to Assess the Capital Impact of Various Adjustments
- The Analysis will Not Impact the Base GCC Ratio
- Main Sensitivity Analyses include:
  - XXX / AXXX adjustments
  - Permitted and prescribed practices
  - Foreign insurer capital requirements unscaled
  - Alternative calculated capital

Sensitivity Analysis – Cont.

Instructions pages 38, 39, 42

- Type 2: To evaluate Data to Inform Potential Future Criteria:
  - Excluded entities
  - Additional capital allowance for capital instruments classified as “Other”
  - Other regulator discretion

Other Information

Instructions Pages 43-44

- Material Risk Definition Applied by Lead-State to Approve Reduced Scope of Application
- Intangible Assets
- Currency Adjustments
- Methodology for Tracking Down-streamed Debt (if Down-streamed Debt Category is Retained)

Suggested Changes: Schedule 1

Instructions pages 17-21

- Instructions
- Data Removed
- Data Added

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Suggested Changes: Inventory Tab

- Instructions
  - Added charts to instructions regarding carrying values to be reported in Columns 1 and 2 of Inventory B and Inventory C (parent and local carrying values / capital calculations) [Pages 23 & 31]
  - Added examples for financial entities without a regulatory capital requirement and for non-financial entities
  - Added examples for financial vs. non-financial subsidiaries of insurance companies

- Template
  - Add column (+ instructions) for accounting adjustments (e.g. GAAP to SAP and or other regulatory adjustments)
  - Add columns for revenue-based options (moved from Schedule 1)
  - Remove permitted and prescribed practices columns (moved to Sensitivity Analysis Tab)

Suggested Other Changes

- Attestation Added [Instructions Page 11]
- Analytics and Guidance to be Added [Separate doc]
  - Addresses use of GCC
  - Uses data collected in the template
  - Guidance and instructions to be reviewed concurrently with revised template / instructions
- Potential Changes to Informational Grouping Alternative and Instructions (Working with some IPS)
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July 24, 2020

Commissioner David Altmaier  
Chairman, NAIC Group Capital Calculation (E) Working Group  
Florida Office of Insurance Regulation  
[via-email to lfelice@naic.org]

Re: NAIC Group Capital Calculation ("GCC") Working Group’s exposure on the GCC template and instructions

Dear Commissioner David Altmaier,

ACLI is pleased to have the chance to provide an overview of our views on the exposed GCC template and instructions. We fully acknowledge the deadlines the NAIC is working against. However, the GCC instructions and template asked for feedback on a broad range of substantive issues, ranging from scalars, the definition and treatment of financial and non-financial entities, the treatment of senior and hybrid debt, plus others. The issues in the exposure are complex and the consequences for our members are potentially significant. In addition to the complexity inherent in this group level calculation, the ongoing, extraordinary circumstances related to the coronavirus make it even harder to properly analyze and assess the GCC without assessing its impact over time. ACLI members agree that more time is needed to analyze many of the GCC components. ACLI members expect other areas of concern, beyond those identified in this letter, to emerge as regulators and industry observe the GCC’s performance over time. Therefore, as indicated in several instances below, the ACLI urges the NAIC to continue to engage with stakeholders and to publicly consult again on these key elements, overall design and implementation of the GCC over the coming months.

To the greatest extent possible, our letter provides ACLI’s specific recommendations on the exposure. ACLI has also provided a set of general, overarching comments on the GCC, and highlights several process and governance related issues. In addition to those areas, our letter provides a preliminary issue-spotting list of other areas that are in need of additional analysis and work by the NAIC, including the treatment of capital instruments in the GCC, and the treatment of financial entities and non-financial entities.
PART I. OVERARCHING COMMENTS ON THE GCC AND EXPOSURE

This part of our letter provides general, overarching comments that are generally applicable to the entire exposure, instead of a single recommendation.

ACLI fully supports an aggregation-based approach that is consistent with the existing legal entity RBC framework. ACLI supports the development of an aggregation-based approach that is “intended to build on existing legal entity capital requirements where they exist, rather than developing replacement/additional standards.”¹ We fully support this objective and believe the GCC should leverage and adhere to the existing regulatory frameworks – including legal entity RBC rules – and industry practices and norms to the greatest extent possible.

ACLI encourages the Working Group to ensure that design choices enhance transparency into group risk and avoid introducing procyclicality into the GCC. ACLI believes the current proposal may include elements that could be procyclical and have the unintended consequence of disrupting the ability of regulators and insurance groups to navigate periods of stress. For example, the proposed debt limits, which are based on available capital could have procyclical effects in times of stress, when available capital tends to contract and capital requirements tend to increase. ACLI urges the Working Group to devote the appropriate resources and time to review these items to avoid introducing procyclical risks into the GCC.

ACLI believes GCC design choices should be consistent with the intent for the GCC to be a tool, rather than a standard or binding requirement. ACLI supports the NAIC’s development of a GCC as an additional “tool” that is intended to provide regulators with greater insight into insurance groups.² However, we are concerned some aspects of the instructions and the preliminary Draft Analysis Handbook give rise to a GCC that goes beyond this objective and would have the effect of turning the GCC into a binding standard or constraint.

All references to “Base GCC” should be eliminated. The references to “Base GCC” may be a holdover from previous versions of the instructions when formal on-top adjustments were contemplated. We are concerned that the use of the term “Base GCC” throughout the document insinuates that there are multiple GCC’s, and we believe this could cause unnecessary confusion around the GCC.

ACLI believes the process for developing and refining the GCC requires further consideration. Given the potential consequences the GCC may have on members, ACLI believes the Working Group should take time to consider further alternative approaches to certain elements and perform additional quantitative analysis. We also believe a clear process must be established for future revisions to the GCC, a rationale for decisions should be provided that is consistent with the stated


² See Attachment B-2, GCC Instructions, at p. 5, para. 2 (describing the GCC as a tool intended to provide regulators greater insight into insurance groups – e.g., a holistic understanding of the non-insurance entities in the group, insight into capital distribution across the group, etc.).
purpose of the GCC, and the Draft Analysis Handbook should be exposed for public review and
comment before it is finalized.

Decision points on items in the instructions should be guided by the purpose and objective of the
GCC, as described in the Instructions. ACLI believes the decision points should favor design
choices that provide more transparency to regulators and do not conflict existing standards or
introducing new standards.³ Although this is not directly addressed in the Instructions, we believe a
prudent group solvency regime should avoid imposing measures that impede the ability of
regulators and insurers to navigate periods of stress.

PART II. ACLI’S COMMENTS ON RELATED PROCESS AND GOVERNANCE ISSUES

This section identifies and issues recommendations on process and governance issues related to
the GCC and exposure.

ACLI believes alternative approaches should be considered and additional data collection,
quantitative analysis and monitoring should be performed prior to finalizing the design of the GCC.
ACLI strongly believes that this is critical to determine if the GCC components are fit for purpose
and would be consistent with the Working Groups message that getting the GCC right is more
important than getting it done soon.

ACLI believes a clear and transparent process for future revisions to the GCC framework must be
established. Paragraph 7 of the draft instructions notes that the GCC instructions are expected to
be “modified, improved, and maintained in the future.” We believe the process for making changes
to the GCC should require notice to stakeholders and include an opportunity for public
consultation. We recommend that the Working Group develop a GCC governance process like
Separately, we believe the process for updating scalars for design changes or to account for
evolution in supervisory regimes should also be transparent and subject to a clearly defined
governance process.

The Draft Analysis Handbook should be exposed. The Draft Analysis Handbook should be
exposed for public review and comment before it is finalized. While ACLI appreciates the
opportunity to serve as a participant in a drafting group composed of a limited number of
regulators and industry participants, we believe all interested parties should have an opportunity to
weigh in on the content given the significant impact it may have on the role the GCC plays in
practice. For example, the previously distributed version of the draft analysis included a proposed
175% intervention point, which appears to conflict with the description of the GCC as a tool meant
to enhance transparency into a group’s risks rather than a binding standard or constraint. Given
the high-profile nature of the GCC, public exposure of the Handbook and any potential intervention
points are necessary.

³ The avoidance of new standards is consistent with the description of the GCC in the Instructions and the
NAIC’s August 16, 2018 letter to Senators Scott and Rounds. In the August letter, the NAIC notes that the
“NAIC is not creating a new capital standard for insurers that will necessitate higher capital levels. Rather, the
GCC will be an additional reporting requirement built off existing legal authorities.” Available at
PART III. RECOMMENDED IMPROVEMENTS TO THE GCC INSTRUCTIONS AND TEMPLATE

This section of our comments addresses the issues where ACLI has provided specific recommendations for the instructions or template during our preliminary review. Some of these items, such as the treatment of senior debt, are also candidates for further work and analysis.

1. Scalars. ACLI members recommend the Excess Capital Ratio Approach.

The primary goal of a scalar is to ensure aggregated data and thereby ratios across jurisdictions are comparable. While the Pure Relative Ratio ("Pure") and Excess Capital Ratio ("Excess") Approaches are both relevant supervisory capital metrics, only the Excess Approach uses a total balance sheet approach and leads to an appropriate measure of excess capital.

As a result, ACLI recommends the Excess Approach over the Pure Approach. Unlike the Pure Approach, the Excess Approach keeps the total asset requirement (reserves plus required capital) constant before and after scaling. As a result, the Excess Approach places greater weight on differences in reserve requirements, which can vary significantly across the globe. We believe this creates a more level playing field regardless of an insurer’s subsidiary locations and will provide a comprehensive approach for aligning foreign regimes to the U.S. RBC framework.

The Pure Approach does not adjust for available capital and could result in a distortion of excess capital levels, depending on the entity’s capitalization levels and its jurisdiction. For example, by not taking into account the intervention levels of local regimes, the Pure Approach would allow entities that a jurisdiction deems to be undercapitalized to be considered adequately capitalized for group ratio purposes, simply due to scaling, which could ultimately detract from the credibility of the GCC.

Another benefit of the Excess Approach is that it maintains the actual levels of excess capital because it adjusts both available and required capital, which improves the accuracy of the GCC with respect to the actual amounts of excess capital held by a group. The management and maintenance of excess capital levels is a top priority for treasurers of insurance companies, and the GCC should accurately reflect the amount of excess capital levels that is held by a group.

Members also believe that the total balance sheet approach employed by the Excess Approach may better position the GCC, and Aggregation Method ("AM"), for the forthcoming efforts to secure recognition of the AM as comparable to the market-based version of the Insurance Capital Standard ("ICS"). The principles and criteria for the comparability assessment will take into account “analysis of individual elements of a group solvency approach, i.e. valuation, capital resources, and capital requirement.” Consequently, a scaling approach that effectively provides for a translation of reserve levels and capital requirements would be better suited for the comparability assessment than the Pure Approach. Further, the Excess Approach supports the goal of comparability by providing a more accurate comparison of the total assets (all loss absorbing resources within a

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group) that are required when comparing regimes. We have attached a brief explanation of the differences between the Pure and Excess Approaches.

2. The calibration of the GCC and scalars for foreign insurance regimes should be 200% ACL RBC.

ACLI disagrees with the proposed calibration of the non-U.S. insurance scalars and the GCC ratio at the RBC trend test level (300% ACL RBC). We believe the GCC should be calibrated to the 200% ACL RBC, which is consistent with 100% Company Action Level (CAL) RBC. In addition, calibrations of other factors and regimes should be based on 200% ACL level RBC as well. Using 300% as the calibration for the GCC is likely to introduce confusion because the GCC calibration will depart from a well-established market-norms for legal entity insurers of assessing RBC based on a 100% CAL level, without offering any identifiable benefits. We are also concerned that establishing a different calibration point for the GCC could result in unintended consequences such as changes in market expectations for the capitalization of underlying insurance entities.

3. The GCC’s proposed treatment of capital instruments, in particular the qualifying criteria for senior and hybrid debt, should be subject to further study and analysis.

We believe that the current debt caps are too restrictive and could negatively impact a group’s ability to prudently manage capital and liquidity risks. Further, it is not clear how the inclusion of the proposed limits would enhance transparency into risks within an insurance group, which the NAIC has noted is the primary intent of the GCC.

There are times when companies may need to quickly raise capital, and issuing senior or hybrid debt is a reliable way to accomplish this, especially during times of economic stress. We do not believe it is appropriate for the GCC to introduce constraints that may inhibit the ability for insurers to prudently use these capital instruments. In addition, we believe that tying the constraint to a percentage of the group’s available capital embeds an undesirable element of procyclicality into the GCC, because a company’s available capital is likely to decrease in times of stress, especially if markets crash.\footnote{ACLI is aware that the analysis of field-testing results showed that approximately 25% of volunteers would not receive full credit for the capital instruments they issued because of the prescribed limits. We are concerned that the field testing captured a point-in-time point of view that may not demonstrate the impact these restrictions might have on groups during periods of economic decline. During periods of economic stress, an insurer’s available capital tends to constrict, and its capital requirement rises, which would further limit the recognition of these capital instruments and discourage their use.}

To the extent the Working Group believes some form of limit is necessary, we believe it must consider a suite of less restrictive options and would welcome the opportunity to work with you to conduct further analysis on the subject.

On a more granular level, the GCC instructions (p. 34, para. 65) require that the capital instrument has a fixed term of a minimum of 5 years at the date of issuance or refinance, including call options. The presence of call options should not prevent a capital instrument’s inclusion as a qualifying instrument. Call options are a common feature of U.S. issued capital instruments. This
criterion would shorten the term and prevent most instruments from qualifying as structurally subordinated. We recommend removing the call option criteria, because the exercise of a call option is typically followed by refinancing of the instrument which supports its permanence and structural subordination.

4. Capital Instruments. ACLI recommends eliminating the down-stream tracking requirement.

ACLI agrees with the NAIC staff’s recommendation to eliminate the down-stream tracking requirement for senior debt. There are a number of reasons why the downstream tracking requirement could prove difficult to implement, such as complications that could arise when the debt has been refinanced by the parent, or how to track upsize transactions where debt is borrowed at one date and then down-streamed on a different date. Downstream tracking also raises questions about how to treat up-streamed dividends (are they netted against down-streamed capital?), as well as how to treat M&A transactions. For example, if a company is acquired, does the new parent company assume the historical relationship to the down-streamed debt, so long as its debt at least equals the debt of the old parent company?

Some of our members have also expressed concern that groups with an operating holding company who utilize a more centralized capital and liquidity management strategy that prioritizes holding funds at the holding company level would be disadvantaged by this approach. If the proceeds must be down streamed for the company to get any credit, then a group would have to issue more debt at the legal entity insurance level if it wished to maintain the same debt-funding levels at the operating holding company level without hurting its capital ratio.

5. ACLI supports the Working Groups recommendation to remove parts of the Sensitivity Tab, and more broadly, believes the remaining elements of the tab should be removed from the template.

ACLI has long advocated that the GCC should be consistent with entity level RBC rules and we are concerned that the inclusion of approaches within the GCC that deviate from legal entity rules, such as the unwinding of permitted and prescribed practices should not be included in a sensitivity tab. Further, ACLI members ability to comment on the specifics of the sensitivity tab was also constrained by the lack of formulas inside the tabs. Therefore, further discussion of its purpose and use, as well as a discussion on the context of this information is warranted if the tab is retained. To the extent the information on the Sensitivity Analysis Tab is of interest to state regulators, ACLI believes they should use their discretionary powers to obtain it rather than embedding it in the GCC template.

Irrespective of the tabs continued existence (or not) in the template, we strongly believe that all references to “Base GCC” should be removed from the Instructions and replaced with “GCC”. Using the term “Base GCC” creates confusion and a potentially false narrative that there are multiple versions of the GCC. Eliminating this need to distinguish between a “Base GCC” and multiple alternative GCCs will provide a stronger foundation for the NAIC to advance an AM at the global level.

6. Grouping/De-stacking and Materiality
ACLI supports efforts to simplify and streamline the GCC by permitting companies to either group related entities, or to relax the requirements to “de-stack” an entity. ACLI also supports the grouping or netting of non-operating holding companies. To the extent there are concerns that these simplification efforts may obstruct a regulator’s ability to obtain adequate insight into the potential group risks, this is addressed by giving regulators the option to ask groups to submit more detailed information (i.e., supervisors may direct a company to de-stack certain entities or desegregate some groupings).

In general, ACLI believes that the GCC should be consistent with the legal entity rules applied to insurance legal entities – including the subsidiaries of insurance legal entities. The GCC de-stacks subsidiaries from insurance legal entities and in some cases, applies a GCC treatment to the subsidiary that differs from the legal entity treatment. To the extent that there are differences in the GCC and legal RBC treatment for subsidiaries that have been de-stacked and reported separately from their legal entity parent, then it seems desirable for the GCC and RBC treatment to align. To the extent that there are differences between the two, we recommend the Working Group explain the rationale for the difference (e.g., achieving substantial consistency in charges regardless of corporate organizational structure) and, if appropriate, refer the issue to the appropriate RBC working for further dialogue. In the long run, we believe this approach will benefit regulators and the industry by promoting a more consistent and up-to-date risk framework.

ACLI believes it would be helpful if the GCC Instructions employed a consistent definition and threshold of materiality for de-stacking and other GCC purposes where consistent with the purposes of the GCC. However, this is an area that clearly requires additional thought and consideration to establish an appropriate threshold for materiality.

PART IV. ACLI’S PRELIMINARY LIST OF ISSUES NEEDING FURTHER ANALYSIS

This section of our comments addresses issues that ACLI members have identified as significant concerns, but that require additional clarity from the Working Group and/or further member development and discussion, in order for ACLI to make a specific recommendation. These are areas where we suggest more time be allowed for NAIC staff and interested parties to work together to develop specific recommendations.

1. Financial entities and non-financial entities

   1.1. Additional clarity is needed for the definition of financial entity, non-financial entities, and material schedule A/BA affiliates.

   The definition of financial entity remains unclear and needs additional clarification. In general, we believe that financial entities should be limited to operating entities with meaningful obligations to third parties. Passive investment vehicles or subsidiaries that manage or hold investments predominantly on behalf of the insurer should not be considered financial entities. An operating entity may issue debt, create syndications, issue loans, accept deposits and/or generally act as a fiduciary. The activities of an operating entity require active management on behalf of third parties. In contrast, a passive investment vehicle, like an investment subsidiary, as defined by NAIC rules [Schedule D], or other subsidiary that holds investments on behalf of the insurer [e.g., Schedule BA entities], should not be considered a financial entity. This rubric of using active management on behalf of others versus simply holding or managing an
investment on behalf of the insurer works well to determine if an entity should be classified as a financial entity or non-financial entity, even when an entity, like a mutual fund, may have a mix of activities.\(^6\)

Based on the existing definition of “financial entity” in the Instructions, we believe that the Working Group intended to exclude passive investment vehicles and subsidiaries that manage or hold investments predominantly on behalf of the insurer, but we believe additional clarity is necessary to telegraph that intent.

As such, we recommend the following for your consideration:

“For purposes of this definition, a subsidiary of an insurance company whose predominant purpose is to manage or hold investments on behalf of the insurance company and its affiliated insurance (greater than 90% of the investment subsidiary’s assets are for these insurance affiliates) should NOT be considered a Financial Entity.”

If the interpretation of the definition of financial entity is correct, additional clarity is requested on how to record the various affiliates, including but not limited to non-US statutory investment entities and funds that roll-up to the ultimate financial entity and that may manage and hold investments on behalf of the insurer and third parties. Should such entities be split on the basis of US/non-US statutory status or simply included under the financial entity?

1.2 Additional clarity is also needed for the “exception to the exception” for “material” A/BA entities.

ACLI requests additional clarification on what the impacts are of building an exclusion for Schedule A/BA into the definition of “affiliate,” when it seems like the Schedule A/BA exclusion is an exclusion from de-stacking. We believe this may be better placed in the de-stacking instructions.

ACLI recommends that the exception to the exception for material A/BA items be limited to operating entities, and not apply to passive investment vehicles, which may be of significant size but would not provide a regulatory benefit by de-stacking from existing RBC treatment. If the Working Group adopts this exception it will also be necessary to adopt a threshold for materiality. (see comments above regarding desire for consistency in materiality thresholds). In addition, the Working Group will need to address the inconsistency between the “exception to the exception” and the direction in Paragraph 50 that values for non-insurance / non-financial U.S. RBC filers will not be de-stacked.

\(^6\) For example, a mutual fund may have a mix of activities such as taking deposits, holding investments on behalf of third parties, they collect fee income. However, even if a mutual fund has passive investment activity, a mutual fund will generally have liabilities in excess of 5%, which means the mutual fund cannot be classified as an investment subsidiary under NAIC rules.
1.3 Treatment or charge for non-financial entities without a capital requirement and
material Schedule A/BA entities

ACLI was unable to discern how the proposed charges for “other non-insurance/non-financial
entities” and “material Schedule A/BA entities” were created. The Working Group field tested
seven different potential charges for these entities, but staff is now recommending a new
charge that was not field tested. Additionally, despite NAIC staff’s attempt to explain how the
new 7% charge was created, our members are still unsure how the charge was derived, why it
was selected, and why it differs substantially from the corresponding RBC treatment. Further
clarification on this issue is necessary, including an explanation of why the Working Group is
recommending a novel approach that has not been subject to field testing.

2. GCC Instructions.

2.1 The Instructions should be reviewed to ensure consistency regarding regulatory
discretion and clarify expectations for certain elements.

For example, the Instructions provide several clear examples of lead-state supervisory discretion
that could impact how the lead-state supervisor and the insurance group define the scope of
the group (see e.g., para 18, para 20, and drafting note to para 61).

We recommend supplementing the Instruction’s definition of “ultimate controlling person” with a
reference to the discretion provided to the lead-state supervisor in the Instructions (see e.g.,
para 18, para 20, and drafting note to para 61). This clarification ensures that the definitions are
consistent with the discretionary language in the instructions, as provided in paragraphs 18, 20,
and the note accompanying paragraph 61:

“Ultimate Controlling Person: As used in the NAIC’s Insurance Holding Company
System Regulatory Act (Model #440) and as implemented by the lead state supervisor.”

2.2. We request that the Working Group revise the Instructions to provide clarity on the
following items:

In light of the instructions for when de-stacking is not required, there needs to be additional,
corresponding instructions about what should be included in “Schedule 1” and “Inventory” tabs,
in light of instructions for when de-stacking is not required. For example, if an entity is not to be
de-stacked, then presumably it should not be listed on Schedule 1/Inventory tabs. Otherwise,
this sets up a confusing “include/exclude” decision, which is a different issue (goes to “scope of
application”). We request that the instructions include language that clearly address this issue.

For Schedule Y entities that are not de-stacked, should they all be listed on the Questions tab,
like Schedule A/BA are currently?

Additional instruction on Inventory B, Column 5 (reported intra-group guarantees, LOCs and
other) would benefit from examples that demonstrate application. It appears that this column,
like those near it, is intended only to eliminate double counting of capital. If the presumption is
correct, then it would be helpful if this was noted in the instructions.

ACLI believes that scalars are an integral part of an aggregation method. We remain concerned that a significant number of countries lack a scalar. It is our understanding that the NAIC staff sought to develop scalars for the countries that had a material amount of business from U.S. parented groups within its borders. While it was understandable for the initial focus to be on countries with a material percentage of U.S. based insurers doing business there, the lack of scalars for certain jurisdictions has created material differences in their GCC ratio. If the NAIC lacks access to the appropriate dataset to create the scalars, we recommend allowing the lead state some flexibility with default assumptions.

In addition, there are formula errors in Column K. For example, K14 is supposed to be taking 12% of the average revenue, but instead it is taking 12% of Reported Calc Capital. Similar issues exist in cells K16, K18, K19, K21 and K22.

We believe the scaling factors for Non-Insurance Entities need a broad review. Specifically, the scaling factors for Asset Managers, financial entities with regulatory requirement, financial entities without a regulatory requirement, and other non-insurance/non-financial entities. The NAIC has selected some of the more conservative scaling factors from the 2019 field test and provided no explanation for their decisions. These factors require a larger discussion.

CONCLUSION

Thank you for the opportunity to provide these comments. ACLI welcomes the opportunity to discuss our comments with you in the future, and we would also welcome the opportunity to contribute to additional analysis and discussion regarding the issues raised in our letter.

Sincerely,

Mariana Gomez
Pure Relative Ratio vs. Excess Capital Ratio

- NAIC GCC proposals uses scalars to add capital regimes with the goal of comparability
- Pure Relative Ratio (PRR) approach adjusts required capital only
  - Available capital is not adjusted and results in excess capital being distorted
- Excess Capital Approach (ECA) adjusts both available and required capital (i.e., total asset requirements)
  - Excess capital is not affected

Implications

- The capital ratio and excess capital are both relevant supervisory capital metrics
- ECA better supports comparability by addressing both metrics
- Excess Capital Approach takes a whole balance sheet approach as it assesses total asset required and accounts for reserve differentials.
- Excess Capital Approach creates a more level playing field regardless of an insurers’ subsidiary locations
- Pure Relative Ratio will create an unlevel playing field depending on an insurer’s subsidiary locations
Pure Relative Ratio (PRR) Example

PRR preserves the relative capital position versus industry average however it distorts excess capital.
- SII subsidiary’s capital ratio remains above industry avg after scaling and Japan stays below (see blue circles)
- Excess capital changes after scaling which creates an unlevel playing field (see red circles)

US insurer with SII subsidiary

| Unscaled | PRR Scaled
<table>
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<tr>
<td>US</td>
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<td>Excess Capital</td>
<td>150</td>
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<tr>
<td>Required Capital</td>
<td>50</td>
</tr>
<tr>
<td>Reserve Margin</td>
<td>100</td>
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<tr>
<td>Best Estimate Liability</td>
<td>100</td>
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A  B  C  D  E=C+D  E/C

A: Best Estimate Liability
B: Reserve Margin
C: Required Capital
D: Excess Capital
E: Available Capital
E=C+D: Total Assets
E/C: Solvency Ratio

Industry avg capital ratio: 400% 200% 400% 400% 400% 400% 400% 400% 400% 400% 400% 400% 400% 400% 400% 400% 400% 400%

1 Assuming US insurer is operating at industry avg capital ratio, Euro is above and Japan is below avg.
Excess Capital Approach (ECA) Example

ECA preserves both relative capital position versus industry average and excess capital by adjusting available capital and creates comparability

- SII subsidiary’s capital ratio remains above industry avg after scaling and Japan stays below (see blue circles)
- Excess capital remains unchanged after scaling (see red circles)
July 20, 2020

Commissioner David Altmaier, Chair
Group Capital Calculation (E) Working Group
National Association of Insurance Commissioners

Via e-mail to Lou Felice: lfelice@naic.org

Re: Exposure of Proposed Group Capital Calculation Instructions and Template

Dear Commissioner Altmaier:

America’s Health Insurance Plans (AHIP) appreciates the opportunity to comment on the changes that have been proposed by the NAIC’s Group Capital Calculation (E) Working Group to the Group Capital Calculation (GCC) Draft Instructions and Template, as well as the related FAQ Document, and PowerPoint.

AHIP appreciates the hard work of the GCCWG and of NAIC staff in developing the GCC under tight timeframes as well as in suboptimal working conditions that persist with the ongoing pandemic. In a separate letter submitted on July 15, we stated our appreciation to the working group for recognizing appropriate exemptions and expedited treatments for filing of the GCC. We have some comments below regarding the GCC Instructions that we hope will be seen as constructive. But we first want to call out what we see as clear “positives” in the revised draft GCC and acknowledge the efforts of you and your working group to bring these to bear:

- The overall approach maintains that the GCC is an analytical tool for use by the lead state that will not, in and of itself, dictate capital requirements.
- Appropriate exemptions and expedited treatments from filing all or part of the GCC template have been provided and which provide, in certain instances, for the Lead State Commissioner to use discretion to allow filing only of Schedule 1, i.e., as an analytical construct it could be a sufficient supervisory measure without aggregation to a single group-wide measure.
- Groups could exclude certain non-financial entities from the Scope of Application and large, decentralized groups could request up front a reduction in the scope.
• Determination of materiality of risk posed to the insurance group by non-insurance entities in the broader group will be a qualitative determination (the Financial Analysis Handbook Drafting Group is to consider appropriate criteria).
• Modified instructions for the GCC template are less onerous (than in field testing), i.e., with more grouping and less de-stacking.
• Senior and hybrid debt criteria and limits will accommodate a large majority of debt held by insurance groups to be recognized in group capital.

With that, AHIP would like to provide the following suggestions relative to the GCC Instructions.

I. Scope of Application

Determination of Material Risk

AHIP believes the GCC Instructions could improve the readability of the principle-based guidance for establishing the Scope of Application of the GCC. Currently, some of the principles are included in the section on “definitions” which follows other text where both an understanding of those definitions and the principles therein would be useful for the reader. As well, sections which would appear by the heading to be about principles are more focused on instructions for completing parts of the template.

The section of the GCC instructions on scope of application is intended to help the holding company and its lead state to reach an understanding as to whether a non-insurance entity within the Broader Group poses material risk to the Insurance Group. It should provide principles-based guidance for companies and their lead-state regulators to identify such entities that do not pose material risk and therefore can be excluded from the Scope of Application.

As a threshold matter, the GCC Instructions should provide a definition of “material risk” for purposes of the Scope of Application. In this context, we believe “material risk” should be defined as “risk emanating from a non-insurance entity that is of a magnitude that would adversely impact a group’s insurance operations and its ability to pay policyholder claims.” Likewise, the GCC Instructions should explicitly state that non-material entities within the Broader Group but outside the Insurance Group (as both terms are defined in the GCC instructions) should be excluded from the Scope of Application.

These points naturally follow from the fundamental reason for state insurance regulation and the stated objective of the GCC: policyholder protection. Indeed, paragraph 13 of the GCC Instructions already makes clear that “the overall purpose of this assessment is to better understand the risks that could adversely impact the ability…to pay policyholder claims”.

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This reasoning is also in accordance with international standards. For example, under ICP 23, the fact that a non-insurance entity poses risk is not, alone, determinative of whether that entity should be in or out of the scope of group supervision; rather, to be considered included in scope, there also must be some means by which the non-insurance entity could actually transmit that risk to the group’s insurance operations, as well as a lack of adequate safeguards that would mitigate that risk of transmission. We believe that the GCC instructions currently embrace those concepts. However, terms such as “cross support mechanisms,” and “safeguards” are not defined and it is unclear how they are intended to apply in the context of the scope of application.

For effectuating the materiality analysis for purposes of the Scope of Application, AHIP believes it is necessary for holding companies and lead states to consider the facts and circumstances of a particular entity within a group in a holistic manner. Given the diverse structures and business models of insurers, it would be impracticable to develop a one-size-fits-all checklist of guidelines that would be useful for materiality determinations across all groups. Strict or formulaic quantitative measures are likewise an insufficient proxy for materiality. Instead, the materiality analysis must be assessed in the manner it has been historically – by considering the unique circumstances of the relevant entity and group. We believe that to be the intent of what has evolved through field testing, i.e., an interactive process whereby the group brings forward its suggestions as to entities that should be excluded from the scope of application for a discussion with the lead state, ultimately culminating in an agreement on the scope.

We are not suggesting to somehow upset that interactive process or discussion between the group and its lead state. Rather, AHIP simply recommends facilitating it with definitions for “cross support mechanisms” as well as “safeguards” over the possible transmission of risk between the subject entities of that discussion.

We note that the Form B and D processes entail similar considerations and are already enshrined in the state regulatory process. For example, a detailed review is made of inter-company transactions and agreements that could, depending upon their terms and other pertinent information, fall into the category of “cross support mechanisms” as contemplated by the GCC instructions. Examples could (depending on the facts and circumstances) include certain loans, transactions not in the ordinary course of business; guarantees or other undertakings for the benefit of an affiliate, management agreements, service contracts, cost-sharing arrangements, reinsurance agreements; tax allocation agreements, and more. These agreements are already filed and approved with states. States can leverage these processes already in existence for visibility into cross support mechanisms that may be able to transfer material risk.

As well, Enterprise Risk Reports filed with the lead state already provide information as to the existence of “enterprise risk” defined as “any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole…”
Taken together, Forms B and D and Enterprise Risk Reports establish examples of “cross support mechanisms” as well as whether there is risk that could have a material impact to the insurers in the group (presumably via transfer through at least one such mechanism). It stands to reason that in the GCC, only such risks of non-insurance non-financial entities outside the insurance group that are already identified through those processes could therefore have a material impact and for which the subject entity(ies) that are the source of that risk would therefore be included in the scope of the GCC.

Finally, the GCC Instructions currently contemplate excluding only non-material, non-financial entities from the Scope of Application. However, the Working Group should also consider allowing non-material financial entities within the Broader Group (but outside the Insurance Group) to be excluded from the Scope of Application. We understand that the Working Group views financial entities, in general, to be of greater risk than other affiliates. Even so, all entities that meet the broad definition of “financial” in the GCC Instructions do not necessarily pose material risk (as defined above) under all circumstances. The fact that an entity would be classified as “financial” for purposes of the GCC should be weighed as a factor in the materiality analysis described above, but that alone should not be determinative of materiality.

II. Risk Charges for Material Non-Insurance Entities

Non-Financial Entities

AHIP’s view is that risk charges for non-financial entities should be equal or very similar to the current charge in the sectoral RBC formulas, i.e., 3% in the case of health insurers. The GCCWG has not provided data to suggest that a more substantial risk charge is needed to protect policyholders. In addition, existing regulatory processes, such as the Form B and D processes, are already in place to ensure that the regulated legal entity is protected from the non-regulated, non-insurance entity. Adding an additional risk charge is unwarranted in light of existing regulatory requirements.

Further, the GCCWG has not provided data indicating that policyholders are any more at risk in a diversified insurance holding company than in a non-diversified group. If that is a concern, and if it is desired to consider changes to underlying RBC levels, that should be handled through the appropriate (e.g., Health) RBC Working Group.

Financial Entities

On a related matter, AHIP is concerned with the breadth of the expanded definition of “financial entity” in the GCC Instructions. If the Working Group maintains this expanded definition of “financial entity”, we recommend using a capital charge that is roughly equivalent to an entity’s current post-covariance RBC charge. If it is desired to consider changes to underlying RBC levels, that should be handled through the appropriate (e.g., Health) RBC Working Group.
The exposed GCC Instructions provide that certain non-insurance affiliates of an insurer be
deemed as financial. We understand that the Working Group views such affiliates to be of
greater risk relative to other types of affiliates, and by deeming them to be financial, they would
be listed separately for analytical purposes as well as subjected to a higher capital charge.
Specifically, the exposed GCC Instructions add the following to the definition of “financial
entity”:

“Affiliates that are integral to the performance of the insurance contract or the provision
of insurance or financial products or services to policyholders, members or depositors
[Examples include: agents, reinsurance intermediaries, claims adjusters or processors,
third party administrators, pharmacy and other benefit managers, provider groups or
entities that provide more than X percent of the policy benefits under policies issued by
insurers within the group, and ] will be treated as financial entities.”

AHIP fundamentally disagrees with the notion that certain affiliates are inherently riskier than
others, as based on the language cited above which would effectively deem some affiliates to be
considered financial, including third-party administrators and pharmacy benefit managers,
provider groups, and pharmacy benefit managers. There is a wide array of types of non-affiliated
entities within insurance groups, and it is overly simplistic to conclude that all that are somehow
associated with assisting the insurer with contract performance or policyholder services are
inherently riskier than others. Indeed, the Form B and D processes recognize that transactions
with affiliates may have risks, and that a determination of such risk is very fact-specific to the
subject entities and underlying transactions or agreements.

Further, subjecting these entities to a capital charge for financial entities (12% of 3-year average
gross revenue – possibly to be increased to 15%) could result in a significant additional charge as
compared to current RBC for several reasons:

- The base of the entity’s charge would be changed from BACV to gross revenue.
- The factor applied to the base would increase from 7% BACV to 12% of gross revenue.
- Removing the charge from the insurer’s RBC—where it is subject to the covariance
  adjustment—to a separate line item for the affiliate itself, where the capital charge is
  aggregated without a similar covariance calculation or other recognition of risk
diversification.

In addition, AHIP has concerns about the reference to “entities that derive a majority of their gross
revenue from services that are integral to the performance of the insurance contracts within the
group or from the provision of other financial services to policyholders within the group will be
considered a Financial Entity without a regulatory capital requirement” in the definition of
“Financial Entity.” The GCCWG has not provided evidence to suggest that services performed
by such affiliates add risk to the group. In our view, because of greater regulatory oversight
through the Form B and D and other regulatory processes, these arrangements actually reduce the group’s risk.

Therefore, AHIP recommends using an equity-based capital charge that is roughly equivalent to the current post-covariance charge for such affiliates in RBC.

III. Treatment of Debt as Qualifying Capital

AHIP very much appreciates that the GCC will, in large measure, recognize certain senior and hybrid debt as capital. Debt is a critical capital resource for many of our members. The capital markets are well-established and have proven to be a reliable resource for the funding of debt instruments, even during the 2008-2009 financial crisis. Experience has shown time and again that the debt markets can be tapped quickly and utilized to enhance policyholder protection in a flexible and cost-efficient manner. Moreover, in periods of macroeconomic stress such as the financial crisis, the use of debt can be a more attractive alternative to the issuance of stock in depressed markets while also avoiding dilution of shareholder interests.

IV: Other Comments

In the attachment, AHIP has provided other comments and questions of a technical nature that were provided by our members.

* * * * * *

Again, AHIP appreciates the opportunity to offer comments on the GCC Instructions and Template.

Sincerely,

Bob Ridgeway
Senior Government Relations Counsel
Attachment to Comment Letter of AHIP on the GCC Instructions and Template

1. We note that there are many areas within the template that are labeled “further work needed” or “technical discussions needed.” For example, “Summary Group Alternative 4” is blank. Also, in Summary 2 – Top Level: No formulas appear in the sensitivity section. When will companies have a completed template to review and test, and what other opportunities will there be to provide input on the template based on their review?

2. “Summary Alternative 5 – Organizational Option” is missing from both the template and the instructions. This option is intended to allow the reporting entity to present a summary of the results to assist regulators with understanding the submission.

3. Schedule 1D – Reporting “net dividends paid/(received)” is more practical and meaningful, because many entities act as “pass-through” for moving dividends up the corporate structure. In that context, “dividends received and not retained” becomes unnecessary.

4. I.A.2 in the instructions suggests that another consequence of “subsidization” may be “upward pressure on premiums to the detriment of insurance policyholders.” This implies that the GCC might somehow be a factor in regulating insurance premium rates, which we believe to be an inappropriate use of the GCC based on our understanding of its objectives.

5. I.A.2 in the instructions states that the GCC “provides an additional early warning signal to regulators so they can begin working with a company to resolve any concerns in a manner that will ensure that policyholders will be protected” and will “allow them to make informed decisions on both the need for action, and the type of action to take.” As stated, this is an overly ambitious aspiration for the GCC. In particular, at least in early years of implementation, the GCC will produce a ratio that would require much reliance on other existing regulatory tools to interpret – not the other way around. We understand that the Financial Analysis Handbook Drafting Group is working on guidance for regulators as to how the GCC would be utilized as part of financial analysis and in developing the Group Profile Summary. We recommend deleting the cited phrases in the instructions and await to comment on the work of the Drafting Group in that regard.

6. II.E.20. of the instructions discusses an annual redetermination of scope. This raises concerns about the meaningfulness of year-to-year trends in the GCC should the scope change. And if companies automate processes to produce the GCC, revisions would have to made on an annual basis.
7. AHIP is unclear as to why the NAIC is proposing to collect data on intangible assets, which is not an element that is necessary to calculate the GCC.
July 20, 2020

Commissioner David Altmaier, Chair
Group Capital Calculation (E) Working Group
National Association of Insurance Commissioners

Re: Proposed Revisions to the Group Capital Calculation Instructions

Dear Commissioner Altmaier:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to comment on the Group Capital Calculation (E) Working Group’s revised draft Group Capital Calculation (GCC) Instructions. APCIA is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

APCIA reiterates our appreciation that the NAIC is moving with the appropriate speed to develop the GCC and help incorporate it into state law. We likewise thank the Working Group and NAIC staff for their continued efforts to advance this important project. We offer these comments on the revised GCC Instructions for the following three topics: (1) Scope of Application, (2) risk charges for material non-insurance entities, and (3) treatment of capital instruments and debt.

I. Scope of Application

A. Determination of Material Risk

APCIA believes the GCC Instructions should include more detailed and principle-based guidance for establishing the Scope of Application of the GCC. In particular, guidance is needed for determining whether a non-insurance entity within the Broader Group poses material risk to the Insurance Group. This will allow companies and their lead-state regulators to identify such entities that do not pose material risk and therefore can be excluded from the Scope of Application, with as much consistency as possible across groups and states.

As a threshold matter, the GCC Instructions should provide a definition of “material risk” for purposes of the Scope of Application. In this context, we believe “material risk” should be defined as “risk emanating from a non-insurance entity that could adversely impact a group’s insurance operations and ability to pay policyholder claims.” Likewise, the GCC Instructions should explicitly state that non-material entities within the Broader Group (but outside the Insurance Group) should be excluded from the Scope of Application.
These points naturally follow from the fundamental reason for state insurance regulation and the stated objective of the GCC: policyholder protection. Indeed, paragraph 13 of the GCC Instructions already makes clear that “the overall purpose of this assessment is to better understand the risks that could adversely impact the ability…to pay policyholder claims”. This reasoning is also in accordance with international standards. For example, under ICP 23, the fact that a non-insurance entity poses risk is not, alone, determinative of whether that entity should be in or out of the scope of group supervision; rather, to be considered included in scope, there also must be some means by which the non-insurance entity could transmit that risk to the group’s insurance operations. In sum, there is more than sufficient justification for the GCC Instructions to make clear that the crux of the materiality analysis is whether an entity could adversely impact a group’s ability to pay policyholder claims, and that non-material entities (as determined using the definition of “material risk” in the preceding paragraph) should be excluded from the Scope of Application.

For effectuating the materiality analysis for purposes of the Scope of Application, APCIA believes it is necessary to consider the totality of the facts and circumstances of a particular entity within a group. Given the diverse structures and business models of insurers, it would be impracticable to develop a one-size-fits-all checklist of guidelines that would be useful for materiality determinations across all groups. Strict or formulaic quantitative measures are likewise an insufficient proxy for materiality. Instead, the materiality analysis must consider the unique circumstances of the relevant entity and group.

To that end, APCIA recommends developing a list of factors related to whether an entity could adversely impact a group’s ability to pay policyholder claims. Insurers and regulators could then use these factors to undertake a materiality analysis based on the totality of the facts and circumstances by considering the factors and how they apply to the group’s business. After this analysis, a determination can be made as to whether an entity is material. To be clear, no single factor is determinative of materiality of risk, nor should these factors be used as a scorecard or checklist. Below we offer examples of factors that should be considered when determining materiality of risk:

- The nature of the subject entity and specific activity(ies) that give rise to the risk.
- The means by which risk can be transmitted, or prevented from being transmitted, from the entity to the group’s insurance operations.
- The means applied for risk mitigation or transfer to third parties and the extent to which risk is reduced or transformed (e.g., to credit risk).
- Past experience (i.e., the extent to which risk from the entity has impacted the Insurance Group over prior years/cycles).
- The existence of cross-support mechanisms between the entity and the Insurance Group (e.g., guarantees).
- The location of the entity within the Broader Group and how direct or indirect the linkage may be.
- The existence and relative strength or effectiveness of structural safeguards that could minimize the transmission of risk to the Insurance Group (e.g., whether the corporate shell can be broken).
• The existence of sufficient capital within the entity itself to absorb losses under stress and/or if adequate capital is designated elsewhere in the Broader Group for that purpose.
• The extent to which there is risk diversification (e.g., where risks of one or more entities outside the Insurance Group are potentially offset (or exacerbated) by risks of other entities) and whether the corporate structure or agreements allow for the benefits of such diversification to protect the Insurance Group.
• The degree to which capital management across the Broader Group has historically relied on funding by the Insurance Group to cover losses of the subject entity.
• The degree of risk correlation between the subject entity and the Insurance Group.

The GCC Instructions currently contemplate excluding only non-material, non-financial entities from the Scope of Application. However, the Working Group should also consider allowing non-material financial entities within the Broader Group (but outside the Insurance Group) to be excluded from the Scope of Application. We understand that the Working Group views financial entities, in general, to be of greater risk than other affiliates. Even so, all entities that meet the broad definition of “financial” in the GCC Instructions do not necessarily pose material risk (as defined above) under all circumstances. The fact that an entity would be classified as “financial” for purposes of the GCC should be weighed as a factor in the materiality analysis described above, but that alone should not be determinative of materiality.

B. Scope of Application Starting Point

APCIA supports the new starting point proposed in the revised GCC Instructions that would allow large decentralized groups a reduction in Scope of Application up front in some cases. Likewise, we agree with NAIC staff’s suggestion that regulatory evaluation of an up-front reduction in Scope of Application should be based on established guidance that can be applied consistently across states. For this purpose, the GCC Instructions should provide guidance that is similar to the materiality test detailed in the preceding section. We believe utilizing similar guidance would be appropriate since the underlying purpose of excluding entities from the Scope of Application is the same, regardless of whether entities are first listed on Schedule 1 or excluded up front.

II. Risk Charges for Material Non-Insurance Entities

A. Non-Financial Entities

In the short term, risk charges for non-financial entities should be 3% of 3-year average revenue. By “short term” we mean during the first few years of the GCC’s implementation, a period during which experience will be gained that can then be analyzed in more detail and across more groups than was possible in field testing. In the meantime, APCIA recommends using average revenue over a 3-year period as the base for the risk charge in order to minimize volatility.

Once some experience is gained with the GCC, the Working Group should consider a variable risk charge that would be more risk-sensitive based on the industry or activity(ies) in which the subject non-financial entity participates. APCIA does not believe that the variable charge needs to be developed in an overall complex fashion, especially since the published field-test results show this charge had a fairly minor impact overall (e.g., as compared to the inclusion of debt as qualifying capital or the use of scalars). Rather, a future variable charge could be as simple as a
construct based on an assigned risk category (e.g., high/medium/low) with a differentiated charge for each.

B. Financial Entities

APCIA is concerned with the breadth of the expanded definition of “financial entity” in the GCC Instructions. If the Working Group maintains this expanded definition of “financial entity”, we recommend using, in the short term, a capital charge that is roughly equivalent to an entity’s current post-covariance RBC charge, while also developing a high/medium/low-risk construct with differentiated charges for the long term.

The exposed GCC Instructions provide that certain non-insurance affiliates of an insurer are deemed as financial. We understand the Working Group views such affiliates to be of greater risk relative to other types of affiliates, and by deeming them to be financial, they would be listed separately for analytical purposes as well as subjected to a higher capital charge. Specifically, the exposed GCC Instructions add the following to the definition of “financial entity”:

“Affiliates that are integral to the performance of the insurance contract or the provision of insurance or financial products or services to policyholders, members or depositors [Examples include: agents, reinsurance intermediaries, claims adjusters or processors, third party administrators, pharmacy and other benefit managers, provider groups or entities that provide more than X percent of the policy benefits under policies issued by insurers within the group, and ] will be treated as financial entities.”

We have some concerns about the language cited above, which would effectively deem some affiliates to be considered financial. There is a wide array of types of non-affiliated entities within insurance groups, and it seems overly simplistic to conclude that all that are somehow associated with assisting the insurer with contract performance or policyholder services are inherently riskier than others. Subjecting these entities to a capital charge for financial entities (12% of 3-year average gross revenue – possibly to be increased to 15%) could result in a significant additional charge as compared to current RBC, for several reasons:

- The base of the entity’s charge would be changed from BACV to gross revenue.
- The factor applied to the base would increase from 7% BACV to 12% of gross revenue.
- Removing the charge from the insurer’s RBC—where it is subject to the covariance adjustment—to a separate line item for the affiliate itself, where the capital charge is aggregated without a similar covariance calculation or other recognition of risk diversification.

Therefore, in the short term, APCIA recommends using a capital charge that is roughly equivalent to the current post-covariance charge for such affiliates in RBC. Over the first few years of the GCC’s implementation, data can be collected and used to derive a more risk-sensitive charge, but also one that is pragmatic to develop and implement (e.g., a differentiated charge for entities of high/medium/low risk as determined by specified criteria).
III. Treatment of Debt as Qualifying Capital

APCIA very much appreciates that the GCC will, in large measure, recognize certain senior and hybrid debt as capital. Debt is a critical capital resource for many of our members. The capital markets are well established and have proven to be a reliable resource for the funding of debt instruments, even during the 2008-2009 financial crisis. Experience has shown time and again that the debt markets can be tapped quickly and utilized to enhance policyholder protection in a flexible and cost-efficient manner. Moreover, in periods of macroeconomic stress such as the financial crisis, the use of debt can be a more attractive alternative to the issuance of stock in depressed markets while also avoiding dilution of shareholder interests.

There is, however, an overarching issue that is presented by the way debt is treated in the proposed GCC Instructions. The treatment of debt differs in some key aspects from that which was adopted by the International Association of Insurance Supervisors (IAIS) in the Insurance Capital Standard (ICS) in 2019—which was the culmination of a long and hard negotiation process with U.S. interests supported by the NAIC, Federal Reserve Board (FED), and Federal Insurance Office (“Team USA”). As a result, and given the nature of the differences, the GCC could be viewed as less credible by other jurisdictional supervisors including those who may be parties to a Covered Agreement. Comparability of the GCC with the ICS is a looming issue on the horizon, the resolution of which can impact the views of many IAIS member jurisdictions about the efficacy of state-based regulation over U.S.-based insurance groups.

At the same time, the FED is working to complete its Building Block Approach (BBA) applicable to insurance groups under its supervision (i.e., savings and loan holding companies). The currently proposed approach in the BBA is more closely aligned with the principles-based criteria in the ICS than with the approach taken in the exposed GCC Instructions. While the proposed BBA approach would disallow debt except for grandfathered surplus notes, in some respects that is due to the unique mandate of the FED. For example, a criterion in the proposed BBA is that financial instruments be “subordinated to depositors and general creditors of the building block parent”, thus reflecting the FED’s mandate to protect the depository institution within the group.

With those high-level comments as an introduction, the following comments are intended as constructive suggestions to address some technical points in the GCC Instructions and template regarding debt. In addition, we offer some thoughts that may be helpful in addressing international perceptions.

A. Qualifying Instruments

APCIA recommends using criteria, rather than defined terms, to identify qualifying capital instruments. The GCC takes the approach of testing whether certain types of debt qualify as capital—specifically, senior debt, hybrid debt, surplus notes and “similar” instruments, and “other debt”. This contrasts with the approach taken by the IAIS in its ICS V.2.0 for the Monitoring Period, and by the FED in its proposed BBA. Both the ICS and the FED focus on criteria (e.g., permanence, loss absorbency, etc.) that are agnostic as to the title or name of a particular instrument.
There are two implications that we see. First, should the GCC go forward as currently proposed, the Working Group may need to supplement the GCC Instructions with definitions for each type of instrument. For example, “hybrid debt” is not defined in the Instructions. We understand that rating agencies treat subordinated debt issued by a parent company as “hybrid debt” as long as it is long-dated and has provisions to defer interest payments for a period of time. This could give rise to variation in treatment of hybrid debt (e.g., it may be unclear to a group if it should classify it as “hybrid” or as “subordinated” debt). On another level, comparability with the ICS needs to be considered, and on this point it seems that the more important issue is not whether types of debt are called out by name or more generically by tier, but whether comparable criteria to the ICS are used.

B. Treatment of Senior and Hybrid Debt

Using the calculation described below, the Instructions provide for an “additional capital allowance”. We first note this terminology has a potential connotation of an amount that is granted, in this case, to qualify as capital. We do not believe that to be the true nature of the calculation. Rather, for instruments that qualify for capital treatment based on specified criteria, it is a calculation to determine whether the aggregate dollar value of those instruments is within supervisory limits, and if not, the excess amount that would then disqualify. APCIA believes that focusing the Instructions’ text on "limits", rather than "allowance", will help in some respects with perceptions about comparability.

For subordinated senior and hybrid debt instruments meeting specified criteria, the GCC Instructions are detailed and have certain options remaining for consideration by the Working Group. In brief, the amount that would qualify would be determined based on the following inputs:

1. Tracked down-streamed proceeds.
2. Total paid-in capital and surplus of U.S. insurers.
3. A proxy value, i.e., for senior debt, 30% of available group capital pre-debt plus outstanding senior and hybrid debt (15% in the case of hybrid debt).

The amount that would qualify for treatment as capital in the GCC would be the larger of (3) over the larger of (1) or (2), subject to two caps:

- The total amount of outstanding senior and hybrid debt.
- The amount of senior debt and hybrid instruments allowed in group capital cannot exceed 50% of group capital before such debt.

While APCIA is of course not privy to the confidential, company-specific results of GCC field testing, it appears based on the wording in the GCC Instructions alone that in the vast majority of cases the amount of paid-in capital and surplus will exceed tracked down-streamed proceeds and, possibly, the proxy values as well. (The NAIC reported that field-test results showed only a handful of groups that were impacted by the limit, and only half of those resulted in a “haircut” greater than 10% of reported debt). This, in part, is because the calculation includes the paid-in capital and surplus of all U.S. insurance entities in the group, regardless of the source of that capital (whether from debt proceeds or otherwise).
The GCC Must Test for Subordination to Policyholders. There are indications in the exposed GCC Instructions that consideration is being given to simplifying the process by eliminating the downstreaming criterion altogether such that qualified debt would be the greater of (3) over (2), above, subject to the caps. If so, there would in effect be no explicit test to support that the debt is structurally subordinated. Recognizing that U.S. senior debt is not contractually subordinated, this could raise issues about international perceptions about the GCC. Team USA argued long and hard to support structural subordination in the ICS, finally achieving victory in Abu Dhabi last November. While use of structural subordination in the ICS is termed by the IAIS as a “national discretion”, it is an option nonetheless in the ICS that is now recognized by the IAIS and its key member jurisdictions on the IAIS Executive Committee who voted to adopt ICS 2.0. Therefore, we have concerns with the notion of deleting the downstreaming criteria without any other criteria to support subordination, as explained in the following paragraphs.

At a time when comparability with the ICS is an issue that is quickly coming to the forefront, it is not clear why the GCC would now take a very different route with respect to the treatment of debt. While downstreaming has raised many questions about how debt proceeds can be tracked and verified, the ICS criteria are workable and rely in large measure on each group and its group-wide supervisor to make that determination in light of the unique facts and circumstances surrounding each respective group. The IAIS avoided prescribing detailed rules or criteria for tracking. APCIA believes the NAIC should do the same in the GCC, leaving the determination of the amount downstreamed to the lead state working in conjunction with the group.

APCIA believes a similar approach (to the ICS) can be just as workable in the GCC—focusing on criteria that are agnostic to the type or name of any particular financial instrument. This would include criteria to support that the qualifying amount of debt to be treated as capital is actually subordinated (either contractually by the terms of the instrument, or structurally), and other principle-based criteria, as in the ICS, to support permanence, loss absorbency, etc. Some refinement of the ICS criteria may be necessary to address U.S.-specific nuances for the GCC. Indeed, structural subordination is an example of such a nuance for which Team USA successfully negotiated before the IAIS to accommodate U.S. practices in the ICS. This would avoid a comparability issue with respect to which capital instruments qualify as capital resources. That said, one area where there could be explainable and appropriate differences with the ICS involves limits on the amount of those qualifying capital resources (such as described below with respect to surplus notes, which in our view, and as argued by Team USA before the IAIS in the case of the ICS, should have no limit) given some of the unique features of state-based regulation in the United States.

Therefore, to the questions posed by the exposed GCC Instructions as to whether the downstreaming/tracking test should be maintained and, if so, what criteria should be in place, APCIA recommends keeping the test and using the criteria (with any U.S.-specific refinements necessary) that have been approved in ICS 2.0 for the Monitoring Period. That is, structurally subordinated debt should increase available capital to the extent the group and its lead state have determined such amount supports the insurance operations and is insulated from recourse by the lender, through tracking of downstreamed proceeds of the instruments into insurance subsidiaries.
There is, however, one other criterion for down-streaming that the Working Group could consider as an option to tracking down-streaming. Fundamentally, jurisdictional supervisors who permit subordinated debt to be treated for regulatory purposes as capital do so because policyholders remain protected; whether structurally subordinated or by the terms of the instrument, legally enforced restrictions and safeguards prevent the lender from “pulling the rug out from under” policyholders such that the debt is considered sufficiently permanent and loss absorbing. The issue becomes, to what assets and how much of those assets would the lender nonetheless have recourse?

As a practical matter, the lender would have recourse only to the liquid assets that remain in the entity that issued the debt (i.e., the holding company in the case of senior debt). For many groups, the unconsolidated balance sheet of the holding company (for public companies, the separate financial statements of the registrant are publicly reported in Form 10-K filed annually with the SEC) reflects a very large, illiquid investment in insurance subsidiaries, control over which is subject to regulatory oversight and approval. The amount of other, liquid assets in the holding company is typically much smaller. So, another option to test structural subordination is to limit the amount of senior debt to qualify as capital to that which is in excess of the liquid assets in the holding company. This would be easier to determine and to verify and may produce a value that would satisfy the group. If not, the group could revert to the tracking of down-streaming criterion.

C. Other Debt

Debt other than senior and hybrid debt is not allowed as capital pursuant to the exposed GCC Instructions. However, we understand that data will be collected in the GCC template for purposes of facilitating a sensitivity test based on a 15% allowance (of available group capital pre-debt plus outstanding senior and hybrid debt). We understand that the Working Group may later consider allowing limited amounts of other debt as capital if criteria can be determined. APCIA is open to the possibility of some allowance for other debt in the future. However, we believe that consideration should also be given to comparability with the ICS and adherence to the principle of subordination.

D. Surplus Notes

APCIA agrees surplus notes should be treated as capital in the GCC and with no limit, as proposed in the Instructions. We understand that Team USA argued before the IAIS for a similar outcome in the ICS, especially for mutual insurance companies. The IAIS ultimately decided to make some accommodations for mutual-company surplus notes (included in Tier 2 instruments) but retained limits, albeit limits that are slightly higher than those applied to non-mutuals. Nonetheless, APCIA supports the GCC treatment with no limit, given the well-established supervisory requirements and safeguards that surround all aspects of the issuance, maintenance, and repayment of surplus notes in the U.S.

E. Foreign Debt

APCIA likewise supports the GCC’s treatment of foreign debt. For debt issued by foreign entities, the GCC respects the treatment afforded by the local supervisor while also holding to the principle of subordination, whether that be achieved structurally or through the terms of the
instrument. If subordination is in place and if approved by the local supervisor as capital, the debt would qualify as capital in the GCC, a position with which APCIA agrees.

**F. Overall Limitations on Debt as Capital**

The exposed GCC Instructions have an overall limit on the use of debt as capital (i.e., senior debt and hybrid instruments allowed in group capital cannot exceed 50% of group capital before such debt). It is unclear if “group capital” as used for this test would include full value for surplus notes and qualifying foreign debt. Given that there is a separate limit applied to senior and hybrid debt – no more than 100% of such debt can qualify – it would seem appropriate that the overall limitation should apply to all debt, including surplus notes and foreign debt. That said, and as noted above, APCIA supports no limit on surplus notes of mutual insurers. It is important that all insurers be able to include unlimited amounts of capital from at least one organic source and one external source. In the case of stock companies, those would be retained earnings and common stock, respectively. In the case of mutuals and similar companies that cannot issue common stock, those would be retained earnings and surplus notes.

We observe that there are members of NAIC staff who participate in the development of the GCC as well as field testing of the ICS through their role on the IAIS Capital and Solvency Field Testing Working Group. Only they would be in a position to assess how the impact of the proposed limits in the GCC compare to those in the ICS for groups that have participated in both the GCC and ICS field testing exercises. Because APCIA is not in the same position, we do not offer a view on the overall limit of 50%. However, we do recognize that the comparability issue is also an important part of navigating the way forward with the GCC and encourage the Working Group to give due consideration in the context of the overall limit.

We look forward to discussing our comments with you and the Working Group.

Sincerely,

______________________________
Stephen W. Broadie
Vice President, Financial & Counsel

______________________________
Matthew B. Vece
Manager & Tax Counsel
July 20, 2020

Commissioner David Altmaier
Florida Office of Insurance Regulation
Chair, NAIC Group Capital Calculation (E) Working Group
via e-mail to ddaveline@naic.org and lfelice@naic.org

Re: GCC Working Group Exposures

Dear Commissioner Altmaier:

A coalition of fourteen companies (Brighthouse Financial, CNO Financial, Genworth Financial, Global Atlantic Financial Group, Hannover Life Reassurance Company of America, Jackson National Life Insurance, Lincoln Financial Group, National Life Group, Principal Financial Group, Protective Life, Reinsurance Group of America, Sammons Financial Group, Standard Insurance Company/StanCorp Financial Group, and Transamerica) (collectively, the “Coalition”) appreciates the opportunity to comment on the exposure of the: a) Staff Group Capital Calculation (GCC) PowerPoint (the “PowerPoint”); b) revised draft instructions; c) revised GCC template; and d) FAQs relating to these documents.

The Coalition’s primary area of advocacy has been the need for the GCC to adhere fully to legal entity rules in support of the state-based legal entity solvency system. Accordingly, we welcome significant improvements within the exposed materials that eliminate several proposed “on top adjustments.” In this letter, we specifically want to indicate our support for the proposed treatment of XXX/AXXX captives.

In particular, we understand the revised instructions to include no “on top adjustments” for captives or permitted/prescribed practices. Furthermore, slide 11 of the PowerPoint indicates that a proposed sensitivity analysis for XXX/AXXX captives will be excluded from the GCC template “upon referral to an E Committee Group or Subgroup for Further Risk Assessment.” Once this occurs, we understand that further analysis would be separate from the GCC itself. Assuming our understanding is correct, the Coalition fully supports the proposed treatment and looks forward to working with the relevant group of regulators.

We thank you, the Working Group, and NAIC staff for your attention to this letter and prior Coalition correspondence. We look forward to continuing to work with you and your team as the NAIC moves towards finalization of the GCC.

Sincerely,

Brighthouse Financial
CNO Financial
Genworth Financial
Global Atlantic Financial Group
Hannover Life Reassurance Company of America
Jackson National Life Insurance
Lincoln Financial Group
National Life Group
Principal Financial Group
Protective Life
Reinsurance Group of America
Sammons Financial Group
Standard Insurance Company/StanCorp Financial Group
Transamerica
Dear Mr. Felice,

Global Atlantic appreciates the opportunity to comment on the exposure draft of the revised GCC instructions and the revised GCC template. Our comments address concerns with the following:

- Capital calibration
- Downstream tracking of debt
- Scalar methodology
- Scalar governance

We also seek guidance on whether GAAP equity values should include or exclude OCI when GAAP is used as the accounting method to determine the carrying value of an entity.

Capital Calibration

We have concerns with the current proposed approach of using the trend test level of 300% ACL as the capital calibration level. First of all, 300% ACL is inconsistent with the 200% ACL (= 100% CAL) calibration level widely used in the insurance industry for RBC. We believe this will lead to confusion and misunderstandings when comparing RBC to GCC, potentially undermining the current RBC standard. RBC ratios are typically in the 350% to 450% range, but the GCC ratio will be much lower. For example, if the underlying RBC ratios of the companies in the group average 450% RBC, the resulting group capital ratio will be ~300%.

In addition, we believe the insurance industry’s current reporting of two capital calibration levels, (100% ACL and 200% ACL) results in confusion and frequent misinterpretation of reported ratios; adding a third calibration level for the GCC of 300% ACL will compound the problem. We believe this will lead to additional confusion and misunderstanding by users of financial information, including the regulatory, rating agency, and banking communities.

We strongly request that the NAIC adopt a 200% ACL calibration level for the GCC.

Downstream Tracking of Debt

The current instructions rely on downstream tracking in order to count debt proceeds as part of available capital. In practice, our company borrows externally in order to downstream it to the insurance companies; however, we have not found it necessary to track downstream transactions and question whether a tracking system would simply introduce complexity without providing a benefit.
We are in favor of a proposal to eliminate downstream tracking logic and replace it with a simple comparison to paid-in capital and surplus, for the following reasons:

- Simpler, more efficient, and more reliable test
- Avoids complications that could result from debt that has been refinanced by the parent as there would be no contribution of the debt amount issued.
- Avoids complications of tracking upsize transactions where debt is borrowed at one date and then down streamed at a different date.
- Avoids complications of tracking the reverse: dividends which are up streamed. Are those upstream transactions to be netted against down streamed capital or not?
- Avoids complications and questions related to M&A transactions – if a company is acquired, does the new parent company automatically assume the historical relationship of down streamed debt, so long as its debt at least equals the debt of the old parent company?

If the downstream tracking approach is maintained, once layers of transactions of the type described above are introduced, a comprehensive downstream tracking system will need to be developed, communicated, applied and reported across the industry in a way which is comparable and reliable. Our view is that industry and regulator efforts to track down streaming will not add value. In our case, the resulting capital adjustment will be the same whether we develop a downstream tracking process or whether we run a simple test ensuring that paid in capital at least exceeds the capital adjustment amount.

Scalar Methodology

We support the Excess Relative Ratio Approach for scaling non-U.S. capital ratios to U.S. RBC. This method utilizes two anchor points for scaling:

1. The respective industry average capital ratio
2. The regulatory intervention level.

The alternative scaling approach, the Pure Relative Ratio, relies solely on the industry average capital ratio to translate a non-U.S. capital ratio to U.S. RBC. It does not take in to account the regulatory intervention level. Since the Pure Relative Ratio approach adjusts required capital only, available capital is not adjusted, resulting in excess capital being distorted. Since the Excess Relative Ratio approach adjusts both available capital and required capital, excess capital is not affected.

Thus, the Pure Relative Ratio lacks a mechanism to ensure that a non-U.S. firm at the regulatory intervention level within it’s respective country will be at the U.S. RBC intervention level once scaled. This is a material fault. Again, we support the Excess Relative Ratio Approach, and its ability to align regulatory intervention levels across jurisdictions.

Scalar Formulation

Transparency of how the scalars are calculated will be critical, regardless of which scaling methodology is selected. In order to appropriately manage capital under the group framework, firms must have a thorough understanding of how scalars behave. Many non-U.S. countries rely on market-
value based capital ratios, which have potential to behave differently than the book-value based RBC measure.

We believe the following themes should define the scalars:

Consistency – scalars should be calculated and applied consistently across all non-U.S. regimes.

Specificity – scalars should be discretely computed and applied amongst life, property casualty and health insurance companies.

Stability – the results of applying scalars to Non-U.S. capital ratios should not be volatile; for example, converting to U.S. RBC should not yield a significant headwind in one year, and a significant tailwind in the following year.

Additionally, we believe answers to the following questions are critical for firms to understand the impact of the scalars:

1. How is the country average computed? Is the concept of country average based on equal weighting each firm? Alternatively, is it size weighted, such that a large provider in Country Y may dominate the average of Country Y?

2. How frequently will the scalars be updated?

3. Will scalars derived from Year 20XX be applied to 20XX actual results, or will timing of filings and data availability create a lag?

4. Will scalars take in to consideration only a single year, or alternatively, will a rolling average mechanism be utilized?

GAAP Equity

The GCC instructions are silent on whether OCI should be included or excluded when GAAP equity is used as the carrying value of an entity. Companies typically report GAAP equity excluding OCI to lessen the amount of volatility that can arise when including market value adjustments of assets. Excluding OCI is also consistent with statutory accounting rules that generally do not reflect the market value of assets. We suggest that the GCC instructions include guidance on whether OCI should included or excluding when reporting GAAP equity. Otherwise there could be inconsistencies in how companies report GAAP equity amounts.

Again, thanks for allowing us to provide our comments on the revised GCC instructions.

Sincerely,

Lauren Scott
Head of Regulatory and Government Affairs
Global Atlantic Financial Group
July 20, 2020

Via Electronic Delivery

Commissioner David Altmaier
Florida Office of Insurance Regulation
Chairman, NAIC Group Capital Calculation (E) Working Group
Via email to Lou Felice (lfelice@naic.org)

Re: The National Association of Insurance Commissioners (“NAIC’s”) Draft Group Capital Calculation (“GCC”) Instructions and Template

Dear Commissioner Altmaier:

Prudential Financial, Inc. (“we”) thank the Group Capital Calculation Working Group (“Working Group”) for continuing to seek input on key elements of the GCC. We support the development of supervisory tools, such as the GCC, that will enhance state regulators’ ability to protect policyholders and insurance markets. Further, we believe the GCC framework – through its employment of an inventory approach to obtain insight into all entities within the group and the location and sources of capital – can achieve the NAIC’s stated objective of providing state regulators a “panoramic, transparent view of the interconnectedness, business activities, and underlying capital support for an insurance group.”

While the foundation of the GCC framework is strong, we believe appropriate outcomes for a number of key design elements is essential to ensure the final version provides state regulators appropriate insight into risks while minimizing the potential for unintended consequences. In the pages that follow, we identify the approaches that we believe would best position the GCC to accomplish these objectives.

We again thank the Working Group for seeking stakeholder input on key elements of the GCC and would welcome the opportunity to discuss the information included in this response should the Working Group or NAIC staff engaged in the GCC project wish to do so.

Sincerely,

Ann Kappler
Senior Vice President, Deputy General Counsel and Head of External Affairs
Prudential Financial, Inc.
Overview

We strongly support the Working Group’s decision to employ an aggregation based approach in order to “build on existing legal entity capital requirements where they exist rather than developing replacement/ additional standards.” As the Working Group has rightfully noted, such an approach strikes an ideal balance of “satisfying regulatory needs while at the same time having the advantages of being less burdensome and costly to regulators and industry and respecting other jurisdictions’ existing capital regimes.”

As the Working Group takes steps to finalize the GCC, we encourage it to pursue approaches that are aligned with the objective of providing regulators transparency into risks while avoiding the creation of additional standards that are unnecessary and may be burdensome and costly. Further, we also encourage the Working Group to consider the impact the various design choices may have on the ability of the GCC to provide appropriate insight into risks (e.g., avoid false positives and negatives) and how they could affect the ability of supervisors and/or insurers to navigate periods of stress.

Limitations on the Recognition of Senior and Hybrid Debt Should be Removed

We believe the proposed limitations on the recognition of senior and hybrid debt are inconsistent with the NAIC’s stated intent for the GCC to serve as tool for obtaining insight into insurance groups rather than a binding constraint and further, could discourage the prudent use of debt instruments as an effective capital and liquidity management tool – particularly during times of stress. We therefore believe the Working Group should eliminate the proposed limits on the degree to which senior and hybrid debt qualify as available capital.

Insurers weigh a number of critical elements when establishing and managing their capital structures such as rating agency targets, cost, tax implications, etc. In practice, these considerations serve as effective guardrails against behavior that may be detrimental to the insurer or policyholders. Similar to the Working Group’s decision to leverage the strength of existing solvency regimes rather than developing replacement/additional standards, we believe the GCC should leverage existing market forces that promote sound capital management practices across the sector. The May 19 NAIC Group Capital Calculation Post Field Testing Staff Input presentation highlighted that under the current GCC proposal, 25% of the volunteer companies from the 2019 field test that reported senior and/or hybrid debt would not receive full credit for the capital instruments they have issued. We believe this percent could increase significantly during economic downturns as an insurer’s available capital declines and required capital increases, which would further limit the recognition of these resources and inappropriately discourage their use. Eliminating the proposed limits on the recognition of senior and hybrid debt would avoid the potential for the GCC to trigger such procyclicality.

Should the Working Group insist on maintaining limitations, we request the following changes to better acknowledge the presence of existing market guardrails and reduce the potential for the GCC to inhibit an insurer’s ability to manage its capital structure in a manner it feels is most appropriate and have procyclical effects during economic downturns. Further, the purpose of any imposed limitations that are retained should be explained in light of the stated intent for the GCC to serve as tool to obtain insight into risks as opposed to a binding constraint.
The cap of the allowance at 50% of total adjusted carrying value in Inventory B should be eliminated given that the underlying allowances, which are modeled largely after rating agency approaches, already have conservatism embedded in them.

- Specifically, the 30% factor for senior debt and 15% for hybrid debt are being applied to a more conservative base than rating agencies use for establishing limits – i.e., the GCC intends to apply the factors to the sum of total adjusted carrying value + outstanding senior and hybrid debt while rating agencies typically base their assessment on the group’s total consolidated U.S. GAAP equity.

- Adding a limit of 50% of total adjusted carrying value to the conservative 30% and 15% limits for senior and hybrid debt (relative to total adjusted carrying value + outstanding senior and hybrid debt) effectively lowers the 45% permitted (i.e., 30% + 15%) to approximately 33%.

- More broadly, the different objectives of the GCC versus rating agency frameworks must also be considered. For example, S&P’s capital model is calibrated to much higher confidence levels (e.g., 97.2% for “BBB”) and views 20% to 40% financial leverage, based on a group’s total consolidated U.S. GAAP equity, plus outstanding debt, as “neutral”.

- Requirements for tracking the down-streaming of debt issuance proceeds to regulated entities should be eliminated. Keeping funds at the holding company level is a prudent strategy that provides insurance groups flexibility to quickly and easily manage capital and liquidity needs across the group. We believe a tracking requirement could give rise to unintended consequences such as reducing the availability and fungibility of capital resources and forcing U.S. insurance groups to issue greater amounts of debt.

**The Base GCC Should Use the Excess Capital Ratio Scalar Approach**

Prudential disagrees with the suggested change to apply the Pure Relative Ratio option at 300% RBC Calibration in the Base GCC. We believe that a total balance sheet approach to scalars – as embodied in the Excess Capital Ratio Approach – is necessary to adequately account for key differences across insurance regimes, such as the level of conservatism embedded in reserves versus required capital, different valuation and asset admissibility standards, etc. and avoid distorting the measure of required, available, and excess capital. Further, we believe embedding a scalar methodology with shortcomings (i.e., the Pure Relative Ratio Approach) in the Base GCC could undermine the NAIC’s ongoing work at the global level to secure recognition of the Aggregation Method (“AM”). Therefore, while we believe the Excess Capital Ratio Approach is an appropriate method for including in the Base GCC we would also support using a scalar of 100% (i.e., not scaling foreign insurance regimes) until there is greater clarity on what scaling approach will ultimately be included in the AM.

Through its simplistic approach of only focusing on required capital, the Pure Relative Ratio Approach fails to adequately account for key differences in insurance regimes (e.g., level of conservatism embedded in reserves versus required capital, different valuation and asset admissibility standards, etc.). While the limited analysis to date may suggest the two approaches yield similar results, we believe they would diverge in cases where individual insurer or industry capitalization levels change and that the conceptual shortcomings of the Pure Relative Ratio Approach could result in false positives or negatives.
More broadly, we are concerned that adopting the Pure Relative Ratio Approach for purposes of the Base GCC would undermine the ongoing work at the NAIC’s work at the global level to secure recognition of the AM as comparable to the reference method version of the Risk-based Global Insurance Capital Standard (“ICS”). Specifically, we believe that the decision would prejudge the Pure Relative Ratio Approach as the methodology that should be adopted for the AM. Further, we believe it will be essential for the comparability assessment work to take a holistic approach to accounting for the different tools and methods supervisors employ to ensure insurers hold adequate loss absorbing resources to protect policyholders; of the two approaches the Working Group has considered, the Excess Capital Ratio Approach – with its total balance sheet approach – is the only one of the two that would accomplish this.

In the May 19 NAIC Group Capital Calculation Post Field Testing Staff Input presentation, NAIC staff noted the need to continue to explore the topic of scaling in conjunction with similar work for ICS – AM. We support this recommendation and believe it highlights the importance of keeping the GCC and AM in step with each other and taking time to consider the appropriateness of the methodology relative to a suite of criteria, including the reasonableness of the assumptions, ease of implementation, and stability of the parameterization. That said, while we strongly believe the Excess Capital Ratio Approach should be used in the Base GCC (and the Base AM), an alternative path that should be considered is to use a scalar of 100% for the Base GCC until there is greater clarity on what scaling approach will ultimately be included in the AM. Such an approach would avoid prejudging that the AM should employ the Pure Relative Ratio Approach and avoid the potential need to modify the Base GCC in the future if a different scaling methodology is embraced for the AM.

The Calibration of the Base GCC and Scalars for Foreign Insurance Regimes Should be 200% ACL RBC

Prudential disagrees with the suggestion to calibrate the Base GCC ratio or scalars for foreign insurance regimes at 300% authorized control level (“ACL”) RBC – i.e., the Trend Test level. Instead, we believe they should be calibrated to 200% ACL RBC – i.e., Company Action Level (“CAL”) as it has long been common practice for insurers to communicate and stakeholder to assess financial strength on this basis. We believe using 300% as the calibration would unnecessarily interrupt well-established market norms and introduce unwarranted confusion for insurers and stakeholders without any discernable benefit. Further, we believe calibrating to a 300% ACL RBC level could create confusion over, or trigger an unwarranted reset of, how the NAIC’s time tested ladders of intervention approach to the supervision of capital adequacy works in practice.

We recognize a relationship has been established between the 300% ACL RBC level and 100% Solvency Capital Requirement (“SCR”) for Solvency II in the U.S.-EU and U.S.-UK Covered Agreements and further, that the NAIC’s Evaluations of Reciprocal Jurisdictions have similarly established relationships between the 300% ACL RBC level and intervention points under the solvency regimes of Bermuda, Japan, and Switzerland. However, we do not believe these developments justify upending years of industry norms, and the likely confusion that would result from calibrating the Base GCC or scalars of foreign insurance regimes at a 300% ACL RBC level. While we speculate that international considerations may be contributing to the interest in using the 300% ACL RBC level for calibration purposes, we believe it is incumbent on the Working Group to confirm its rationale so a more informed debate could be held with interested parties before a final decision is made.
The Sensitivity Analysis Tab Should Be Removed from the GCC Template

Prudential believes the GCC template should be limited to reporting of the Base GCC (and the required inputs thereto) and that the Sensitivity Analysis tab should be deleted. Narrowing the design of the GCC will ensure insurers, supervisors (domestic and foreign) and other stakeholders have a clear vision and understanding of what the GCC is (e.g., it would eliminate the need to distinguish between a “Base” view and alternative measures). Notwithstanding the comments above regarding scalar methodology, we believe clarity in the design of the GCC is critical as insurers and supervisors move to introduce the GCC as an additional metric to monitor and manage and would provide a stronger foundation for the NAIC’s ongoing efforts to advance the AM at the global level.

To the extent broader information on the insurance group is of interest to a state regulator, we believe it should be obtained through discretionary powers as opposed to embedding it in the GCC template. We believe “Input 6 – Questions” should be transitioned to a Microsoft Word document as it is more user friendly format (note that the NAIC employs such an approach for its work on the AM at the global level). A word based file could serve as a more flexible vehicle for insurers and state regulators, including potential instances where the regulator wishes to receive information beyond that which is included in the GCC template (note a fillable PDF could also be used).

Grouping of Similar Non-insurance Entities and / or Relaxing De-stacking Requirements for Non-insurance Entities Should Be Permitted

Prudential appreciates the Working Group’s consideration of permitting grouping of similar non-insurance entities and / or relaxing the requirement for de-stacking as we believe such flexibility would reduce the burden of completing the GCC template. While we support such flexibility, we believe state regulators should retain the option of requesting more granular information should they feel it is needed to obtain a sufficient view of risks within the group.

Simple Approaches Should be Adopted for Financial Entities and Non-financial Entities Without Regulatory Capital Requirements

For simplicity, Prudential supports adopting a single approach for establishing a proxy capital measure for all financial entities that are not subject to a regulatory capital requirement. Further, we believe it would be beneficial for the Working Group to select the method it believes most aligns with how the AM will ultimately treat this item. Per our comments above, we support grouping of similar entities and thus support the netting of non-operating holding companies. We similarly support adopting a single approach for establishing a proxy capital measure for all non-financial entities that are not subject to a regulatory capital requirement.

We believe ensuring state regulators obtain adequate insight into the entities within the insurance group and risks associated with them is the key point of consideration for these entities and this is best accomplished through the inventory element of the GCC as opposed to an arbitrary proxy capital calculation. To the extent a state regulator believes a non-regulated entity poses material risk to the group, they have discretion to request additional information to understand the risks. Further, such situations would be better addressed through in-depth analysis on a case-by-case basis as a formula driven proxy capital calculation would likely fail to reflect the underlying risk exposures. That said, we believe further consideration of approaches is unwarranted and the Working Group should narrow the
GCC template to single approach for each respective category of entities rather than continuing to test multiple approaches.

**The Draft Financial Analysis Handbook Guidance Should Be Exposed for Comment**

Materials for the May 19 public meeting of the Working Group included an Attachment C – “Draft Regulatory Guidance on GCC”, which was not part of the materials recently exposed for comment. We request that the Working Group provide interested parties an opportunity to provide input on this material before it is finalized.

Below are some initial thoughts on the draft version that was included in the May 19 meeting materials.

- Establishing a minimum threshold that must be maintained to avoid triggering a more in depth supervisor review and/or the need to develop a plan to reduce risks would be inconsistent with the NAIC’s stated intent for the GCC to serve as a tool rather than a binding standard.
- The detailed nature of the guidance seems premature given the range of design elements that have yet to be finalized, which could have a material impact on GCC ratios, and ongoing consideration of which insurers will be exempt from having to file the GCC.
Commissioner David Altmaier
Florida Office of Insurance Regulation
Attention: Mr. Lou Felice
J. Edwin Larson Building
200 E. Gaines Street, Room 101A
Tallahassee, Florida 32399

RE: Draft Instructions from the Chair of the Group Capital Calculation (E) Working Group
to the Chair of the Group Solvency Issues (E) Working Group

Commissioner Altmaier:

State Farm Mutual® Automobile Insurance Company and its affiliates ("State Farm"), appreciate
the opportunity to submit these comments concerning the Draft Instructions from the Group
Capital Calculation (E) Working Group (the “Working Group”). As you know State Farm
participated as a volunteer group and provided feedback as to the Group Capital Calculation
("GCC") and its supporting informational elements during its development. State Farm
understands that the GCC provides an evaluation tool for domestic regulators to consider along
with various other risk information already being provided by groups, such as the Own Risk
Solvency Assessment ("ORSA") Report filing.

State Farm urges the Working Group to consider the entirety of the regulatory structure when
evaluating whether to include additional measures through the Draft Instructions on insurers or
the holding company of those insurers that are not entirely exempted, especially when the group
structure is simplistic, focused on insurance operations and when such parent of the holding
company is a regulated insurer.

As a volunteer participant State Farm benefitted from the effort and transparency the Working
Group has utilized all along in developing the GCC and appreciates that the Draft Instructions
incorporates many of the industry’s clarifications and suggested additions. However, State Farm
suggests a few more amendments to the Draft Instructions to recognize today’s overall
financial regulatory scheme and limit duplication as much as possible for regulators and those
being regulated when such groups are not exempted from GCC and are substantially an
insurance group.
Scope

State Farm requests that the same isolation method of excluding non-financial entities be available for other entities in a group.

State Farm supports the Draft Instructions statement in paragraph 12 that recognizes there are groups that have material diverse non-financial activities that are isolated from the financial/insurance group and that could lead to a narrowing of the scope of the GCC in agreement with the Lead State Regulator. However, State Farm questions why the Draft Instructions do not similarly recognize financial or insurance entities that are also similarly isolated from the group. The purpose of the GCC is to evaluate a group’s solvency soundness through a numerical calculation to ensure the primary regulated insurance entities within the group remain sound. Acknowledging the isolation of financial and insurance entities fits within already existing regulatory arrangements as well as the GCC, and acknowledges that capital is not freely fungible for use by the group or entities within the group. Since the same mechanisms recognized by the Draft Instructions to isolate the non-financial entities can be and are being used to isolate financial or insurance entities, the Draft Instructions should recognize the isolation no matter the entity type.

The GCC should not ignore the other existing provisions of the Holding Company Act or solvency provisions applicable to the individual insurance member of the group, such as the Risk Based Capital (RBC) calculation that provides a similar numerical calculation of soundness, financial statements and other applicable regulatory requirements. These provisions, commonly referred to as the windows and walls regulatory scheme, protect the capital of that insurance entity such that capital is not freely available for the use by the group or any other entity within the group. Similar to the recognized ability of non-financial entities to be isolated from the rest of the group, the windows and walls approach isolates the insurance entities from material transaction with affiliates and in a sense isolates the entities. Expanding the acknowledgement of the ability to isolate financial and insurance entities is not radical and fits within the overall goal of the current windows and walls regulatory approach as well as the GCC, to protect the solvency of the insurance members of a group. Just as a non-financial entity may be isolated and pose no risk to an insurance entity in the group, if a financial entity is isolated from the group, it does not pose a solvency risk to the insurance entity. Finally, an argument could also be made that if the insurance entity is isolated from the group in a similar fashion, the group does not pose a risk to the isolated insurance entity. For these reasons, State Farm requests that groups be allowed to present a narrower scope for entities that are otherwise isolated to the Lead State Regulator who would have discretion to accept such narrowing of the scope for that group’s GCC.

State Farm requests that excluded entities not be required to be included on the Inventory Tab or discretion be provided to the Lead State Regulator to exclude, especially when the information is otherwise provided.

State Farm
Corporate Headquarters
1 State Farm Plaza
Bloomington, IL 61710-0001
In paragraph 14, the third bullet provides that “All entities, whether to be included in or excluded from the Scope of Application are to be reported in the Inventory Tab of the template.” Presumably, this includes the non-financial entities that are isolated and excluded under paragraph 12 or paragraph 30 and financial/insurance entities that are excluded under paragraph 10 and 18. If this is accurate, preparers will be required to provide the required information on entities that are excluded from the scope of the GCC. While there may be certain situations when such information would not otherwise be provided to the Lead State Regulator, in an insurer parent lead group this information is already provided through other required regulatory submissions including but not limited to, financial statements and RBC calculations of the parent insurer or the insurance entities. Gathering information under the GCC from entities that are excluded from the GCC seems counterintuitive and duplicative in certain situations. State Farm requests that excluded entities not be required to be on the Inventory Tab or, at least, the Lead State Regulator have the discretion to not require excluded entities on the Inventory Tab if requested by the preparer.

State Farm requests a baseline materiality definition be provided while maintaining Lead State Regulator discretion to determine if a higher or lower material threshold is appropriate.

The Draft Instructions use the term “material” in discussion whether an entity can be excluded or is to be included in the GCC. State Farm believes discretion should remain with the Lead State Regulator, however, it is important to have a clear understanding of what is meant by “material” and to create some consistency in application. For paragraphs 10 and 18 there is no guidance, but for paragraph 30, which addresses determining what is an “affiliate” to be included in the GCC, it states in part:

For purposes of the GCC, affiliates will NOT include those affiliates reported on Schedule A or Schedule BA, EXCEPT in cases where there are financial entities reported as or owned indirectly through Schedule A or Schedule BA affiliates or where a non-financial, non-insurance Schedule A or Schedule BA affiliate represents greater than X percent of an insurance entity’s adjusted available capital.

The paragraph provides a Drafting Note providing guidance to regulators:

**DRAFTING NOTE:** Initial suggestion is to set “X” threshold for material non-financial entities no higher than 5%.

State Farm suggests adding to the Draft Instructions, additional Drafting Notes in the paragraphs using the term “material”, a baseline for materiality of 5% of the group’s net worth while still allowing the Lead State Regulator and the preparer to use a higher or lower threshold given the particular circumstances presented by the preparer.

State Farm believes that there should be some consistency in application under these provisions and that materiality should be based on the group’s net worth given the GCC is measuring risk of the group and not a particular entity in the group. RBC calculation along with other regulatory
requirements provides the Lead State Regulator the information necessary to evaluate the solvency risk of an individual insurance entity and the GCC should be focused on information that a Lead State Regulator doesn’t already receive and be focused on the impacts to the group. Including a Drafting Note provides guidance, allows the Lead State Regulator and the preparer to utilize a different value for unique situations, and allows the focus of the GCC on those matters that truly impact a particular group.

State Farm offers these comments on the Draft Instructions to help streamline the process for those groups required to conduct the GCC. The intent of the comments is to help the focus of the preparer and Lead State Regulator to be on the insurers of that group and the material impacts of other members of the group that may have on the solvency of the insurance members.

Thank you for your time and consideration in this project and to our comments. If there are any questions concerning the comments, please contact me.

Sincerely,

Chuck Feinen
State Farm Mutual Automobile Insurance Company
July 20, 2020

Hon. David Altmaier
Commissioner
Florida Office of Insurance Regulation
Chair, Group Capital Calculation Working Group
The Larson Building
200 East Gaines Street
Tallahassee, FL 32399-0305

Via electronic mail to Lou Felice

Re: Comments on GCC Instructions and Template

Dear Commissioner Altmaier:

We write today on behalf of UnitedHealth Group, one of the nation’s largest managed care and healthcare services companies, which, through its UnitedHealthcare business platform, administers and provides healthcare benefits to more than 45 million individuals in all fifty states and the District of Columbia. UnitedHealth Group’s Optum business segments provide health services, including pharmacy services, health care delivery, population health management, collaborative care delivery, information technology, and health care financial services to 115 million individuals and more than 100,000 physicians, practices, and other health care facilities nationwide. We thank you for the opportunity to provide comments on the recently released draft Group Capital Calculation (“GCC”) template and instructions.

We appreciate the simultaneous disclosure of the template, instructions, confidentiality provisions and the handbook draft. This is helpful context for understanding the working group’s intent for this initiative.

**Comments on the Instructions**

The GCC Instructions address not only the mechanics of filling in the template, but also many considerations that regulators are supposed to apply when using the template. We have comments about both aspects of the Instructions. We have divided our comments on the instructions into two sections – our key concerns, and additional concerns that do not rise to the level of a key concern but nevertheless are important to consider as these instructions are finalized.

Our comments in both sections are labeled according to the paragraph labels in the GCC Instructions.
**Instructions Comments – Key Concerns**

**Key Concern #1: Calibration Level**

V.A.40: As we have explained previously, with supporting numerical examples, the method being used to produce the “scalars” [sic] for alien insurers is incorrect, as it takes into account only differences in the average capital being held, and not the relative conservatism of reserves. While there are other conceptual problems with the concept of scalers as being employed here, this particular error should be corrected; we had previously offered a suggestion as to how to make the correction.

VI.57 and VI.58: For entities that file an RBC report, the requirement is to report “entity required capital” at 150% of Company Action Level (CAL). There is no justification for this. Reference is made to the trend test in the RBC formula, which may result in an action level event for entities with Total Adjusted Capital below 150% of CAL; however, that can only occur if certain other, relatively unusual conditions exist, and those other conditions are not tested for in the GCC. Consider the illogical result this would produce for a group where the ultimate controlling person was an RBC filer with Total Adjusted Capital equal to 130% of CAL: the entity would be considered well capitalized from an RBC standpoint, and yet would fall below the 100% level in the GCC. This seems especially misguided given that early drafts of the Financial Analysis Handbook procedures suggest further scrutiny of a group when the GCC ratio is below 175%—i.e., is below 262.5% of CAL.

Furthermore, 100% of CAL may itself be excessive. Early in the development of the GCC, the question was raised as to how the diversification benefit of large, heterogeneous groups would be reflected. Clearly, such a group is less risky than its individual components standing alone would be. The NAIC’s decision at that time was not to have an explicit diversification adjustment (like the covariance adjustment in RBC) built into the GCC, but instead to take diversification into account when interpreting the results. Accordingly, a diversified group should have a capital benchmark that is less than the corresponding benchmark for an individual entity—which in the case of an RBC filer would be CAL. From that standpoint, calibrating the GCC even to 100% of CAL would be conservative; using 150% of CAL is unjustifiably conservative. The mere addition of legal entity capital and capital requirement, without any provision for diversification should is not be interpreted as group risk-based capital regulation.

These concerns about calibration are heightened by the language in paragraph I.A.2 (discussed above) indicating that the GCC will be a basis for regulators to take actions with respect to a group. Even if the GCC will be used solely as an analytical tool, the analysis should be based on an appropriate calibration, to avoid unnecessary follow-up questions and prolonged discussions. However, if the GCC will, in and of itself, be grounds for regulatory action (as suggested by some of the language in the instructions), it is absolutely critical that the calibration not misstate the riskiness of the group.

**Key Concern #2: Definition of “Financial Entity”**

IV.22: We believe that the definition of “Financial Entity” is far too broad, in that it sweeps in “Affiliates that are integral to the performance of the insurance contract or the provision of insurance or financial products or services to policyholders, members or depositors,” such as “claims adjusters or processors, third party administrators, pharmacy, medical provider groups, and other benefit managers,” etc., even when those entities are not material to the group or calculation as a whole. Affiliates that merely provide contracted services to a carrier should not be defined as “financial”: they do not create any more financial
risk to their affiliated insurers than do non-affiliates that provide the same services to other insurers. In fact, given that regulators have oversight over inter-affiliate service agreements, we suggest that affiliated service providers present less risk than do non-affiliates. In the case of health groups, some of the examples given actually diversify risk for the insurance entity in the group, facilitating more access to capital by the insurance entity. The aim of the working group should not be to promote smaller, less integrated or diversified groups.

VI.61: We again object to the notion that “entities that derive a majority of their gross revenue from services that are integral to the performance of the insurance contracts within the group or from the provision of other financial services to policyholders within the group will be considered a Financial Entity without a regulatory capital requirement” [emphasis added]. As noted in our comments on paragraph IV.22, the fact that those services are being performed by an affiliate does not add risk to the group, but in fact because of greater regulatory oversight should be considered to reduce the group’s risk. We also point out that the “Financial Entity” designation is being applied only to such entities that provide services primarily to affiliates; clearly, therefore, it is not the activities of those service entities that are considered risky, since if they provide those services primarily to non-affiliates they are not considered “Financial Entities.” Again, the working group should not want the GCC to limit the scale, diversification, integration or efficiency of groups, given historical evidence of the benefit of size, diversification, and efficiency to group credit standing, as evidenced in public credit ratings.

Key Concern #3: Intangible Assets

VI.83: We question the rationale for collecting information on intangible assets (such as deferred acquisition costs, provider contracts, customer lists, and goodwill). The focus on intangible assets, to the exclusion of other types of assets, seems unwarranted. While it may not always be possible to sell intangibles quickly for cash equal to their reported value, that is true of a wide variety of tangible assets (such as real estate, plant and equipment, and airplanes) that are not being singled out. Furthermore, regardless of their availability for sale, intangible assets do produce a stream of income to the group; otherwise, GAAP accounting would require that they be written down in value or written off entirely. As businesses rely more and more on digital assets and intellectual property as the basis for their operations, and less and less on fixed assets, there is more scrutiny of the value of those assets, and there should be less concern about whether the stated values are appropriate. We believe that any focus on intangible assets—which has not previously been discussed by the working group—is unwarranted, and there is no valid reason to collect information in the GCC or otherwise differentiate this specific category of assets.

We note that securities in a “tangible” investment portfolio are valued on the net present value of expected cash flows to the investor in the private and public markets—despite the tangible nature of the issuers’ assets or capital producing these cash flows. Just over one-third of the S&P 500, which is well represented in corporate debt and equity investment asset classes, have negative tangible net worth. The differential treatment of “tangible” financial investments and physical assets versus income-producing intangible assets is inconsistent.

We note also that the increasingly digital economy is based on software and information assets. Under GAAP, the capitalization of software assets is narrow, and amortization relatively short, compared to traditional fixed assets. Furthermore, changes made to GAAP in 2001 eliminated both the “pooling of interests” accounting in acquisitions and the amortization of goodwill. Accordingly, both business trends and accounting changes have made the differentiation of “intangible” assets increasingly less relevant.
Key concern #4: Use of the GCC

I.A.2.: We suggest several revisions to this paragraph.

One key area of concern is the statement that “insurance companies may be subsidizing the operations of non-insurance entities, potentially undermining the insurance company’s financial condition.” Whether or not all or any of the insurance companies in a group are “subsidizing” other operations within the group is not relevant to the insurance company’s financial condition. Insurance regulators are already empowered to monitor and restrict the flow of capital out of the insurance entities, by means of restrictions on dividends, oversight of transactions with affiliates, and application of the statutory provisions regarding hazardous financial condition, among other methods. If the outflows from insurers to other members of the group are endangering the solvency of the insurers, that points to a regulatory failure that cannot be solved by the GCC. The GCC was never, in our understanding, intended to be a tool for each legal entity regulator to use for legal entity solvency monitoring. That is a function of U.S. risk-based capital (RBC) and state-based insurance regulation, not group-level supervision.

That same sentence in paragraph I.A.2 suggests that another consequence of “subsidization” may be “upward pressure on premiums to the detriment of insurance policyholders.” The GCC was never intended to be a tool for the regulation of insurance premium rates, and we find it highly concerning that this consideration is being introduced in this fashion.

The idea that non-insurance operations within the group pose a proximate risk to the solvency of the group’s insurers has little historical evidence to support it. The real lessons of the financial crisis of 2008 proved that even when an insurer belonged to a group with significant financial risk in other areas of operations, its policyholders were not subjected to significant risk, because the legal entity structure in the United States effectively protected them, especially relative to other group-oriented insurance regulatory regimes. It is clearly not the case that risk within a complex, diversified holding company system necessarily translates to risk to the individually regulated insurance entities or to their policyholders. Each state is responsible for reviewing the financial condition of the legal entities within its jurisdiction, and for decades, including the financial crisis of 2008, that first line of review has proved to be the most effective system worldwide. The GCC may identify “risk” in the larger holding company system, but that will not necessarily translate to better identification of risks to any insurer within that system. We suggest that the Financial Analysis Handbook is the more appropriate location for commentary about how to interpret the risks identified by the GCC.

Another concern arises from the statements in paragraph I.A.2 that the GCC “provides an additional early warning signal to regulators so they can begin working with a company to resolve any concerns” and will “allow them to make informed decisions on both the need for action, and the type of action to take.” It seems inappropriate to suggest that the GCC, in and of itself, would be grounds for regulatory action to protect policyholders; that is the function of a regulatory standard, not an analytical tool. The ratio produced by the GCC as well as the additional information provided in the GCC template may provide grounds for a regulator to have discussions with a group about its risks, but they would not be grounds for inferring that policyholders must be “protected” so that the regulator must “take action” by requiring the group to “resolve concerns.”

We also have a concern that the instructions as written may not make clear that the GCC is intended to be used solely by the lead state regulator. In the statement that the GCC “provides an additional early warning signal to regulators so they can begin working with a company to resolve any concerns,” the use
of the word “company,” rather than “group,” could be taken to suggest that the GCC is intended to be a tool for any regulator responsible for any legal entity within a group. Likewise, the statement, “State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to ... allow them to make informed decisions on both the need for action, and the type of action to take,” suggests that the GCC will be used by the domiciliary regulator of each insurer. We do not believe that is intended to be the function of the GCC.

In accordance with the foregoing comments, we propose revising paragraph I.A.2 as follows.

2. More specifically, the GCC and related reporting provides more transparency to insurance regulators regarding the insurance group and make risks more identifiable and more easily quantified. In this regard, the tool assists regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies may be subsidizing the operations of non-insurance entities, potentially undermining the insurance company’s financial condition and/or placing upward pressure on premiums to the detriment of insurance policyholders. This calculation provides an additional early warning signal to regulators so they can begin working with a company to resolve any concerns in a manner that will ensure that policyholders will be protected. The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide lead state regulators with further insights into the risks of the group as a whole, to allow them to reach make informed conclusions decisions about the financial condition of the group both the need for action, and the type of action to take.

I.A.3. This paragraph contains a statement indicating that the GCC could be used “in conjunction with group-specific risks and stresses identified in the Own Risk and Solvency Assessment (ORSA) Summary Report as well as risks identified in Form F filings that may not be captured in legal entity RBC filings.” While the GCC, the ORSA, and Form F are all intended to evaluate the risks of the group, we think it likely will be misleading to financial analysts to suggest that the GCC can be used together with the other two. They lack comparability to each other, for several reasons.

- The ORSA report and Form F reflect a company’s own internal risk analysis, whereas the GCC depends largely on rules prescribed by the regulators.
- The ORSA is forward-looking, and typically considers multiple future years. The GCC relies on historical data, mostly from the single most recent year.
- The “capital” that is considered for purposes of ORSA may be defined differently than the “capital” identified by the GCC.

The last sentence of the paragraph states, “Finally, it’s important to understand that regulators believed that a group capital calculation would be another valuable tool to complement the states’ legal entity focused solvency assessments.” Again, we are concerned that this statement could be construed to encourage use of the GCC by individual state regulators other than the lead state. The stated purpose of the GCC has always been to provide a tool to allow the lead state to better understand the risks to the group as a whole.

In light of those two concerns, we recommend that the paragraph be revised as follows.

3. State insurance regulators currently perform group analysis on all U.S. insurance groups, including assessing the risks and financial position of the insurance holding company system based on currently available information; however, they do not have the benefit of a consolidated statutory accounting system
and financial statements to assist them in these efforts. It was noted prior to development that a consistent
method of calculating group capital for typical group risks would provide a very useful tool for state financial
regulators to utilize in their group assessment work. It was also noted that a group capital calculation could
serve as a baseline quantitative measure to be used by regulators, to supplement in conjunction with the
view of group-specific risks and stresses provided by identified in the Own Risk and Solvency Assessment
(ORSA) Summary Report filings and as well as risks identified in Form F filings that may not be captured in
legal entity RBC filings. Finally, it’s important to understand that regulators believed that a group capital
calculation would be another valuable tool to complement the states’ legal entity focused solvency
assessments.

II.E.20.: We are concerned about the potential for an annual redetermination of scope. If the scope of
application were revised frequently, then year-over-year trends in the GCC would not be meaningful.
There should be a materiality standard developed to determine when and if a group’s scope is
reconsidered; e.g., something based on the cumulative increase in the amount of the group’s capital that
is out-of-scope. To reduce burden on the group, such redetermination should be based upon material
changes in the group, not changes in the reviewer.

V.A.33: This paragraph refers to “the lead state regulator and template reviewer.” We question whether
this is intended to suggest that the template reviewer can be someone other than the lead state regulator.
If not, we suggest removing the phrase “and template reviewer” as it appears to be redundant and
confusing. If there are intended to be multiple reviewers, we renew our concerns about the use of this
tool by any party other than the lead state regulator.

V.A.37: Given that the GCC analytical procedures in the Financial Analysis Handbook are still undergoing
development, it is not possible to speak in any but the broadest way about analytics. Probably, the
description should be limited to the statement, “This tab includes or draws from entity-category-level
inputs reported in the Tab or elsewhere in the GCC template to be used in GCC analytics.”

Instructions Comments – Additional Concerns

We provide the following as some additional considerations for revisions to the instructions.

I.A.7. In the third sentence of this paragraph, the phrase “similar such as” appears to be an editing error.
We suggest revising the sentence as follows.

The GCC instructions and template are intended to be modified, improved and maintained by the NAIC in
the future, similar such as are existing tools such as the Accounting Practices and Procedures Manual, the
Annual Statement Instructions and Risk-Based Capital formula and Instructions.

Also, we suggest deleting the final sentence of the paragraph. While “additional items, such as stress
testing” may still be considered open, they are not relevant to the instructions for the current version of
the GCC.

II.C.12: It is not clear exactly what is meant to be included in “cross support mechanisms.” We would ask
the work group to consider the following when working to define “cross support mechanisms”:

• Is this limited to formal, legally enforceable financial guarantees among members of the group?
• Does it matter whether such guarantees can only result in payment to insurers, not from
  insurers?
• Can the definition of “cross support mechanisms” ever result in the ultimate controlling person being out of scope?
• If the ultimate controlling person is always in scope, would all of its subsidiaries of material size automatically be in scope, since they could have a material impact on the ultimate controlling person?

II.C. 13.: The last sentence of this paragraph says, “Consistent with sound regulation, the benefits of the quantitative analysis facilitated by the GCC should exceed the cost of implementation.” We question why this is referenced as part of the instructions. We do not believe there has been an attempt to quantify the benefit of the GCC; and, in fact, the procedures for how the GCC will be used in practice are only now being developed. Until we know how the GCC will be employed, it seems to be premature to include an assertion about its benefits here. We also suggest that any attempt at determining the “cost of implementation” needs to take into consideration other tools regulators are mandating that carriers complete, such as the ORSA and Form F, and the legal entity grid, all of which were similarly described as tools to assist in group supervision.

II.E.17.: Early in the development of the GCC, the NAIC stated that one of the fundamental principles underlying the calculation was that it would ignore group structure; an entity would be treated essentially the same, regardless of where it was positioned in the group. That principle was relaxed somewhat for subsidiaries of insurers, to try to maintain consistency with RBC as much as possible. Now it seems to have been abandoned altogether, since a non-financial entity that is not part of the “Insurance Group” may be excluded from the scope of the GCC, whereas an otherwise identical entity that is part of the “Insurance Group” must be included. In the current draft, it appears that even the ultimate controlling entity may be excluded from group scope, despite clear influence in the group on corporate governance and capital allocation. Given the definition of “Insurance Group” (paragraph IV.23), this could lead to the inclusion of a non-financial subsidiary that has no connection to the insurance operations other than being owned by the same holding company as the insurers in the group. The rationale for this disparate treatment is not at all clear. Overall, the working group should not create a GCC that leads to preferential group organizational structure.

II.E.18.: This paragraph introduces the concept of exclusion being justified by the determination that the entities excluded “do not pose material risk to its [i.e., the group’s] insurance operations.” This seems eminently reasonable. It is not clear why that same concept should not be adopted to resolve the problem noted in the comment above on paragraph II.E.17.

Section III: There is no Section III. We assume this is merely a tabulation error and not an entire section that has been omitted.

IV.23: With regard to the definition of “Insurance Group,” please see our comment above on paragraph II.E.17. As currently defined, the “Insurance Group” is not limited to the insurers within a group and their own subsidiaries. Merely being owned by the same intermediate holding company that happens to own the insurers in the group is enough to make a non-financial entity part of the insurance group. This does not seem reasonable. The “Insurance Group” should be defined to exclude any non-financial entities that are not actually owned by the insurers.

IV.28: The “Ultimate Controlling Person” is defined to be, “As used in the NAIC’s Insurance Holding Company System Regulatory Act (Model #440).” Model #440 does indeed use the term, but while it defines “control” and “person,” “ultimate controlling person” itself is never defined—that is, there is no
explanation of what “ultimate” means. This seems an important concept that should be defined more precisely, especially since the “head of the Insurance Group” may be distinct from the “Ultimate Controlling Person.”

IV.30: The definition of “Affiliate” applies an inappropriate threshold for materiality to Schedule A and Schedule BA assets, based on the capital of the insurance entity that owns the asset. The GCC is intended to be a measure of the group’s capital, and any materiality threshold should be set relative to the entire group (insofar as it is in scope), and not relative to any individual entity within the group. Note, in fact, that paragraph VI.51 states a materiality criterion for Schedule A and Schedule BA assets based on the capital of the group, not the entity that owns them.

VI.54: The instructions call for the reporting of all dividends paid within the group. This is significant—and, in the context of a balance-sheet-oriented calculation, unnecessary—additional burden. We note that in many cases, a dividend may pass through one or more holding companies before it reaches its final destination (e.g., from insurer to intermediate holding company to ultimate controlling person). Seeing the same dividend being recorded multiple times is very likely to create confusion. We suggest it would be more useful to show, for each entity, only the net of dividends paid and dividends received. In that case, the columns for Dividends Paid and Dividends Received could be collapsed into a single column. Also, it is not clear that the Yes/No response in the Dividends Received and Not Retained column is useful, as it relies on what is “expected” rather than what is certain; a better approach might be to include dividends declared but unpaid in the column for dividends.

Also with regard to paragraph VI.54, we question how meaningful it is to designate some capital contributions as being funded from debt proceeds. There may be a lag between when debt proceeds are received by the debt issuer and when capital is contributed to a downstream entity; how long may the lag be before the capital contribution is no longer considered to be “from debt proceeds”? Also, if a parent makes a capital contribution when needed, and then subsequently replenishes its own capital through debt issuance, shouldn’t that be deemed to be essentially the same as receiving the debt proceeds and then infusing them into the subsidiary? Furthermore, debt-funded capital injections may well survive the maturity of the debt. Because cash is fungible, it does not seem to be a worthwhile effort to try to determine the particular source from which a capital contribution was funded. We recommend that if holding company debt is to be included in capital, then the limitation should be the insurance entities’ total paid-in capital.

VI.56: We point out that intra-group guarantees, solvency reinsurance, and capital maintenance agreements typically do not have notional values. Moreover, triggering of these arrangements has historically been very unlikely. In an earlier communication from the NAIC on this subject, the estimated notional value was weighted by expected utilization. This weighted approach should be used here.

**Comments on the Template**

Although we understand the need to have a tool that quantitatively calculates group results, we suggest it is inappropriate to use the tool as a way to simply gather information about unregulated entities that do not impact the results of the GCC calculation itself, especially as most of this information is available to regulators from other filings. The following are examples of the information being collected that does not impact the results of the calculation:
- a significant amount of information related to trend analytics, which on the legal entity basis are not meaningful to the calculation;
- Reinsurance Assumed from Affiliates and Reinsurance Ceded to Affiliates. We question the relevance of the information to the calculation and note that this information is readily available in the annual statements;
- the notional values of both Intercompany Guarantees and Capital Maintenance Agreements, because 1) most, like insolvency reinsurance, have no stated value or have values that are based upon a calculation and not a fixed amount; and 2) in practice, these have extremely low probability of triggering guarantor action (earlier versions of this analysis weighted any notional amount by currently expected use);
- the value of intangible assets;
- descriptions related to intragroup assets; the values of some intragroup assets are also asked for on the Questions tab;
- descriptions related to reported adjustments;
- dividends paid and received;
- how downstream debt proceeds are tracked; and
- a listing of Schedule A and BA assets, which can easily be found in the NAIC financial statements.

Thank you for the opportunity to provide our input. We believe that addressing the issues we raise above will lead to the GCC being a more useful tool for regulators.

Sincerely,

James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Kathryn Belfi, Vice-Chair, Group Capital Calculation Working Group
    Dan Daveline, NAIC
    Randi Reichel, UnitedHealth Group
## Comment Summary - GCC Template and Instructions

**July 29, 2020**

<table>
<thead>
<tr>
<th>Issue 1</th>
<th>Commenter</th>
<th>Essence of Comment</th>
<th>Primary Rationale</th>
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</thead>
<tbody>
<tr>
<td>Use of the GCC</td>
<td>ACLI</td>
<td>Concerned that some aspects of the instructions and preliminary Draft Analysis Handbook infer a GCC that goes beyond its objective and would turn the GCC into a binding standard or constraint.</td>
<td>General comment but likely consistent with United HealthCare rationale</td>
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<td>United HealthCare</td>
<td>Key area of concern is the statement that “insurance companies may be subsidizing the operations of non-insurance entities, potentially undermining the insurance company’s financial condition.”</td>
<td>The idea that non-insurance operations within the group pose a proximate risk to the solvency of the group’s insurers has little historical evidence to support it.</td>
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<td>Another concern arises from the statements in that the GCC “provides an additional early warning signal so regulators can begin working with a company to resolve any concerns” and will “allow them to make informed decisions on both the need for action.”</td>
<td>It seems inappropriate to suggest that the GCC, in and of itself, would be grounds for regulatory action to protect policyholders; that is the function of a regulatory standard, not an analytical tool.</td>
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<td>Concern that the instructions as written may not make clear that the GCC is intended to be used solely by the lead state regulator.</td>
<td>The statement, “State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to “allow them to make informed decisions on both the need for action, and the type of action to take,” suggests that the GCC will be used by the domiciliary regulator of each insurer.</td>
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</table>
Initial NAIC Staff Comments:

Some of the Introductory wording could be revised and/or moved to the Analysis Guidance being drafted & reviewed by the drafting subgroup, particularly with reference to cross subsidization. Comments on other thresholds applied in the analysis guidance can be addressed there. Staff notes that industry representatives are assisting in revising and reviewing the analysis guidance.

Although the GCC in totality can be viewed as an early warning vehicle, the GCC ratio itself is just one piece. This is similar to other analytical tools. Early warning is distinct from capital standard driving statutorily authorized regulator action. Although made clear throughout the GCC process that it will not be a capital standard, clarification of language to avoid any such inference will be considered.

As a group rather than entity-based tool, the submission itself is limited to the lead-State regulator (s/b addressed in Model Holding Company Act), it seems logical that post review regulatory concerns may be shared with other involved regulators in collaborative forums. Staff will look at the suggested language. Staff recommends that a 300% calibration be retained for a group-wide analytical tool that compliments entity-based RBC. The working group should consider whether using CAL or lower could imply that some specified regulatory action is imminent, especially within the context recommended by some commenters that risk charges mirror entity RBC. Staff believes that would add confusion between RBC as a standard and GCC as an analytical tool. Using a level above CAL RBC is consistent with a regulator analytical tool and consistent with an RBC reference point (Trend Test). Further it applies a reference point that is agnostic to the structure of the group.

A secondary issue is ability to be somewhat consistent with the AM – ICS being proposed by the NAIC in cooperation with other U.S. regulatory partners.

Staff believes that issues related to calibration are better addressed via the working group decisions on the definition of a financial entities, level of post covariance charges to be applied to non-financial entities, and definition of material risk for purposes of potential exclusion of entities from the calculation.

Staff agrees that there should be careful coordination between the GCC Template, and the analysis guidance as regards the level of the GCC ratio. Staff notes that industry representatives are assisting in revising and reviewing the analysis guidance.

<p>| Calibration Level | ACLI Global Atlantic Prudential | Adopt a 200% ACL calibration level for the GCC. In addition, calibrations of other factors and regimes should be based on 200% ACL level RBC as well. | Inconsistent with RBC reporting and industry’s current reporting of two capital calibration levels, (100% ACL and 200% ACL) results in confusion and frequent misinterpretation of reported ratios; adding a third calibration level for the GCC of 300% ACL will compound the problem. This will lead to additional confusion and misunderstanding by users of financial information, including the regulatory, rating agency, and banking communities. |
| United HealthCare | Lower 300% Calibration (consider lower than 200%) and/or add a diversification component | The calibration does not adequately consider the capital mitigation in diversified integrated holding company systems. |</p>
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<th>Issue 3</th>
<th>Commenter</th>
<th>Essence of Comment</th>
<th>Primary Rationale</th>
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</table>
| **Scope of Application** | AHIP, APCIA     | GCC Instructions should explicitly state that non-material entities (including financial) within the Broader Group (but outside the Insurance Group) should be excluded from the Scope of Application.          | All entities that meet the broad definition of “financial” in the GCC Instructions do not necessarily pose material risk (as defined above) under all circumstances.  
The fact that an entity would be classified as “financial” should be weighed as a factor in the materiality analysis. |
|          | State Farm     | Requests that excluded entities not be required to be on the Inventory Tab or, at least, the Lead State Regulator have the discretion to not require excluded entities on the Inventory Tab if requested by the preparer. | Gathering information under the GCC from entities that are excluded from the GCC seems counterintuitive and duplicative in certain situations.                                                                                     |
|          | State Farm     | State Farm questions why the Draft Instructions do not allow exclusion of immaterial financial or insurance entities that are isolated from the group as are non-financial entities. | Acknowledging the isolation of financial and insurance entities fits within already existing regulatory arrangements as well as the GCC and acknowledges that capital is not freely fungible for use by the group or entities within the group. |

**Initial NAIC Staff Comments:**

Staff believes that given prior problems (e.g. during the financial crisis) with financial entities, some that appeared immaterial at the time, all financial entities should initially be included in the calculation for both risk and consistency purposes. Staff does appreciate the comments on the breadth and targeting of defining certain affiliates as financial entities as that was one of several areas of the instructions where comments were specifically requested and agrees that revisions are appropriate. The prior and current versions of the instructions do identify some financial entities without regulatory capital requirements with closer reference to their activities, so the working group could consider revisions targeted more specificity related to activities of financial entities.

The instructions currently limit the amount of data that is required from entities that the lead-State regulator agrees should be excluded.
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<th>Issue 4</th>
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<th>Essence of Comment</th>
<th>Primary Rationale</th>
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<tbody>
<tr>
<td>Excluded entities / Material Risk</td>
<td>ACLI, AHIP, APCIA</td>
<td>GCC Instructions should provide a definition of “material risk” for purposes of the Scope of Application as follows “risk emanating from a non-insurance entity that is of a magnitude that would adversely impact a group’s insurance operations and its ability to pay policyholder claims.” GCC Instructions should provide a principles-based definition of “material risk” for purposes of the Scope of Application. Suggest that “material risk” should be defined as “risk emanating from a non-insurance entity that could adversely impact a group’s insurance operations and ability to pay policyholder claims.” APCIA recommends developing a list of factors related to whether an entity could adversely impact a group’s ability to pay policyholder claims. (List included in letter – Page 2). No single factor is determinative of materiality of risk, nor should these factors be used as a scorecard or checklist.</td>
<td>• Follows the fundamental reason for state insurance regulation and the stated objective of the GCC: policyholder protection. • Is in accordance with international standards. For example, under ICP 23. • Given the diverse structures and business models of insurers, it would be impracticable to develop a one-size-fits-all checklist of guidelines that would be useful for materiality determinations across all groups. • Form B and D processes and Enterprise Risk Reports entail similar considerations and are already enshrined in the state regulatory process. Insurers and regulators could then use these factors to undertake a materiality analysis based on the totality of the facts and circumstances by considering the factors and how they apply to the group’s business.</td>
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<td>State Farm</td>
<td>Requests a baseline materiality definition be provided while maintaining Lead State Regulator discretion to determine if a higher or lower material threshold is appropriate. Suggests a group equity threshold for materiality with a drafting note suggesting 5% threshold subject to regulator discretion</td>
<td>There should be some consistency in application under these provisions and that materiality should be based on the group’s net worth given the GCC is measuring risk of the group and not a particular entity in the group. Baseline for materiality while still allowing the Lead State Regulator and the preparer to use a higher or lower threshold given circumstances presented by the preparer.</td>
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Initial NAIC Staff Comments:
Staff agrees that materiality of risk is important in deciding whether to exclude non-financial entities. Staff supports a definition to promote consistency in completion of the GCC. We are supportive of principles-based criteria being included in the instructions. We are also supportive of quantitative Criteria if preferred by the working group but recognize that there has not up until now been coalescence around a single quantitative benchmark.

See staff comments above under Scope of Application (Issue #3) regarding financial entities.
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<th>Issue 5</th>
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<th>Primary Rationale</th>
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<tbody>
<tr>
<td>Grouping</td>
<td>Prudential</td>
<td>Supports flexibility of current grouping language, but state regulators should retain the option of requesting more granular information should they feel it is needed to obtain a sufficient view of risks within the group.</td>
<td>Self-Explanatory</td>
</tr>
</tbody>
</table>

**Initial NAIC Staff Comments:**
Although staff believes this is implicit, we support adding explicit language.
<table>
<thead>
<tr>
<th>Issue 6</th>
<th>Commenter</th>
<th>Essence of Comment</th>
<th>Primary Rationale</th>
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</table>
| Definition of Financial Entities | AHIP                   | Disagrees with the notion that certain affiliates are inherently riskier than others and more generally with the expanded definition of financial affiliates. Third-party administrators and pharmacy benefit managers, provider groups, and pharmacy benefit managers should not be considered financial entities. | • There is a wide array of types of non-affiliated entities within insurance groups, and it is overly simplistic to conclude that all that are somehow associated with assisting the insurer with contract performance or policyholder services are inherently riskier than others.  
• Form B and D processes recognize that transactions with affiliates may have risks. |
|        | APCIA                  | APCIA is concerned with the expanded definition of financial entity in the GCC.                                                                                                                                                                           |                                                                                                                                                                                                                                         |
|        | United HealthCare      | Base comments are similar to AHIP Comments.  
This is amplified by lack of diversification credit for the wide array of entities defined as “financial”                                                                                                                                 | • Affiliates that merely provide contracted services to a carrier should not be defined as “financial”: they do not create any more financial risk to their affiliated insurers than do non-affiliates that provide the same services to other insurers.  
• Some of the examples given diversify risk for the insurance entity in the group, facilitating more access to capital by the insurance entity. The aim of the working group should not be to promote smaller, less integrated or diversified groups.  
• Greater regulatory oversight to certain currently defined entities and regulatory review of intercompany agreements should be considered to reduce the group’s risk. |

Initial NAIC Staff Comments:
Staff appreciates the comments on the breadth and targeting of defining certain affiliates as financial entities as that was one of several areas of the instructions where comments were specifically requested. The issue of an appropriate definition of financial entities impacts other concerns identified in the comments including, calibration, scope of application, materiality of risk, and consistency across group structures. The instructions currently do identify some specific financial entities without regulatory capital requirements and some associated activities, so the working group could consider more specificity related to activities based on the activities of those identified entities. As intended, staff also believes that the quantitative aspects of the GCC in the context of a regulatory view, as well as the additional data supporting analytics does compliment rather than overlap the benefits of other regulatory filing requirements.
<table>
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<th>Issue 7</th>
<th>Commenter</th>
<th>Essence of Comment</th>
<th>Primary Rationale</th>
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<tbody>
<tr>
<td>Treatment / Charges</td>
<td>ACLI</td>
<td>To the extent that there are differences in the GCC and legal RBC treatment for subsidiaries that have been de-stacked and reported separately from their legal entity parent, then it seems desirable for the GCC and RBC treatment to align. To the extent that there are differences between the two, we recommend the Working Group explain the rationale for the difference (e.g., achieving substantial consistency in charges regardless of corporate organizational structure) and, if appropriate, refer the issue to the appropriate RBC working for further dialogue.</td>
<td>ACLI believes that the GCC should be consistent with the legal entity rules applied to insurance legal entities – including the subsidiaries of insurance legal entities. In the long run, we believe this approach will benefit regulators and the industry by promoting a more consistent and up-to-date risk framework.</td>
</tr>
<tr>
<td>Financial Entities</td>
<td>AHIP</td>
<td>Recommends applying the equity-based capital charge that is recommended for non-financial affiliates to all affiliates that are not subject to a regulatory capital requirement.</td>
<td>Subjecting these entities to a capital charge for financial entities (12% of 3-year average gross revenue – possibly to be increased to 15%) could result in a significant additional charge as compared to current RBC.</td>
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<td>APCIA</td>
<td>in the short term, use a capital charge that is roughly equivalent to the current post-covariance charge <em>(presumably equity charge)</em> for such affiliates in RBC.</td>
<td>Over the first few years of the GCC’s implementation, data can be collected and used to derive a more risk-sensitive charge that is pragmatic (e.g., a differentiated charge for entities of high/medium/low risk as determined by specified criteria).</td>
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|                            | Prudential| Supports adopting a single approach for establishing a proxy capital measure for all financial entities that are not subject to a regulatory capital requirement. Supports a method that most closely aligns with how the AM - ICS will ultimately treat this item.                                                                atoire | • Ensuring state regulators obtain adequate insight into the entities within the insurance group and risks associated with them is the key point of consideration for these entities and this is best accomplished through the inventory element of the GCC as opposed to an arbitrary proxy capital calculation.  
• To the extent a state regulator believes an entity poses material risk to the group, they have discretion to request additional information to understand the risks. |
Initial NAIC Staff Comments:
Staff notes that as a complimentary group analytical tool covering entities other than those owned by RBC filer, total consistency with RBC is not entirely relevant, particularly for financial entities. Staff does agree that the Capital Adequacy Task Force should determine whether the treatment of financial entities in the GCC is relevant for U.S. Insurer entity-based RBC. This can be tasked to the current Ad Hoc Affiliates Subgroup or directly to the RBC Working Groups.

Staff agrees that an overarching explanation of where differences exist is helpful.

Staff does not recommend using a post covariance charge for most financial entities that are not subject to a regulatory capital charge. Properly defined financial entities can pose additional non-diversifiable risk. Staff agrees that a narrower more activities focused definition of such financial entities will address many stated concerns.

Staff recommends continuing a revenue-based / enhanced operational risk type charge. Up until this point there seems to have been more agreement around a revenue-based charge for these entities.

Staff has no issue with treating all financial entities that are not subject to a regulatory capital charge the same at least initially. The only current difference is whether to use a 3-year average revenue (currently used for asset managers) or current year revenue only (currently used for other financial entities that are not subject to a regulatory capital charge) as the base used to apply the charge.

Staff supports the 15% charge as reflective of a 300% calibration and consistency whether where international standards are headed but understands that the working group may consider a scaled version as a starting point for the near-term. Staff supports the proposal to consider refinements over time for financial entities not subject to a regulatory capital requirement in order to be more risk sensitive along the lines of the low / medium / high approach suggested by APCIA (e.g. lower risk entities could go with the post covariance non-financial entity charge / medium risk entities, a scaled revenue-based charge / and high risk entities, the full revenue based charge).
<table>
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<th>Issue 8</th>
<th>Commenter</th>
<th>Essence of Comment</th>
<th>Primary Rationale</th>
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<tbody>
<tr>
<td>Treatment / Charges - Non-Financial Entities (incl. material non-financial A / BA)</td>
<td>ACLI</td>
<td>ACLI was unable to discern how the proposed charges for “other non-insurance/non-financial entities” and “material Schedule A/BA entities” were created.</td>
<td>Further clarification on this issue is necessary, including an explanation of why the Working Group is recommending a novel approach that has not been subject to field testing.</td>
</tr>
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</table>
| | AHIP | Risk charges for non-financial entities should be equal or very similar to the current charge in the sectoral RBC formulas, i.e., 3% post-covariance charge in the case of health insurers. | • The GCCWG has not provided data to suggest that a more substantial risk charge is needed to protect policyholders.  
• Form B and D processes are already in place to ensure that the regulated legal entity is protected from the non-regulated, non-insurance entity. |
| | APCIA | During the first few years of the GCC’s implementation use 3% of 3-year average revenue. Once some experience is gained with the GCC, the Working Group should consider a simple variable risk charge (low / medium / high risk charge) that is more risk-sensitive based on industry and activity. | A period during which experience will be gained that can then be analyzed in more detail and across more groups than was possible in field testing. |
| | Prudential | Supports adopting a single approach for establishing a proxy capital measure for all non-financial entities | See rational for financial entities. |
| | United HealthCare | Charge should be based on the group specific after covariance equity charge. | Using an average industry post covariance charge is not reflective of the proportion of insurance vs. non-insurance business within a group. |

**Initial NAIC Staff Comments:**

Once materiality of risk has been established, Staff supports a post covariance equivalent equity-based charge that is broadly consistent with RBC treatment for non-financial entities that are “included” in the GCC. The current template uses a single average post covariance factor across all industry types, but Staff believes that an industry specific charge has merit. A group specific charge was previously tested and could be considered by the working group, but unlikely to have a significant impact on the GCC. However, NAIC Staff would be interested in information to the contrary by a group that has run the numbers given that the NAIC will not be receiving the GCC filings.

Staff supports the suggestion to make future refinements based on continued collection of data but again notes that NAIC will not have access to the submissions.
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<th>Issue 9</th>
<th>Commenter</th>
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<th>Primary Rationale</th>
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</thead>
<tbody>
<tr>
<td>Allowance for Debt</td>
<td>ACLI</td>
<td>The current debt caps are too restrictive.</td>
<td>• Could negatively impact a group’s ability to prudently manage capital and liquidity risks.</td>
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<td></td>
<td>Prudential</td>
<td></td>
<td>• Tying the constraint to a percentage of the group’s available capital embeds an undesirable element of procyclicality into the GCC, because a company’s available capital is likely to decrease in times of stress, especially if markets crash.</td>
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<td>United HealthCare</td>
<td></td>
<td>• The 30% factor for senior debt and 15% for hybrid debt are being applied to a more conservative base than rating agencies use for establishing limits</td>
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<td>ACLI Prudential</td>
<td>Requirements for tracking the down-streaming of debt issuance proceeds to regulated entities should be eliminated.</td>
<td>• Adding a limit of 50% of total adjusted carrying value to the conservative 30% and 15% limits for senior and hybrid debt (relative to total adjusted carrying value + outstanding senior and hybrid debt) effectively lowers the 45% permitted (i.e., 30% + 15%) to approximately 33%.</td>
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<td>United HealthCare</td>
<td></td>
<td>• Interpretations related to how to support “tracking” will be difficult to verify and may lead to inconsistencies across groups.</td>
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<td></td>
<td>ACLI</td>
<td>Remove the call option criteria, because the exercise of a call option is typically followed by refinance of the instrument which supports its permanence and structural subordination.</td>
<td>• Keeping funds at the holding company level is a prudent strategy that provides insurance groups flexibility to quickly and easily manage capital and liquidity needs across the group.</td>
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<td>• A tracking requirement could give rise to unintended consequences such as reducing the availability and fungibility of capital resources and forcing U.S. insurance groups to issue greater amounts of debt.</td>
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<td>Relative to the 5-year term, the presence of call options should not prevent a capital instrument’s inclusion as a qualifying instrument. Call options are a common feature of U.S. issued capital instruments.</td>
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</table>
| Allowance for Debt | Global Atlantic | • Simpler, more efficient, and more reliable test  
• Avoids complications that could result from debt that has been refinanced by the parent as there would be no contribution of the debt amount issued.  
• Avoids complications of tracking upsize transactions where debt is borrowed at one date and then down streamed at a different date.  
• Avoids complications of tracking the reverse: dividends which are up streamed. Are those upstream transactions to be netted against down streamed capital or not?  
• Avoids complications and questions related to M&A transactions – if a company is acquired, does the new parent company automatically assume the historical relationship of down streamed debt, so long as its debt at least equals the debt of the old parent company? |
|---|---|---|
| APCIA | The treatment of debt differs in some key respects from that which was adopted by the International Association of Insurance Supervisors (IAIS) in the Insurance Capital Standard (ICS) in 2019.  
The GCC could be viewed as less credible by other jurisdictional supervisors including those who may be parties to a Covered Agreement. Comparability of the GCC with the ICS is a looming issue on the horizon, the resolution of which can impact the views of many IAIS member jurisdictions about the efficacy of state-based regulation over U.S.-based insurance groups. | |
| FED BBA | More closely aligned with the principles-based criteria in the ICS than with the approach taken in the exposed GCC Instructions | |
| Working Group | Working Group may need to supplement the GCC Instructions with definitions for each type of instrument. For example, “hybrid debt” is not defined in the Instructions | • Rating agencies treat subordinated debt issued by a parent company as “hybrid debt” if it is long-dated and has provisions to defer interest payments for a period of time. This could give rise to variation in treatment of hybrid debt (e.g., it may be unclear to a group if it should classify it as “hybrid” or as “subordinated” debt)  
• Comparability with the ICS needs to be considered, and on this point it seems that the more important issue is not whether types of debt are called out by name or more generically by tier, but whether comparable criteria to the ICS are used. |
<table>
<thead>
<tr>
<th>Allowance for Debt</th>
<th>APCIA</th>
<th>Replace terminology “additional capital allowance” with “within supervisory limits”.</th>
<th>Focusing the Instructions’ text on “limits”, rather than ‘allowance’, will help in some respects with perceptions about comparability.</th>
</tr>
</thead>
</table>
|                   |       | Add criteria supporting structural subordination to “Tracked Down-streamed Debt” proceeds rather than eliminate that test. | • Team USA argued long and hard to support structural subordination in the ICS.  
• While down-streaming has raised many questions about how debt proceeds can be tracked and verified, the ICS criteria are workable and rely in large measure on each group and its group-wide supervisor to make that determination in light of the unique facts and circumstances.  
• The IAIS avoided prescribing detailed rules or criteria for tracking. APCIA believes the NAIC should do the same in the GCC, leaving the determination of the amount down streamed to the lead state working in conjunction with the group.  
• This would include criteria to support that the qualifying amount of debt to be treated as capital is actually subordinated (either contractually by the terms of the instrument, or structurally), and other principle-based criteria, as in the ICS, to support permanence, loss absorbency, etc. Some refinement of the ICS criteria may be necessary to address U.S.-specific nuances for the GCC. |
|                   |       | Another option to test structural subordination is to limit the amount of senior debt to qualify as capital to that which is in excess of the liquid assets in the holding company. | As a practical matter, the lender would have recourse only to the liquid assets that remain in the entity that issued the debt (i.e., the holding company in the case of senior debt). The unconsolidated balance sheet of the holding company (reflects a very large, illiquid investment in insurance subsidiaries, control over which is subject to regulatory oversight and approval. |
|                   | APCIA | APCIA is open to the possibility of some allowance for other debt in the future. | Self-Explanatory |
|                   |       | It would seem appropriate that the overall limitation should apply to all debt, including surplus notes and |  |
### Initial NAIC Staff Comments:

Staff is open to eliminating the tracked down-streamed option as suggested by some commenters. The arguments put forth by APCIA are relevant, however, structural subordination is strongly represented by insurer paid in capital and surplus which has the most rigorous regulatory control over distributions.

Staff is sympathetic to the point that the proxy allowance for Senior Debt is applied to regulatory available capital rather than GAAP available capital and the 50% limit of otherwise available capital could be adjusted upward if the working group concurs. Staff would initially suggest no more than 75% in order to balance the point raised with recognizing that there is no tiering of capital in reference to the ICS and that the GCC applies the limits to the larger base of available capital rather than required capital.

Staff understands the issue of including Foreign Debt in the limit. However, fully including contractually subordinated debt already recognized by a regulatory authority as capital and included in the carrying values in Inventory B (e.g. U.S. surplus notes and contractually subordinated foreign debt) seems consistent from a regulatory perspective. Staff agrees that foreign senior and hybrid debt that is not included in the value of an entity in Inventory B should be included within the limit.

Staff has some concerns about the APCIA alternative methodology as it may provide too much of an allowance since large groups may rely on illiquid assets at the holding company level and the method would seem to result in including the entire book value of insurers in the group.

Staff supports the suggestion to continue to collect data on “Other Debt” for purposes of future refinements but notes that NAIC will not have access to the filings.

Staff will review language for clarity considering edits provided and definitions of debt instrument types.

Staff will follow-up on the issue of terminology “additional capital allowance” vs. “within supervisory limits” but notes that there is currently no GAAP or SAP allowance for subordinated debt other than surplus notes (so the supervisory limit is essentially zero per accounting requirements). The GCC provides an on top allowance that reflects a supportable proxy alternative for structural subordination.

Allowance for Debt as additional capital is an area of potential divergence between the GCC and AM-ICS.
<table>
<thead>
<tr>
<th>Issue 10</th>
<th>Commenter</th>
<th>Essence of Comment</th>
<th>Primary Rationale</th>
</tr>
</thead>
</table>
| Scalars  | ACLI      | Use the Excess Approach over the Pure Approach. Use the Excess Relative Ratio Approach for scaling non-U.S. capital ratios to U.S. RBC. | • This method utilizes two anchor points for scaling.  
• The Pure Relative Ratio lacks a mechanism to ensure that a non-U.S. firm at the regulatory intervention level within its respective country will be at the U.S. RBC intervention level once scaled.  
• The Pure Relative Ratio Approach fails to adequately account for key differences in insurance regimes (e.g., level of conservatism embedded in reserves versus required capital, different valuation and asset admissibility standards, etc.).  
• The decision would prejudge the Pure Relative Ratio Approach as the methodology that should be adopted for the AM and could undermine the ongoing work at the NAIC’s work at the global level to secure recognition of the AM. |
|          | Global Atlantic | Transparency of how the scalars are calculated will be critical, regardless of which scaling methodology is selected | • Consistency – scalars should be calculated and applied consistently across all non-U.S. regimes.  
• Specificity – scalars should be discretely computed and applied amongst life, property casualty and health insurance companies.  
• Stability – the results of applying scalars to Non-U.S. capital ratios should not be volatile; for example, converting to U.S. RBC should not yield a significant headwind in one year, and a significant tailwind in the following year. |

Initial NAIC Staff Comments:  
Scalars remains an open issue. The use of the Pure Relative Ratio appeared to strike a good balance between precision, simplicity and ease of explanation.  
However, staff has no strong feelings between the two approaches and believes that the working group should be open additional approaches while maintaining a placeholder methodology.  
The working group should be aware of ongoing work on the AM-ICS as scalar methodology is an area of potential convergence between the GCC and AM-ICS.
<table>
<thead>
<tr>
<th>Issue 11</th>
<th>Commenter</th>
<th>Essence of Comment</th>
<th>Primary Rationale</th>
</tr>
</thead>
</table>
| Sensitivity Analysis | ACLI Prudential | Eliminate Sensitivity Analysis Tab altogether | • Narrowing the design of the GCC will ensure insurers, supervisors (domestic and foreign) and other stakeholders have a clear vision and understanding of what the GCC is (e.g., it would eliminate the need to distinguish between a “Base” view and alternative measures).  
• To the extent broader information on the insurance group is of interest to a state regulator, we believe it should be obtained through discretionary powers as opposed to embedding it in the GCC template. |
| Coalition | Supports Eliminating the XXX/ AXXX analysis in favor of a referral. | • The need for the GCC to adhere fully to legal entity rules in support of the state-based legal entity solvency system |

Initial NAIC Staff Comments:

Staff recommends against deleting the sensitivity analysis tab in its entirety. The XXX/ AXXX sensitivity test is in process of removal. The information contained in most other analysis points informs future decisions on capital charges, and more generally the primary purpose of the template as an analytical tool and should be retained for a period of time for further assessment of its value.

Staff understands that some of the sensitivity analysis will fall away as more finalized decisions on treatment of financial entities not subject to regulatory capital requirement and for treatment of non-financial entities and possibly on scalars are incorporated into the GCC template.

Staff believes that the data is more readily accumulated in the Sensitivity Tab from other parts of the template. Separating it would require additional work particularly for non-insurance entities.
<table>
<thead>
<tr>
<th>Issue 12</th>
<th>Commenter</th>
<th>Essence of Comment</th>
<th>Primary Rationale</th>
</tr>
</thead>
</table>
| Other Information Collected         | United HealthCare| Questions the rationale for collecting information on intangible assets (such as deferred acquisition costs, provider contracts, customer lists, and goodwill). | • The focus on intangible assets, to the exclusion of other types of assets, seems unwarranted.  
  • Regardless of their availability for sale, intangible assets do produce a stream of income to the group; otherwise, GAAP accounting would require that they be written down in value or written off entirely.  
  • As businesses rely more and more on digital assets and intellectual property as the basis for their operations, and less and less on fixed assets, there is more scrutiny of the value of those assets, and there should be less concern about whether the stated values are appropriate. We  
  • Both business trends and accounting changes have made the differentiation of “intangible” assets increasingly less relevant. |

**Initial NAIC Staff Comments:**
Staff notes that the GCC represents a regulatory view of group available capital. It is not intended that the value of intangibles allowed under GAAP, SAP or another accounting basis should be excluded. However, staff believes that there is some value in quantifying the extent that group capital is comprised of illiquid non-physical assets. This can provide good regulatory information in addition to the views of rating agencies or other group stakeholders.

Staff is comfortable with assessment of the value of the data collected in the Tab by the Analytics Guidance Drafting Group and making any adjustments accordingly.

| Issue 13                             | Commenter     | Other Technical Comments, Language Edits, Clarification requests and Second Tier Concerns | AHIP, APCIA, UHG |

**Initial NAIC Staff Comments:**
These items will be reviewed and accepted, adjusted or rejected after this meeting based on the direction taken in response to the comments discussed today.
The Group Solvency Issues (E) Working Group of the Financial Condition (E) Committee met via conference call July 29, 2020. The following Working Group members participated: Justin Schrader, Chair (NE); Jamie Walker, Vice Chair (TX); Susan Bernard and Kim Hudson (CA); Kathy Belfi (CT); Charles Santana (DE); Virginia Christy and Carolyn Morgan (FL); Kim Cross (IA); Cindy Andersen and Eric Moser (IL); Roy Eft (IN); John Turchi (MA); Judy Weaver (MI); Debbie Doggett and John Rehagen (MO); Diana Sherman (NJ); Dale Bruggeman (OH); Kimberly Rankin (PA); Doug Stolte (VA); and Steve Junior (WI).

1. **Adopted its 2019 Fall National Meeting Minutes**

Mr. Schrader stated that the Working Group last met at the 2019 Fall National Meeting, but also met Feb. 11, 2020, via conference call in regulator-to-regulator session, pursuant to paragraph 6 (consultations with staff on technical guidance) of the NAIC Policy Statement on Open Meetings.

Ms. Walker made a motion, seconded by Mr. Bruggeman, to adopt the Working Group’s Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Financial Condition (E) Committee, Attachment Seven). The motion passed.

2. **Heard an Update from the ORSA Implementation (E) Subgroup**

Ms. Belfi provided an update of recent activities of the ORSA Implementation (E) Subgroup, noting that the Subgroup met via conference call July 13 in joint session with the Risk-Focused Surveillance (E) Working Group. The meeting was held in regulator-to-regulator session, pursuant to paragraph 3 (discussions of specific companies, entities or individuals) of the NAIC Open Meetings Policy, to discuss takeaways from the 2019 Own Risk and Solvency Assessment (ORSA) Peer Review session and the development of potential changes to NAIC handbooks in response to those takeaways.

Ms. Belfi stated that as each of the NAIC handbooks containing ORSA review guidance are public documents, any revisions to such guidance will be discussed on public conference calls and subject to a public comment period. As such, the Subgroup plans to continue working in this area and schedule open calls to discuss the proposed revisions as necessary.

In addition, Ms. Belfi stated that the Subgroup has received inquiries from companies regarding regulator expectations for COVID-19 exposure and scenario analysis in ORSA filings. Ms. Belfi stated that the Subgroup intends to schedule a conference call to discuss regulator expectations and may develop some considerations for the industry in this area.

3. **Heard a Report on IAIS Activities**

Mr. Schrader provided a report on recent group-related activities of the International Association of Insurance Supervisors (IAIS), including the status of ongoing projects of the Insurance Groups Working Group (IGWG). While the efforts of the IGWG have been affected by COVID-19, virtual meetings continue to be held. As such, work continues to move forward on updates to the Application Paper on Supervisory Colleges to reflect revisions to Insurance Core Principle (ICP) 3 (Information Sharing and Confidentiality Requirements) and ICP 25 (Supervisory Cooperation and Coordination), which were adopted in November 2019.

The IGWG is also contemplating developing an application paper or training and educational materials on best practices supporting a supervisory assessment framework. The idea is to collect good supervisory practices from IAIS members supporting a group-wide supervisory assessment framework. These materials would be developed as a “members-only” document.
4. Discussed a Referral from the Group Capital Calculation (E) Working Group

Mr. Schrader stated that the Working Group received a referral from the Group Capital Calculation (E) Working Group requesting assistance in quantifying and evaluating the impact of XXX/AXXX reserves held by grandfathered captives on the group’s overall capital position. Mr. Schrader stated that a drafting group of several member states was formed to take up the request and will be reporting its results to the full Working Group.

5. Discussed Comments Received on ComFrame Gap Analysis

Mr. Schrader stated that the next agenda item relates to a new charge the Working Group received for 2020: “Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and make recommendations on its implementation in a manner appropriate for the U.S.”

Mr. Schrader stated that the IAIS adopted ComFrame on Nov. 14, 2019, which establishes supervisory standards and guidance focusing on the effective group-wide supervision of internationally active insurance groups (IAIGs). The intent of ComFrame is to help supervisors address group-wide risks and avoid supervisory gaps by supporting coordination across jurisdictions. ComFrame builds on, and expands upon, the high-level standards and guidance currently set out in the ICPs of the IAIS, which generally apply on both an insurance legal entity and group-wide level. There are ComFrame elements included in 10 of the 25 ICPs, as well as the ICP Introduction and Assessment Methodology. Consistent with the application of the ICPs, the minimum requirements established by ComFrame are expected to be implemented and applied in a proportionate manner. However, supervisors have the flexibility to tailor implementation of supervisory requirements and application of insurance supervision to achieve the outcomes described in ComFrame standards.

Mr. Schrader stated that as the IAIS has now finalized and adopted ComFrame, it is time for state insurance regulators to review and assess their implementation domestically. Mr. Schrader stated that while certain elements of ComFrame were already incorporated into the 2014 revisions to the Insurance Holding Company System Regulatory Act (#440), there have been several additions and enhancements to ComFrame since that time. As such, following discussions on implementation considerations at the 2019 Fall National Meeting, the Working Group asked NAIC staff to proceed with performing a ComFrame gap analysis to highlight any elements that might need to be considered for implementation in the U.S. system of state-based insurance regulation.

Mr. Schrader stated that in conducting the analysis, NAIC staff noted that many of the key elements of ComFrame have already been incorporated into the U.S. system through amendments to the holding company models, the establishment of ORSA requirements and other ongoing regulatory practices. NAIC staff also noted that some of the more prescriptive elements of ComFrame do not appear appropriate for the U.S. system and are not being recommended for consideration. However, NAIC staff identified certain other elements of ComFrame that do not appear to be fully addressed and should be considered for implementation.

Mr. Schrader asked Bruce Jenson (NAIC) to provide an overview of the results of the gap analysis performed, focusing on the key recommendations for consideration. Mr. Jenson stated that the key recommendations include proposed additions to the NAIC’s Financial Analysis Handbook and Financial Condition Examiners Handbook, as well as potential updates to the ORSA Guidance Manual for ComFrame elements. Mr. Jenson also recommended that the Working Group consider whether it is appropriate to require a Corporate Governance Annual Disclosure (CGAD) filing and/or ORSA Summary Report filing at the Head of the IAIG level to implement ComFrame elements. Finally, Mr. Jenson noted that ongoing projects of other NAIC groups will assist in implementing ComFrame elements in the areas of group capital, recovery and resolution planning, and liquidity stress testing.

Mr. Schrader stated that after the gap analysis was completed and a summary was provided to the Working Group, it was exposed for a public comment period that ended March 18. Five comment letters were received, and Mr. Schrader invited each commenter to summarize the key points from their letter during the meeting.

Tom Finnell (America’s Health Insurance Plans—AHIP) stated that while much of the ComFrame wording tends to encourage a centralized approach to IAIG monitoring and oversight, the introductory guidance and assessment methodology in the ICPs allow for additional flexibility in applying oversight to different types of insurance groups. Mr. Finnell stated that the gap analysis performed by NAIC staff appears to overlook some of these overarching concepts and overemphasizes review and
assessment of groupwide governance and control functions. Mr. Finnell also stated that the recommendation to require a groupwide ORSA Summary Report should keep in mind guidance in ICP 23 (Group-wide Supervision), which states certain entities or activities of the full group can be omitted from group supervision if there is no linkage that would cause risks to be transferred to the insurance operations. As such, Mr. Finnell encouraged regulators to engage in additional dialogue with the industry in assessing any ComFrame gaps and to put more consideration into the overarching principles allowing for flexibility in approaches.

Wayne Mehlman (American Council of Life Insurers—ACLI) stated that the industry would like to see more detail supporting the ComFrame gap analysis, including whether the proposed implementation efforts are intended to address the IAIS’ Holistic Framework considerations.

Mr. Bruggeman asked whether the proposed recommendations in the gap analysis are geared more towards meeting IAIS expectations than fitting with the U.S.’ existing system of state-based insurance regulation. Mr. Schrader stated that NAIC staff were asked to do a comprehensive gap analysis to identify any potential gaps and recommend potential enhancements to address those gaps. Mr. Schrader stated that it will be up to the Working Group to determine whether the potential enhancements are appropriate for incorporation into the existing system of state-based insurance regulation. Mr. Jenson provided an example of ComFrame language requiring a groupwide investment policy and oversight practices at the Head of the IAIG and noted that investment policies and practices outside of the insurance entities may not currently be within the scope of state analysis and examination functions. Mr. Finnell recommended that as regulators conduct their work in relation to various ICPs, they keep the overarching concepts in mind to determine whether reviewing all control functions from a groupwide perspective is necessary.

Stephen Broadie (American Property Casualty Insurance Association—APCIA) stated his support for additional discussion with the industry regarding the support for any gaps identified, as well as the importance of considering the overarching concepts in implementation activities. Throughout the ComFrame development process, interested parties expressed concerns to the IAIS regarding the language emphasizing a top-down approach to ComFrame, which may not be a good fit for the U.S. system given that groups are organized in so many different ways. As such, Mr. Broadie encouraged regulators to keep the overarching concepts and the existing U.S. system in mind in considering whether some of the more prescriptive elements of ComFrame should be implemented. For example, Mr. Broadie stated that the APCIA does not feel it is appropriate to require all IAIGs to file a CGAD and ORSA Summary Report at the Head of the IAIG level across the board. In addition, Mr. Broadie stated that interested parties would like to be involved in any detailed discussions around additions to NAIC handbooks to implement ComFrame elements.

Bill Schwegler (Transamerica) asked regulators how they intend to incorporate the IAIS’ Holistic Framework and whether that will be done in tandem with ComFrame implementation given how the guidance is comingled in the ICPs. Mr. Schrader stated that implementation of the Holistic Framework is charged to the Financial Stability (EX) Task Force, but the Working Group will need to coordinate efforts given that the two projects are so closely linked.

Mr. Jenson stated that the ongoing Financial Sector Assessment Program (FSAP) that state insurance regulators are participating in includes some review of ComFrame implementation. While the results of the FSAP have not yet been publicly released, the report is expected to be released in the coming weeks and will include comments and recommendations regarding ComFrame implementation. As such, regulators and interested parties should consider and evaluate those recommendations once they become available.
Mr. Shrader thanked interested parties for their comments and expressed a commitment towards working together to develop targeted enhancements to the U.S. system of stat-based insurance regulation to incorporate ComFrame elements, where appropriate. Mr. Schrader outlined a plan to form two drafting groups to develop proposed enhancements to NAIC handbooks for the Working Group to consider. In addition, Mr. Schrader recommended that the ORSA Implementation (E) Subgroup take on the project to consider ComFrame elements related to ORSA and risk management, as well as whether the CGAD and ORSA Summary Report should be received from the Head of the IAIG. Ms. Belfi stated her support for assigning this project to the ORSA Implementation (E) Subgroup.

Ms. Doggett asked whether the handbook drafting work should be referred over to the Risk-Focused Surveillance (E) Working Group. Mr. Schrader stated his preference for forming separate drafting groups as opposed to referring the work to another group and asked NAIC staff for their recommendation. Mr. Jenson stated that forming drafting groups under the Working Group would allow for states that act as group-wide supervisors of IAIGs to be more involved in the project.

Ms. Berry asked whether guidance related to the determination of the Head of the IAIG is intended to be addressed by one of the drafting groups. Mr. Schrader stated that he expects the analysis drafting group to review ICP 23 and incorporate guidance into the handbook in that area.

Having no further business, the Group Solvency Issues (E) Working Group adjourned.
Interpretation of the Statutory Accounting Principles Working Group

INT 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends

INT 20-08 Dates Discussed

Email Vote to Expose May 5, 2020; May 20, 2020; June 15, 2020, July 22, 2020

INT 20-08 References

SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets
SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items
SSAP No. 53—Property Casualty Contracts—Premiums
SSAP No. 54R—Individual and Group Accident and Health Contracts
SSAP No. 65—Property and Casualty Contracts
SSAP No. 66—Retrospectively Rated Contracts

INT 20-08 Issue

COVID-19

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

Refunds, Rate Reductions and Policyholder Dividends

2. The federal, state or local government orders requiring non-essential workers to “stay home” caused a significant reduction in commercial and non-commercial activity, including automotive usage. Some consumer groups wrote letters and issued press releases calling for insurance premium refunds or pricing decreases, which included specific comments directed toward consumer automotive lines. The comments presumed that the decrease in activity would result in fewer losses.

3. Many insurers began issuing voluntary premium refunds, future rate reductions or policyholder dividends because of the decreased activity. The majority of the refunds were related to automotive lines of business however, some accident and health products also provided payments. Insurers have provided the reductions in a variety of ways. Some of the rate reductions were specific for in-force policies, whereas some of the rate reductions would apply to future policy renewals. Insurers provided unprecedentedly large payments to policyholders in an expedited fashion. These payments were viewed by regulators and insurers as being in the best interests of policyholders.

Voluntary

4. The majority of the refunds or rate reductions are being offered voluntarily and are not amounts required under the policy terms. The aggregate monetary amount of the return of funds is considered materially significant.
Jurisdiction Directed

5. In addition, a few jurisdictions have issued bulletins directing refunds and rate reductions on accident and health insurance and varying lines of property and casualty insurance, including but not limited to: private passenger automobile, commercial automobile, workers’ compensation, commercial multiple peril, commercial liability and medical professional liability. In addition, some jurisdictions have indicated support for refunds or rate reductions, but also directed that payment of such amounts require either premium rate filings or policy form amendments.

Accounting Issues

6. This intent of this interpretation is to address questions related to refunds, rate reductions and policyholder dividends in response to the decreased activity related to COVID-19. Because there are a variety of ways that reporting entities are accomplishing a similar objective of returning money or reducing premiums, this interpretation provides guidance on the following issues:

- Issue 1: How to account for refunds not required under the policy terms.
- Issue 2: How to account for refunds required under the policy terms.
- Issue 3: How to account for rate reductions on inforce and renewal business.
- Issue 4: How to account for policyholder dividends.
- Issue 5: Where to disclose refunds, rate reductions and policyholder dividends related to COVID-19 decreases in activity.

INT 20-08 Discussion

7. As an overall guiding principle, the accounting shall follow existing statutory accounting principles and annual statement reporting where feasible with more specific accounting applicable for the issues within this interpretation.

INT 20-08 Consensus

Issue 1: How to Account for Refunds Not Required Under the Policy Terms

7-8. The Working Group reached a consensus that voluntary refunds, because of decreased activity related to COVID-19 and jurisdiction-directed refunds which are not required by the policy terms, are fundamentally a return of premium. Absent meeting the criteria for the limited-time exception to report as an aggregate write in for other underwriting expense as discussed in paragraphs 12-13, such refunds shall be accounted for as immediate adjustments to premium. The refunds shall be recognized as a reduction to written or earned premium and the unearned premium reserve adjusted accordingly.

8-9. Refunds shall be recognized as a liability when the definition of a liability in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets is met. For example, the declaration of a voluntary dividend by the board of directors will trigger liability recognition. In cases where the refunds are directed by a jurisdiction, the SSAP No. 5R definition of a liability shall be used to determine timing of liability recognition.

9-10. Immediate adjustment to premium is consistent with the existing guidance in SSAP No. 53—Property Casualty Contracts—Premiums. SSAP No. 53 guidance requires adjustments to the premium charged for changes
in the level of exposure to insurance risk. It is also consistent with the treatment of loss sensitive premium adjustments in SSAP No. 66—Retrospectively Rated Contracts. While some of the voluntary or jurisdiction-directed refunds may not be required by the explicit policy terms, the principle of reversing premium in the same way that the premium was originally recognized continues to apply.

11. Immediate adjustments to premium for voluntary accident and health premium refunds is also consistent with the guidance in SSAP No. 54R—Individual and Group Accident and Health Contracts on contracts subject to redetermination. While some of the voluntary or jurisdiction-directed refunds may not be required by the explicit policy terms, the principle of reversing premium in the same way that the premium was originally recognized continues to apply. The liability for voluntary health premium refunds attributable to COVID-19 and which are not required under the policy terms shall be recognized in aggregate write-ins for other liabilities.

Limited-Time Exception – Expense Reporting

12. Reporting the voluntary or jurisdiction-directed refund as an expense is not consistent with statutory accounting guidance. However, due to the variety of ways that COVID-19 premium reductions were approved by the various jurisdictions, this interpretation grants a limited-time exception to the existing reporting guidance to allow underwriting expense reporting. This limited-time exception applies to property and casualty lines of business in which the reporting entity filed policy endorsements or manual rate filings prior to June 15, 2020 which allow for discretionary payments to policyholders due to the COVID-19 related issues. In these cases, the reporting entities disclosed to the jurisdictions where the policies are written their intention to report their payments to policyholders as expenses. These property and casualty lines of business are permitted to report such policyholder payments as other underwriting expenses. This interpretation intends to be clear that manual rate filings and policy endorsements are not a source of authoritative accounting and this limited-time exception should not be used as an analogy for application to other such filings.

13. Application of this limited-time exception shall also be subject to the additional disclosures provided in Issue 5 below. Reporting the COVID-19 premium reductions as an expense as provided for in this limited-time exception, shall be disclosed as if it were a permitted practice. The reporting entity shall complete the permitted practices disclosures required by SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures in annual statement Note 1 and any other disclosures pursuant to Issue 5 of this interpretation. This interpretation provides a limited-time exception for reporting premium refunds, and does not require domiciliary jurisdiction approval as a permitted practice if the requirements of this interpretation are met. However, disclosure in Note 1 in a manner consistent with permitted practices is required because of the impact on premium which is a key measurement metric for insurers. If a domestic jurisdiction disapproved reporting as an underwriting expense, the limited-time exception does not apply.

42. Reporting the voluntary or jurisdiction-directed refund as an expense is not consistent with statutory accounting guidance and would inappropriately present the expense ratios in the statutory accounting financial statements. Reporting the refund as an expense, or any other method besides a decrease to premium, would be considered a permitted or prescribed practice and shall be disclosed as required by SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures:

a. Reporting the refunded amounts as a miscellaneous underwriting expense is not consistent with the underwriting expense description. This reporting option is inconsistent with the characterization of the amount as a return of premium.

b. Reporting the refunds as premium balances charged off (e.g., bad debt expense) is inconsistent with guidance in SSAP No. 53, paragraph 14, on earned but uncollected premium. It is also inconsistent
with the annual statement instructions as the amount is not an uncollectible amount, but rather a voluntary choice by the reporting entity to reduce the amount charged.

Issue 2: How to Account for Refunds Required Under the Policy Terms

While most of the premium refunds are voluntary or jurisdiction-directed and not required under the policy terms, some policies have terms that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses. If the policy terms change the amount charged, existing guidance in SSAP No. 53, SSAP No. 54R or SSAP No. 66 continues to apply:

a. SSAP No. 53 provides guidance for policies in which the premium amount is adjusted for changes in the level of exposure to insurance risk. This is often seen in commercial lines of business such as workers’ compensation. The guidance notes that audits often occur after the policy term or mid-term in the policy. SSAP No. 53 refers to the adjustment to premium (either due to the customer or to the insurer) as earned but unbilled (EBUB) premium. SSAP No. 53 requires such adjustment to premium to be made immediately either through written premium or earned premium. SSAP No. 53 also requires recognition of the related liabilities and expenses such as commissions and premium taxes based on when the premium is earned.

b. SSAP No. 54R provides guidance for policies subject to redetermination in which the premium is subject to adjustments by contract terms. This is commonly seen in federal and state groups. The guidance notes that estimates are based on experience to date and premium adjustments are estimated for the portion of the policy that has expired. Accrued return premiums are recorded as a liability with a corresponding entry to written premium. Refunds required under the policy terms would continue to be reported as retrospective or redetermination premium liabilities if applicable.

c. SSAP No. 66 provides guidance for policies whose terms or legal formulas determine premium based on losses. SSAP No. 66 references other applicable statements based on contract type for the initial accrual of premium. Estimates of premium adjustments are accrued based on activity to date and result in immediate adjustments to premium. SSAP No. 66 guidance specifies the corresponding annual statement reporting lines for different entity types.

Issue 3: How to Account for Rate Reductions

Some reporting entities are offering rate reductions instead of premium refunds. Some of these rate reductions provide one-time price decreases to future payments on in-force policies. Other reporting entities have provided offers of rate reductions on future renewals. Some of the offers for future rate reductions are only applicable to in-force policyholders as of a specified date. Some reporting entities have offered one-time rate reductions for future renewals for both existing and new policyholders for 2020.

a. Rate reductions on in-force business, shall be recognized as immediate adjustments to premium.

b. Rate reductions on future renewals shall be reflected in the premium rate charged on renewal. This is because it is outside of the policy boundary to require the accrual before contract inception. While the amount of future rate reduction can be estimated, it is not a change to existing policy terms and policyholders are not obligated to renew at the reduced rate, therefore, payment of the amount is avoidable. Such amounts shall be disclosed as discussed in Issue No. 5.
Issue 4: How to Account for Policyholder Dividends

15.16. SSAP No. 65—Property and Casualty Contracts, paragraph 46 requires that dividends to policyholders immediately become liabilities of the reporting entity when they are declared by the board of directors and shall be recorded as a liability.

16.17. The Working Group noted that policyholder dividends are typically only provided on participating policies or policies issued by non-stock companies, such as mutual entities and other corporate entity types in which profits are shared with policyholders.

17.18. Research during the development of this item identified that a small number of jurisdictions have legal restrictions which only allow policyholder dividends to be provided after the expiration of the policy period for which the dividend was earned. This interpretation only addresses policyholder dividends which are permitted by the applicable jurisdiction.

18.19. The property and casualty annual statement blank provides specific reporting lines for policyholder dividends including, but not limited to a liability line and a line in the income statement and statement of cash flow. For those entities whose policies are participating or whose corporate shell type and/or membership structure allow for policyholder dividends, the accounting for policyholder dividends is unchanged by this interpretation.

19.20. This interpretation does not change the policyholder dividend disclosure or reporting but provides additional guidance that such policyholder dividends issued in response to COVID-19 decreases in activity shall also be disclosed as discussed in Issue 5.

Issue 5: Where to Disclose Refunds, Rate Reductions and Policyholder Dividends Related to COVID-19 Decreases in Activity

20.21. There are various places in the notes to the statutory annual statement where disclosures of various aspects of premium refunds, premium reductions or policyholder dividends are required. This interpretation does not recommend changes to those existing disclosures. This interpretation does, however, recommend providing a consistent annual statement disclosure for all such amounts to allow for comparable disclosures.

21.22. SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items requires disclosure of the nature and financial effects of each unusual or infrequent event or transaction. Gains or losses of a similar nature that are not individually material shall be aggregated. This disclosure shall include the line items which have been affected by the event or transaction considered to be unusual and/or infrequent. This disclosure is currently required to be reported in annual statement Note 21A. (Reporting entities shall maintain jurisdiction-specific information to be made available upon request from department of insurance or revenue regulators.)

23. To allow for aggregate, consistent assessment, the Working Group came to a consensus that all COVID-19 inspired premium refunds, rate reductions, and policyholder dividends shall be disclosed as unusual or infrequent items in annual statement Note 21A. This disclosure is in addition to other existing disclosures on various items related to the policyholder payments.

   a. For clarification, refunds required under policy terms in-force prior to the federal declaration of emergency for the COVID-19 pandemic as discussed in paragraph 13 (i.e., policies that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses) are not required to be aggregated in disclosures of COVID-19 inspired premium refunds, rate reductions and policyholder dividends.
Policies whose terms were modified after the declaration of emergency in response to COVID-19 are required to disclose the COVID-19 inspired premium refunds, rate reductions and policyholder dividends.

24. All reporting entities shall provide the following information regarding their COVID-19 premium refunds, limited-time exception payments, rate reductions and policyholder dividends as unusual or infrequent items:
   b. The amount of COVID-19 “payments” to policyholders by major category (premium refunds, limited-time exception payments, rate reductions or policyholder dividends).

25. Reporting entities that utilize the limited-time exception expense reporting described in paragraphs 12 and 13 shall additionally provide the following to illustrate in annual statement Note 1 the impact of reporting the payments as an aggregate underwriting expense rather than a return of premium as if it were a permitted practice. As detailed in paragraph 13 domiciliary jurisdiction approval as a permitted practice is not required to apply the limited-time exception. Disclosure is required because of the impact on premium which is a key measurement metric for insurers:
   a. A statement that the accounting practice is a limited-time exception to recognize such amounts as an aggregate underwriting expense rather than an return of premium. This disclosure shall include the financial statement reporting line(s) predominantly impacted by the limited-time exception. (Although most practices impact net income or surplus, direct reference to those lines should be avoided. The intent is to capture the financial statement line(s) reflecting the practice which ultimately impacts net income or statutory surplus.) Additionally, a reference to Note 1 shall be included in the individual notes to financial statements impacted by the limited-time exception as applicable.
   b. The monetary effect on revenue and expense.
   c. If a reporting entity’s risk-based capital would have triggered a regulatory event had it not used the limited-time exception, that fact should be disclosed.
   d. The reasons the reporting entity elected to use the limited-time exception rather than as a return of premium.
   e. Note 1 shall also identify the impact of not reporting such amounts as a return of premium on the operating percentages and other percentages reported in the Five Year Historical Data Exhibit and disclose the percentages/ratios as reported and as adjusted to report payments to policyholders as a return of premium.
      i. The operating ratios to be reported include:
         1. Premium earned,
         2. Losses incurred,
         3. Loss expenses incurred,
         4. Other underwriting expenses incurred,
5. Net underwriting gain or loss.

ii. The other ratios to be reported include:

1. Other underwriting expenses to net premiums written,
2. Losses and loss expenses incurred to premiums earned, and
3. Net premiums written to policyholder’s surplus.

26. If a domiciliary jurisdiction’s prescribed or permitted practices allow voluntary COVID-19 payments which are either consistent with the limited-time exception or different from a reduction in premium, the reporting entity shall complete the disclosures in Note 1 which identify that a permitted or prescribed practice was applied and in paragraphs 24 and 25 of this Interpretation. The disclosure in paragraph 25 in such instances shall reflect the impact on the ratios in paragraph 25 compared to the default premium treatment.

INT 20-08 Consensus

22. The Working Group reached a consensus to prescribe statutory accounting guidance for insurance reporting entities providing refunds in response to COVID-19. Pursuant to this consensus:

a. Reporting entities that provide voluntary or jurisdiction-directed refunds which are not required under the policy terms shall follow the guidance in paragraphs 8-12 of this interpretation. This guidance stipulates that such refunds shall be recognized as a reduction of premium. Refunds that are recognized in a different manner (e.g., as an expense), shall be considered a permitted or prescribed practice pursuant to SSAP No. 1.

b. Reporting entities that provide refunds in accordance with insurance policy terms shall follow paragraph 13 of this interpretation. This guidance indicates that existing statutory accounting principles in SSAP No. 53, SSAP No. 54R or SSAP No. 66 shall be followed as applicable.

c. Reporting entities that provide rate reductions shall follow paragraph 14 of this interpretation. This guidance provides direction based on whether the rate reduction is for in-force or future policies.

d. Reporting entities that provide policyholder dividend shall follow the existing guidance for policyholder dividends which is summarized in paragraphs 15-19 and in addition, shall complete the disclosures described in paragraphs 20-22.

e. This interpretation, paragraphs 20-22 indicates that reporting entities shall continue to comply with all statutory accounting disclosure requirements, but also requires that all premium refunds, rate reductions and/or policyholder dividends provided because of the decreased activity due to COVID-19 shall be aggregated and reported in Note 21A as unusual or infrequent items.

Does Not Address Premium Taxation

27. The Working Group noted that premium taxation requirements vary by jurisdiction and this interpretation is not intended to address premium taxation in any jurisdiction. Taxation is determined by the jurisdiction where the premium is written/returned to the policyholder according to the laws, regulations and general administrative rules applicable to all insurance enterprises licensed in a of that jurisdiction. This interpretation defers to each jurisdiction’s premium tax requirements for purposes of determining taxable amounts.
Effective Date

23-28. The limited-time exception allowance for expense reporting for endorsements and rate filings prior to June 15, 2020, applies only to these specific issues arising from COVID-19, is effective for second quarter reporting and will sunset January 1, 2021. This interpretation will be automatically nullified on January 1, 2021 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

INT 20-08 Status

24-29. This interpretation was amended on July 22, 2020 to include the limited-time exception and specific related disclosures by a two-thirds majority of the Accounting Practices and Procedures (E) Task Force membership. Further discussion is planned.
INT 20-01: ASU 2020-04 – Reference Rate Reform (Attachment One-F3) .......................... 10-452
INT 20-03: Troubled Debt Restructuring Due to COVID-19 (Attachment One-F5) .......................... 10-458
INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19 (Attachment One-F6) .......................... 10-466
Statutory Accounting Principles (E) Working Group March 26, 2020, Minutes (Attachment One-G) .......................... 10-471
Statutory Accounting Principles (E) Working Group March 18, 2020, Minutes (Attachment One-H) .......................... 10-472
Statutory Accounting Principles (E) Working Group Jan. 8, 2020, Minutes (Attachment One-H1) .......................... 10-484
NAIC Accounting Practices and Procedures Manual Editorial and Maintenance Update,
Dec. 7, 2019; Ref #2019-44EP (Attachment One-H1a) .......................... 10-487
Oct. 11, 2019, Comment Letter to Dale Bruggeman, Chair of the Statutory Accounting
Principles (E) Working Group, from Interested Parties Regarding Exposure Draft
Ref #2019-21: SSAP No. 43R – Equity Instruments Released for Comment During
NAIC National Meeting with Comments due Oct. 11 (Attachment One-H1b) .......................... 10-493
Comments Received on Previously Exposed Items (Attachment One-H2) .......................... 10-508
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2018-26; SCA Loss Tracking – Accounting Guidance (Attachment One-H3) .......................... 10-562
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2018-38; Prepayments to Service and Claims Adjusting Providers
(Attachment One-H4) .......................... 10-594
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-32; Look-Through with Multiple Holding Companies (Attachment One-H5) .......................... 10-609
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-35; Update Withdrawal Disclosures (Attachment One-H6) .......................... 10-612
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-43; ASU 2017-11, Financial Instruments with Down Round Features
(Attachment One-H7) .......................... 10-620
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-45; ASU 2013-11, Presentation of an Unrecognized Tax Benefit
(Attachment One-H8) .......................... 10-627
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-48; Disclosure Update for Reciprocal Jurisdiction Reinsurers
(Attachment One-H9) .......................... 10-630
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-46; ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities
(Attachment One-H10) .......................... 10-632
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-08; Update Reporting Deposit-Type Contracts (Attachment One-H11) .......................... 10-634
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-40; Reporting of Installment Fees and Expenses (Attachment One-H12) .......................... 10-643
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-33; SSAP No. 25 – Disclosures (Attachment One-H13) .......................... 10-651
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-39; Acceptable Collateral – Counterparty Exposure for Derivative Instruments
(Attachment One-H14) .......................... 10-663
Comments Received on Previously Exposed Items for Discussion at the Statutory Accounting
Principles (E) Working Group March 18, 2020, Meeting (Attachment One-I) .......................... 10-670
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Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2019-38; Financing Derivatives (Attachment One-K) .......................... 10-732
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2020-01; Update/Remove References to SVO Listings (Attachment One-L) .......................... 10-760
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2020-04; Commissioner Discretion in the Valuation Manual (Attachment One-M) .......................... 10-764
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2020-05; Repeal of Affordable Care Act Section 9010 Assessment (Attachment One-N) .......................... 10-772
Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A;
Ref #2020-13; Health Industry Request on 2020 Health Insurance Assessment
(Attachment One-O) .......................... 10-774

Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2019-04; SSAP No. 32 – Investment Classification Project (Attachment One-Q) ........................................... 10-781

Statutory Issue Paper No. 164—Preferred Stock (Attachment One-R) ................................................................. 10-794

Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2020-02; Accounting for Bond Tender Offers (Attachment One-S) ................................................................. 10-810

Statutory Accounting Principles (E) Working Group Maintenance Agenda Submission Form A; Ref #2020-03; Enhanced Goodwill Disclosures (Attachment One-T) ................................................................. 10-815

INT 20-09: Basis Swaps as a Result of the LIBOR Transition (Attachment One-U) ........................................... 10-828

May 29, 2020, Memorandum to Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group, from Kevin Fry, Chair of the Valuation of Securities (E) Task Force, Regarding Referral to the Statutory Accounting Principles (E) Working Group Requesting Affirmation that Non-Conforming Credit Tenant Loan (CTL) Transactions that Relied Upon Credit Ratings are Included in SSAP No. 43R—Loan-Backed and Structured Securities and Have the Characteristics of a Bond if Assigned an NAIC Designation by SVO Staff (Attachment One-V) ................................................................. 10-830

June 12, 2020, Memorandum to Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group, From Commissioner Scott A. White (VA), Chair of the Financial Condition (E) Committee, Regarding Referral Regarding Reporting of “Basis” Swaps (Attachment One-W) ................................................................. 10-838

Accounting Practices and Procedures (E) Task Force 2021 Proposed Charges (Attachment Two) ................................................................. 10-839

Accounting Practices and Procedures (E) Task Force July 22, 2020, Minutes (Attachment Three) ................................................................. 10-841

Comments Received on Previously Exposed Items (Attachment Three-A) ................................................................. 10-844

Accounting Practices and Procedures (E) Task Force June 22, 2020, Minutes (Attachment Four) ................................................................. 10-855

Blanks (E) Working Group May 28, 2020, Minutes (Attachment Four-A) ................................................................. 10-867

Blanks (E) Working Group Dec. 17, 2019, Minutes (Attachment Four-A1) ................................................................. 10-877


Blanks (E) Working Group Agenda Item Submission Form 2019-27BWG; Effective Annual 2020; Remove the Alphabetic Index from Inclusion at the Back of the Annual Statement Blank, Instructions and Blanks Working Group Web Page (Attachment Four-A1b) ................................................................. 10-884

Blanks (E) Working Group Editorial Revisions to the Blanks and Instructions Presented at the Dec. 17, 2019, Meeting (Attachment Four-A1c) ................................................................. 10-886

Blanks (E) Working Group Agenda Item Submission Form 2019-25BWG Modified; Effective Annual 2020; Modify Instruction for Column 10 (Schedule F, Part 3 – Property and Schedule F, Part 2 – Life/Fraternals Workers’ Compensation Carve-Out Supplement) to Remove Instruction to Exclude Adjusting and Other Reserves from the Column and Add Instruction Include Along with the Defense and Cost Containment Reserves; Add a New Instruction for Column 12 for Same Schedules; Add Crosschecks to Schedule P, Part 1 (Attachment Four-A2) ................................................................. 10-888

Blanks (E) Working Group Agenda Item Submission Form 2019-28BWG; Effective Annual 2020; Modify the Instruction for Supplemental Investment Risk Interrogatories Lines 13.02 through 13.11 Clarifying When to Identify the Actual Equity Interests Within a Fund and Aggregate those Equity Interests for Determination of the Ten Largest Equity Interests (Attachment Four-A3) ................................................................. 10-891

Blanks (E) Working Group Agenda Item Submission Form 2019-29BWG; Effective Annual 2020; Modify the Instruction and Blank for Supplemental Investment Risk Interrogatories Question 14.01 (Attachment Four-A4) ................................................................. 10-893

Blanks (E) Working Group Agenda Item Submission Form 2019-30BWG Modified; Effective Annual 2020; Consider Revisions to the Appropriate Reinsurance Schedules and Instructions to Collect Relevant Information Regarding Reinsurance Transactions Following Adopted Revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) (Attachment Four-A5) ................................................................. 10-895
Blanks (E) Working Group Agenda Item Submission Form 2020-01BWG; Effective Annual 2020; Add Crosschecks to Lines 13 and 14 of the State Page to Lines 10 and 11 of the Underwriting and Investment Exhibit, Part 1; Add Crosschecks to Lines 9, 10 and 11 of the Underwriting and Investment Exhibit, Part 1 and Schedule T, Line 61 (Attachment Four-A6) .................................................................................................................. 10-961
Blanks (E) Working Group Agenda Item Submission Form 2020-03BWG Modified; Effective Annual 2020; Modify the Instruction and Illustration for 13(11) to the Notes to Financial Statement; Change the Numbering from 1 through 13 to A through M (Attachment Four-A7) .......... 10-964
Blanks (E) Working Group Agenda Item Submission Form 2020-04BWG; Effective Annual 2020; Modify the Instruction and Illustration for Note 23A – Unsecured Reinsurance Recoverables (Attachment Four-A8) ........................................................................................................ 10-972
Blanks (E) Working Group Agenda Item Submission Form 2020-05BWG Modified; Effective Annual 2020; Modify the Instruction and Illustration for Note 2 – Accounting Changes and Correction of Errors (Attachment Four-A9) .......................................................................................... 10-975
Blanks (E) Working Group Agenda Item Submission Form 2020-07BWG; Effective Annual 2020; Add New Disclosure Note 23 – Reinsurance for Reinsurance Credit (23H – Life/Fraternal, 23E Health and 23K Property) (Attachment Four-A10) .......................................................... 10-978
Blanks (E) Working Group Agenda Item Submission Form 2020-08BWG Modified; Effective Annual 2020; Add a Disclosure Instruction for 10C to the Notes to Financial Statement for Related Party Transactions not Captured on Schedule Y; Combine Existing 10C into 1B Instructions and Illustration Narrative (Attachment Four-A11) ............ 10-984
Blanks (E) Working Group Agenda Item Submission Form 2020-09BWG; Effective Annual 2020; Modify the Annual Statement Instructions for Schedule F, Part 3 to Reflect the Factors for all Uncollateralized Reinsurance Recoverable from Unrated Reinsurers be the Same for Authorized, Unauthorized, Certified and Reciprocal Reinsurance (Attachment Four-A12) .......................................................................................... 10-990
Blanks (E) Working Group Agenda Item Submission Form 2020-10BWG; Effective Annual 2020; Variable Annuities Supplement Blank: Changing Header for Column 10; Changing Lines 1-3 and Adding Line 4; Variable Annuities Supplement Instructions: Adjusting Instructions to Correspond with Changes Made to the Blanks and the 2020 Valuation Manual for the New VA Framework (Attachment Four-A13) .......................................................................................... 10-993
Blanks (E) Working Group Agenda Item Submission Form 2020-11BWG; Effective Annual 2020; Changes to VM-20 Reserves Supplement Blanks and VM-20 Reserves Supplement Instructions (Attachment Four-A14) .......................................................................................... 10-999
Blanks (E) Working Group Agenda Item Submission Form 2020-12BWG; Effective Annual 2020; The Proposal will Require Appointed Actuaries to Attest to Meeting Continuing Education (CE) Requirements and Participate in the CAS/SoA CE Review Procedures, if Requested (Attachment Four-A15) .......................................................................................... 10-1010
Blanks (E) Working Group Agenda Item Submission Form 2020-13BWG Modified; Effective Annual 2020; Remove Line 24.04 from General Interrogatories, Part 1 and Renumber Remaining Lines for Interrogatory Question 24. Modify Lines 24.05 and 24.06 to Require Reporting Amounts for Conforming and Non-Conforming Collateral Programs (Attachment Four-A16) .......................................................................................... 10-1012
Blanks (E) Working Group Agenda Item Submission Form 2020-14BWG Modified; Effective Annual 2020; Modify the Columns and Rows on the Blank Pages for Long-Term Care Reporting Forms 1 through 5 and Make Appropriate Changes to the Instructions (Experience Attachment Four-A17) .......................................................................................... 10-1015
Blanks (E) Working Group Agenda Item Submission Form 2020-15BWG Modified; Effective Annual 2020; A New Private Flood Insurance Supplement Collecting Residential and Commercial Private Flood Insurance Data and Revisions to the Credit Insurance Experience Exhibit (CIEE) to Collect Lender-Placed Flood Coverages (Attachment Four-A18) .......................................................................................... 10-1046
Blanks (E) Working Group Agenda Item Submission Form 2020-16BWG Modified; Effective Annual 2020; Modify Questions 3.1 and 3.2 of General Interrogatories Part 2 and Provide Instructions for the Questions (Attachment Four-A19) .......................................................................................... 10-1059
Blanks (E) Working Group Agenda Item Submission Form 2020-17BWG; Effective Annual 2020; Adjust the AVR Presentation to Include Separate Lines for Each of the Expanded Bond Designation Categories (Attachment Four-A20) .......................................................................................... 10-1061
Blanks (E) Working Group Agenda Item Submission Form 2020-18BWG Modified; Effective Annual 2020; Clarify the Instructions for What Funds Reported on Schedule D, Part 2, Section 2 (Annual Filing) and Schedules D, Part 3 and 4 (quarterly filing) must have NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol; Modify References to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* Found in the Investment Instructions in the Annual and Quarterly Statement Instructions (Attachment Four-A21)........................................................................................................................ 10-1065
Blanks (E) Working Group Agenda Item Submission Form 2020-19BWG Modified; Effective Annual 2020; Add a Code of “%” to the Code Column for all Investments Which Have Been Reported in Schedule DA, Part 1 and Schedule E, Part 2 for More than One Consecutive Year; Add Certification to the General Interrogatories, Part 1 Inclusion of These Investments on Schedule DA, Part 1 and Schedule E, Part 2; (Attachment Four-A22).................................................................................. 10-1078
Blanks (E) Working Group Agenda Item Submission Form 2020-20BWG Modified; Effective Annual 2020; For Schedule D, Part 1, add Code “10” to Column 26 – Collateral Type for Ground Lease Financing; Renumber “Other” Code to 11 (Attachment Four-A23)............. 10-1085
Blanks (E) Working Group Agenda Item Submission Form 2020-21BWG Modified; Effective Annual 2020; Add New Line 4.05 for Valuation Allowance for Mortgage Loans to the Summary Investment Schedule and Renumber Existing Line 4.05 to 4.06; Modify the Instructions to Include a Crosscheck for New Line 4.05 Back to Schedule B – Verification Between Years; Clarify the Instructions for 4.01- 4.04 to Explicitly Show Crosschecking to Column 8 of Schedule B, Part 1 (Attachment Four-A24)............................................................ 10-1088
Blanks (E) Working Group Agenda Item Submission Form 2020-23BWG Modified; Effective Annual 2020; Add Footnote to Exhibit 5 (Life/Fraternal & Health – Life Supplement) and Exhibit 3 Separate Accounts (Attachment Four-A25)............................................................................. 10-1092
Blanks (E) Working Group Editorial Revisions to the Blanks and Instructions Presented at the May 28, 2020, Meeting (Attachment Four-A26)........................................................................................................... 10-1096
The Accounting Practices and Procedures (E) Task Force met via conference call Aug. 3, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Jamie Walker (TX); Trinidad Navarro, Vice Chair, represented by Rylynn Brown (DE); Lori K. Wing-Heier represented by David Phifer (AK); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima M. Woods represented by N. Kevin Brown (DC); Dean L. Cameron represented by Nathan Faragher (ID); Stephen W. Robertson and Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither and Bill Clark (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by John Turchi (MA); Eric A. Cioppa represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Steve Kelley represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Mike Causey represented by Monique Smith (NC); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by Diana Sherman (NJ); Russell Toal represented by Robert Doucette (NM); Linda A. Lacewell represented by Robert Kasinow (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Jessica K. Altman represented by Kimberly Rankin (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Larry D. Deiter represented by Johanna Nickelson (SD); Hodgen Mainda represented by Troy Hancock (TN); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte and David Smith (VA); Michael S. Pieciak represented by Karen Ducharme (VT); Mike Kreidler represented by Steve Drutz (WA); Mark Afable represented by Amy Malm (WI); James A. Dodrill represented by Jamie Taylor (WV); and Jeff Rude represented by Linda Johnson (WY).

1. **Adopted its July 22, June 22, and 2019 Fall National Meeting Minutes**

Ms. Walker directed the members to the Task Force’s July 22, June 22 and 2019 Fall National Meeting minutes. During the July 22 meeting, the Task Force adopted revisions to *Interpretation (INT) 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends.* These revisions were requested by the Financial Condition (E) Committee to add flexibility, which allows a limited-time exception to apply other underwriting expense treatment for certain policies.

During its June 22 meeting, the Task Force took the following action: 1) adopted the report of the Statutory Accounting Principles (E) Working Group for its actions on June 15, May 20, April 15 and March 18; 2) adopted INT 20-08 as adopted by the Statutory Accounting Principles (E) Working Group on June 15 by a separate vote of the Task Force; and 3) adopted the May 28 report of the Blanks (E) Working Group.

Mr. Doucette made a motion, seconded by Mr. Kasinow, to adopt the Task Force’s July 22 (Attachment Three), June 22 (Attachment Four), and Dec. 8, 2019, (see *NAIC Proceedings – Fall 2019, Accounting Practices and Procedures (E) Task Force*) minutes. The motion passed unanimously.

2. **Adopted its 2021 Proposed Charges**

Ms. Walker directed the Task Force to the Task Force’s 2021 proposed charges. Robin Marcotte (NAIC) stated that the Task Force oversees the activities of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group. She stated that the 2021 proposed charges of the working groups reflect the ongoing nature of their work, and they are the same as 2020 except for one revised charge for each working group.

Ms. Marcotte stated that for the Blanks (E) Working Group, the proposed revision is to update the charge to review requests to the investment schedules and instructions. She noted that the charge is the same, just the name of the referenced group is proposed to be updated from the Investment Risk Based Capital (E) Working Group to the Capital Adequacy (E) Task Force and its working groups. She stated that this is because all of the risk-based capital (RBC) working groups could potentially propose revisions.
Ms. Marcotte stated that for the Statutory Accounting Principles (E) Working Group, the charge related to updating the reinsurance Schedule F and related revisions to reflect the changes to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) has been addressed. She said the updates were initiated by the Statutory Accounting Principles (E) Working Group and adopted by the Blanks (E) Working Group, along with a few very minor edits to the statutory accounting. She noted that statutory accounting includes impairment guidance, so no revisions were drafted regarding doubtful accounts. She stated that the charge is proposed for deletion, as the revisions to address the model changes are complete.

Ms. Malm made a motion, seconded by Ms. Nickelson, to adopt the Task Force’s 2021 proposed charges (Attachment Two).


Mr. Bruggeman provided the July 30 report of the Statutory Accounting Principles (E) Working Group. He said the Working Group adopted its July 15, June 15, May 20, May 5, April 17, April 15, March 26 and March 18 minutes.

Mr. Bruggeman stated the Working Group adopted the following substantive revisions to statutory accounting guidance:

- **Statement of Statutory Accounting Principles (SSAP) No. 32R—Preferred Stock:** Adopted substantively revised SSAP No. 32R and corresponding Issue Paper No. 164—Preferred Stock, which updates the definitions, measurement and impairment guidance for preferred stock pursuant to the investment classification project. Revised SSAP No. 32R is effective Jan. 1, 2021. (Ref #2019-04)

- **SSAP No. 106—Affordable Care Act Section 9010 Assessment:** Revisions supersede SSAP No. 106 and nullify INT 18-02: ACA Section 9010 Assessment Moratoriums. With this adoption, a blanks proposal will be sponsored to incorporate reporting changes for 2021 reporting and recommend guidance for 2020 year-end reporting. (Ref #2020-05)

Mr. Bruggeman noted that the Working Group adopted the following nonsubstantive revisions to statutory accounting guidance:

- **SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments:** Revisions update the reporting line for qualifying cash pools and make clarifying edits. (Ref #2020-16EP)

- **SSAP No. 26R—Bonds and SSAP No. 30R—Unaffiliated Common Stock:** Revisions eliminate references to the NAIC Bond Fund List (Bond List) in SSAP No. 26R and add reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R. (Ref #2020-01)

- **SSAP No. 26R:** Revisions clarify that the accounting and reporting of investment income and capital gain/loss, due to the early liquidation either through a called bond or a tender offer, shall be similarly applied. This adoption has a Jan. 1, 2021, effective date with early adoption permitted. (Ref #2020-02)

- **SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts, and SSAP No. 54R—Individual and Group Accident and Health Contracts:** Revisions specify that voluntary decisions to choose one allowable reserving methodology over another, which requires commissioner approval under the Valuation Manual, shall be reported as a change in valuation basis. (Ref #2020-04)

- **SSAP No. 68—Business Combinations and Goodwill:** Revisions add disclosure elements for reported goodwill. The additional disclosures will improve the validity and accuracy of the financial statements, and they will assist with state insurance regulators’ review of reported assets that are not readily available for policyholder claims. These disclosure revisions will be effective for the 2021 reporting year to correspond with blanks changes. (Ref #2020-03)

- **SSAP No. 86—Derivatives:** Revisions ensure reporting consistency in that derivatives are reported “gross”; i.e., without the inclusion of financing components. Additionally, amounts owed to/from the reporting entity from the acquisition or writing of derivatives shall be separately reflected. The concepts are consistent with existing statutory...
accounting guidelines, but the revisions clarify the guidance and improve uniform application. The revisions have an effective date of Jan. 1, 2021. (Ref #2019-38)

g. Appendix B—Interpretations of Statutory Accounting Principles: INT 20-09: Basis Swaps as a Result of the LIBOR Transition basis swaps are compulsory derivatives issued by central clearing parties (CCPs) in response to the market-wide transition away from the London Interbank Offered Rate (LIBOR). The interpretation directs that the basis swaps be reported as "hedging - other" and at fair value, thus qualifying for admittance. To be considered or reported as an "effective" hedging, the instrument must qualify as a highly effective hedge under SSAP No. 86.

Mr. Bruggeman said the Working Group exposed the following nonsubstantive revisions to statutory accounting guidance:

a. SSAP No. 2R: Revisions require the identification/disclosure of cash equivalents, or substantially similar investments, that remain on the same reporting schedule for more than one consecutive reporting period. This is an expansion of the current disclosure requirements that only referenced short-term investments and a clarification that the disclosure is satisfied through the use of the code on the investment schedules. (Ref #2020-20)

b. SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements and SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities: Revisions update the amortization guidance for leasehold improvements. The updated language will allow leasehold improvements to have lives that match the associated lease term, which agrees with U.S. Generally Accepted Accounting Principles (GAAP). (Ref #2020-23)

c. SSAP No. 25—Affiliates and Other Related Parties: Revisions clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation, a disclaimer of control does not eliminate the classification as a related party, and disclosure of material transactions are required under SSAP No. 25. The revisions also propose rejection of several U.S. GAAP standards addressing variable interest entities, and update the related party disclosures. (Ref #2019-34)

d. SSAP No. 26R: Revisions clarify that perpetual bonds shall be reported at fair value, not to exceed any currently effective call price, with a proposed effective date of Jan. 1, 2021, with early application permitted. (Ref #2020-22)

e. SSAP No. 37—Mortgage Loans: Revisions clarify that a participant’s financial rights in a mortgage participation agreement may include the right to take legal action against the borrower or participate in the determination of legal action, but they do not require that the participant has the right to solely initiate legal action; foreclosure; or under normal circumstances, require the ability to communicate directly with the borrower. (Ref #2020-19)

f. SSAP No. 43R—Loan-Backed and Structured Securities:


2. Exposed agenda item to solicit comments on two options for the accounting of credit tenant loans (CTLs). The Valuation of Securities (E) Task Force will be notified of this exposure with a request for further confirmation that a Securities Valuation Office (SVO)-Listing could be developed to capture the CTLs that meet the SVO’s structural and legal analysis and possess bond characteristics. (Ref #2020-24)

g. SSAP No. 53—Property and Casualty Contracts–Premiums, SSAP No. 54R, and SSAP No. 66—Retrospectively Rated Contracts: Exposed agenda item with a request for comments on the development of authoritative guidance for policyholder refunds and other premium adjustments for accident and health and property and casualty lines of business. Assistance from industry was requested in developing principles-based guidance, particularly for the varieties of data-telematics policies. (Ref #2020-30)

h. SSAP No. 71—Policy Acquisition Costs and Commissions: Exposed revisions clarify existing levelized commissions guidance, which requires full recognition of the funding liabilities incurred to date for commission expenses prepaid on behalf of an insurer. The revisions also clarify that the recognition of commission expense is based on experience.
to date. The exposed revisions are consistent with the 2019 Fall National Meeting exposure, with the inclusion of guidance to clarify that reporting entities that have not complied with the original intent shall reflect the change as a correction of an error, in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors, in the year-end 2020 financial statements. (Ref #2019-24)

i. SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities:

1. Revisions update the subsidiary, controlled and affiliated entities (SCA) review process descriptive language and the procedures for availability and delivery of completed SCA reviews for domestic regulators and financial statement filers. (Ref #2020-17)

2. Revisions remove the statement that guarantees or commitments from the insurance reporting entity to the SCA can result in a negative equity valuation of the SCA. (Ref #2020-18)

j. Appendix B—Interpretations of Statutory Accounting Principles: Exposed revisions to extend the following interpretations issued in response to COVID-19 to the third quarter 2020 financial statements. With these revisions, these interpretations will expire Dec. 30; therefore, they will not be applicable for year-end 2020. The exposure has a shortened comment period ending Aug. 14. Adoption of these extensions may be considered by an e-vote if there are no concerns with the extensions received during the exposure period:


2. INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19

3. INT 20-05: Investment Income Due and Accrued

k. Appendix D—Nonapplicable GAAP Pronouncements: The following U.S. GAAP standards were rejected as not applicable to statutory accounting:

1. ASU 2015-10, Technical Corrections and Improvements. (Ref #2020-26)

2. ASU 2019-09, Financial Services—Insurance (Topic 944): Effective Date. (Ref #2020-27)

3. ASU 2020-01, Investments—Equity Securities (Topic 321), Investments—Equity Method and Joint Ventures (Topic 323), and Derivatives and Hedging (Topic 815), Clarifying the Interactions between Topic 321, Topic 323, and Topic 815. (Ref #2020-28)

4. ASU 2020-05—Effective Dates for Certain Entities. (Ref #2020-29)

l. Exposed the following editorial revisions to statutory accounting: (Ref #2020-25EP)

1. SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets: Removed redundant paragraph references.

2. SSAP No. 62R—Property and Casualty Reinsurance: Added a table that lists the questions addressed in Exhibit A - Implementation Questions and Answers.

Mr. Bruggeman noted that the Working Group rejected agenda item 2020-13: Health Industry Request on 2020 Health Insurance Assessment without statutory revisions. (Note that the sponsor requested withdrawal). (Ref #2020-13)

Mr. Bruggeman stated that the Working Group received an update and determined that the following two interpretations, issued in response to COVID-19, are specifically tied to the timeframes described in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). As such, an extension was not deemed necessary at this time.

a. INT 20-03: Troubled Debt Restructuring Due to COVID-19
b. **INT 20-07: Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19**

Mr. Bruggeman noted that the Working Group received an update that the issue paper to consider substantive revisions to SSAP No. 43R was exposed through July 31, and a subsequent conference call will be scheduled to consider comments and continue the discussion. It was also noted that NAIC staff have had ongoing conversations with industry representatives and investment providers to discuss differing structures during the exposure period. (Ref #2019-21)

Mr. Bruggeman stated that the Working Group deferred discussion of the following agenda items for a subsequent call or meeting:

a. Ref #2018-07: Surplus Note Accounting – Referral from the Reinsurance (E) Task Force

b. Ref #2019-12: *ASU 2014-17, Business Combinations, Pushdown Accounting*

c. Ref #2019-49: Retroactive Reinsurance Exception

Mr. Bruggeman stated that the Working Group received an update on two referrals:

a. Referral from the Valuation of Securities (E) Task Force regarding the accounting and reporting treatment of CTLs is being addressed in agenda item Ref #2020-24.

b. Referral from the Financial Condition (E) Committee regarding an American Council of Life Insurers’ (ACLI) request relative to the accounting treatment of certain “basis swaps” permitted under state law, as a result of the transition away from LIBOR. This referral was addressed with the adoption of INT 20-09.

Mr. Bruggeman stated that the Working Group received an update on current U.S. GAAP exposures/invitations to comment.

Mr. Bruggeman noted that, with the exception of INT 20-02, INT 20-04 and INT 20-05, which have a comment deadline of Aug. 14, the comment deadline for all exposed agenda items is Sept. 18.

Mr. Bruggeman made a motion, seconded by Mr. Hudson, to adopt the report of the Statutory Accounting Principles (E) Working Group (Attachment One). The motion passed unanimously.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met via conference call July 30, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair, and Kevin Clark (IA); Sheila Travis (AL); Kim Hudson (CA); Kathy Belfi and William Arfanis (CT); Rylynn Brown (DE); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Tom Dudek (NY); Joe DiMemmo (PA); Shawn Frederick (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI). Also participating was: Eli Snowbarger (OK).

1. **Adopted its July 15, June 15, May 20, May 5, April 17, April 15, March 26 and March 18 Minutes**

Ms. Malm made a motion, seconded by Mr. Moser, to adopt the Working Group’s July 15 (Attachment One-A), June 15 (Attachment One-B), May 20 (Attachment One-C), May 5 (Attachment One-D), April 17 (Attachment One-E), April 15 (Attachment One-F), March 26 (Attachment One-G) and March 18 (Attachment One-H) minutes. The motion passed unanimously.

2. **Adopted Non-Contested Statutory Accounting Revisions During its Public Hearing**

The Working Group held a public hearing to review comments (Attachment One-I and Attachment One-J) on previously exposed items.

Mr. Hudson made a motion, seconded by Ms. Mears, to adopt the statutory accounting revisions detailed below as non-contested statutory accounting revisions. This motion also included the rejection, without statutory revisions, of agenda item 2020-13. The motion passed unanimously.

a. **Agenda Item 2019-38**

Mr. Bruggeman directed the Working Group to agenda item 2019-38: Financing Derivatives (Attachment One-K). Julie Gann (NAIC) stated that this nonsubstantive agenda item requires the gross reporting of derivatives, without the impact of financing premiums. The agenda item also requires that premiums payable or premiums receivable be separately reported. The revisions to *Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives* have corresponding annual statement revisions to capture derivative financing components in the calculation of net derivative exposure.

Ms. Gann stated that this inclusion will affect the risk-based capital (RBC) for life entities. The revisions have a Jan. 1, 2021, effective date to correspond with the annual financial statement revisions.

b. **Agenda Item 2020-01**

Mr. Bruggeman directed the Working Group to agenda item 2020-01: Update/Remove References to SVO Listings (Attachment One-L).

Jim Pinegar (NAIC) stated that this nonsubstantive agenda item reflects a Valuation of Securities (E) Task Force notice regarding two adopted revisions to the *Purpose and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)*. He stated that the Task Force renamed the “U.S. Direct Obligations/Full Faith and Credit Exempt List” to the “NAIC U.S. Government Money Market Fund List.” He noted that no revisions to the statutory accounting principles (SAP) would be required for this revision, as this list is not specifically identified in the *Accounting Practices and Procedures Manual (AP&P Manual)*. He stated that the second revision was to discontinue the “NAIC Bond Fund List.” He noted that items on this list would be eligible for consideration in the “NAIC Fixed Income-Like SEC Registered Funds List.” The discontinuance of the “NAIC Bond Fund List” required updates to eliminate references to it in *SSAP No. 26R—Bonds* while adding reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in *SSAP No. 30R—Unaffiliated Common Stock*. 
c. **Agenda Item 2020-04**

Mr. Bruggeman directed the Working Group to agenda item 2020-04: Commissioner Discretion in the *Valuation Manual* (Attachment One-M).

Robin Marcotte (NAIC) stated that this agenda item incorporates a disclosure on the use of commissioner discretion when choosing between acceptable methods permitted in the *Valuation Manual*. She stated that the nonsubstantive disclosure revisions are reflected in SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts, and SSAP No. 54R—Individual and Group Accident and Health Contracts. Pursuant to commissioner approval, a reporting entity has the ability to choose one allowable reserving methodology over another; accordingly, the revisions require that any modifications be disclosed as a change in valuation basis.

d. **Agenda Item 2020-05**

Mr. Bruggeman directed the Working Group to agenda item 2020-05: Repeal of the Affordable Care Act Section 9010 Assessment (Attachment One–N).

Ms. Marcotte stated that the federal Affordable Care Act (ACA) Section 9010 assessment has had more than one deferral or moratorium, as addressed in *Interpretation (INT) 18-02: ACA Section 9010 Assessment Moratorium*. She stated that in December 2019, the U.S. House of Representatives (House) and U.S. Senate (Senate) passed bills repealing Section 9010 assessments for calendar years beginning Jan. 1, 2021. She stated that the agenda item addresses the substantive impacts of the Section 9010 assessment repeal for calendar years beginning on Jan. 1, 2021, by superseding SSAP No. 106—Affordable Care Act Section 9010 Assessment and nullifying INT 18-02. With these actions, both SSAP No. 106 and INT 18-02 would be moved to *Appendix H – Superseded Statements of Statutory Accounting Principles and Nullified Interpretations* for the 2021 publication of the AP&P Manual.

Ms. Marcotte stated that in response to interested parties’ comments, it is too late in the year to change the Section 9010 disclosures in the 2020 financial statements; however, instructional guidance for completing the disclosure will be developed and posted on the Blanks (E) Working Group webpage. The SSAP No. 106 disclosures will be eliminated from the 2021 financial statements.

e. **Agenda Item 2020-13**

Mr. Bruggeman directed the Working Group to agenda item 2020-13: Health Industry Request on 2020 Health Insurance Assessment (Attachment One-O).

Ms. Marcotte stated that the Working Group received a request from America’s Health Insurance Plans (AHIP) to consider altering the recognition of the “insurer provider fee” required in SSAP No. 106. She stated that an agenda item was exposed with a recommendation to reject the proposed AHIP revisions. She stated that subsequently, AHIP requested to withdraw this agenda item from further consideration.

Mr. Bruggeman stated that in accordance with the Working Group’s procedural process, despite the withdrawal request, this agenda item will be moved to the rejected listing, without statutory revisions.

f. **Agenda Item 2020-16EP**

Mr. Bruggeman directed the Working Group to agenda item 2020-06EP: Editorial Maintenance Update (Attachment One-P).

Mr. Pinegar stated that this item provides nonsubstantive editorial updates in accordance with the maintenance process, updates a reporting line reference for qualified cash pools, and corrects sentence structure for guidance in SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments.
3. **Adopted Revisions to Statutory Accounting with Minimal Discussion**

The Working Group held a public hearing to review comments (Attachment One-I and Attachment One-J) on previously exposed items.

   a. **Agenda Item 2019-04**

Mr. Bruggeman directed the Working Group to agenda item 2019-04: SSAP No. 32 – Investment Classification Project. Mr. Pinegar stated that the intent of the agenda item was to substantively revise SSAP No. 32—Preferred Stock pursuant to the investment classification project. The revisions include updated definitions, measurement and impairment guidance for preferred stock held as an investment.

Mr. Pinegar stated that comments received during a prior exposure regarding the proposed definitions (e.g., whether redemption is within control of the holder) have been fully resolved, and the comments received during this most recent exposure are minor. He stated that NAIC staff recommend adoption of Issue Paper No. 164—Preferred Stock and the substantively revised SSAP No. 32R, with the proposed edits from interested parties with an effective date of Jan. 1, 2021.

   b. **Agenda Item 2020-02**

Mr. Bruggeman directed the Working Group to agenda item 2020-02: Accounting for Bond Tender Offers.

Mr. Pinegar stated that a bond tender offer is like a called bond, except a tender offer is contingent on acceptance of the offer by the holder. He stated that specific guidance for the reporting and allocation of investment income and/or capital gain/loss associated with callable bonds is noted in SSAP No. 26R; however, guidance is not reflected when a bond is retired early through a tender offer. He stated that the nonsubstantive revisions clarify that the accounting and reporting of investment income and capital gain/loss due to the early liquidation, either through a call or a tender offer, shall be similarly applied.

Mr. Pinegar stated that comments received indicated support for the accounting treatment however, requested a Jan. 1, 2021, effective date. He stated that NAIC staff are supportive of adding effective date guidance, noting that while the accounting guidance is effective immediately, reporting entities may wait until Jan. 1, 2021, if: 1) the reporting entity has not historically followed the accounting and reporting of investment income and capital gain/loss from a tender bond as proposed in this agenda item; and 2) the reporting entity requires internal financial accounting system updates.

Mr. Smith made a motion, seconded by Mr. Bartlett, to adopt the substantially revised SSAP No. 32R—Preferred Stock to include the proposed edits from interested parties, with an effective date of Jan. 1, 2021 (Attachment One-Q) and the issue paper (Attachment One-R). This motion also included adopting nonsubstantive revisions to SSAP No. 26R, with the effective date language as proposed by NAIC staff (Attachment One-S). The motion passed unanimously.

4. **Reviewed Previously Adopted Interpretations for Possible Extension**

Mr. Bruggeman directed the Working Group to receive an update and consider possible extensions on several accounting interpretations. Ms. Gann stated that the interpretations have been grouped to facilitate discussion based on periods in which they are effective.

Interpretations that are effective through the second quarter 2020 reporting include:

- **INT 20-02: Extension of Ninety-Day Rule for the Impact of COVID-19**: This interpretation provides an optional extension of the 90-day rule before nonadmitting premium receivables and receivables from non-government uninsured plans in response to COVID-19. (INT 20-02)

- **INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19**: This interpretation provides limited-time exceptions to defer the assessment of impairment for certain bank loans, mortgage loans and investments that predominantly hold underlying mortgage loans, which are affected by forbearance or modifications in response to COVID-19. (INT 20-04)
**INT 20-05: Investment Income Due and Accrued:** This interpretation provides limited-time collectibility assessments and admittance exceptions for SSAP No. 34—Investment Income Due and Accrued. This interpretation allows an exception to the collectibility assessment for investments that have had a forbearance or modifications in response to COVID-19 that were both current as of Dec. 31, 2019, and not experiencing financial difficulties at the time of the modification. For these items, further evaluation of collectibility would not be required for the first and second quarter financial statements unless other indicators of interest would not be collected were known. (INT 20-05)

Ms. Gann stated that as these interpretations are only effective through the second quarter, NAIC staff recommend a short exposure, seeking industry and state insurance regulator feedback on whether the interpretations should be extended to include third quarter reporting. If no objections are noted, the Working Group may consider adoption via an e-vote. If extended, INT 20-02, INT 20-04 and INT 20-05 would expire on Dec. 30, which would preclude their usage for year-end financial reporting.

Ms. Gann stated that informal inquiries have been received on possible year-end application for these interpretations. However, she stated that there are potential concerns with another extension, particularly for INT 20-04, that provides exceptions for certain impairment assessments if impairment is not shown in the year-end financial statements. She stated that the current consideration is only for the third-quarter financial statements, but she wanted to bring these inquiries and comments to the attention of the Working Group.

Mr. Bruggeman stated that subsequent consideration could occur for year-end reporting, but INT 20-04 would likely need to be modified, as an extension could further delay recognition of impairment.

Interpretations that are effective for 60 days after the termination of the national emergency, or Dec. 31, whichever occurs first, include:

- **INT 20-03: Troubled Debt Restructuring Due to COVID-19:** This interpretation clarifies that a modification of mortgage loan or bank loan terms, in response to COVID-19, shall follow the provisions detailed in the April 7 “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus,” and the provisions of the federal Coronavirus Aid, Relief, and Economic Security Act (CARES Act) in determining whether the modification shall be reported as a troubled debt restructuring. (INT 20-03)

- **INT 20-07: Troubled Debt Restructuring of Certain Debt Instruments Due to COVID-19.** This interpretation proposes limited-time practical expedients in determining whether a restructuring reflects a “concession” under paragraph 10 of SSAP No. 36—Troubled Debt Restructuring. Under existing statutory accounting guidance, a restructuring that is insignificant is not a concession; therefore, it is not a troubled debt restructuring. The interpretation provides practical expedients in determining what is an insignificant debt modification. (INT 20-07)

Ms. Gann stated that the effective dates for INT 20-03 and INT 20-07 are tied to the CARES Act, and unless the national emergency is declared over by Aug. 1, the interpretations will be in effect for third-quarter financial reporting; thus, an exposure to consider possible extension is not necessary at this time. Mr. Bruggeman agreed that with the current effective dates, INT 20-03 and INT 20-07 would not need to be considered for extension at this time.

John Waldeck (Pacific Life Insurance) requested clarification regarding the discussion on an e-vote for consideration of adoption.

Ms. Gann stated that while the Working Group has not previously held an e-vote to adopt statutory accounting revisions, this option would only occur if there were not any comments that were contrary to supporting extension. However, if the comments received indicate the need for a public meeting, a conference call will occur to facilitate the review and discussion.

Mr. Hudson made a motion, seconded by Ms. Malm, to expose INT 20-02, INT 20-04 and INT 20-05 for public comment regarding possible extension for third-quarter reporting. The motion passed unanimously.
5. Reviewed Comments and Considered Action on Exposed Items

The Working Group held a public hearing to review comments (Attachment One-I and Attachment One-J) on previously exposed items.

a. Agenda Item 2019-34

Mr. Bruggeman directed the Working Group to agenda item 2019-34: Related Parties, Disclaimer of Affiliation and Variable Interest Entities.

Jake Stultz (NAIC) stated that the intent of this nonsubstantive agenda item is to clarify identification of related parties and affiliates in SSAP No. 25—Affiliates and Other Related Parties to incorporate new disclosures to ensure that state insurance regulators have a full picture of complicated business structures. He stated that this agenda item has been drafted to clarify the identification of related parties and ensure that any related party identified under U.S. generally accepted accounting principles (GAAP) or within U.S. Securities and Exchange Commission (SEC) reporting requirements would be considered a related party for statutory accounting. Additionally, any non-controlling ownership over 10% would result in related party classification, regardless of any disclaimer of control or affiliation.

Mr. Stultz stated that this agenda item also proposes the rejection of several U.S. GAAP standards addressing variable interest entities. He stated that interested parties’ comment letters expressed concern regarding the reference to U.S. GAAP or SEC guidance as mutual filers do not prepare U.S. GAAP financials and do not file with the SEC. As such, inclusion by reference would result in overly complicated guidance. Mr. Stultz stated that as a result of these comments, direct references have been removed while certain descriptive language has been retained. Additionally, he stated that this agenda item does not change the reporting of related party transactions that currently occur in the financial statements.

Mr. Stultz stated that comments were received from the Group Solvency Issues (E) Working Group, requesting an additional disclosure that would provide information on minority ownership as well as other significant relationships between minority owners and other U.S. domestic insurers. He stated that NAIC staff recommend exposure of this agenda item, seeking industry and state insurance regulator feedback on the proposed modifications and inclusion of an additional related party disclosure.

Mr. Hudson made a motion, seconded by Ms. Travis, to expose agenda item 2019-34, which proposes nonsubstantive changes to SSAP No. 25, for a public comment period. The motion passed unanimously.

b. Agenda Item 2020-03

Mr. Bruggeman directed the Working Group to agenda item 2020-03: Enhanced Goodwill Disclosures.

Fatima Sediqzad (NAIC) stated that this agenda item proposes to capture additional goodwill information and clarify reporting on Schedule D, Part 6, Section 1—Valuation of Shares of Subsidiary, Controlled and Affiliated Companies. She stated that this agenda item adds the original amounts of goodwill to existing disclosure requirements, thus assisting in the review and validation of a subsidiary, controlled and affiliated entity’s (SCA) admitted goodwill.

Mr. Pinegar stated that this agenda item also updates this schedule to identify goodwill, instead of intangible assets, to reflect current reporting practices. He stated that the main focus of this agenda item is to add a new footnote disclosure, detailing the intangible subcomponents that are used to derive the admitted goodwill calculation. Additionally, goodwill as a percentage of capital/surplus will be disclosed, giving state insurance regulators a granular view of intangible assets. However, due to the required structural changes as a result of the new disclosure, the earliest that the new disclosures can take effect is year-end 2021.

Mr. Pinegar stated that interested parties requested the exclusion of “push down” goodwill from the disclosure requirements. He stated that NAIC staff recommend adoption of this agenda item in its current form, as the additional disclosures to not provide guidance on the determination, calculation or admissibility of goodwill; rather, they only enhance disclosure of existing goodwill. Additionally, omitting certain goodwill from the disclosures would greatly reduce the usefulness of the financial information.
Mr. Bruggeman clarified that due to the structural changes of the additional disclosure, capturing the intangible subcomponents of goodwill will not take effect until year-end 2021.

Richard Poniatowski (Travelers), representing interested parties, stated support for modifying the effective date of the disclosures to sync with the related annual statement blanks data captured proposal.

Mr. Hudson made a motion, seconded by Ms. Mears, to adopt agenda item 2020-03, incorporating additional goodwill disclosures in SSAP No. 68—Business Combinations and Goodwill, with an effective date of Dec. 31, 2021 (Attachment One-T). The motion passed unanimously.

c. Agenda Item 2019-24

Mr. Bruggeman directed the Working Group to agenda item 2019-24: Levelized and Persistency Commission.

Ms. Marcotte stated that this agenda item was originally exposed in August 2019 and exposed with revisions at the 2019 Fall National Meeting. She stated that the item was deferred on the March conference call. She stated that this agenda item proposes revisions to SSAP No. 71—Policy Acquisition Costs and Commissions, providing clarifications to the long standing levelized commissions guidance and providing guidance regarding commission that is based on policy persistency. She stated that the revisions clarify that a levelized commission arrangement, whether linked to traditional or nontraditional elements, requires the establishment of a liability for unpaid principal and accrued interest payable, regardless of the timing of payments made to a third party. Additionally, persistency commission shall be accrued proportionately over the policy period in which the commission relates, and it is not deferred until fully earned.

Ms. Marcotte stated that the exposed recommendations are intended to be consistent with the original intent of SSAP No. 71, which requires acquisition costs to be expensed as incurred. She noted that it is also intended to be consistent with the Statutory Statement of Concepts focusing on Recognition (noted in the Preamble, paragraphs 37 and 38), which states that liabilities require recognition as they are incurred, and accounting treatments, which tend to defer expense recognition, do not generally represent acceptable statutory accounting treatment. For instance, if a third party pays agent commission expense upfront, repayments to a third party need to be recognized as a liability for the funding agreement, even if repayment to the third party is not guaranteed. Even with the risk of non-repayment, SSAP No. 71 requires full recognition of the liability.

Ms. Marcotte stated that interested parties’ comments propose to delete most of the proposed revisions and propose new revisions redefining a funding agreement to only include instances in which repayment is guaranteed. She stated that this would conflict with the long-standing principles of SSAP No. 71, which require accrual of a liability even if repayment to the funding agent is not guaranteed.

Ms. Marcotte stated that comments received from Arcadia Capital Solutions focused on the potential negative impact of adopting the clarifying language, asserting that the proposed clarifying language is a substantive change to existing principles. She stated that in response to the comments concerning a substantive change, the proposed edits only clarify existing conceptual principles that have been in effect since before the 1998 codification of SAPs. She stated that it is believed that some reporting entities have intentionally ignored long standing statutory principles that require acquisition costs to be expensed when incurred, not deferred as is permitted under U.S. GAAP.

Ms. Marcotte stated that a third comment letter was received from Greenberg Traurig on behalf of DRB Insurance Solutions proposing guidance that upfront commissions that are prepaid by a third party should not be recognized as a liability when prepaid by a third party that was not under common control of the insurance reporting entity. This would presume that if an independent party paid commissions on behalf of the reporting entity, acquisition costs would be deferred. However due to the fact pattern being nearly identical, similar accounting treatment—i.e., expensing per SSAP No. 71—remains appropriate. Additionally, the third comment letter suggests that insurance brokers who fund the upfront commission expenses have assumed lapse risk; however, Ms. Marcotte noted that NAIC staff and state insurance regulators question the ability to transfer insurance risk to a noninsurance entity. She noted that insurance risks can only be transferred through a reinsurance agreement to another insurance entity.

Ms. Marcotte stated that because the revisions proposed by the commenters were inconsistent with the existing principles in SSAP No. 71, they are not viewed by NAIC staff as viable solutions. Accordingly, she stated that NAIC staff recommend adopting the exposed agenda item, which clarifies existing guidance that would not allow the use of a third-party agent

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agreement to delay recognition of a liability and expense from an in-force insurance contract. Additionally, a liability and expense are both incurred when the insurance contract is written, not when the payment is due. Ms. Marcotte stated that the accounting treatment necessary to reconcile current practice with the guidance as directed in SSAP No. 71 should be reflected as a correction of an error in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. She recommended that the Working Group provide direction on an effective date and review the additional proposed language regarding the correction of an error.

Mr. Bruggeman stated that the language proposed by NAIC staff only clarifies existing principles in SSAP No. 71, and he inquired of the Working Group if it had a similar understanding. He stated that the additional language regarding referencing SSAP No. 3 will likely warrant an additional exposure; however, it would be effective for year-end 2020. Mr. Hudson stated that California agrees that the language as proposed by NAIC staff represents a clarification to existing authoritative guidance. Ms. Mears indicated support for a year-end 2020 application.

Mr. Snowbarger stated that Oklahoma notes that the revisions will potentially affect some entities. He stated that Oklahoma is supportive of an additional exposure and supports the Working Group’s consideration of such.

Lynn Kelley (Delaware Life), representing interested parties, stated that companies would need adequate time to evaluate existing contracts and communicate with external regulators and auditors regarding the potential impact of such a clarification. Due to the extent of the measures required, she stated that interested parties request an effective date of Jan. 1, 2021, rather than year-end 2020, and they maintain that this clarification will be a significant change compared to how many reporting entities are applying the guidance.

Mr. Bruggeman stated that in terms of a Jan 1. 2021, effective date, additional considerations would likely be required, including disclosures, accruals, etc. However, with a Dec. 31, 2020, effective date, reporting entities should have adequate time to address concerns with their domestic regulators.

Danny Saenz (NTG Consultants) representing Arcadia Capital Solutions, stated that the changes proposed would have a significant impact on a number of its reporting entity clients, some incurring as much as a 30% reduction in RBC. He stated that while the proposed language may be insignificant to the SAPs, the financial impact would be significant to many insurance reporting entities. Additionally, this change may affect agents, through modified commission plans, and the public through possibly reduced insurance offerings. Mr. Saenz stated that the Working Group should also consider the broader economic environment—i.e., COVID-19’s financial impact on insurers—when determining an effective date. He stated that this business practice has been in place for years, and he requested that state insurance regulators provide an exception in an effort not to disrupt current business or marketplace practices. Additionally, he stated that the current practice does not negatively affect policyholders.

Mr. Bruggeman stated that he understands that this may have a significant impact on many reporting entities. Additionally, these nonsubstantive revisions may cease a current method utilized to ensure adequate capital to continue offering additional insurance products. Mr. Bruggeman stated that alternative methods, such as reinsurance, may need to be examined to preserve capital reserves or obtain capital relief.

Mr. Stolte stated that the guidance in SSAP No. 71 existed before the codification. He stated that the use of these finance agreements is a method to generate illusory surplus and circumvent the SAP of expensing acquisition costs as incurred. He noted that he finds this as problematic. He stated that Virginia would support adoption by Dec. 31. Policyholders are potentially affected by artificial surplus, and appropriate accounting is required for solvency regulation.

Mr. Saenz indicated that as a former regulator, this is not the first time regulators have seen insurance entities reporting transactions based on changes in how the market has developed or companies deviating from guidance based on marketplace interpretations. He said there are other regulatory tools to address this topic without causing some entities to face hazardous financial consequences. He noted that the reserves for policyholders are intact and unaffected by the commission agreements. Mr. Stolte noted that policyholders are affected by potentially illusory surplus.

Julie Mix McPeak (Greenberg Traurig), on behalf of DRB Insurance Solutions, stated that she understands the Working Group’s concern with deferring expense recognition; however, the proposed language captures all third-party financing arrangements, even those that are not affiliated. She stated that true independent, third-party financing should be excluded, as the reporting entity may not know the method or frequency in which the sub-agents are paid on behalf of the reporting entity.
She stated that there are many, varying commission arrangements, all of which would be affected by the modification to SSAP No. 71. She stated that levelized commission arrangements have existed since about 10 years prior to the 1998 codification, and they have continued after codification. Additionally, she stated that the proposed modifications will have a significant impact and should be considered substantive. She noted support for an additional exposure.

Mr. Bruggeman stated that his understanding is that the insurance reporting entity knows the individual agents who placed business on its behalf, as they are appointed by the insurance company. He requested clarification from Ms. McPeak on her comments regarding the insurer not knowing the agent’s compensation. She stated that it is the master agent/producer who is responsible for paying the sub-agents, and there are a number of ways the master agent has assumed the liability to compensate the sub-agents. She stated that the direct insurer may be unaware of the compensation agreement details between the master agent and the sub-agent. She stated that the payment examples include a bonus arrangement, immediate payment or trailing commission.

Mr. Bruggeman noted that there is a distinction between initial sales commission (acquisition cost) for a new policy and renewal commission, which is payable on the subsequent policy anniversary. He said requiring liability recognition of funding agreements, which attempt to delay the recognition of initial sales commission, is the intent of the clarifications. He noted that subsequent minor policy renewal commissions are not the focus of the agenda item. He stated that the naming conventions, which are being used in different ways, are clouding the issue. He noted that the principle is that the policy acquisition costs cannot be made the responsibility of a non-insurance entity. He noted that it is important that all parties are using terms consistently.

Ms. McPeak stated that the language defining levelized commission in paragraph 4 is so broad that it encompasses all types of commission arrangements between a master producer and a sub-agent; i.e., sales commission, trailing commission, heaped commission, partially heaped and trailing. She indicated that the obligation to pay the sub-agent has been transferred. She indicated that the current language is broad enough that it captures if the agents are paid in cash or “ham sandwiches.” She indicated that if the master agent is affiliated with the insurer, DRB Insurance Solutions agrees that the risk has not been transferred. She stated that only the contract and repayment terms between the master agent and the insurance reporting entity should be considered when referring to acquisition costs.

Mr. Bruggeman reiterated that the intent is that acquisition costs are expensed up front. He indicated that insurance companies should know and understand how their appointed agents are compensated in the marketplace. He stated that commenters should focus on specific paragraph and sentence references when relaying to the Working Group why certain practices are not within scope of the intent of SSAP No. 71, and those comments should be specific regarding the types of commission under discussion. Accordingly, first year commissions cannot be deferred or transferred, absent of a reinsurance contract. All first-year acquisition costs are to be expensed, not deferred or capitalized.

Brendan Bridgeland (Center for Insurance Research—CIR), NAIC consumer representative, stated that he shares the concerns expressed by a few state insurance regulators, including Mr. Stolte, with the deferral of certain acquisition costs thus creating illusory surplus. He stated his support for the clarifying language for SSAP No. 71.

Mr. Smith stated that per the AP&P Manual, substantive revisions introduce or modify accounting principles, while nonsubstantive revisions are characterized as language clarifications that do not modify the original intent of a SSAP. He stated that Virginia believes the clarifications proposed are nonsubstantive in nature, and the fact that this may have a material impact on a few insurers should not have bearing on being classified as nonsubstantive.

Martin Carus (Martin Carus Consulting) stated that as a consumer, he would be concerned if any accounting or solvency practice would have adverse policy pricing implications. He recommended that a cost benefit study be performed prior to implementing regulation or accounting action.

Mr. Stolte stated that consistency among insurers, so that state insurance regulators can ensure solvency, is the focus of statutory accounting. Mr. Bruggeman stated that the benefit to the consumer is solvency and financial statement comparability. He noted that nonsubstantive changes are clarifying the original guidance, and this is not introducing new principles.
Mr. Bruggeman stated a preference for a Dec. 31 effective date in the proposed revisions to expose the correction of an error in wording proposed by NAIC staff. He asked if any Working Group members preferred a different date, and no members indicated a preference for a different date.

Mr. Hudson made a motion, seconded by Mr. Stolte, to expose agenda item 2019-24, noting an anticipated effective date of Dec. 31, and the additional language regarding the correction of an error. The motion passed unanimously.

d. Tentative INT 20-09T

Mr. Bruggeman directed the Working Group to INT 20-09: Basis Swaps as a Result of the LIBOR Transition.

Mr. Pinegar stated that this interpretation is in response to a referral from the Financial Condition (E) Committee regarding an American Council of Life Insurers (ACLI) request relative to the accounting treatment of certain “basis swaps” issued as a result of the transition away from the London Interbank Offered Rate (LIBOR). INT 20-09T directs that basis swaps, received from central clearing parties (CCPs), shall be reflected as a “hedging other” transaction and shall be valued as a noneffective hedge (at fair value), unless the reporting entity can demonstrate and maintain appropriate documentation, evidencing that the basis swap derivative qualifies for effective hedge accounting per SSAP No. 86.

Mr. Hudson made a motion, seconded by Ms. Weaver, to adopt INT 20-09 for statutory accounting (Attachment One-U). The motion passed unanimously.

6. Considered Maintenance Agenda – Pending Listing – Exposures

Mr. Hudson made a motion, seconded by Ms. Malm, to move agenda items 2020-17 through 2020-30 to the active listing and expose all items for public comment. The motion passed unanimously.

a. Agenda Item 2020-17

Mr. Bruggeman directed the Working Group to agenda item 2020-17: Updating the SCA Review Process.

Ms. Sediqzad stated that this agenda proposes an update to the SCA filing review process required in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities. This process change would require financial statement filers to retrieve finalized SCA review information from VISION, which will eliminate the need for NAIC staff to manually insert this information into a template to be emailed to the filer.

Ms. Sediqzad stated that state insurance regulators would receive one monthly report with the details concerning all reviewed and approved SCA filings. As state insurance regulators currently receive a communication on every review, feedback is sought to ensure that going to a single, monthly email communication would not adversely affect operations.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

b. Agenda Item 2020-18

Mr. Bruggeman directed the Working Group to agenda item 2020-18: SSAP No. 97 Update.

Ms. Sediqzad stated that this agenda item provides a minor revision to corroborate previous revisions adopted in agenda item 2018-26, removing a remaining reference that guarantees or commitments can result in a negative equity value of an SCA.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

c. Agenda Item 2020-19

Mr. Bruggeman directed the Working Group to agenda item 2020-19: Clarifying Edits – Participating in Mortgages.
Mr. Pinegar stated that this agenda item proposes clarification edits to the statutory accounting guidance for participation in mortgage loans. He stated that the Working Group had previously adopted guidance detailing the requirements for a participating agreement and that the “financial rights” of the participant be on equal footing to that of the original lender. He stated that questions regarding the scope of the financial rights remain.

Mr. Pinegar stated that NAIC staff believe the scope was not intended to require the participant to have the sole ability to initiate legal action; foreclosure; or under normal circumstances, require the ability to communicate directly with the borrower. He stated that through collaboration with NAIC Securities Valuation Office (SVO) staff, state insurance regulators, and industry, it is believed that should these actions be a requirement, most participant agreements in the marketplace would no longer be in scope of SSAP No. 37—Mortgage Loans. He stated that this agenda item clarifies that the “financial rights” are to reflect cash flows, not necessarily other operational aspects that, under normal business circumstances, are reserved for the lead lender.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

d. **Agenda Item 2020-20**

Mr. Bruggeman directed the Working Group to agenda item 2020-20: Cash Equivalent Disclosures.

Mr. Pinegar stated that this agenda item adds an additional disclosure element that was intended in agenda item 2019-20: Rolling Short-Term Investments. He stated that agenda item 2019-20 adopted principle concepts restricting the classification of certain related party or affiliated investments as a cash equivalent or short-term investment. However, the agenda item only required disclosure of short-term investments, or substantially similar investments, that remain on the short-term schedule for more than one year.

Mr. Pinegar stated that this agenda item would require disclosure of both cash equivalents and short-term investments, or substantially similar investments, that remain on the same reporting schedule for more than one consecutive reporting period. Additionally, the revisions clarify that the disclosure is satisfied through the use of a reporting code in the investment schedules.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

e. **Agenda Item 2020-21**

Mr. Bruggeman directed the Working Group to agenda item 2020-21: SSAP No. 43R – Designation Categories for RMBS/CMBS Investments.

Mr. Pinegar stated that this agenda item reflects revisions recently adopted by the Valuation of Securities (E) Task Force concerning the accounting and reporting of residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) investments. He stated that the current financial modeling process remains unaffected; however, the NAIC designation produced by the financial model will now be mapped to an NAIC designation category. This final NAIC designation category will then be utilized for accounting and reporting purposes. This agenda item simply updates SSAP No. 43R—Loan-Backed and Structured Securities to reflect the updated practice of the NAIC Investment Analysis Office.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

f. **Agenda Item 2020-22**

Mr. Bruggeman directed the Working Group to agenda item 2020-22: Accounting for Perpetual Bonds.

Mr. Pinegar stated that this agenda item addresses the accounting treatment for perpetual bonds held as investments within the scope of SSAP No. 26R. A perpetual bond is a fixed income security, representing a creditor relationship, with a fixed schedule of future payments; however, it does not contain a maturity date. He stated that due to the numerous payment similarities between perpetual bonds and perpetual preferred stock, this agenda item proposes that similar accounting and reporting treatment be applied for these two instruments.
Mr. Pinegar stated that if adopted at the Fall National Meeting, NAIC staff would be supportive of a Jan. 1, 2021, effective date, which would correspond with the effective date of the substantially revised SSAP No. 32R, and it would require that perpetual bonds be reported at fair value, not to exceed any current effective call price.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

g. Agenda Item 2020-23

Mr. Bruggeman directed the Working Group to agenda item 2020-23: Leasehold Improvements.

Mr. Stultz stated that in response to the Working Group having previously adopted substantive revisions to SSAP No. 22R—Leases, this agenda item updates the guidance for the depreciable lives of leasehold improvements in SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements and SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities to reflect adopted guidance regarding the definition of lease terms in SSAP No. 22R. The updated guidance will allow leasehold improvements to have lives that match the associated lease term, including optional renewal periods, if these periods are anticipated to be exercised.

Mr. Stultz stated that while this may increase the depreciable life of these nonadmitted assets, it is not expected to have an impact on a reporting entity’s capital and surplus.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

h. Agenda Item 2020-24

Mr. Bruggeman directed the Working Group to agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans.

Ms. Gann stated that credit tenant loans (CTLs) that met certain structural requirements, as stated in the P&P Manual, have historically been captured in SSAP No. 43R. However, it was recently identified that some CTLs that do not meet the required structural analysis were reported on Schedule D, Part 1: Bonds as if they were in scope of SSAP No. 43R. One of the primary considerations for structural analysis is the concept of residual real-estate risk. Only CTLs that have little residual real-estate risk at the maturity of the loan are deemed to be “conforming.”

Ms. Gann stated the focus of this agenda item is to inquire about whether conforming CTLs should continue to be captured in the scope of SSAP No. 43R or whether these investments should be captured in SSAP No. 21R—Other Admitted Assets. If the Working Group determines that CTLs should remain in scope of SSAP No. 43R, statutory accounting revisions will be drafted to explicitly include CTLs that are on an SVO-identified listing in the scope section of SSAP No. 43R.

Ms. Gann stated that if this is the direction of the Working Group, further advisement will be necessary for the reporting of nonqualifying CTLs, such as in the scope of SSAP No. 37 and reported on Schedule B, or as an “other invested asset” under SSAP No. 21R and reported on Schedule BA.

Ms. Gann stated that an additional option is to move both conforming and nonconforming CTLs to the scope of SSAP No. 21R and report all CTLs on Schedule BA. With this approach, all CTLs would be reported on the same schedule, and revisions will be proposed to allow CTLs that are reviewed and approved by the NAIC SVO to be reported with an NAIC designation. This process will be similar to the existing approach for other non-bond items reported on Schedule BA that have underlying characteristics of fixed income instruments.

Ms. Gann stated that with this approach, there would not be a need for an SVO-Identified listing of qualifying CTLs. Pursuant to the P&P Manual, CTLs will not qualify as filing exempt (FE), and a CTL would need an SVO provided NAIC designation if there was a desire to obtain a more favorable RBC on Schedule BA.

Ms. Gann noted that the ability for a more favorable RBC on Schedule BA, based on NAIC designation, is only permitted for life entities; however, from information obtained, these investments are predominantly held by life entities. She stated that this agenda item does not make a recommendation, but it seeks feedback from state insurance regulators on the two proposed reporting options. Additionally, she stated that NAIC staff recommends notifying the Valuation of Securities (E) Task Force of this agenda item in response to its referral. With this notification, NAIC staff will request further confirmation that an
SVO listing could be developed to capture the CTLs that meet the SVO’s structural and legal analysis and possess bond characteristics.

John Garrison, representing an industry Lease-Backed Securities Working Group, stated that this agenda item overlaps with a referral received from the Valuation of Securities (E) Task Force. He noted that a third option is available, which would include reporting all conforming and nonconforming CTLs on Schedule D, Part 1, in the scope of SSAP No. 43R.

Mr. Bruggeman stated that the third option that was noted in comment letters to the Valuation of Securities (E) Task Force will not be included in the exposure item at this time. However, when the Working Group considers comments, letters issued to the Valuation of Securities (E) Task Force will be reviewed in conjunction with letters received by the Working Group.

Ms. Gann stated that the agenda item is in response to the referral received by the Task Force, and the reflection of the Task Force allowance to permit nonconforming CTLs to be reported on Schedule D, Part 1 for a limited time is addressed in the agenda item. She stated that comment letters received by the Task Force regarding this topic were included in the posted materials as requested by industry.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

i. **Agenda Item 2020-25EP**

Mr. Bruggeman directed the Working Group to agenda item 2020-25EP: Editorial and Maintenance Update.

Ms. Marcotte stated that this agenda item provides nonsubstantive editorial corrections in accordance with the maintenance process. She stated that the proposed revisions delete a redundant paragraph in SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets and add a table of contents for questions addressed in Exhibit A in SSAP No. 62R—Property and Casualty Reinsurance.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

j. **Agenda Item 2020-26**

Mr. Bruggeman directed the Working Group to agenda item 2020-26: ASU 2015-10, Technical Corrections & Improvements.

Ms. Sediqzad stated that the Financial Accounting Standards Board (FASB) issued ASU 2015-10 to update various FASB Accounting Standards for minor corrections or clarifications. She noted that the nonsubstantive revisions to Appendix D—Nonapplicable GAAP Pronouncements are to reject ASU 2015-10 as not applicable to statutory accounting.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

k. **Agenda Item 2020-27**

Mr. Bruggeman directed the Working Group to agenda item 2020-27: ASU 2019-09, Financial Services – Insurance; Effective Date.

Ms. Sediqzad stated that ASU 2019-09 defers the effective date of the amendments in ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts; however, ASU 2018-12 was previously rejected for statutory accounting. She noted that the nonsubstantive revisions to Appendix D reject ASU 2019-09 as not applicable to statutory accounting.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.
l. Agenda Item 2020-28

Mr. Bruggeman directed the Working Group to agenda item 2020-28: ASU 2020-01, Investments—Equity Securities (Topic 321), Investments—Equity Method and Joint Ventures (Topic 323), and Derivatives and Hedging (Topic 815), Clarifying the Interactions between Topic 321, Topic 323, and Topic 815.

Ms. Sediqzad stated that in January 2016, the FASB issued ASU 2016-01, Financial Instruments, Recognition and Measurement of Financial Assets and Financial Liabilities, which allows an entity to measure certain equity securities without a readily determinable fair value at cost, less any impairments. This alternative measurement method and ASU 2016-01 were previously rejected in their entirety for statutory accounting.

Ms. Sediqzad noted that the nonsubstantive revisions reject ASU 2020-01, and they are proposed to SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies, SSAP No. 86, and SSAP No. 97.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

m. Agenda Item 2020-29

Mr. Bruggeman directed the Working Group to agenda item 2020-29: ASU 2020-05—Effective Dates for Certain Entities. Mr. Stultz stated that ASU 2020-05 updates the effective dates for ASU 2014-19, Revenue from Contracts with Customers (Topic 606) and ASU 2016-02, Leases (Topic 842), both of which were previously rejected for statutory accounting. He noted that the nonsubstantive revisions to Appendix D reject ASU 2020-05 as not applicable to statutory accounting.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

n. Agenda Item 2020-30

Mr. Bruggeman directed the Working Group to agenda item 2020-30: Premium Refunds and Other Adjustments.

Ms. Marcotte stated that this agenda item provides more explicit guidance on the return of premium and other premium adjustments. The need for enhanced guidance was noted during the discussions of INT 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends. She stated that agenda item 2020-30 was to gather conceptual feedback on guidance to address premium refunds and other policy adjustments for both property/casualty and accident & health lines of business.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

7. Discussed Other Matters

a. Agenda Item 2019-21

Ms. Gann provided an update that the issue paper to review and consider substantive revisions to SSAP No. 43R has a comment deadline of July 31. A subsequent conference call will be scheduled to consider comments and continue discussion.

b. Deferred Items

Mr. Bruggeman stated that due to time constraints, the Working Group did not discuss the following items; however, discussions will continue on a subsequent conference call or national meeting:

- Ref #2018-07: Surplus Note Accounting – Referral from the Reinsurance (E) Task Force
- Ref #2019-12: ASU 2014-17, Business Combinations, Pushdown Accounting
- Ref #2019-49: Retroactive Reinsurance Exception
c. Referrals

Mr. Bruggeman noted that the referral received from the Valuation of Securities (E) Task Force regarding the accounting and reporting of CTLs (Attachment One-V) is addressed in agenda item 2020-24. Additionally, the referral received from the Financial Condition (E) Committee (Attachment One-W) has been addressed with the adoption of INT 20-09.

d. Review of U.S. GAAP Exposures

Mr. Pinegar stated that the FASB has issued an exposure draft concerning possible modifications to the U.S. GAAP concepts framework for financial reporting. He stated that concepts statements are not authoritative, and they do not override authoritative standards. However, if accounting for a transaction or event is not specified in authoritative guidance, an entity will then consider accounting principles or concepts for similar transactions or events. Regarding statutory accounting, U.S. GAAP concepts are mentioned in the preamble as a level 4 in the statutory hierarchy, coming in just above other non-authoritative accounting literature.

Mr. Pinegar stated that the exposure draft proposes modifications to the historical conceptual definitions of an asset and liability; however, the changes will only be used to further develop standards for financial accounting and reporting, and any changes in terms should not result in the movement of any financial item.

Mr. Pinegar stated that the FASB is considering two changes to the conceptual definition of an asset: 1) removal of the terminology ‘past transaction or event,’ as the FASB believed the phraseology to be redundant; and 2) elimination of the term control while maintaining the notion of control. He stated that in terms of control, an asset must give the entity rights to the economic benefit, not necessarily control of the asset itself.

Mr. Pinegar stated that the FASB is also considering two changes to the conceptual definition of a liability: 1) removal of the terminology ‘past transaction or event,’ as the FASB board believed the phraseology to be redundant; and 2) removal of the term ‘probable.’ He stated that the FASB has indicated that other concepts, such as “the notion of having little or no discretion to avoid future sacrifices” or “an obligation that requires the transfer of assets or providing services,” may be elevated in the replacement of the term ‘probable.’

Mr. Pinegar stated that SSAP No. 4—Assets and Nonadmitted Assets and SSAP No. 5R are the two SSAPs that may require consideration of definitional revisions, as these both directly reference FASB accounting concepts. He noted that any possible changes should not cause any financial statement impact, and a comment letter to the FASB is likely not required; however, NAIC staff are preparing a memorandum for the Working Group, detailing the exposure draft and any potential statutory accounting impact.

Mr. Bruggeman stated that with the exception of INT 20-02, INT 20-04 and INT 20-05, which have a comment deadline of Aug. 14, the comment deadline for all exposed agenda items is Sept. 18.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
Statutory Accounting Principles (E) Working Group
E-Vote
July 15, 2020

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded July 15, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair (IA); Shelia Travis (AL); Kim Hudson (CA); William Arfanis (CT); Ryllynn Brown (DE); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Joe DiMemmo (PA); David Smith (VA); and Amy Malm (WI).

1. Exposed INT 20-09

The Working Group conducted an e-vote to consider exposure of Interpretation (INT) 20-09: Basis Swaps As a result of the LIBOR Transition for a seven-day public comment period ending July 22. A summary of the exposed interpretation is as follows:

- INT 20-09 - This guidance proposes provisions for the accounting and reporting of certain “basis swaps.” Basis swaps are defined as compulsory derivatives issued by Central Clearing Parties, for certain cleared derivatives issued solely in response to the market-wide transition away from the London Interbank Offered Rate (LIBOR) and toward the Secured Overnight Financing Rate (SOFR). The interpretation directs that the basis swaps shall be reported as “hedging – other” and reported at fair value, thus qualifying for admittance; however, the basis swaps cannot be considered or reported as “effective” hedging derivatives unless the instrument qualifies with the required documentation as a highly effective hedge as directed in Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives.

Ms. Mears made a motion, seconded by Mr. Moser, to expose INT 20-09. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met via conference call June 15, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); Kathy Belfi (CT); Rylynn Brown (DE); Eric Moser and Kevin Fry (IL); Stewart Guerin (LA); Steve Mayhew (MI); Doug Bartlett (NH); Tom Dudek (NY); Joe DiMemmo (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Reviewed Comments on Exposed Items and Adopted the Consensus in INT 20-08 With Modifications

The Working Group held a public hearing to review comments (Attachment One-B1) on previously exposed items. Julie Gann (NAIC) stated that prior to discussing any topics, the tentative interpretation (INT 20-08), per the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, must have 67% of the Working Group members voting with a super majority supporting adoption.

a. INT 20-08

Mr. Bruggeman directed the Working Group to INT 20-08: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends. Robin Marcotte (NAIC) stated that this interpretation was exposed to address questions related to refunds, rate reductions and policyholder dividends in response to decreased insured activity related to COVID-19 stay-at-home orders. She noted that the overall guiding principle is that the accounting shall follow existing statutory accounting principles and annual statement reporting, where feasible. The interpretation noted that accident and health (A&H) and multiple property/casualty (P/C) lines of business had offered refunds, rate reductions or policyholder dividends, all of which were performed in a variety of methods, warranting the numerous discussion issues in this interpretation.

Ms. Marcotte stated that several comment letters were received, noting that most commenters focused on Issue 1: How to account for refunds not required under policy terms.

Ms. Marcotte stated there seems to be general support for:
- Issue 2: How to account for refunds required under policy terms.
- Issue 3: How to account for rate reductions on in-force and renewal business.
- Issue 4: Requires policyholder dividends to follow existing guidance and complete the disclosures per Issue 5.
- Issue 5: Requires reporting entities to comply with statutory accounting disclosure requirements, and requires that all premium refunds, rate reductions or policyholder dividends provided because of the decreased activity due to COVID-19 be aggregated and reported in Note 21A as unusual and infrequent items. She noted that the P/C actuaries who perform rate reviews and analysis noted that transparency will assist them in evaluating 2020 activity.

Ms. Marcotte stated regarding issue 1, the refund will be an adjustment to written or earned premium with corresponding adjustments to unearned premium, as applicable. Liability recognition is required in accordance with Statement of Statutory Accounting Principles (SSAP) No. 5R—Liabilities, Contingencies and Impairments of Assets. It also states that refunds that are recognized in a different manner (e.g., as an expense) shall be considered a permitted or prescribed practice pursuant to SSAP No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures. She stated Issue 2 specified that refunds required under policy terms shall be recognized as an adjustment to premium. However, discounts on future business shall be recognized during the future policy period. Issue 3 addresses rate reductions on in-force and renewal business and requires rate reductions on in-force business to be recognized as immediate adjustments to income. Additionally, rate reductions on future business shall be reflected in premium upon renewal. Issue 4 requires policyholder dividends to continue following existing guidance and to complete the disclosures described in Issue 5. She stated that the interpretation notes that premium taxation requirements vary by jurisdiction and is determined by each jurisdiction as to whether premium taxation that occurs on premium is written or returned to the policyholder. Additionally, due to the short-term nature of the items included, this interpretation will be automatically nullified on Jan. 1, 2021.
Ms. Marcotte stated the Working Group received nine comment letters. She noted, however, that comments received were not regarding the modifications added to the May 20 exposure. She stated the primary issue for discussion is whether to allow reporting entities that filed policy endorsements, allowing the insurers to voluntarily provide a return of funds to policyholders, to report the payments as a return of premium or as an other underwriting expense. She stated that some of the current and prior comment letters were in support of treating voluntary payments or rate reductions to policyholders as an adjustment to premiums. Additionally, the comment letter provided by the Connecticut Department of Insurance (DOI) was also supportive of premium adjustments and further supported guidance in the interpretation, which also provides that if reported as an underwriting expense, it should be a prescribed or permitted practice. UnitedHealth was supportive of reporting as an adjustment to premium. Ms. Marcotte noted that UnitedHealth also provided comments specific to the health industry. UnitedHealth noted that the exposed guidance is consistent with current accounting guidance for other types of premium refunds that are required by either policy terms or regulations. She additionally stated that UnitedHealth indicated that any associated liability should be reported as an aggregate write-in since the premium refund was not required by policy terms, and therefore would not be accounted for as retrospective or redetermination premium liability.

Ms. Marcotte stated several comment letters expressed support for allowing the voluntary payments or return of funds to policyholders to be reported as an other underwriting expense, especially if the policy endorsement allows discretionary payments to the policyholder at the option of the insurer. This approach was supported by the Illinois DOI, Allstate, Cincinnati Insurance Companies, Co-operative Insurance, Grange, National Association of Mutual Insurance Companies (NAMIC) and Progressive.

Ms. Marcotte stated the Illinois DOI indicated support that if an insurer has filed and received approval for policy endorsements related to such payments, then those payments would be reported as an expense in their statement of operations. She stated that comments received from industry included that amounts returned to policyholders were not as a result of re-underwriting or analysis of loss data. However, the credits were determined on a percentage of premium, and the use of an underwriting expense classification was preferred in an effort to avoid having an impact on non-policyholder stakeholders such as agent commissions or state premium taxes; additionally rate plans were not refiled with state insurance departments. Ms. Marcotte stated that Co-operative, Grange and NAMIC provided mutual specific comments indicating that even though they were not able to provide dividends to isolated lines of business, they viewed these policyholder payments as an expense as they are akin to the treatment of a policyholder dividend. Additionally, NAMIC supported allowing the reporting entity to choose between recognizing the relief payment as an expense, a premium refund, policyholder dividend or an up-front bad debt expense. Further, NAMIC’s position supported the reporting of relief similar to a dividend, even if they were not technically policyholder dividends, so the payments are reflected in the combined ratio, not the pure loss ratio.

Ms. Marcotte stated that U.S. generally accepted accounting principles (GAAP) specific comments were received from Allstate and Progressive. Allstate indicated support for other underwriting expense treatment, although it acknowledged that expenses related to insurance contracts are those typically paid or incurred in connection with originating and servicing a contract. Allstate viewed that it is appropriate to classify the incremental amount paid to the customer as a policyholder expense for U.S. GAAP and as an other underwriting expense for statutory accounting. She stated that Progressive indicated it was not aware of a difference between statutory accounting and U.S. GAAP as it relates to the accounting for insurance premiums. However, similar to other several public company registrants, it recorded the policyholder credits and payments as an underwriting expense when filing its Form 8-K with the U.S. Securities and Exchange Commission (SEC). The GAAP accounting treatment was based on the underlying premise that the credits and payments are akin to a policyholder dividend and are in essence noncontractual discretionary returning of profits that resulted from a reduction in loss due to the shelter-in-place order. Additionally, the relief payments to policyholders was determined on an enterprise-wide level as opposed to a contract level.

Ms. Marcotte stated that NAIC staff recommended regulator discussion of the two various approaches discussed. She recommended adoption or re-exposure with two minor modifications that addressed minor health-specific comments received from UnitedHealth. She stated that the Working Group has the ability to adopt individual issues within the interpretation while continuing discussion on other topics (i.e., adopting Issues 2–5, while continuing discussions on Issue 1). She noted that NAIC staff are concerned with the comparability issues that would result from allowing different options for reporting discretionary payments to policyholders, such as reporting as reduced premium, an underwriting expense or an uncollectible bad-debt expense. She said that NAIC staff recommend that such reporting would be a prescribed or permitted practice because existing statutory accounting guidance requires the return of such monetary items to policyholders be recognized as an adjustment to premium. Ms. Marcotte stated that the principle of reversing premium in the same manner in which the premium was originally recognized continues to apply. She noted that this principle is critical to health insurers, which are subject to the medical loss ratio (MLR) calculations. She stated that while the state of domicile can provide a prescribed or permitted practice, other jurisdictions may choose not to accept the prescribed or permitted practice. The non-domiciliary state can provide other.
direction and require differing financial statement reporting as it deems appropriate. She stated underwriting expense recognition criteria related to insurance contracts are typically for those items paid or incurred in connection with originating and servicing the contract; these discretionary payments are not for that purpose. The payment is not consistent with any of the underwriting expense categories and is not a cost of servicing the policy, but rather a voluntary payment at the option of the insurer, generally returning previously billed premium.

Mr. Hudson and Ms. Belfi stated support for the amendments that NAIC staff proposed, incorporating minor modifications stating the liability for voluntary health premium refunds attributable to COVID-19 and that are not required under the policy terms shall be recognized in aggregate write-ins for other liabilities (while also adjusting premium).

Ms. Belfi stated an important aspect regarding statutory accounting is the concept of consistency and while states have been flexible in meeting many of the requests of industry due to COVID-19, consistent reporting would be supported by the Connecticut DOI. Ms. Belfi noted that additionally, if certain domestic states wish to grant additional reporting flexibility, the permitted practice procedures provide for such an avenue. Mr. Stolte stated agreement with Ms. Belfi and stated that Virginia will associate itself with the position of consistent reporting per the statement of concepts as developed during the codification of statutory accounting principles, unless a domestic regulator provides a permitted practice.

Mr. Moser stated that Illinois supported flexibility in reporting, noting that while consistency is important, consistent reporting would likely not occur due to the high number of permitted practices that will likely occur if the Working Group does not permit flexibility in the interpretation. He stated that comparability will be affected due to the wide range of insurers and wide range of methods in which proceeds were returned to policyholders. He stated that Illinois believes that if an insurer has filed and received approval for policy endorsements related to such payments, then those payments would be reported as an expense in their statement of operations, as the policy endorsement allows such policyholder payments.

Kevin Spataro (Allstate) stated support of the interpretation as it relates to premium refunds, rate reductions and policyholder dividends, but he stated the interpretation should be expanded to include accounting and reporting guidance for discretionary payments provided to policyholders pursuant to policy endorsements that were not designed to be and are not premium refunds, rate reductions or policyholder dividends. He stated that Allstate executed a policy endorsement because it was believed to be in the best interest of policyholders and did not want to negatively affect other parties, such as reduced commissions to agents or reduced premium taxes to states. Additionally, a rate filing was not elected due to the fact that at the time the funds were disbursed to policyholders, actuarial information such as differences in crash severity, distracted driving or other vehicle uses was not available; thus, an amended rate filing was not a viable option. Additional investment returns were also unknown, which is a critical component of a rate filing. Mr. Spataro stated that dictating an accounting method could potentially be penalizing to the organization, however, understanding that this is an unprecedented event requiring special attention. He stated that upon its review of the statutory accounting principles, Allstate believes the nature of its payments to policyholders would qualify as another underwriting expense and supports expanded comprehensive disclosures of the elective policyholder COVID-19 relief payments. Mr. Spataro stated that the discretionary payments did not affect any reinsurance agreements as Allstate’s agreements only cover excess losses.

Mr. Stolte asked Mr. Spataro for information on how reporting entities could be disadvantaged by a permitted or prescribed practice, should the Working Group direct consistent reporting among all filers. He stated that state analyst would then appropriately review footnote 1 in the statutory financial statements to assess the impact of any permitted practice. Mr. Spataro stated he believes the disadvantage would be that the financial statements would not reflect the nature and characteristics of the program and, thus, not reflect the substance of the transaction. That is, they would reflect a discretionary payment as an expense, not a reduction in premium.

Birny Birnbaum (Center for Economic Justice—CEJ) stated the CEJ began calling for premium relief payments at the early onset of COVID-19. He stated the relief was in correlation with the reduction in risk exposure of affected policies—i.e., a significant reduction in automobile usage. The aggregate risk exposures for current policies reflect an overnight reduction in risk, and the return of funds reflect the return of premium associated with the reduced insured risk. Additionally, premium relief was only provided on in-force policies, and in many cases, the relief was calculated as a percentage of premium for a certain number of affected months. The proposed accounting treatment is analogous to removing a vehicle off a policy, thus resulting in a refund due as the risk transferred to the insurance company was reduced. Similarly, due to a significant number of vehicles not driving, the risk transferred to the insurance company was greatly reduced. He stated support for the accounting treatment as a return of premium, which would assist in the comparability of financial statements.
Rachel Underwood (Cincinnati Insurance Companies) stated support for recognizing as an expense those relief payments made in relation to nonparticipating policies without premium refund terms in response to decreased activity due to COVID-19. She stated that per SSAP No. 53—Property Casualty Contracts—Premium, premiums are defined as the contractually determined amount charged by the reporting entity to the policyholder for the effective period of the contract, based on the expectation of risk, policy benefits and expenses associated with the coverage period provided by the terms of the insurance contract. Additionally, premium adjustments due to changes in the exposure level are generally determined based upon audits conducted after the policy terms. She stated her position is that the relief provided to policyholders was outside the scope of both of these statements. She noted that payments made to policyholders were made in the absence of loss data. Additionally, while the insured risk was reduced for a couple of months, premium charged for the policy covers the entire policy period, not just a short time frame, such as two months. Thus, the relief should not be solely affiliated with premium. However, the relief provided to policyholders is akin to a policyholder dividend, but that option was not available as the policies written by Cincinnati Insurance Companies are not participating policies and thus are not eligible for dividends. Ms. Underwood stated that voluntary payments were in an effort to help policyholders, similar to how a donation would be accounted for as an expense. Additionally, the impact of a premium reduction would negatively affect producers through reduced commissions and states through reduced premium taxes. She stated concerns with pursuing the permitted practice process because it is uncertain whether the state will approve the request, and for those states that do not approve the deviation, further inconsistent reporting will likely result. Additionally, if a holding company has two reporting entities in two different jurisdictions, depending upon the permitted practice granted (i.e., permitted in one state and not in another), a holding company may have to report the same transaction in differing methods (i.e., one as an expense, one as a reduction in revenue). Ms. Underwood stated that the company’s reinsurance agreements would likely be affected if the relief payments are reported as a reduction in premium.

Mr. Stolte stated that through the use of a permitted practice, and its disclosure in footnote 1 of the statutory financial statements, entities would be able to quickly identify and reconcile any differences from adopted statutory accounting guidance. He stated he would support this continued, traditional approach because allowing reporting entities with flexibility in reporting would negatively affect reporting consistency among the industry.

Ms. Belfi stated that during the financial crisis, multiple permitted practices were given to multiple companies covering a wide range of issues. However, despite this, there were not any issues with comparability due to the details that are required to be provided in footnote 1. In a similar manner, the financial crisis affected an entire industry and is analogous to the COVID-19 events of today.

Jonathan Rodgers (NAMIC) stated that this event is unprecedented and that there is great diversity of actions and preferences among NAMIC’s members. He stated that characterizing the return of funds to policyholders as a return of premium does not work for everyone. Due to the unprecedented nature of the return of funds to policyholders, without flexibility being granted by the Working Group, state regulators will see an unprecedented volume of permitted practice requests. Without flexibility, the process of obtaining a permitted practice will create an unnecessary hurdle as flexibility could be granted, thus not requiring the exercise, cost and uncertainty in requesting a permitted practice. The return of funds to policyholders was done in a sense of urgency and generally with ongoing communications with domestic regulators. Additionally, at the time the funds were given, loss data was not known and not a factor. Thus, relief payments should not be considered a return of premium. If treated as a reduction in premiums, the loss ratio, an important metric, would be improperly negatively affected. While not viewed as a return of premium, NAMIC was supportive of enhanced disclosures, detailing the impact of the COVID-19 relief payments. Mr. Rodgers stated if the Working Group elects to treat the relief payments as a reduction in revenues, the impact will be felt by agents through reduced commissions and by states through reduced premium taxes.

Mariann Marshall (Progressive) stated support for allowing reporting entities to classify the policyholder credit as an other underwriting expense. She stated Progressive filed a policy endorsement, not a rate filing, to authorize and facilitate discretionary credits and payments to policyholders in response to the COVID-19 pandemic. She stated that the process to obtain a permitted practice from every state would be problematic for insurers, especially in light of not knowing which states would permit the reporting exceptions. Additionally, if not granted by all states, holding companies would have inconsistent reporting among downstream reporting entities. She said that while Progressive is supportive of reporting flexibility, it is also supportive of enhanced disclosures so regulators could assess the impact of the COVID-19 relief payments. She stated the funds provided to policyholders were done solely in the interest of the policyholders. However, if required to be treated as a reduction of premium, agents would be negatively affected through reduced commissions, and states would be negatively impacted through reduced premium taxes. Ms. Marshall stated that if treated as a premium reduction, their reinsurance agreement would be negatively affected and would likely result in the reinsurer refunding reinsurance premiums paid by Progressive. She noted that no differentiation was made between policyholders in terms of the COVID-19 relief payments. Thus, all auto customers received some relief funds. Ms. Marshall stated that premiums received from policyholders were only...
used as a beginning basis for the determination of the amount of relief payment received. However, in the absence of loss data, Progressive viewed the payments as an expense, not a policyholder refund.

Mr. Birnbaum stated many of the comments received today reference the absence of loss data, thus the inability to amend a rate filing. However, insurers recognized the insured risk drastically dropped, and in the absence of a premium refund, the rates compared to the insured risk were excessive. He said due to this fact, these relief funds reflect a reduction in risk exposure and thus warrant accounting treatment as a reduction in premiums.

Ms. Underwood stated their belief was that a relief payment should be most appropriately reflected in an entity’s combined ratio, not the pure loss ratio, because the payments are akin to a policyholder dividend (returning excess profits). Additionally, while the insured risk was reduced for a short period of time, the insurance policy covers a significantly larger time frame, thus requiring a one-time relief payment, based on a temporary reduction of risk, to be accounted for as returned premium was not appropriate, in their view.

Mr. Spataro stated Allstate’s intention was to act in the best interest of the policyholder and did not have the actuarial data necessary to underwrite or rate the policy. Thus, the relief payments were not necessarily reflective of a reduction in risk that would be associated with a reduction in premium.

Mr. Birnbaum stated disagreement with the commenters in that the relief payment was not for the term of the policy period, but in fact was only for the short-term period, which reflects the reduced activity and lower insured risk. He stated insurance companies had real-time claims information and were aware of the significant reductions in claims. Without these premium relief payments, insurers would have experienced windfall profits. Thus, the accounting treatment as a reduction in premium is most appropriate.

Jim Braue (UnitedHealth Group—UHG) stated UHG agrees with the treatment of the relief payments as a reduction to written or earned premiums, in that this treatment reflects the substance of the transaction. He stated this treatment is consistent with the intent of the transaction (a return of premium to the policyholder) and is consistent with current accounting guidance for other types of premium refunds that are required by either policy terms or regulations. The timing of recognition of the premium refund also corresponds with the associated coverage period affected by the premium action. In the case of premium refunds issued for current or prior coverage periods, the recognition should be in the current reporting period. However, in situations where the premium rate is being reduced over the remaining policy period, the premium reduction may need to be recognized over the policy period affected. Additionally, with respect to any liability required to be recognized in accordance with in SSAP No. 5R, UHG believes the liability should be reported as an aggregate write-in since the premium refund was not required by policy terms, and therefore would not be accounted for as retrospective or redetermination premium liability. He stated if concerns continue regarding accounting for the relief payments as a reduction of premiums, bad debt expense may be the next logical choice. However, the reduction of premiums remains the most appropriate accounting treatment.

Steve Broadie (American Property Casualty Insurance Association—APCIA) stated the APCIA has had continuing discussions with its members and supports the position that if an insurer has filed an endorsement or an amended rate filing with the state, it communicated its intent to report the relief payments as a policyholder expense and should be allowed to do so while disclosing those payments per the requirements of this interpretation. This treatment would allow insurers that have taken such actions to be allowed to continue their earlier accounting treatment and not be disadvantaged by a subsequent accounting guideline as directed by the Working Group.

Keith Bell (Travelers) stated the evaluation process that Travelers used to arrive at the conclusion that these relief payments are in fact a reduction in premium may be helpful to the Working Group. First, Travelers eliminated categories of what the relief payments were not. He stated that the relief payments are not losses, as they are not a covered loss under the terms of the policy. Additionally, they do not reflect loss adjusting expenses as they are not payments to a third-party for cost containment, adjusting, etc. Mr. Bell noted that these clearly are not investment expenses, and they do not represent bad debt expense because in many cases, the relief was provided as a reduction of future premiums due. With regard to other underwriting expenses, a current category for discretionary policyholder payments does not exist, so that generally precludes its use. He stated that after eliminating the expense categories, the Statutory Hierarchy in the Preamble was reviewed for further guidance. Revenues are generally defined as cash inflows as a result of continuing business operations, while expenses are generally defined as cash outflows as a result of continuing business operations. While the types of expenses vary by industry type, they all share a common component in that they reflect cash outflows to a third party for the payment of goods or services. Thus, payments to customers that do not involve the purchase of goods or services should not qualify as an expense. He stated the relief payments reflect the reduced exposure of risk and most logically should be reflected as a premium reduction. Additionally, he noted that
other accounting issues may need to be considered if the policy has been modified to include a discretionary, noninsurance-related payment. If such a modification has occurred, he stated some of the inflows from premium should be reclassified because they may no longer reflect premium payments associated with the transfer of risk. He also stated concern that if the accounting treatment for transactions follows the label associated with a state filing, the accounting for transactions would vary greatly and likely no longer follow the essence of the transaction. He stated that across all legal entities, Travelers reported such transactions as a reduction in premium for both policyholders and intercompany reinsurance agreements. Mr. Bell stated that not withstanding the differences in opinion regarding accounting treatment, insurance companies did the right thing for policyholders in providing some type of relief as a result of the reduced activity resulting from COVID-19.

Mr. Bruggeman stated he is open to flexibility in reporting, noting that these payments are akin to a policyholder dividend. However, he stated he wants to consider an alternative approach, such as an aggregate write-in for miscellaneous income as a negative, used solely for the purpose of the COVID-19 relief payments. He stated he understood the relief provided was not necessarily specific to underwriting, was provided to all applicable policyholders, and was performed at an enterprise level rather than at an individual policy level. The challenge with maintaining comparability and consistency with this issue is that the formula used to determine relief payments varied greatly (i.e., a percentage of premium, a minimum payment, etc.) among all insurers. He stated he would be open to situational accounting of not necessarily requiring a reduction in premium. However, he stated he prefers an aggregate write-in for miscellaneous income as a negative, allowing for easier identification and analysis for use in future rate filings. Additionally, the aggregate write-in for miscellaneous income method would not affect many of the performance ratios used for analysis purposes. Mr. Bruggeman stated he agrees with earlier regulator comments regarding the usefulness of a permitted practice. However, he stated the diversity of acceptance could create additional comparability issues.

Mr. Hudson stated California is supportive of the comments received regarding accounting for the relief payments as a reduction of premium and appreciated comments received that detailed the many perspectives on this issue. Ms. Mears stated Iowa is also supportive of the position to account for these transactions as a reduction of premium, and any deviations should be a permitted or prescribed practice.

Mr. Hudson made a motion, seconded by Ms. Belfi, to adopt the consensus in INT 20-08, with the modification as proposed by NAIC staff, for statutory accounting (Attachment One-B2). The motion passed, with Delaware and Illinois dissenting and Alabama abstaining.

2. Considered Maintenance Agenda—Pending Listing—Exposures
   a. Agenda Item 2020-16EP

Mr. Bruggeman directed the Working Group to agenda item 2020-06EP: Editorial and Maintenance Update. Jim Pinegar (NAIC) stated that this item provides non-substantive editorial updates in accordance with the maintenance process and updates a reporting line reference and corrects sentence structure for guidance in SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments.

Mr. Hudson made a motion, seconded by Mr. Guerin, to expose this agenda item for a 30-day public comment period ending July 15. The motion passed unanimously.

3. Discussed Other Matters
   a. ACA risk Corridors – Supreme Court

Ms. Marcotte stated that in April, the Supreme Court of the United States issued an opinion stating insurers were entitled to pursue more than $12 billion in unpaid federal Affordable Care Act (ACA) risk corridor payments from the 2014 to 2016 program. She noted that the recent Supreme Court decision, in favor of four insurers, only provides the ability to seek payment through a damages action via the Court of Federal Claims. As such, at this time, and until resolution is reached through the damages action process, reporting entities would not have any new accruals or admission of a previously nonadmitted accrual for a risk corridor receivable. This is consistent with INT 15-01: ACA Risk Corridors Collectability. In addition, SSAP No. 5R prevents the recognition of gain contingencies until the transaction is fully completed and determinable, so it would be improper to accrue amounts at this time. Ms. Marcotte asked the Working Group if additional guidance was needed because many accounting inquiries have been received.
Mr. Bruggeman stated he believes INT 15-01 appropriately addresses the inquiries and directed NAIC staff to refer inquirers to existing guidance, noting that updates will occur as the pursuit of recoveries progresses through the Court of Federal Claims.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
## Comment Letters Received for Items Exposed for the June 15, 2020 Conference Call

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DATE: June 5, 2020

TO: Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles (E) Working Group

FROM: Kathy Belfi, Director of Financial Regulation for Connecticut

SUBJECT: INT 20-08T – COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

Thank you for the opportunity to comment on INT 20-08T.

Connecticut supports the "tentative consensus" points related to reduction of premium.

Due to COVID-19, there has been changes in insured exposures resulting in lowering of premiums (causing premium refund payments). Current statutory guidance requires upon return of premium to policyholders, earned premiums should be reduced.

We agree that if a company reports the refund as an expense it should be disclosed as a permitted or prescribed practice.

Thank you for your consideration.

Kathy Belfi

cc: Julie Gann, NAIC Staff
Robin Marcotte, NAIC Staff
William Arfanis, Connecticut Insurance Department
Michael Estabrook, Connecticut Insurance Department
June 1, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles (E) Working Group
Sent via email

Re: INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends.

Dear Mr. Bruggeman,

The Illinois Department of Insurance (“IDOI”) has reviewed this item and would like to provide comments.

The IDOI is the lead state regulator for several large insurance groups that write auto and other lines of business addressed by INT 20-08T. It is the IDOI’s position that there should be flexibility regarding the accounting treatment for monies given back to policyholders related to the current pandemic conditions. Particularly, if an insurer has filed and received approval for policy endorsements related to such payments, then the IDOI believes those payments would be reported as an expense in their Statement of Operations if the policy endorsement would allow as such. In our opinion, the most important reporting consideration for these payments is that adequate disclosure is provided in the financial statement, and that requirement appears to already be included in the INT as written.

Please let us know if there are further questions.

Sincerely,

Eric Moser, AIAF
Assistant Deputy Director, Financial Analysis
Illinois Department of Insurance
June 5, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

The Allstate Corporation (Allstate) appreciates the opportunity to comment on the re-exposure of Statutory Accounting Principles Working Group (SAPWG) INT 20-08T, COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends (INT) which addresses the accounting for certain payments to policyholders due to reduced economic activity as a result of COVID-19.

While Allstate supports the content of the INT as it relates to premium refunds, rate reductions, and policyholder dividends we believe the scope of the INT is incomplete and should be expanded to include accounting and reporting guidance for discretionary payments provided to policyholders pursuant to policy endorsements that were not designed to be and are not premium refunds, rate reductions, or policyholder dividends. Moreover, because discretionary policyholder payments provided through policy endorsements were designed to meet the same objective (i.e., providing policyholder relief due to COVID-19 circumstances), albeit in a different manner, we believe the accounting and classification should be addressed in the same INT as opposed to a separate INT or through a separate regulatory process.

In response to the COVID-19 pandemic, insurers designed and implemented a variety of programs to provide payments to policyholders in recognition of decreased vehicle usage and claim experience due to the presence of shelter in place (SIP) orders that existed in many states throughout the country. In the case of Allstate, we designed a program to provide discretionary payments to policyholders in the most practically expedient manner and without impacting non-policyholder stakeholders; e.g., agents and states in which we conduct business.

While certain insurers designed and executed policyholder payment programs attributable to the impact of SIP orders in the form of premium refunds, rate reductions, and policyholder dividends, others, including Allstate, designed and executed programs in the form of discretionary payments to policyholders made pursuant to policy endorsements. After thoughtful consideration of the alternatives, Allstate utilized the filing of policy endorsements as opposed to a premium refund or rate reduction (policyholder dividends was not an available option) to expedite the payment process and because we did not have the ability to re-underwrite the underlying risks and re-determine the amount of premium we would have charged under SIP conditions. Specifically, we did not possess the actuarial data necessary to complete the full re-underwriting exercise we believe would have been necessary to support a premium refund or rate reduction. Moreover, while we had information about reduced miles driven, we did not possess reliable information to predict the future path of the pandemic or its impact on accident frequency which is influenced by driving habits (including speed, distracted driving, etc. for miles driven), incidence of loss, and loss severities.
Notwithstanding our inability to re-underwrite our policyholders and adjust premiums, we possessed enough information to provide relief to our policyholders in the form of discretionary payments. Our ultimate decision to make discretionary payments pursuant to policy endorsements considered both expediency of execution and our desire to not impact non-policyholder stakeholders.

By way of this letter, our intent is to clarify that while the scope of INT 20-08T is sufficient as it relates to policyholder relief programs executed in the form of policyholder refunds, rate reductions and policyholder dividends, it needs to be expanded to incorporate the accounting and reporting for policyholder relief programs executed in the form of discretionary policy payments provided pursuant to policy endorsements.

Following is a more complete description of Allstate’s policyholder benefit program followed by a description of how we believe our program should be incorporated into INT 20-08T.

I. DESCRIPTION OF ALLSTATE’S POLICYHOLDER RELIEF PROGRAM

   Basis of Payments

   In March 2020, Allstate recognized a decline in miles driven by policyholders and claim frequency as a result of SIP orders instituted across the country. At the same time, we observed the financial hardship experienced broadly by individuals subject to SIP orders. As a result, and despite not possessing sufficient actuarial information to re-underwrite our auto book of business and execute a premium refund or rate reduction, we relied on available anecdotal information about reduced miles driven and assumed that would result in lower realized accident frequencies in designing a program that allowed for discretionary payments to policyholders. Consistent with our underlying rationale that reduced miles would produce reduced accident frequency we moved forward with our program and began providing relief in the month of March 2020, the month in which most SIP orders began. In addition, relief was provided to auto policyholders of record in April and May of 2020 who met certain criteria. The program was further extended to policyholders of record for June of 2020. Allstate’s SIP payment program was not extended to commercial auto policyholders or motorcycle policies where a reduction in claim activity was not anticipated.

   Tool Used to Permit Policyholder Payments – Policy Endorsement

   Allstate considered a range of options to provide payments to policyholders and ultimately designed and executed a policy endorsement to provide for the discretionary payments to policyholders as it (a) was the most practically expedient alternative and (b) was the alternative that did not impact other key non-policyholder stakeholders (i.e., agents and the states in which we do business).

   Form of Allstate Policy Endorsement

   “Special Shelter-in-Place Payback Endorsement – AU14923

   This endorsement authorizes a payment to you. This payment is in response to the extraordinary circumstances surrounding the Covid-19 pandemic.

   Any payment is not guaranteed. We have sole discretion for determining the amount and frequency of payment, if any. We will determine the method of distributing any payment. Except as provided in this endorsement, all terms and conditions of the policy apply and remain unchanged.”
**External Communications to Policyholders**

“The purpose of the endorsement is to authorize and facilitate discretionary payments to policyholders. With insurance costs going down, Allstate is working to do what’s right for policyholders.

The payment recognizes the shelter orders are impacting miles driven and the number of auto accidents. Although customers are driving less and in fewer accidents, the full impact of the pandemic remains uncertain and this payment represents our best estimate of what we are seeing. We also are monitoring the impact on repair costs, premiums being received, customer retention, coverage levels and investment returns. It is too early to determine the full impact of all these factors on insurance rates. The payback is a way to get money back to consumers quickly before the full impact of the pandemic is sorted out.

The payback will equal 15% of a customer’s March and April auto premiums and will be calculated on a per policy basis, subject to a $10 minimum. We expect each monthly payment to average close to $30 per policy. There are no prorated calculations for purposes of this payback since the payback is a function of the total premium (calculated to be monthly) as of 3/31/2020 and 4/30/2020 regardless of the policy effective date or any endorsement activity. Customers with Allstate’s pay-per-mile product will be included.

Although much uncertainty remains over the full impact of the pandemic on all of our costs, we are filing the endorsement to remain in effect for 180 days to provide flexibility for future payments, if appropriate. The payments are being treated as an underwriting expense, so the company’s rating plan is not impacted and does not require modification as a result of this filing. Furthermore, this payment does not involve a projection of future premium.”

### II. ACCOUNTING FOR ENDORSEMENT-BASED DISCRETIONARY POLICYHOLDER PAYMENTS

In determining the accounting for SIP payments for both statutory and GAAP, Allstate assessed whether the payments constitute and should be classified as either (1) a loss/loss adjustment expense, (2) a reduction of premium under the associated contracts or (3) a policy expense.

1) **Classification as a loss/loss adjustment expense** – a loss under the contract would exist only to the extent there is an indemnifiable insured event. We do not believe SIP payments represent losses or loss adjustment expenses as the payments do not relate to a specific indemnifiable loss event under the contract nor do the payments relate to a change in the level of insurance risk. Additionally, the policy endorsements do not create an indemnifiable loss event but rather a different type of policy payment that is more akin to an expense.

2) **Classification as a premium adjustment** – Allstate considered and rejected classification of SIP payments as a premium adjustment primarily because no changes were made to filed rate plans in place throughout the U.S. Allstate considered, but rejected, the idea of filing new rate plans because (a) it would have required a lengthy process and would not have achieved our objective of getting economic relief to our policyholders in an expedient manner, and (b) as our policies cover six months we did not believe we possessed the required visibility to file modified rate plans as we lacked sufficient clarity on how the policies will perform beyond the next one to two months once the SIP orders are lifted and a “new normal” emerges. Allstate believes premium classification is only appropriate in situations where a premium refund is required under policy terms or a rating plan change is filed. In lieu of a required premium refund under policy terms or filing a new rating plan, the appropriate classification of the newly created contract benefit is as a policy expense.
3) **Classification as an expense** – expenses related to insurance contracts are those typically paid or incurred in connection with originating and servicing the contract. Notwithstanding the preceding, Allstate views payments under the endorsement, while made to the policyholder, are fundamentally different than loss/loss adjustment expenses attributable to “indemnifiable contract losses” and as such it is appropriate to classify the incremental amount paid to the customer as a policyholder expense for GAAP and an “other underwriting expense” for Statutory.

**GAAP** - Given the unique nature of the “expense” Allstate presented SIP payments on a separate line in the GAAP income statement to distinguish the payments from both losses and typical underwriting expenses. We believe that even if presented in a separate line item, SIP payments would be included in the determination of underwriting income and would be a component of the expense ratio.

**Statutory** – Given the unique nature of the “expense” for discretionary payments authorized under modified contract terms and which do not relate to a change in the level of insurance risk, Allstate relied on the underlying tenets of SSAP 70, Allocation of Expenses. Under SSAP 70, allocable expenses for property and casualty insurance companies shall be classified into one of three categories in the Underwriting and Investment Exhibit: loss adjustment expenses (classification assessed in 1) above), investment expenses (not applicable) or other underwriting expenses. Other underwriting expenses are defined as allocable expenses other than loss adjustment expenses and investment related expenses.

**Conclusion**

Allstate recommends that INT 20-08T be expanded to include a classification alternative for policyholder payments that are not premium refunds, rate reductions or policyholder dividends. The basis, form, and substance of Allstate’s policyholder payments related to the reduced personal lines auto frequency due primarily to SIP orders instituted as a result of COVID-19, were designed to facilitate expeditious state approval and implementation to provide relief to policyholders in the form of discretionary policyholder payments. When designing our policyholder relief program, we considered impacts on a range of stakeholders including our agents and the states in which we do business and determined that discretionary policyholder payments would not impact agent commissions or premium tax revenues that states rely on to meet the needs of their constituents.

Comment letters submitted by other insurers to the original exposure of INT 20-08T described policyholder payment programs similar to Allstate’s and requested the INT be expanded to include a classification for discretionary policyholder payments in the form of an underwriting expense. In addition, the comment letter from Interested Parties to the initial exposure of INT 20-08T included suggested revisions to the original INT to reflect the inclusion of new Issue 4 to describe the accounting for policyholder payments which are not premium refunds, rate reductions or policyholder dividends and which result from filing memorandums and policy endorsements as an underwriting expense. Allstate supports the suggested revisions to INT 20-08T related to new Issue 4.

The Allstate Corporation filed its Q1 2020 Form 10-Q which reflects as illustrated in the attached Appendix I, a new line item in the income statement for policyholder payments created for the material, non-recurring expense related to SIP orders. The importance of the GAAP treatment is that Statutory accounting is intended to follow GAAP except in those situations where a departure from GAAP is necessary; we do not believe this is one of those areas of necessary departure. We believe the Statutory treatment should be consistent with GAAP in terms of reporting as an expense; in the case of Statutory accounting as an “other underwriting expense”. The Allstate insurance companies that computed and accrued SIP payments for March 2020, classified those
expenses in their first quarter statutory filings in line 4, Other underwriting expenses incurred in the Statement of Income (corresponding classification at year-end in the Insurance Expense Exhibit is line 24, Aggregate write-ins for miscellaneous operating expenses, column 3 General Expenses under the heading of Other Underwriting Expenses) and disclosed the nature of the SIP payments and expense classification in Note 21A – Unusual or Infrequent Items. We believe the consistency in disclosure between all methods of providing policyholder relief will allow regulators to view the impact of these programs on a consistent basis regardless of how they were executed.

Please do not hesitate to contact me to discuss the contents of this letter.

Kevin Spataro
Senior Vice President, Corporate Accounting Research
kspataro@allstate.com

Copies to:
DiAnn Behrens - Director, Corporate Accounting Research
Tom Helsdingen - Director, Statutory Reporting
Julie Gann, NAIC Staff
Robin Marcotte, NAIC Staff
## Appendix I

### Condensed Consolidated Financial Statements

#### Item 1. Financial Statements

**The Allstate Corporation and Subsidiaries**

**Condensed Consolidated Statements of Operations (unaudited)**

<table>
<thead>
<tr>
<th></th>
<th>Three months ended March 31,</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>2020</td>
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<tr>
<td><strong>Revenues</strong></td>
<td></td>
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<tr>
<td>Property and casualty insurance premiums</td>
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<td>Life premiums and contract charges</td>
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<tr>
<td>Other revenue</td>
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<tr>
<td>Net investment income</td>
<td>421</td>
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<td>Realized capital gains (losses)</td>
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<td><strong>Total revenues</strong></td>
<td>10,076</td>
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<td><strong>Costs and expenses</strong></td>
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<tr>
<td>Property and casualty insurance claims and claims expense</td>
<td>5,341</td>
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<tr>
<td>Shelter-in-Place Payback expense</td>
<td>210</td>
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<tr>
<td>Life contract benefits</td>
<td>501</td>
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<tr>
<td>Interest credited to contractholder funds</td>
<td>132</td>
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<tr>
<td>Amortization of deferred policy acquisition costs</td>
<td>1,401</td>
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<tr>
<td>Operating costs and expenses</td>
<td>1,399</td>
</tr>
<tr>
<td>Pension and other postretirement remeasurement (gains) losses</td>
<td>318</td>
</tr>
<tr>
<td>Restructuring and related charges</td>
<td>5</td>
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<tr>
<td>Amortization of purchased intangibles</td>
<td>28</td>
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<tr>
<td>Interest expense</td>
<td>81</td>
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<tr>
<td><strong>Total costs and expenses</strong></td>
<td>9,416</td>
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<td>Gain on disposition of operations</td>
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<tr>
<td><strong>Income from operations before income tax expense</strong></td>
<td>651</td>
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<tr>
<td>Income tax expense</td>
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<tr>
<td><strong>Net income</strong></td>
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<tr>
<td>Preferred stock dividends</td>
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<td><strong>Net income applicable to common shareholders</strong></td>
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<tr>
<td><strong>Earnings per common share</strong></td>
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<tr>
<td>Net income applicable to common shareholders per common share - Basic</td>
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<tr>
<td>Weighted average common shares - Basic</td>
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<tr>
<td>Net income applicable to common shareholders per common share - Diluted</td>
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</tr>
<tr>
<td>Weighted average common shares - Diluted</td>
<td>322.4</td>
</tr>
</tbody>
</table>

See notes to condensed consolidated financial statements.

First Quarter 2020 Form 10-Q 1
June 4, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: INT 20-08T – COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

The Cincinnati Insurance Company (“Cincinnati”) appreciates the opportunity to provide comments for consideration on the Statutory Accounting Principles Working Group (“SAPWG”) re-exposed interpretation, INT #20-08T: COVID-19 Premium Refunds, Rate Reductions, and Policyholder Dividends (“the Tentative INT”). Cincinnati’s property casualty group is among the 25 largest groups in the United States, based upon net written premium.

Cincinnati provided comments during the original exposure period of May 5, 2020 through May 14, 2020. During this second exposure period of May 21, 2020 through June 5, 2020, our points remain relevant and we reiterate our support to modify the Tentative INT to allow relief payments to be accounted for and reported as expense where companies utilized rule filings or policy endorsements to allow these payments. Our position has also been communicated directly to the APCIA and interested parties.

Our support for recognizing as an expense, those relief payments made in relation to, at least, non-participating policies without premium refund terms, include the following points and premium refund contrasts:

- The payments were intended to provide immediate financial relief to policyholders, regardless of existing contractual obligations, on the premise of companies sharing their anticipated favorable loss experience with business segments of their policyholders.
- For participating policies, sharing favorable loss experience is accomplished through payment of policyholder dividends.
- Relief payment amounts were decided without having actual loss experience data, regarding the ultimate impact of federal and state shelter-in-place orders.
  - Cincinnati did not utilize rate filings to provide relief payments.
  - Premium adjustments, whether contractual refunds or by rate filings, include consideration of actual loss experience, which is not completely available in this situation.
  - Actual loss experience data, when available, may reveal an increase in accident severity from fast driving and an increase in distracted driving accident occurrences.
  - Additionally, extended auto coverage, or waiver of policy restrictions, to allow utilization of personal automobiles for deliveries has been called for in some states.
- Even if companies expressed the relief payment amount as a percentage of premium, that does not make it a premium refund. Premiums are commonly used in calculation methodologies such as assessments, surcharges, and allocation of expenses.
- Cincinnati revised the impacted policyholder contracts through rule filings to states, explicitly stating payments are being treated as an expense, and provided company letters to all impacted policyholders, allowing this payment benefit. No state denied Cincinnati’s rule filing.

The Cincinnati Insurance Company
The Cincinnati Indemnity Company
Cincinnati Casualty Company • The Cincinnati Specialty Underwriters Insurance Company
The Cincinnati Life Insurance Company
• Cincinnati’s relief payment plan, and the relief payment plan of other companies, are more characteristic of company expenses, such as policyholder dividends, policyholder benefits, assessments, surcharges, guaranty funds, and donations.

• As an expense, companies bear the majority of the financial burden for the payment.
  o As a reduction of premium, the financial burden of relief payments would be shared by further exacerbating revenue shortfalls
    ▪ For state governments through reduced premium taxes and commission related income taxes.
    ▪ For small businesses and individuals through commission claw-backs.
    ▪ If states intend to include relief payment amounts in premium tax calculations or companies intend to otherwise compensate their producers, these actions would further support relief payments are an expense.

• Reporting the relief payments as an expense brings an advantage to analyzing insurance company results as it will impact only the expense ratio component of the combined ratio, similar to policyholder dividends impacting only the policyholder dividend ratio component.
  o Reporting the payments as a premium refund would distort analysis of insurance company results as it will impact all components of the combined ratio: loss, dividend, and expense ratios.
  o It seems counterintuitive that the relief payments should impact, negatively, the loss ratio, given that the premise of the relief payment is for companies to share their anticipated favorable loss experience.

• These payments are the result of an unusual and infrequent event that would be disclosed in financial statements and excluded from future rate filing consideration.

• Cincinnati acted with a sense of urgency in light of the pandemic, notified states of the company’s relief payment plans, and then proceeded to act, in good faith, in accordance with those plans, absent any state objections.

• In addition to these payments to our policyholders for immediate financial relief, actual premium relief could come in the future through normal rate reviews and consideration of actual loss experience.

In conclusion, Cincinnati supports modifying the Tentative INT, either by expanding Issue 1 or adding a new Issue, to allow relief payments to be accounted for and reported as expense in situations where companies utilized rule filings or contract endorsements to allow for these relief payments. We do not propose that expense treatment is the only answer, but rather, it is appropriate depending on the relief payment program communicated by each company in their state filings. We respect that other companies may have utilized payment methods different from ours, leading to other accounting treatment decisions. Ultimately, each company would consistently provide accounting transparency through disclosure of their handling of this unusual and infrequent event.

Sincerely,

Michael J. Sewell
Chief Financial Officer
Senior Vice President

CC: Julie Gann, NAIC Staff
    Robin Marcotte, NAIC Staff
    Theresa Hoffer, Senior Vice President and Treasurer
    Andrew Schnell, Assistant Vice President
    James Sims, Assistant Treasurer
    Rachel Underwood, Technical Accounting Manager

Mailing Address: P.O. Box 145496 • Cincinnati, Ohio 45250-5496
Headquarters: 6200 S. Gilmore Road • Fairfield, Ohio 45014-5141
www.cinfin.com • 513-870-2000
June 3, 2020

NAIC Statutory Accounting Principles Working Group
Attn: Dale Bruggeman, Chair
Via e-mail to: Julie Gann  JGann@naic.org

Re: Proposed INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Chairman Bruggeman,

Co-operative Insurance Companies appreciates the opportunity to comment on the items exposed by the Statutory Accounting Principles Working Group (“SAPWG”) on May 5, 2020. Co-operative Insurance Companies is a mutual co-operative that was established in 1915 and is writing personal and commercial business in Vermont and New Hampshire.

Like many insurance companies, we’ve seen some initial favorable loss development on our personal auto book of business as a result of the various stay at home orders issued by the states. And like many insurance companies, we made the decision to provide some financial reprieve for our personal auto policyholders and issued a one-time refund earlier this month. The Company views this refund like a policyholder dividend, with the difference being that it was not issued to all policyholders based on profits. As such, we have taken the view that the one-time refund should be treated as an expense for accounting purposes. To treat it as a reduction in premiums, as INT 20-08T suggests given our fact pattern, places an undue burden on our agents and the state as our intent was not to impact agent commissions or state premium tax liabilities.

Furthermore, in reading comment letters from other parties, Co-operative Insurance Companies agrees with the perspective that The Cincinnati Insurance Companies laid out in their letter dated May 20, 2020. Some states mandated refunds and most strongly encouraged it, so why wouldn’t companies account for this like a state assessment which would be recorded as an expense. As Andrew Schnell of The Cincinnati Insurance Companies stated, “If treated as premium, all aspects of the combined ratio, including the loss ratio, are impacted, which does not seem appropriate. Given that the premise of the payment request is for companies to share their anticipated favorable loss experience, it seems counterintuitive that loss experience ratios be negatively impacted by the payment.”

We hope that the SAPWG will take our perspective into account before adopting the proposed interpretation and revise it to allow for accounting of this unusual circumstance as an expense without individual companies having to seek approval for a permitted practice from their state of domicile.

Best Regards,

Tamaron Loger, CFE, CPA, MAFM
VP – Finance
Co-operative Insurance Companies
June 5, 2020

Mr. Dale Bruggeman, Chair
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: INT 20-08T – COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

Grange Insurance Company ("Grange") appreciates the opportunity to provide comments for consideration on the exposure drafts released for comment by the Statutory Accounting Principles Working Group ("SAPWG") on interpretation exposure, INT #20-08T: COVID-19 Premium Refunds, Rate Reductions, and Policyholder Dividends ("the Tentative INT"). Grange’s property & casualty group is among the 75 largest insurance groups in the United States of America, based upon our approximately $1.3 billion in net written premium.

The Tentative INT contemplates classifying policyholder relief payments in reaction to the current COVID-19 pandemic either as a reduction to premiums written or as policyholder dividends and provides proposed statutory accounting and reporting guidance accordingly. Grange’s comments will primarily focus on rationale to revise the Tentative INT to allow reporting these payments as other underwriting expenses due to other fact patterns that were not contemplated by the original policy exposure. Grange’s position is based on the following logic:

- The payments were intended to provide immediate financial relief to our policyholders regardless of our contractual obligations.
- The payments were made voluntarily in our operating states.
- Grange revised the impacted policyholder contracts through filing policy endorsements with certain states and provided company letters to all impacted policyholders to provide the contractual language needed to allow such payments.
- Grange did not file for premium rate changes in any state as a result of issuing these payments to our policyholders. These payments are the result of an unusual and infrequent event that will be excluded from future rate filing considerations.
- Loss experience data was mostly unknown at the time of announcing and issuing the relief payments during the 2nd week of April, regarding the ultimate impact of federal and state shelter-in-place orders. Loss experience improvements were estimated for the personal auto book in total based on the expectation of lower miles being driven during April and May.
Formal policyholder dividends were not a viable option for Grange as dividends must be paid to all policyholders, not just the lines of business expected to be favorably impacted by the shelter-in-place orders. Also, due to required approvals, dividends would not be the most immediate payment option.

These payments are more in line with a one-time company expense, such as a policyholder dividend.

When we looked for relative consistency in reporting treatment for payments made outside of contractual premium refunds, categorizing these payments as an expense was the closest option to policyholder dividend reporting.

Classification as a premium refund will have unintended ancillary financial consequences, such as reducing premium taxes to state agencies. Like many of our competitors, we assured our independent agent partners, many of which are small businesses, that their commissions would not be impacted by these payments. Accordingly, commission ratios will be inflated for this calendar year if reporting as a premium refund is required.

Reporting the payments as an expense brings an advantage to analyzing insurance company results as it will impact only the expense ratio component of the combined ratio.

Reporting the payments as a premium refund would distort analysis of insurance company results as it will impact all components of the combined ratio: loss, dividend, and expense ratios.

Premium adjustments, whether contractual refunds or by rate filings, include consideration of actual loss experience, which was not completely available in this situation.

In addition to these payments to our policyholders for immediate financial relief, which we view as a one-time expense, actual premium relief could come in the future through normal rate reviews and consideration of actual loss experience.

Insurance companies acted with a sense of urgency in light of the unprecedented scale of the pandemic, notified states of company payment plans, and then proceeded to swiftly act, in good faith, in accordance with those plans, absent any state objections. To that point, Grange issued nearly 340,000 relief payments to our policyholders during the last week of April and first week of May.

In light of the COVID-19 pandemic, regulators from a majority of states issued a number of bulletins, orders, advisories, and other guidance (collectively “Bulletins”) urging property & casualty insurance carriers nationwide to provide some means of immediate financial relief to policyholders, at least in private passenger automotive lines. The principle was that insurers should provide immediate financial relief in anticipation of lower than expected loss experience arising from a decrease in driving activity due to federal and state shelter-in-place orders. Such payments needed to be applied reasonably and consistently in order to avoid being considered a rebate or unfair discrimination. Though payments by insurance carriers would be a voluntary action in most states, they were required in the State of California (Bulletin 2020-3). The issuance of Bulletins by each state, each with their own guideline nuances, created uncertainty across insurance carriers of how to accommodate making such payments within applicable compliance standards.
Grange considered the magnitude of the situation and guidance available at the time. A policyholder dividend was deemed inappropriate, at least in part, as it would take longer to enact given the required approval process. A premium refund would create unintended negative financial consequences to state agencies and our independent agent partners (absent the decision by Grange, like many carriers, to not impact agent compensation) by reducing premium amounts, thereby reducing premium taxes and commissions. Premium refunds also have the negative impact of altering comparability for all components of the combined ratio. Additionally, these policyholder relief payments were based on the expectation of profits from favorable loss experience, yet the data to determine such experience had not yet occurred. Therefore, Grange communicated to states that the payment program would be treated as an expense when policy endorsements were filed. Grange included that we intend to review the actual loss experience results and adjust premiums on a forward looking basis as part of regularly planned future rate reviews. These one-time payments would be excluded from future rate calculations and filings. No state rejected Grange’s payment program.

In the absence of any state objections, Grange acted in accordance with the relief payment program and contends that reporting these pandemic related payments as an expense would fall within the guidance of SSAP 70 – Allocation of Expenses and be disclosed in accordance with SSAP 24 – Discontinued Operations and Unusual or Infrequent Items. INT 20-08T already includes disclosure guidance under SSAP 24. SSAP 70 – Allocation of Expenses, paragraph 3 states:

3. Allocable expenses for property and casualty insurance companies shall be classified into one of three categories in the Underwriting and Investment Exhibit as follows:

And then goes on to list the three expense categories as a) Loss adjustment expenses, b) Investment expenses, or c) Other underwriting expenses. Other underwriting expenses are defined as allocable expenses other than loss adjustment expenses and investment related expenses. Grange would report the one-time relief payments as a write-in item under other underwriting expenses.

In conclusion, Grange believes it is reasonable and appropriate for INT 20-08T to provide guidance to companies to report the relief payments as an expense. The payments achieved immediate financial relief for policyholders without unintended negative consequences for state agencies and our independent agent partners. Policyholders would see premium relief, when experience supports it, in future rates. We also believe that comparability of insurance company results is least impacted if these payments are recorded as other underwriting expenses.

Sincerely,
Brian Poling
VP - Finance
June 5, 2020

Dale Bruggeman
Chair, Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners
VIA Email Transmission: jgann@naic.org;

RE: INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

The following comments are submitted on behalf of the member companies of the National Association of Mutual Insurance Companies1 regarding the interpretive reporting guidance issued to account for premium refunds, rate reductions, and policyholder dividends. We previously submitted a comment letter on this topic to the working group on May 14, 2020 and continue to support the points raised in that letter.

The purpose of this follow-up letter is to emphasize the point that insurance company statutory financial statements should reflect the actions and approaches taken by management that best reflects company experience; therefore, in regards to accounting for premium relief measures, statutory accounting should be flexible to accommodate the various approaches taken by insurers. The COVID-19 ongoing crisis prompted many insurance companies to respond to policyholders experiencing economic hardship in various ways. While different approaches were taken, one common theme among insurers who provided premium relief to policyholders was evident, that is there was a sense of urgency to get money back to impacted policyholders.

That urgency and drive to get money back to policyholders created some obstacles for companies. Traditional methods of returning premium to policyholders was not a viable option for some carriers. For example, issuing a policyholder dividend presented challenges around timing and restrictions on issuing dividends for only single line of business contracts. Companies unable to issue a dividend but were able to provide premium relief to policyholders did so without having complete loss experience data. As part of normal business operations, a full review of actual loss experience results is conducted leading to a potential adjustment to future premiums. Without that complete analysis, some insurers view treating these payments as an “other underwriting expense” to be the cleanest method of accounting. Treating these payments as an “other underwriting expense” avoids certain unintended consequences for those insurers that were unable to issue a dividend or were not able to file for new rates in an expeditious fashion. If regulators agree to allow for flexibility, insurers that treat these payments as expenses will avoid impacting both the combined ratio and loss ratio. Instead it would only impact the expense ratio. Critical to understanding the

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1 NAMIC is the largest property/casualty insurance trade association in the country, with more than 1,400-member companies representing 39 percent of the total market. NAMIC supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies serve more than 170 million policyholders and write more than $230 billion in annual premiums. Our members account for 54 percent of homeowners, 43 percent of automobile, and 32 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
the profitability of a line of business, or more importantly, determining the adequacy of rates for certain lines is an analysis of the loss ratio. When you treat these payments as a return of premium, that automatically increases the loss ratio. Given the importance of rate adequacy, classifying these payments as an expense will help in determining future rates as these unusual and infrequent expenses would be excluded from future rate filings.

In addition to these unintended consequences to the financial statements, other challenges should be considered by the working group. For example, if expense treatment is not allowed for any insurer, that has the impact of reducing the amount of premium taxes paid to the state. While many insurers will treat these relief measures as a return of premium, reducing their premium tax bill, those who classify as an “other underwriting expense” will not have their premium tax bill reduced.

Finally, the statutory financial statements assist state insurance regulators with regulating the solvency of insurance companies, and the proposed INT includes a new disclosure that requires insurers to disclose all COVID-19 inspired premium refunds, rate reductions, and policyholder dividends as unusual or infrequent items in annual statement note 21A. This disclosure will help regulators understand the approaches taken by various insurance companies around providing policyholder relief, regardless of whether they classified it as a return of premium or an “other underwriting expense”. If the working group doesn’t allow for “other underwriting expense” treatment, companies will be forced to seek alternative options, such as state permitted or prescribed practices leading to additional and unnecessary disclosures. In this case, a duplicative disclosure to the new note 21A.

Thank you for your consideration of these comments. This issue is critically important to NAMIC members and their policyholders. If there are any questions, please feel free to contact me at 317-876-4206.

Sincerely,

Jonathan Rodgers
Director of Financial and Tax Policy
National Association of Mutual Insurance Companies
June 5, 2020

Mr. Dale Bruggeman  
Chair, Statutory Accounting Principles (E) Working Group  
National Association of Insurance Commissioners  
VIA Email Transmission, c/o jgann@naic.org; rmarcotte@naic.org  
RE: INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

The Progressive Group of Insurance Companies, on behalf of its property & casualty insurance companies, (“Progressive”) appreciates the opportunity to provide comments for consideration on the exposure draft released for comment by the Statutory Accounting Principles Working Group (“SAPWG”) on interpretation exposure, INT #20-08T: COVID-19 Premium Refunds, Rate Reductions, and Policyholder Dividends (“the Tentative INT”). Progressive is the third largest private passenger auto insurance company in the United States of America, based upon our approximately $31 billion in direct premiums written for 2019.

In response to the Tentative INT, Progressive agrees in principle with the comments previously submitted to SAPWG by The Cincinnati Insurance Company and Grange Insurance and agrees with the draft edits to the Tentative INT by the interested parties, particularly the addition of Issue 4.

Progressive’s position is based on the following:

• Where required, we filed a policy endorsement and/or rule, not a rate filing, to authorize and facilitate discretionary credits and payments to policyholders in response to the COVID-19 pandemic and was a one-time action to provide immediate relief
• The credits and payments are available to all customers with an active personal automobile policy on April 30 and/or May 31 and there was no differentiation among customers
• To ensure consistency, the credit was calculated based on 20% of the amount of premium earned by each policyholder during the months of April and/or May (for New York policyholders, the credit will be calculated based on 20% of May and/or June premiums earned, instead of April and/or May)
• To accommodate the urgency of the situation, the amount of the credits and payments was determined without specific known loss experience but was based on changes in: average miles travelled per vehicle, as derived from our usage-based insurance (UBI) program; weekly incoming claim features; and total personal auto frequency pre and post the COVID-19 restrictions period. We did not determine the credit for policyholders enrolled in our UBI program based on their individual miles driven.
• Reducing premiums in conjunction with the policyholder credits and payments would conflict with the rate filings that are currently in place and would reduce the amount of premium taxes, independent agents’ commissions, and various assessments that would be due based on these
filed rates; we have never had any intention of receiving a return of premium taxes, assessments, or commissions paid

- We are not aware that there has ever been a difference between statutory accounting and generally accepted accounting principles in the United States of America ("GAAP") as it relates to accounting for premiums. Similar to several other public company registrants, we recorded the policyholder credits and payments as an underwriting expense when we filed our April results via a Current Report on Form 8-K with the Securities and Exchange Commission (SEC) on May 20, 2020; the GAAP accounting treatment was based on the underlying premise that the credits and payments are akin to a policyholder dividend in the sense that we are, at our noncontractual discretion, returning profits that resulted from a reduction in loss costs due to the shelter-in-place orders with policyholders based on a program that was derived at the enterprise-wide level as opposed to the contract level.

- Given that our rating plans were not impacted as a result of the policy endorsement and/or rule that was filed, it would seem appropriate that the statutory accounting treatment would follow the GAAP accounting treatment.

- The intent to treat the policyholder credits and payments as an underwriting expense has been clearly disclosed in the filing memorandum issued to the states’ departments of insurance and as a separate financial statement line item in our April GAAP-basis financial statements released and filed with the SEC on May 20, 2020. We intend to show the credits as a write-in line item in our statutory financial statements. The transparency of these credits enables the users of the financial statements to understand the financial impact resulting from this issue.

The current draft of the Tentative INT only provides for the classification of policyholder relief payments in reaction to the current COVID-19 pandemic as either premium refunds, rate reductions, or policyholder dividends, and provides proposed statutory accounting and reporting guidance based on these classifications. Progressive instead supports the addition of Issue 4 as proposed in the comment letter submitted by the interested parties to allow the flexibility of accounting for these policyholder relief payments based on the underlying methodology used by the insurance companies.

Regards,

/s/ John P. Sauerland

John P. Sauerland
Chief Financial Officer
The Progressive Group of Insurance Companies

cc: Mariann Wojtkun Marshall, Chief Accounting Officer, The Progressive Group of Insurance Companies
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UnitedHealthcare appreciates the opportunity to comment on INT 20-08T, COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends. UnitedHealthcare is a diversified health care company dedicated to helping people live healthier lives and helping to make the health system work better for everyone. Over the last several months, the emergence of the COVID-19 virus has caused well-documented challenges to people, businesses and institutions across national and global health care systems. Among them is the disruption to traditional patterns of delivering health care causing related economic disruption and imbalances to the nation’s health care coverage systems.

In response to this challenge, UnitedHealthcare and many other insurers are taking actions in a variety of ways to help provide financial relief to insured members. Since the form of the financial relief varies among insurers, the accounting treatment may need to be tailored to the specific form of the relief program. Our comments are focused on the voluntary issuance of premium refunds or credits to in-force policyholders which are not outlined in the policy terms.

We agree with and support the current proposal to treat these types of premium refunds as a reduction to written and earned premium. We believe this treatment is consistent with the intent of the transaction (a return of premium to the policyholder) and is consistent with current accounting guidance for other types of premium refunds that are required by either policy terms or regulations. The timing of recognition of the premium refund should correspond with the associated coverage period impacted by the premium action. In the case of premium refunds issued for current or prior coverage periods, the recognition should be immediate. There may be situations where the premium rate is being reduced over the remaining policy period, in which case, the premium reduction may need to be recognized over the policy period impacted.

With respect to any liability required to be recognized in accordance with in SSAP No. 5R - Liabilities, Contingencies and Impairments of Assets, we believe the liability should be reported as an aggregate write-in since the premium refund was not required by policy terms, and therefore would not be accounted for as retrospective or redetermination premium liability.

While we believe the above-described reduction to premium approach is the appropriate accounting treatment, we understand other interested parties and some regulators have expressed concerns with the
distortion of reported loss or operating ratios resulting from this classification. As an alternative acceptable option to address these concerns, we feel there could be some justification for treatment as bad debt expense. The election to not collect premium could result in the premiums being written off as bad debts when it is determined to be uncollectable.

We appreciate the consideration of our comments. We would be happy to discuss further and address any questions you may have.

Sincerely,

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CC: Randi Reichel, UnitedHealthcare
    Robin Marcotte, NAIC SAPWG Staff
    Julie Gann, NAIC SAPWG Staff
Interpretation of the Statutory Accounting Principles Working Group

INT 20-08: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

INT 20-08 Dates Discussed

Email Vote to Expose May 5, 2020; May 20, 2020; June 15, 2020

INT 20-08 References

SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets
SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items
SSAP No. 53—Property Casualty Contracts—Premiums
SSAP No. 54R—Individual and Group Accident and Health Contracts
SSAP No. 65—Property and Casualty Contracts
SSAP No. 66—Retrospectively Rated Contracts

INT 20-08 Issue

COVID-19

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

Refunds, Rate Reductions and Policyholder Dividends

2. The federal, state or local government orders requiring non-essential workers to “stay home” caused a significant reduction in commercial and non-commercial activity, including automotive usage. Some consumer groups wrote letters and issued press releases calling for insurance premium refunds or pricing decreases, which included specific comments directed toward consumer automotive lines. The comments presumed that the decrease in activity would result in fewer losses.

3. Many insurers began issuing voluntary premium refunds, future rate reductions or policyholder dividends because of the decreased activity. The majority of the refunds were related to automotive lines of business. Insurers have provided the reductions in a variety of ways. Some of the rate reductions were specific for in-force policies, whereas some of the rate reductions would apply to future policy renewals.

Voluntary

4. The majority of the refunds or rate reductions are being offered voluntarily and are not amounts required under the policy terms. The aggregate monetary amount of the return of funds is considered materially significant.
Jurisdiction Directed

5. In addition, a few jurisdictions have issued bulletins directing refunds and rate reductions on accident and health insurance and varying lines of property and casualty insurance, including but not limited to: private passenger automobile, commercial automobile, workers’ compensation, commercial multiple peril, commercial liability and medical professional liability. In addition, some jurisdictions have indicated support for refunds or rate reductions, but also directed that payment of such amounts require either premium rate filings or policy form amendments.

Accounting Issues

6. This intent of this interpretation is to address questions related to refunds, rate reductions and policyholder dividends in response to the decreased activity related to COVID-19. Because there are a variety of ways that reporting entities are accomplishing a similar objective of returning money or reducing premiums, this interpretation provides guidance on the following issues:

   • Issue 1: How to account for refunds not required under the policy terms.
   • Issue 2: How to account for refunds required under the policy terms.
   • Issue 3: How to account for rate reductions on inforce and renewal business.
   • Issue 4: How to account for policyholder dividends.
   • Issue 5: Where to disclose refunds, rate reductions and policyholder dividends related to COVID-19 decreases in activity.

INT 20-08 Discussion

7. As an overall guiding principle, the accounting shall follow existing statutory accounting principles and annual statement reporting where feasible.

Issue 1: How to Account for Refunds Not Required Under the Policy Terms

8. The Working Group reached a consensus that voluntary refunds because of decreased activity related to COVID-19 and jurisdiction-directed refunds which are not required by the policy terms, are fundamentally a return of premium. Such refunds shall be accounted for as immediate adjustments to premium. The refunds shall be recognized as a reduction to written or earned premium and the unearned premium reserve adjusted accordingly.

9. Refunds shall be recognized as a liability when the definition of a liability in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets is met. For example, the declaration of a voluntary dividend by the board of directors will trigger liability recognition. In cases where the refunds are directed by a jurisdiction, the SSAP No. 5R definition of a liability shall be used to determine timing of liability recognition.

10. Immediate adjustment to premium is consistent with the existing guidance in SSAP No. 53—Property Casualty Contracts—Premiums. SSAP No. 53 guidance requires adjustments to the premium charged for changes in the level of exposure to insurance risk. It is also consistent with the treatment of loss sensitive premium adjustments in SSAP No. 66—Retrospectively Rated Contracts. While some of the
voluntary or jurisdiction-directed refunds may not be required by the explicit policy terms, the principle of reversing premium in the same way that the premium was originally recognized continues to apply.

11. Immediate adjustments to premium for voluntary accident and health premium refunds is also consistent with the guidance in SSAP No. 54R—Individual and Group Accident and Health Contracts on contracts subject to redetermination. While some of the voluntary or jurisdiction-directed refunds may not be required by the explicit policy terms, the principle of reversing premium in the same way that the premium was originally recognized continues to apply. The liability for voluntary health premium refunds attributable to COVID-19 and which are not required under the policy terms shall be recognized in aggregate write-ins for other liabilities.

12. Reporting the voluntary or jurisdiction-directed refund as an expense is not consistent with statutory accounting guidance and would improperly present the expense ratios in the statutory accounting financial statements. Reporting the refund as an expense, or any other method besides a decrease to premium, would be considered a permitted or prescribed practice and shall be disclosed as required by SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures:

   a. Reporting the refunded amounts as a miscellaneous underwriting expense is not consistent with the underwriting expense description. This reporting option is inconsistent with the characterization of the amount as a return of premium.

   b. Reporting the refunds as premium balances charged off (e.g., bad debt expense) is inconsistent with guidance in SSAP No. 53, paragraph 14, on earned but uncollected premium. It is also inconsistent with the annual statement instructions as the amount is not an uncollectible amount, but rather a voluntary choice by the reporting entity to reduce the amount charged.

**Issue 2: How to Account for Refunds Required Under the Policy Terms**

13. While most of the premium refunds are voluntary or jurisdiction-directed and not required under the policy terms, some policies have terms that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses. If the policy terms change the amount charged, existing guidance in SSAP No. 53, SSAP No. 54R or SSAP No. 66 continues to apply:

   a. SSAP No. 53 provides guidance for policies in which the premium amount is adjusted for changes in the level of exposure to insurance risk. This is often seen in commercial lines of business such as workers’ compensation. The guidance notes that audits often occur after the policy term or mid-term in the policy. SSAP No. 53 refers to the adjustment to premium (either due to the customer or to the insurer) as earned but unbilled (EBUB) premium. SSAP No. 53 requires such adjustment to premium to be made immediately either through written premium or earned premium. SSAP No. 53 also requires recognition of the related liabilities and expenses such as commissions and premium taxes based on when the premium is earned.

   b. SSAP No. 54R provides guidance for policies subject to redetermination in which the premium is subject to adjustments by contract terms. This is commonly seen in federal and state groups. The guidance notes that estimates are based on experience to date and premium adjustments are estimated for the portion of the policy that has expired. Accrued return premiums are recorded as a liability with a corresponding entry to written premium. Refunds required under the policy terms would continue to be reported as retrospective or redetermination premium liabilities if applicable.
c. SSAP No. 66 provides guidance for policies whose terms or legal formulas determine premium based on losses. SSAP No. 66 references other applicable statements based on contract type for the initial accrual of premium. Estimates of premium adjustments are accrued based on activity to date and result in immediate adjustments to premium. SSAP No. 66 guidance specifies the corresponding annual statement reporting lines for different entity types.

Issue 3: How to Account for Rate Reductions

14. Some reporting entities are offering rate reductions instead of premium refunds. Some of these rate reductions provide one-time price decreases to future payments on in-force policies. Other reporting entities have provided offers of rate reductions on future renewals. Some of the offers for future rate reductions are only applicable to in-force policyholders as of a specified date. Some reporting entities have offered one-time rate reductions for future renewals for both existing and new policyholders for 2020.

   a. Rate reductions on in-force business, shall be recognized as immediate adjustments to premium.

   b. Rate reductions on future renewals shall be reflected in the premium rate charged on renewal. This is because it is outside of the policy boundary to require the accrual before contract inception. While the amount of future rate reduction can be estimated, it is not a change to existing policy terms and policyholders are not obligated to renew at the reduced rate, therefore, payment of the amount is avoidable. Such amounts shall be disclosed as discussed in Issue No. 5.

Issue 4: How to Account for Policyholder Dividends

15. SSAP No. 65—Property and Casualty Contracts, paragraph 46 requires that dividends to policyholders immediately become liabilities of the reporting entity when they are declared by the board of directors and shall be recorded as a liability.

16. The Working Group noted that policyholder dividends are typically only provided on participating policies or policies issued by non-stock companies, such as mutual entities and other corporate entity types in which profits are shared with policyholders.

17. Research during the development of this item identified that a small number of jurisdictions have legal restrictions which only allow policyholder dividends to be provided after the expiration of the policy period for which the dividend was earned. This interpretation only addresses policyholder dividends which are permitted by the applicable jurisdiction.

18. The property and casualty annual statement blank provides specific reporting lines for policyholder dividends including, but not limited to a liability line and a line in the income statement and statement of cash flow. For those entities whose policies are participating or whose corporate shell type and/or membership structure allow for policyholder dividends, the accounting for policyholder dividends is unchanged by this interpretation.

19. This interpretation does not change the policyholder dividend disclosure or reporting but provides additional guidance that such policyholder dividends issued in response to COVID-19 decreases in activity shall also be disclosed as discussed in Issue 5.
Issue 5: Where to Disclose Refunds, Rate Reductions and Policyholder Dividends Related to COVID-19 Decreases in Activity

20. There are various places in the notes to the statutory annual statement where disclosures of various aspects of premium refunds, premium reductions or policyholder dividends are required. This interpretation does not recommend changes to those existing disclosures. This interpretation does, however, recommend a consistent annual statement disclosure for all such amounts to allow for comparable disclosures.

21. SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items requires disclosure of the nature and financial effects of each unusual or infrequent event or transaction. Gains or losses of a similar nature that are not individually material shall be aggregated. This disclosure shall include the line items which have been affected by the event or transaction considered to be unusual and/or infrequent. This disclosure is currently required to be reported in annual statement Note 21A. (Reporting entities shall maintain jurisdiction-specific information to be made available upon request from department of insurance or revenue regulators.)

22. To allow for aggregate, consistent assessment, the Working Group came to a consensus that all COVID-19 inspired premium refunds, rate reductions, and policyholder dividends shall be disclosed as unusual or infrequent items in annual statement 21A. This disclosure is in addition to other existing disclosures on various items related to the policyholder payments. For clarification, refunds required under policy terms in-force prior to the federal declaration of emergency for the COVID-19 pandemic as discussed in paragraph 13 (i.e., policies that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses) are not required to be aggregated in disclosures of COVID-19 inspired premium refunds, rate reductions and policyholder dividends. Policies whose terms were modified after the declaration of emergency in response to COVID-19 are required to disclose the COVID-19 inspired premium refunds, rate reductions and policyholder dividends.

INT 20-08 Consensus

23. The Working Group reached a consensus to prescribe statutory accounting guidance for insurance reporting entities providing refunds in response to COVID-19. Pursuant to this consensus:

   a. Reporting entities that provide voluntary or jurisdiction-directed refunds which are not required under the policy terms shall follow the guidance in paragraphs 8-12 of this interpretation. This guidance stipulates that such refunds shall be recognized as a reduction of premium. Refunds that are recognized in a different manner (e.g., as an expense), shall be considered a permitted or prescribed practice pursuant to SSAP No. 1.

   b. Reporting entities that provide refunds in accordance with insurance policy terms shall follow paragraph 13 of this interpretation. This guidance indicates that existing statutory accounting principles in SSAP No. 53, SSAP No. 54R or SSAP No. 66 shall be followed as applicable.

   c. Reporting entities that provide rate reductions shall follow paragraph 14 of this interpretation. This guidance provides direction based on whether the rate reduction is for in-force or future policies.
d. Reporting entities that provide policyholder dividend shall follow the existing guidance for policyholder dividends which is summarized in paragraphs 15-19 and in addition, shall complete the disclosures described in paragraphs 20-22.

e. This interpretation, paragraphs 20-22 indicates that reporting entities shall continue to comply with all statutory accounting disclosure requirements, but also requires that all premium refunds, rate reductions and/or policyholder dividends provided because of the decreased activity due to COVID-19 shall be aggregated and reported in Note 21A as unusual or infrequent items.

24. The Working Group noted that premium taxation requirements vary by jurisdiction. Taxation is determined by the jurisdiction where the premium is written/returned to the policyholder according to the laws of that jurisdiction.

25. This interpretation will be automatically nullified on January 1, 2021 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

INT 20-08 Status

26. Further discussion is planned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met via conference call May 20, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); Kathy Belfi (CT); Rylynn Brown (DE); Eric Moser and Kevin Fry (IL); Stewart Guerin (LA); Judy Weaver (MI); Tom Dudek (NY); Joe DiMemmo (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Adopted Non-Contested Statutory Accounting Revisions During its Public Hearing

The Working Group held a public hearing to review comments (Attachment One-C1 and One-C2) on previously exposed items. Ms. Malm made a motion, seconded by Mr. Hudson, to adopt the statutory accounting revisions detailed below as non-contested statutory accounting revisions. This motion also included the disposal of agenda item 2019-41. The motion passed unanimously.

a. Agenda Item 2019-37

Mr. Bruggeman directed the Working Group to agenda item 2019-37: Surplus Notes – Enhanced Disclosures (Attachment One-C3). Jim Pinegar (NAIC) stated that this nonsubstantive agenda item was drafted from the Working Group’s request that additional disclosures be captured in Statement of Statutory Accounting Principle (SSAP) No. 41R—Surplus Notes. He stated that the proposed disclosures materially reflected certain key details from the 2019 surplus note data call. These disclosures were intended to give state insurance regulators further insight into the issuances of surplus notes that do not contain the cash flows typically associated with surplus notes while providing adequate pricing confidentiality sought by interested parties.

b. Agenda Item 2019-41

Mr. Bruggeman directed the Working Group to agenda item 2019-41: Eliminating Financial Modeling Process (Attachment One-C4). Mr. Pinegar stated that this nonsubstantive agenda item was in response to an earlier referral received from the Valuation of Securities (E) Task Force. The agenda item originally was drafted so the Accounting Practice and Procedures Manual (AP&P Manual) would reflect a revision that was under consideration by the Task Force regarding financial modeling of residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) securities. However, the Task Force has since elected to retain the financial modeling approach and will now map the designation derived from the model to a new NAIC designation category. Mr. Pinegar stated that considering this change, the proposed update in this agenda item was no longer applicable and recommended disposal of this agenda item without statutory revisions.

c. Agenda Item 2019-47

Mr. Bruggeman directed the Working Group to agenda item 2019-47: VM 21 Grading (Attachment One-C5). Robin Marcotte (NAIC) noted that the agenda item addresses VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and grade-in requirements for reporting changes in valuation basis for years beginning Jan. 1, 2020. She stated that the revisions to the Valuation Manual allowed different optional phase-in requirements. The exposure includes nonsubstantive revisions to SSAP No. 51R—Life Contracts and SSAP No. 3—Accounting Changes and Corrections of Errors for reporting years beginning Jan. 1, 2020. Ms. Marcotte stated the exposure incorporated many of the previous edits recommended by interested parties and would expand the disclosure for changes in valuation basis, which are reported as a change in accounting principle under SSAP No. 3. The additional disclosure would identify specific details regarding phase-in of changes in valuation basis.

d. Agenda Item 2020-06EP

Mr. Bruggeman directed the Working Group to agenda item 2020-06EP: Editorial and Maintenance Update (Attachment One-C6). Ms. Marcotte stated that this item provides nonsubstantive editorial corrections in accordance with the maintenance process, deleting an unnecessary excerpt and updating various paragraph references in SSAP No. 21R—Other Admitted Assets and SSAP No. 51R.
c. **Agenda Item 2020-07**

Mr. Bruggeman directed the Working Group to agenda item 2020-07: Change to the Summary Investment Schedule (Attachment One-C7). Jake Stultz (NAIC) stated that SSAP No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures requires disclosures as detailed in Appendix A-001: Investments of Reporting Entities (A-001). He stated that Section 3 of A-001 requires the Summary Investment Schedule in the statutory annual statements and the notes of the annual audited financial statements. This agenda item arose because NAIC support staff for the Blanks (E) Working Group were notified of a cross-check error where total mortgage loans reported on the Summary Investment Schedule do not tie to the amounts reported in Schedule B, Mortgages – Part 1. Mr. Stultz noted that the nonsubstantive revisions will add the total valuation allowance to the Summary Investment Schedule to ensure these schedules appropriately tie together.

d. **Agenda Item 2020-08**

Mr. Bruggeman directed the Working Group to agenda item 2020-08: Accounting Standard Update (ASU) 2016-20, Technical Corrections & Improvements – Topic 606 (Attachment One-C8). Mr. Stultz stated that ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers was issued to clarify narrow aspects of the guidance issued in ASU 2014-09, Revenue from Contracts with Customers. He stated that in 2018, the Working Group previously rejected the guidance in ASU 2014-09 and several other ASUs related to revenue recognition in SSAP No. 47—Uninsured Plans. He stated that this agenda item proposes to reject ASU 2016-20 in SSAP No. 47, and the proposed action is consistent with how the prior ASUs related to Topic 606 have been treated.

e. **Agenda Item 2020-09**

Mr. Bruggeman directed the Working Group to agenda item 2020-09: ASU 2018-18, Collaborative Arrangements – Topic 808 (Attachment One-C9). Mr. Stultz stated that this ASU clarifies and aligns revenue recognition under the new Topic 606 for collaborative arrangements. He stated that a collaborative arrangement is defined as a contractual arrangement that involves a joint operating activity involving two or more parties that are active participants in the activity and are exposed to significant risks and rewards dependent on the commercial success of the activity. He stated that this agenda item proposes to reject ASU 2018-18 in SSAP No. 47, and the proposed action is consistent with how the prior ASUs related to Topic 606 have been treated.

f. **Agenda Item 2020-10**

Mr. Bruggeman directed the Working Group to agenda item 2020-10: ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topic 605 and Topic 606 (Attachment One-C10). Mr. Stultz stated that this ASU only affects U.S. Securities and Exchange Commission (SEC) paragraphs in Topic 220, Topic 605 and Topic 606. He noted that the nonsubstantive revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2017-14, Income Statement—Reporting Comprehensive Income (Topic 220), Revenue Recognition (Topic 605), and Revenue from Contracts with Customers (Topic 606), Amendments to SEC Paragraphs Pursuant to Staff Accounting Bulletin No. 116 and SEC Release No. 33-10403 as not applicable to statutory accounting.

g. **Agenda Item 2020-11**

Mr. Bruggeman directed the Working Group to agenda item 2020-11: ASU 2020-02, Amendments to SEC Paragraphs in Credit Losses and Lease (Attachment One-C11). Mr. Stultz stated that this ASU only affects the SEC section in Topic 326, which clarifies reporting for SEC registrants and updates the effective date for these provisions and the updates to Topic 842. He noted that the nonsubstantive revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-02, Financial Instruments—Credit Losses (Topic 326) and Leases (Topic 842), Amendments to SEC Paragraphs Pursuant to SEC Staff Accounting Bulletin No. 119 and Update to SEC Section on Effective Date Related to Accounting Standards Update No. 2016-02, Leases (Topic 842) as not applicable to statutory accounting.

2. **Reviewed Comments on Exposed Items**

The Working Group held a public hearing to review comments (Attachments One-C1 and One-C2) on previously exposed items.
a. **Agenda Item 2019-25**

Mr. Bruggeman directed the Working Group to agenda item 2019-25: Working Capital Finance Investments. Ms. Marcotte noted that the materials contain substantive revisions, incorporating the industry proposed language for the six specific items directed by the Working Group at the 2019 Summer National Meeting to **SSAP No. 105—Working Capital Finance Investments**. She stated that NAIC staff recommended adoption of the substantively revised SSAP No. 105 and **Issue Paper No. 163—Working Capital Finance Investment Updates**, noting a proposed effective date of June 30.

Ms. Belfi stated she requested that the Working Group consider removing the last sentence in paragraph 16, which states, “Initial permission to invest in Working Capital Finance Investment Programs may be required by the domiciliary commissioner.” She stated that since Connecticut does not currently possess the resources to adequately evaluate such an investment program, they would rely upon the NAIC Securities Valuation Office (SVO) for input. Ms. Belfi stated that as the SVO must already preapprove these transactions, that control regarding these investments was sufficient and thus not requiring a secondary preapproval by the domiciliary commissioner. Additionally, the statement could result in regulator misinterpretation in that domiciliary commissioners may feel compelled to review transactions in which they do not possess the resources to adequately evaluate. She stated that regulators already can review any transaction or investment deemed appropriate and the statement in paragraph 16 was unnecessary. Ms. Belfi proposed a friendly amendment to remove this single sentence from paragraph 16.

Mr. Fry stated agreement with Ms. Belfi’s comments and noted that no other investment SSAPs contain such language, adding that the language confuses the substance of the SSAP. He stated that with the current requirements such as the SVO preapproval, investments being restricted to investment grade and state investments laws, these investments should remain short-term and of relatively low risk. Ms. Marcotte stated that NAIC staff did not object to the friendly amendment, noting that in addition to the single sentence removal to paragraph 16 of SSAP No. 105, minor edits would also be required in Issue Paper No. 163 documenting the revision. Michael Monahan (American Council of Life Insurers—ACLI) stated that interested parties support the friendly amendment that Ms. Belfi proposed.

Ms. Belfi made a motion, seconded by Mr. Fry, to adopt the substantially revised SSAP No. 105 and Issue Paper No. 163 incorporating the additional revisions discussed (Attachments One-C12, One-C13 and One-C14). The motion passed unanimously.

b. **Agenda Item 2019-42**

Mr. Bruggeman directed the Working Group to agenda item 2019-42: Cash Equivalent – Cash & Liquidity Pools. Mr. Pinegar stated that this nonsubstantive agenda item was drafted to scope certain cash and liquidity pools into **SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments**. He stated that cash pools that met specific criteria would be permitted to be captured in SSAP No. 2R, but the intent of the agenda item was not to permit reporting entries to move short-term investments into the pool or conduct activities that would not be permitted under statutory accounting, such as circumventing reporting or disclosures. Mr. Pinegar stated that interested parties requested consideration for reporting based on a determination, based on managements’ judgment at the time the pool is formed, as to the expected characteristics of the pool assets. He stated that NAIC staff supported single line reporting in Schedule E – Part 2. Single line reporting will ensure unilateral, uniform reporting among all pool participants and all reporting entities who participate in various, qualified cash pools. Additionally, a unique reporting line specifically for qualified cash pools is expected to be available in 2021. Mr. Pinegar stated that interested parties also requested an effective date of Jan. 1, 2021. However, NAIC staff were supportive of an immediate effective date to ensure that cash pools that do not meet the qualifying parameters, absent permission from a reporting entity’s domestic regulator, would not be allowed to be reported as a cash equivalent or short-term investment. However, for qualifying cash pools that would require a reclassification to Schedule E, the agenda item would allow current schedule reporting until Jan. 1, 2021.

Diane Bellas (Allstate), representing interested parties, noted the importance of single line reporting and agreed with the proposed Jan. 1, 2021, effective date as entities may need to analyze their qualified pools for potential schedule changes. She requested clarification regarding the requirement for a permitted or prescribed practice in terms of entities that hold pools that do not qualify upon adoption of this agenda item.

Julie Gann (NAIC) stated that there are currently no provisions in SSAP No. 2R that permit the admittance of cash pools. She stated that if an entity were to continue to hold a cash pool that does not meet the qualifying parameters, for continued reporting as a cash equivalent or a short-term investment, a permitted or prescribed practice would be required. In terms of the Jan 1,
2021, effective date, this was simply a reclassification deadline for qualifying cash pools that meet the parameters in this agenda item.

Mr. Bruggeman stated that state investment laws may prescribe reporting of cash pool participation. However, reporting entities should work with their domestic regulators for cash pools not within scope. This agenda item effectively proposes guidance for valuation and reporting of cash pools, which were not previously in scope of SSAP No. 2R. He stated that the intent of cash pools is to effectively use the idle cash of several affiliated entities. Regulators do not want to find nonqualifying investments in these pools, and the principles of this agenda item should not be violated.

Mr. Hudson made a motion, seconded by Ms. Mears, to incorporate the modifications as proposed by NAIC staff and adopt nonsubstantive revisions to SSAP No. 2R (Attachment One-C15). The motion passed unanimously.

c. Agenda Item 2019-20

Mr. Bruggeman directed the Working Group to agenda item 2019-20: Rolling Short-Term Investments. Mr. Pinegar stated that this nonsubstantive agenda item was originally exposed to address certain investments that were structured as short-term investments, with those investments being rolled or renewed and remaining on a short-term schedule for multiple consecutive years. This agenda item proposes specific revisions that would restrict related party or affiliated investments in scope of SSAP No. 26R—Bonds, SSAP No 43R—Loan-Backed and Structured Securities or that would be reported as other invested asset investments from being continually classified as a cash equivalent or short-term investment. He stated that additional provisions are included to recognize the independent operational nature of some affiliated or related party reporting entities, and the agenda item provides special carveouts from the short-term rolling restrictions. Mr. Pinegar stated that if a reporting entity re-underwrites the investments, maintains appropriate re-underwriting documentation and each party had the ability to independently review the terms and can terminate the transaction prior to renewal, the short-term rolling restrictions would not apply. He stated that interested parties proposed a few minor, corrective edits, all of which were supported by NAIC staff. Additionally, interested parties proposed to remove the term “substantially similar” from the disclosure requirement that requires identical or substantially similar investments in which remain on the short-term schedule for more than one year be identified. NAIC staff believe that removing the substantially similar verbiage could allow for minor, insignificant modifications to be made to an investment that would then preclude disclosure and remove the substance of the agenda item.

Josh Bean (Transamerica), on behalf of interested parties, suggested one additional minor editorial change (removing an extra period within a sentence) for clarification purposes. Ms. Gann stated agreement with a minor editorial suggestion and noted that any other modifications would occur in the normal process of using an editorial update agenda item.

Angelica Tamayo-Sanchez (New York Life) requested clarification regarding the term “substantially similar” and if disclosure requirements would apply to both short-term and cash equivalent investments. She stated that parameters or expanded guidance would be needed to adequately define “substantially similar,” noting that for liquidity purposes, many nonaffiliated investments continually roll.

Mr. Bruggeman stated that currently the disclosure only specifically identifies short-term investments. However, he stated the intent was to also include cash equivalent investments. Ms. Gann stated the intent of the agenda item was to capture both short-term and cash equivalents due to potential risk-based capital (RBC) arbitrage. However, she stated the edit to explicitly add cash equivalents to the disclosure requirements can be added in a subsequent agenda item, but numerous references regarding identification of cash equivalents are already in the agenda item. Mr. Bruggeman stated that in an effort to have the desired reporting in place for year-end 2020, adoption of the rolled short-term investments could occur, with a future update to clarify the inclusion of cash equivalent investments in the disclosure requirements. Mr. Bean stated agreement with this approach and stated he does not oppose adopting the agenda item in its current form, with the expectation of a future update to clarify the inclusion of cash equivalent investments in the disclosure requirements.
Mr. Hudson made a motion, seconded by Mr. DiMemmo, to incorporate the modifications as proposed by NAIC staff and adopt nonsubstantive revisions to SSAP No. 2R (Attachment One-C16). The motion passed unanimously. The Working Group also directed NAIC staff to draft an editorial agenda item to clarify that cash equivalent investments shall be included in the disclosure requirements.

d. **Agenda Item 2019-36**

Mr. Bruggeeman directed the Working Group to agenda item 2019-36: Expand MGA and TPA Disclosures. Ms. Marcotte stated that this nonsubstantive agenda item was drafted pursuant to a request from two states to expand the existing annual statement disclosure regarding managing general agents (MGAs) or third-party administrators (TPAs) to include additional information. She noted that in agreement with interested parties’ comments, additional work needs to be completed on the definitional terms of TPAs. She stated that the previously referenced NAIC guideline only applies to a few specified lines of business and that the sponsors of the agenda item would like the disclosure to be applied broadly to all lines of business. She stated that NAIC staff are supportive of trying to find reasonable metrics for the disclosure but noted that finding one definition that works for all state laws to define TPA will not be practical or feasible. She recommended that this agenda item be deferred and NAIC staff be directed to coordinate with regulators, industry and the sponsors to develop recommendations including a functional definition. She stated that NAIC staff do not recommend the formation of a study group. She stated that the Working Group should also notify the Blanks (E) Working Group of the decision to withdraw the concurrently exposed annual statement blanks proposal.

The Working Group did not object to the recommendation to defer the agenda item and directed NAIC staff to coordinate with the sponsors and industry to refine the definition of TPA used in the disclosure to one that is inclusive of more lines of business and more functional. The Working Group also directed the notification of the Blanks (E) Working Group of the decision to withdraw the concurrently exposed annual statement blanks proposal.

e. **Agenda Item 2020-14**

Mr. Bruggeeman directed the Working Group to agenda item 2020-14: Assessment of OTTI Based on Original Contract Terms. Ms. Gann stated this nonsubstantive agenda item was drafted to clarify the other-than-temporary impairment (OTTI) guidance in SSAP No. 26R. She stated it has been identified that there is a disconnect between SSAP No. 26R, SSAP No. 36R—Troubled Debt Restructuring and SSAP No. 103R with how modifications to debt instruments are considered for OTTI. Existing guidance in SSAP No. 26R identifies that OTTI assessments are based on the contractual terms of a debt security in effect at the date of acquisition. However, if a debt instrument has been modified pursuant to SSAP No. 36R or SSAP No. 103 (nontroubled situations), subsequent assessments of OTTI shall be based on the modified contractual terms of the debt instrument, and not refer to the original acquisition terms. Ms. Gann stated that NAIC staff agree with the minor edit as proposed by interested parties, clarifying that the OTTI shall be assessed on the modified contract terms.

Mr. Hudson made a motion, seconded by Ms. Malm, to incorporate the modification as proposed by interested parties and adopt nonsubstantive revisions to SSAP No. 26R (Attachment One-C17). The motion passed unanimously.

f. **Tentative INT 20-05**

Mr. Bruggeeman directed the Working Group to Interpretation (INT) 20-05T: Investment Income Due and Accrued. Ms. Gann stated that the upcoming proposed interpretations provide an exception to statutory accounting standards and require a two-thirds vote for adoption. She stated this interpretation provides limited-time collectibility assessments and admittance exceptions for SSAP No. 34—Investment Income Due and Accrued. This interpretation allows an exception to the collectibility assessment for investments that have had a forbearance or modifications, in response to COVID-19, that were both current as of Dec. 31, 2019, were not experiencing financial difficulties at the time of the modification. For these items, further evaluation of collectibility would not be required for the first- and second-quarter financial statements unless other indicators that interest would not be collected were known. Ms. Gann stated the second exception is related to the admittance of recorded investment income due and accrued that is deemed collectible and is more than 90 days past due. With this exception, reported investment income that becomes more than 90 days past due in the first or second quarters may be admitted in the second-quarter financial statements. She stated comments received from interested parties requested clarification regarding impairment for mortgage loans. This interpretation does not provide an exception for accrued interest on mortgage loans in default, as existing guidance in SSAP No. 37—Mortgage Loans already states impairment shall be based on the modified contractual terms. Ms. Gann stated that in response, NAIC staff have proposed minor edits clarifying that accrued interest on mortgage loans that were in default are not in scope of this interpretation.
Ms. Weaver made a motion, seconded by Ms. Mears, to adopt the consensus in INT 20-05, with the modification as proposed by NAIC staff, for statutory accounting (Attachment One-C18). The motion passed unanimously.

g. Tentative INT 20-06

Mr. Bruggeman directed the Working Group to INT 20-06T: Participation in the 2020 TALF Program. Ms. Gann stated this interpretation proposes guidance for reporting entities participating in the federal Term Asset-Backed Securities Lending Facility (TALF) program. The guidance addresses both direct borrowers and reporting entities that participate as an investor to a direct borrower. She stated INT 20-06T differs from the TALF interpretation issued in 2009 as the earlier interpretation only provided accounting and reporting guidance for reporting entities who were direct participants in the program. However, from a public records search, it appears as though most reporting entities were not direct participants but rather were material investors to the direct participant. Ms. Gann stated that for direct participants, this interpretation follows existing statutory accounting guidance with the exception of allowing direct borrowers who pledge assets to the TALF program to continue admittance of those pledged assets. This exception was required as the TALF program does not permit substitutions of collateral. For investors, the interpretation proposes to follow existing statutory accounting guidance in that the investment shall follow the appropriate SSAP. She stated that NAIC staff agreed with interested parties’ proposed edits, which eliminated minor redundant verbiage.

Mr. Hudson made a motion, seconded by Mr. Moser, to adopt the consensus in INT 2020-06, with the modifications as proposed by interested parties, for statutory accounting (Attachment One-C19). The motion passed unanimously.

h. Tentative INT 20-07T

Mr. Bruggeman directed the Working Group to INT 20-07T: Troubled Debt Restructurings of Certain Debt Instruments Due to COVID-19. Ms. Gann stated this interpretation was drafted after receiving comments in response to INT 20-03: Troubled Debt Restructuring Due to COVID-19 and INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19, which requested consideration of similar accounting exceptions for private placement investments. She stated that interested parties had proposed broad exceptions for all debt securities in an effort not to spend resources on obtaining a collaborative agreement regarding the definition of private placement investments. Ms. Gann stated this guidance proposes limited-time practical expedients in determining whether a restructuring reflects a “concession” under paragraph 10 of SSAP No. 36. Under existing statutory accounting guidance, a restructuring that is insignificant is not a concession; therefore, it is not a troubled debt restructuring. The interpretation originally proposed two practical expedients in determining what is an insignificant debt modification. The original expedients proposed were a 10% shortfall threshold in the contractual amount due and a repayment duration delay no greater than six months. Had both occurred, the modification was deemed to be insignificant. However, in response to comments received from interested parties, NAIC staff have proposed a three-year time duration for the modification in place of the original six-month duration as most debt modifications would likely extend well beyond a six-month time horizon. As proposed by NAIC staff, a modification that does not extend the original contract duration by more than three years and does not change the contractual cash flows by more than 10% would be considered an insignificant change and thus, by definition, not a troubled debt restructuring. Ms. Gann stated that debt covenant changes also do not rise to the level of a troubled debt restructuring and if a modification is not automatically deemed insignificant by the provisions of this interpretation, a reporting entity still has the ability to independently assess, or assess with the assistance of its domestic regulator, if the concession was insignificant. Additionally, if a modification was deemed insignificant under SSAP No. 36, even if the modification does not fall within scope of this interpretation, the investment does not need to be derecognized as an exchange of debt instruments under SSAP No. 103R. She stated the guidance in INT 20-07T does not affect the guidance in INT 20-03 and investments, such as commercial mortgage loans would first follow applicable guidance in INT 20-03. If INT 20-03 does not provide applicable guidance, a reporting entity would then follow the temporary expedience in INT 20-07T.

Mr. Bruggeman stated the intent of this interpretation was to provide a practical expedient for determining what was an insignificant modification under SSAP No. 36. However, if a modification does not fall within scope of this interpretation, it does not necessarily mean the modification is not insignificant and thus requiring troubled debt accounting.

Mr. Hudson made a motion, seconded by Mr. Moser, to adopt the consensus in INT 20-07, with the modification as proposed by NAIC staff, for statutory accounting (Attachment One-C20). The motion passed unanimously.
i. Tentative INT 20-08

Mr. Bruggeman directed the Working Group to INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends. Ms. Marcotte stated that this interpretation was exposed to address questions related to refunds, rate reductions and policyholder dividends in response to decreased insured activity related to COVID-19 stay home orders. She noted that the overall guiding principle is that the accounting shall follow existing statutory accounting principles and annual statement reporting where feasible. She stated that the interpretation noted that several property/casualty (P/C) lines of business had offered refunds, rate reductions or policyholder dividends. She said after the exposure, a large health insurance carrier also announced refunds or rate reductions and that the draft in the materials also recommends adding a reference to SSAP No. 54R—Individual and Group Accident and Health Contracts.

Ms. Marcotte stated that seven comment letters were received, including comments from: the group of interested parties representing several companies, America’s Health Insurance Plans (AHIP), American Property Casualty Insurance Association (APCIA), the Cincinnati Insurance Companies, Grange Insurance Company, National Association of Mutual Insurance Companies (NAMIC) and Travelers Insurance Companies. She stated that most of the comments focus on Issue 1: How to account for refunds not required under the policy terms and on clarifying the scope of the proposed disclosure in Issue 5.

Ms. Marcotte stated there seems to be general support for:
- Issue 2: How to account for refunds required under the policy terms.
- Issue 3: How to account for rate reductions on in-force and renewal business.
- Issue 4: Requires policyholder dividends to follow existing guidance and complete the disclosures per Issue 5.

Ms. Marcotte stated that Issue 5 regarding disclosures requires that reporting entities continue to comply with all statutory accounting disclosure requirements and also requires that all premium refunds, rate reductions or policyholder dividends provided because of the decreased activity due to COVID-19 be aggregated and reported in Note 21A as unusual and infrequent items. She noted that the P/C actuaries who perform rate review and analysis noted that transparency will assist them in evaluating 2020 activities.

Ms. Marcotte provided an overview of comments received. She noted that there was primarily support for the exposure by APCIA and Travelers Insurance on Issues 1–4, and interested parties on Issues 2–4.

Ms. Marcotte noted that there was the most diversity in the comments regarding premium refunds in Issue 1. She stated that some of the interested parties, APCIA and Travelers all supported the exposure requirements of reporting as an adjustment to premium. She said that the interested parties group recommended adding more guidance regarding adjustments to unearned premium. She stated that Grange Insurance Company, Cincinnati Insurance Companies and some of the interested parties group recommended adding a new issue that allows payments under modified policy terms to be recognized as an "other underwriting expense" referencing SSAP No. 70—Allocation of Expenses as an alternative to recognizing adjustments to premium. She stated that Grange Insurance Company noted it was not able to provide dividends to isolated lines of business and viewed the payment as akin to the treatment of a policyholder dividend. She stated that the comment letter from interested parties included a proposed draft supported by some of the interested parties, which illustrated industry-proposed revisions. She stated that NAMIC supports allowing the reporting entity to choose between multiple different methods of recognition, including premium refunds, policyholder dividends and also bad debt expense. She noted that NAMIC’s comment letter prefers the flexibility of reporting payments similar to dividends even if they were not technically policyholder dividends so that the payments are reflected in the combined ratio.

Ms. Marcotte stated that AHIP noted its written comments as preliminary and that it prefers more health-specific guidance. She stated that AHIP also noted that immediate adjustments to premium may be too quick as some entities amortize the rate adjustments.

Ms. Marcotte stated that comments regarding Issue 5 were directed at refining the scope of the disclosures. She stated that AHIP, interested parties and APCIA recommended adding a sentence clarifying that other refunds required under policy terms are not required to be aggregated with the COVID-19 refunds. She stated that Travelers Insurance commented that for commercial rate adjusted policies, it will not be practical to separately identify refunds and rate reductions from changes in premium due to loss experience and as such, policies should be excluded from the disclosure. She stated that NAMIC recommended an editorial deletion of a reference to disclosure of stockholder dividends required under SSAP No. 72—Surplus and Quasi Reorganizations to be clearer that the focus of this interpretation is policyholder dividends.
Ms. Marcotte stated that APCIA recommended putting more permanent guidance in the SSAPs on an expedited basis. Ms. Marcotte stated that NAIC staff have proposed a limited number of revisions to reflect a few of the comments. She stated the first proposed revision is to Issue 1 on refunds, adding a reference to unearned premium as suggested by interested parties to note, “The refund shall be recognized as a reduction to written or earned premium and the unearned premium reserve adjusted accordingly.” She stated that the next proposed revision in Issue 1 is to add a new paragraph and a new subparagraph to reference SSAP No. 54 regarding individual accident and health to address refunds and rebates announced on health business subsequent to the exposure. She stated that overall, the recommendations for Issue 1 are consistent with the exposed guidance with minor health specific references.

Ms. Marcotte stated that NAIC staff have proposed modified revisions to Issue 4 – Policyholder Dividends to incorporate the NAMIC comments that provide editorial deletions to remove references to stockholder dividend disclosures as not needed and maintain the focus on policyholder dividends.

Ms. Marcotte stated for Issue 5 on disclosures, NAIC staff recommend a modification to the clarification suggested by AHIP, the interested parties’ group and APCIA. The industry-proposed language would exclude all policies whose terms require an adjustment to premium. The NAIC staff proposed modification is to include policies whose terms were modified in response to COVID-19. She noted that Travelers Insurance made a similar comment in that it noted, “For commercial rate adjusted policies, it will not be practical to separate refunds and rate reductions from changes in premium due to loss experience and therefore, such policies should be excluded.” She stated that the NAIC staff recommendation is to include policies whose terms were modified after the declaration of emergency in the disclosure of the COVID-19 inspired premium refunds, rate reductions and policyholder dividends.

Ms. Marcotte stated the exposed interpretation is also not proposed to be modified to allow reporting the refunds or rate reductions on in-force policies as premium balances charged off (e.g., bad debt expense). She noted this industry recommendation is inconsistent with guidance in SSAP No. 53—Property Casualty Contracts—Premiums, paragraph 14, on earned but uncollected premium. She also noted that it is inconsistent with the annual statement instructions as the amount is not an uncollectible amount, but rather a voluntary choice by the reporting entity to reduce the amount charged.

Mr. Bruggeman stated that it appears there is consensus regarding Issue 2, Issue 3 and Issue 4. He noted that a good example of the scoping problem identified by industry for Issue 5 on disclosure is that for a workers’ compensation policy in which the policyholder would normally have 100 active employees and now has 10 employees, a refund would normally be required under the policy terms because of the decrease in covered risks. Ms. Marcotte noted that the NAIC staff recommendation was, “For clarification, refunds required under policy terms in-force prior to the federal declaration of emergency for the COVID-19 pandemic as discussed in paragraph 13 (i.e., policies that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses) are not required to be aggregated in disclosures of COVID-19 inspired premium refunds, rate reductions and policyholder dividends. Policies whose terms were modified after the declaration of emergency in response to COVID-19 are required to disclose the COVID-19 inspired premium refunds, rate reductions and policyholder dividends.” Mr. Bruggeman said that the NAIC staff recommendation on Issue 5 adequately addressed the issue.

Mr. Bruggeman stated that at this point, he is not certain that he has all of the information regarding the variety of ways and reasons that funds were returned to policyholders. He noted that the comment letter attachments included the illustration proposed by some of the interested parties and that he would like to understand some of the different situations better. Additionally, he noted that most of the payments were made after April 1. Therefore, he said this is predominately a second-quarter reporting issue. He stated that while there is some time to address this issue, there was also a need for consistent guidance to be finalized expeditiously. Mr. Hudson stated California’s support for reflecting Issue 1 as an adjustment to premium but noted he is also mindful of the amount of comments. He asked if Mr. Bruggeman was suggesting exposing the issue again to allow for further discussion, particularly on Issue 1. Mr. Bruggeman responded that he wants to explore the exposure options of either all of the interpretation or finalizing aspects of the interpretation and allowing for further discussion on Issue 1. Mr. Smith said he is not opposed to another exposure, but he supports the initial recommendation to reflect as an adjustment to premium. Mr. Smith said even with different situations provided in the comments, after review of various company actions—including premium credits, premium refund or return, and rate reductions—in his view, all reflect an adjustment to premium.

Mr. Bruggeman said that some entities’ comments noted that they have returned money even though the risk has not been reduced. Mr. Moser noted that Illinois is willing to explore the accounting as an expense if it makes sense. Ms. Marcotte
suggested exposure with the NAIC staff edits to narrow the scope of future comments. Mr. Bruggeman asked for commenters to focus their comments regarding Issue 1.

Keith Bell (Travelers Insurance), representing interested parties, noted that for reporting entities that reflected the payments as an adjustment to premium, they viewed the issue as a distinction of form over substance. If the reason the payment is being made to the insured is because the risk or exposure went down, then it was appropriate to reflect as a reduction of premium. He noted that premium is an important metric that measures the amount of risk that an insurer takes on as part of the contract and that is how they reached that conclusion.

Kevin Spataro (Allstate) noted that Allstate was early to announce a policyholder relief program. He noted its objective was to get relief into the hands of policyholders quickly with the least disruptions to other stakeholders. He noted that it considered reflecting the amounts as a premium refund but ultimately rejected the treatment, principally because Allstate lacked loss data to be able to reliably reassess the underwriting risk related to the policies in the current conditions. He noted that reporting as a premium refund would also affect other key stakeholders, including agents, whose commissions are based on premiums, and also the states in which they do business, who rely on premium taxes to fund their operations. He stated that as a result, Allstate ultimately decided to amend its policy forms to provide an endorsement to provide a new type of policy benefit that it classified as an other underwriting expense pursuant to SSAP No. 70. He said that Allstate believes that due to the unique nature of the payment, it fits well as an other underwriting expense in a write in line. He noted that Allstate also supported disclosure to provide transparency. He noted that Allstate has no issue with other insurers reporting as a return of premium or as a dividend based on program design. He noted that they believe that Allstate and others who designed and executed their programs around a policyholder benefit should be permitted to classify their payments as an expense. Mr. Spataro stated that while Allstate understands that there is not a specific expense category to allow this treatment, for a COVID-19 relief payment, it believes the interpretation is an appropriate vehicle to codify its proposed accounting treatment. Mr. Spataro further noted that Allstate also does not believe that another agenda item or a permitted practice designation is either necessary or appropriate at this time.

Mr. Bruggeman summarized that it appears that Allstate’s recommendation is that the statutory accounting should follow the policy form, which was filed, i.e. a policy benefit. Mr. Spataro confirmed the comment from Mr. Bruggeman. Mr. Bruggeman noted that the subject companies actually filed amendments to their policy forms; they did not base the refund amount on data telematics from policyholders (such as decreased driving miles.) Mr. Spataro stated that Allstate does not have the data to re-underwrite the policies.

Mr. Bell stated that he is not suggesting the reduced prices were because of telematics, but rather the decrease in losses. He stated that again, the argument is form over substance. If you put aside the labels applied to the payments, the amounts were paid back to the policyholder. He stated that if the payment was because there was less exposure or less losses, then the view is that is a reduction in premium and that premium is the most important measure of an insurer’s exposure to loss.

Mr. Spataro said Allstate looks at this issue differently because it did not reassess the exposure to loss. He noted that the stay-at-home orders have resulted in some policyholders that seem to be driving faster. He stated that Allstate believed the payments were important to get into the hands of its policyholders, but it did not have the ability to re-underwrite those policies, and Allstate still believes this is a policy benefit as opposed to a return of premium. Mr. Bruggeman noted that some policyholders were driving less, and others, such as essential workers, were driving the same or sometimes more.

Thomas Finnell (AHIP) noted that AHIP did not have much time to react to the health specific change. However, he said other than a large insurer making an announcement, there is not a lot of activity on the health side regarding the same types of refunds. He said that the example may be restrictive to other insurers if they decide to take action later in the reporting year. Mr. Finnell stated that the interpretation provided more P/C examples and that additional health examples would be helpful. He said one jurisdiction has put out an announcement that such payments would require a rate filing. He noted that a few members have provided premium holidays in prior years that were reported as a reduction of premium which was amortized over the policy year. Mr. Finnell stated that such amortization is not covered by the text in the interpretation. He stated that AHIP would like to have further clarification regarding what is meant by immediate reduction in premium (written, earned or unearned). He stated that AHIP would like to bring the idea of premium holidays into the interpretation. He stated that AHIP shared the concern of interested parties regarding the scoping of the disclosure. It seems that there are retrospective premium assessments because of the totality of activity on the policy not just as a result of COVID-19 payments. Mr. Bruggeman noted that the very large company announcement prompted inclusion of the health contracts in case other entities decided to go down that path.
Steve Broadie (APCIA) noted that APCIA’s financial management regulation committee considered all of the issues and voted to support the conclusions reached in the interpretation as an appropriate application of the existing accounting guidance. He stated that APCIA supports adoption of the INT with respect to Issue 1. Mr. Broadie stated that the diversity of comments received also indicated the need for additional permanent substantive guidance in the statements. He said that APCIA would be happy to support and work with NAIC staff on developing revisions that it believes are necessary on an expedited basis.

Rachel Underwood (Cincinnati Insurance Companies) noted support for the position of reporting the payment in Issue 1 in other underwriting expense as Mr. Spataro presented. She noted that Cincinnati Insurance Companies presented additional reasoning for its position in its comment letter.

Jonathon Rodgers (NAMIC) noted that this is unprecedented and that there is great diversity of actions and preferences among NAMIC’s members. He stated that characterizing the return of funds to policyholders as a return of premium does not work for everyone. He noted some mutual entities wanted to provide policyholder dividends, but their systems were not set up to provide the expedited payments. He noted that often a policyholder dividend is issued to share favorable loss experience. Mr. Rodgers said it is too early to substantiate the impact of the loss experience, but the losses being reported are lower. He noted that the company systems could not accommodate the accelerated payments. He stated that although the payments were not policyholder dividends, NAMIC’s members supported similar treatment. He noted another instance in which premium previously collected and earned was returned. He stated that some members supported reporting these returned amounts as premium and agents balances charged off similar to bad debt expense. He noted that the accounting guidance in SSAP No. 53 and SSAP No. 70 was not a good fit for all of the actions. He stated that this extraordinary event calls for flexibility in reporting.

Mr. Bruggeman said that at this time, he thinks that another exposure that includes the NAIC staff proposed revisions is appropriate. He asked if the Working Group had any issues with another exposure, and no objections were stated.

Mr. Hudson made a motion, seconded by Mr. Moser, to expose INT 20-08T with the modifications recommended by NAIC staff for a 16-day public comment period ending June 5. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
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**Comment Letters Received for Items Exposed for the May 20, 2020 Conference Call**

**Interested Parties – May 1, 2020**
- Ref #2019-20: Rolling Short-Term Investments
- Ref #2019-25: Working Capital Finance Investments
- Ref #2019-36: Expand MGA & TPA Disclosures
- Ref #2019-37: Surplus Notes – Enhanced Disclosures
- Ref #2019-42: Cash Equivalent – Cash & Liquidity Pools
- Ref #2019-47: VM 21 Grading
- Ref #2020-01: Update / Remove References to SVO Listings
- Ref #2020-06EP: Editorial and Maintenance Update
- Ref #2020-07: Change to the Summary Investment Schedule
- Ref #2020-08: ASU 2016-20, Technical Corrections and Improvements – Topic 606
- Ref #2020-09: ASU 2018-18, Collaborative Arrangements – Topic 808
- Ref #2020-10: ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topic 605 and Topic 606
- Ref #2020-11: ASU 2020-02, Amendments to SEC Paragraphs in Credit Losses and Leases
May 1, 2020

Mr. Dale Bruggeman, Chairman  
Statutory Accounting Principles Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

RE: Items Exposed for Comment During the NAIC Spring National Meeting Conference call with Comments due May 1

Dear Mr. Bruggeman:

Interested parties thank the NAIC Statutory Accounting Principles (E) Working Group (the “Working Group”) for your continuing effort to address the various statutory accounting issues during the ongoing pandemic. We appreciate the opportunity to comment on the exposure drafts released for comment the Working Group during the recent NAIC Spring National Meeting via conference call. We offer the following comments:

Ref# 2019-20, Rolling Short-Term Investments

The Working Group exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, with modifications from the prior exposure.

The revisions incorporate additional principle concepts, if certain criteria are not met, that will restrict the classification of related party or affiliated investments as a cash equivalent or short-term investment in the scope of SSAP No. 26R—Bonds, SSAP No. 43R—Loan-backed and Structured Securities, or that would be reported as “Other Invested Assets.”

An additional disclosure has also been proposed to identify short-term investments (or substantially similar investments) which remain on the short-term schedule for more than one consecutive year (i.e. a re-underwritten investment that is renewed). A concurrent blanks proposal will recommend a reporting code for renewed short-term investments as well as a new general interrogatory to certify that re-underwriting has occurred. (This code will also apply to nonaffiliated non-related party transactions for identification purposes.)

Interested parties appreciate the Working Group’s engagement with us on this proposal. We believe the current proposal is well suited to addressing the issues identified in the Form A. We offer the following
suggested changes which we believe will improve the current proposal as well as clarify certain
provisions that may cause confusion on the part of preparers and result in inconsistent application by
insurers.

The proposed new Footnote 1 to both paragraphs 7 and 13 of SSAP No. 2R- Cash, Cash Equivalents and
Short Term Investments (“SSAP No. 2R”) explicitly excludes specific short term investment vehicles
qualifying under the scope of SSAP No. 103R- Transfers and Servicing of Financial Assets and
Extinguishments of Liabilities (“SSAP No. 103R”) from the scope of the proposed long term
reclassification requirements. However, the proposed footnote makes reference to both “reverse
repurchase” transactions, which are defined as collateralized lendings to be reported as short term
investments under SSAP No. 103R and therefore relevant for inclusion in the proposed new Footnote 1
for paragraph 13 of SSAP No. 2R, as well as “repurchase” transactions, which are defined as
collateralized borrowings to be reported as liabilities under SSAP No. 103R and are not relevant to the
proposed SSAP No. 2R footnote. As reverse repurchase agreements are to be reported as short-term
investments, not cash equivalents, there is no reason to mention them in the proposed new Footnote 1
for paragraph 7.

In addition, the proposed new footnote 1 to both paragraphs 7 and 13 of SSAP No. 2R contains two
distinct and separate instructions: one for excluding reverse repurchase agreements (or cash pooling
arrangements in the case of the paragraph 7 footnote) from the scope of the new long term
reclassification guidance; and another regarding subsequent reporting for cash equivalents and short-
term investments that are subject to the new long term reclassification guidance. We recommend
breaking the proposed footnote 1 into two separate footnotes.

Therefore, we recommend the following edits to SSAP No. 2R:

Proposed new footnote 1 to paragraph 7: Cash pooling arrangements permitted under paragraph
8 are excluded from these provisions.

Proposed new footnote 2 to paragraph 7: Cash equivalents subject to the provisions of paragraph
7 are not permitted to be subsequently reported as short-term investments, even if the updated /
reacquired maturity date is within 1 year. These investments shall be reported as long-term
investments. To avoid changes in reporting schedules, reporting entities are permitted to report
securities as long-term investments at initial acquisition regardless of the initial maturity date.

Paragraph 12: “Short-term investments are investments that do not qualify as cash equivalents
with remaining maturities (or repurchase dates under reverse repurchase agreements) of one year
or less at the time of acquisition shall be considered short-term investments. Short-term
investments can include, but are not limited to, bonds, commercial paper, reverse repurchase
agreements, and collateral and mortgage loans. which meet the noted criteria. Short-term
investments shall not include certificates of deposit. Regardless of maturity date, derivative
instruments shall not be reported as short-term investments and shall be reported as derivatives
on Schedule DB.”

Proposed new footnote 1 to paragraph 13: Reverse repurchase transactions are excluded from
these provisions if admitted in accordance with collateral requirements pursuant to SSAP No.
103R- Transfers and Servicing of Financial Assets and Extinguishments of Liabilities.
Proposed new footnote 2 to Paragraph 13: Short term investments subject to the provisions of paragraph 13 are not permitted to be subsequently reported as cash equivalents, even if the updated/reacquired maturity date is within 90 days. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

Finally, interested parties recommend the deletion of the term “or substantially similar investments” in the new proposed disclosure of paragraph 16e of SSAP No. 2R. Unless defined, this terminology is vague and will likely result in inconsistent application by preparers.

Ref# 2019-25, Working Capital Finance Notes


Interested parties agree the changes reflected in the modified version of SSAP No. 105 are appropriate, necessary, and we support their adoption. Nevertheless, interested parties maintain that absent changes reflecting industry input on the four items not supported by the Working Group that adoption of SSAP 105 will remain muted and that the asset class will remain under invested. We respectfully request consideration of regulators to direct staff to revise its proposal and adopt industry-requested changes governing these four requests.

Ref# 2019-36: Expand MGA and TPA Disclosures

In December 2019, the Working Group exposed revisions to SSAP No. 51R—Life Contracts, paragraph 50, SSAP No. 53—Property Casualty Contracts—Premiums, paragraph 19, SSAP No. 54R—Individual and Group Accident and Health Contracts, paragraph 33 and SSAP No. 59—Credit Life and Accident and Health Insurance Contracts, paragraph 19, to expand the MGA/TPA footnote as follows:

- Aggregate direct written premium and total premium written by MGA/TPA;
- Aggregate dollar amount of claims process / total claims processed by MGA/TPA; and
- Information on related party / affiliate status and if the MGA/TPA is independently audited and / or bonded.

Based on responses received on the original exposure, a re-exposure was made in March 2020 with the following attributes:

- A TPA was defined to be consistent with the NAIC Model Guideline, VI-1090 Registration and Regulation of Third-Party Administrators (“TPAs”).
- A claims measure was maintained for determining which TPAs to be disclosed, instead of a written premium measure suggested by interested parties. However, to address the interested parties’ operational concerns the language has been revised from “claims adjusting services are
Interested parties appreciate the incorporation of our previous comments in the re-exposed draft by including a definition of third-party administrators through referencing Version 1 of the Third Party Administrator Act. However, upon further analysis and as noted in the Registration and Regulation of Third-Party Administrators (NAIC Guideline), there are two versions of the model law of the Third-Party Administrator Act, and states have adopted either version, if any. Therefore, a consistent and widely accepted definition of a TPA is not available and needs to be developed to ensure uniform disclosure amongst companies.

Additionally, the reporting threshold and basis remains unclear. Is total count of claims processed by the TPA/MGA measured at a line of business or company level? Would claims paid within insureds’ deductibles be included? We believe it will be quite burdensome for insurers to monitor this metric as there is no reasonable basis for measurement that can be utilized from the Annual Statement.

As we are concerned that the exposure draft includes a definition of a TPA that is inconsistent with state law which will most likely lead to preparer confusion and misapplication of the proposed guidance once adopted, we recommend that a state regulator/industry study group be formed to develop a uniform definition taking into consideration commonalities in existing state law. In addition to developing a uniform definition, the study group could also recommend the best way, and the proper mechanism, to develop the information requested.

**Ref# 2019-37: Surplus Notes – Enhanced Disclosures**

During the 2018 Spring National Meeting, the Working Group exposed revisions to *SSAP No. 41R – Surplus Notes* (“*SSAP No. 41R*”) to indicate that surplus notes, where the proceeds from the issuance of the surplus note were used to purchase an asset directly or indirectly from the holder of the surplus note, are not subordinate and do not qualify for reporting as surplus and should be classified as debt. Furthermore, the exposure draft stated that these assets were not considered available for policyholder claims and should be non-admitted. The exposure was the result of a referral from a Subgroup of the Reinsurance Task Force that was more narrowly focused on whether specific securities could be considered Primary Securities.

At the 2019 Fall National Meeting, the Working Group exposed additional disclosures that should be captured in *SSAP No. 41R*. Interested parties responded to that exposure in early 2020, and more recently in discussions with NAIC staff, with suggestions to enhance the disclosure as summarized below:

**Summary of Proposed Revisions**

- Expand the disclosure requirement to the financial statements of the ceding company as well as the surplus note issuer.
- Retain the current disclosure of total interest paid (gross of any administrative or other netting)
- Replace quantitative disclosure of “interest remitted” and “cost of liquidity” with three Y/N disclosure columns, which correspond to the criteria used in the data call scoping.

- Add information on the percentage of interest payments offset through ‘administrative offsetting’ (not inclusive of amounts paid to a 3rd party liquidity provider).

- Add requirement for narrative disclosure of any related guarantees or support agreements.

On March 18, 2020, the Working Group re-exposed the disclosure and the re-exposure substantially incorporated interested parties’ comments and suggestions. Interested parties appreciate the engagement and collaborative effort we’ve had with the Working Group and NAIC staff over the past six months to arrive at a mutually beneficial robust disclosure, and support adoption of the proposed revisions.

We are aware that the Working Group does intend, later in 2020, to continue discussions on how to treat surplus notes where an associated asset is received by the surplus note issuer. We believe that the disclosure, once adopted, and further analysis of the 2019 data call should allow regulators to focus on areas for further analysis with specific companies on their financing transactions (utilizing surplus notes) as opposed to any restrictions on the usage of surplus notes as currently allowed in statutory guidance.

**Ref# 2019-42: Inclusion of Cash / Liquidity Pools - Cash Equivalents as defined in SSAP No. 2R**

The Working Group exposed this agenda item, with revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, with revisions from the prior exposure marked, to reflect that certain cash / liquidity pools, meeting defined criteria, may be reported as cash, cash equivalents, or short-term investments.

Interested parties appreciate the Working Group addressing the considerations raised in our previous comment letter for Ref #2019-42, Inclusion of Cash/Liquidity Pools-Cash Equivalents as defined in SSAP No. 2R. Cash/Liquidity pools are very important to insurers as they have been used throughout the years for efficient management of cash, cash equivalents, and short-term investments.

After reviewing the modifications proposed by the Working Group, we request one additional change to the proposal. As mentioned in our previous comment letter:

“Given the varied characteristic discussed above, we recommend paragraph 8 be modified to state that, if the requirements of paragraph 8 are met, the reporting entity may look through the ownership structure and report the assets as either cash equivalents or short-term assets based on the predominant characteristic of the underlying assets. This would allow companies the flexibility to report their investments in the pools in the Statutory statement schedule that is more reflective of the type of underlying investments in their pool and prevent the need for companies to reclassify/change their existing reporting to Schedule E2 from DA if they currently report the pools in DA due to the underlying assets.”

In response to our comment noted above, the Working Group proposed the following addition to SSAP No. 2R:

“The reporting entity shall report their total balances in the cash pool on the schedule which represents a majority of the held assets (For example, a qualifying cash pool that contains 20%
cash, 70% cash equivalents, and 10% short-term investments, the reporting entity would report their entire balance invested as a cash equivalent.)”

We note that the Working Group proposal for SSAP No. 2R requires reporting in either Schedule E2 or DA based on the “majority” of the underlying assets held in the Cash/Liquidity pool. After further considering the verbiage, we propose SSAP No. 2R be modified to state that the classification of Cash/Liquidity pools in either Schedule E2 or DA be based on “a determination, based on management’s judgment at the time the pool is formed, as to the expected characteristics of the majority of the underlying assets in the pool”. That is, if based on management’s judgment at the time the pool is formed, the expectation is that the majority of assets in the pool will be invested in short-term investments, the pool would be classified on Schedule DA.

This change in verbiage would allow insurers who have already been using such pools to continue to classify them in either Schedule E2 or DA, consistent with the reporting since forming their pools. It also would prevent the need for insurers to unnecessarily transfer their pools between Schedule E2 and DA, which would cause operational inefficiencies counterproductive to the use of a pool, should the mix of the underlying assets change from period to period. It also would eliminate the need to continue to track the mix of assets in the underlying pool on an on-going basis. We do not believe this approach would be a concern to regulators because, as mentioned in the Working Group’s March 21, 2020 Public Hearing Agenda “…cash, cash equivalent, and short-term investments are aggregated together for solvency and analysis reviews”.

We request an adoption date of January 1, 2021 for the changes to SSAP No. 2R so that insurers can have time to fully evaluate their short-term pools to ensure they meet the requirements in the proposal and determine the appropriate reporting. Additionally, time may be needed to modify pool operating agreements and audit procedures to meet the new requirements.

Ref# 2019-47: Grade in of Variable Annuity Reserves

The Working Group exposed this agenda item, with revisions marked with the heading “Spring National Meeting Discussion.” A referral was also be sent to the Life Actuarial (A) Task Force for notification of this exposure.

Interested parties agree with the conclusion on this item.

Ref# 2020-01: Update / Remove References to SVO Listings

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds and SSAP No. 30R—Unaffiliated Common Stock, to eliminate references to the NAIC Bond Fund List. The revisions also add reference to the “NAIC Fixed-Income Like SEC Registered Funds List” in SSAP No. 30R.

Interested parties agree with the conclusion on this item.

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the editorial maintenance revisions to SSAP No. 21R—Other Admitted Assets and SSAP No. 51R—Life Contracts.

Interested parties have no comment on this item.

Ref# 2020-07: Change to the Summary Investment Schedule

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix A-001, Section 3, Summary Investment Schedule to add a line for Total Valuation Allowance. These revisions mirror those that the Blanks (E) Working Group concurrently exposed.

Interested parties agree with the conclusion on this item.

Ref# 2020-08: ASU 2016-20, Technical Corrections and Improvements to Topic 606

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 47—Uninsured Plans to reject ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers.

Interested parties agree with the Working Group’s conclusion on this item.

Ref# 2020-09: ASU 2018-18, Collaborative Arrangements (Topic 808)

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 47—Uninsured Plans to reject ASU 2018-18, Collaborative Arrangements (Topic 808), Clarifying the Interaction between Topic 808 and Topic 606.

Interested parties have no comment on this item.

Ref# 2020-10: ASU 2017-14—Amendments to SEC Paragraphs in Topic 220, Topic 605 and Topic 606

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topics 605 and Topic 606 for statutory accounting.

Interested parties have no comment on this item.

Ref# 2020-11: ASU 2020-02—Amendments to SEC Paragraphs in Credit Losses (Topic 326) and Leases (Topic 842)

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed
revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-02—Amendments to SEC Paragraphs in Credit Losses (Topic 326) and Leases (Topics 842) as not applicable for statutory accounting.

Interested parties have no comment on this item.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell  
Rose Albrizio
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** These comments were not received in time for distribution for the May 20, 2020 SAPWG conference call. They are, however, being posted with INT 20-08T, which was exposed at the direction of the SAPWG.
May 14, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles (E) Working Group

Via e-mail to: Julie Gann
JGann@naic.org

Re: Proposed INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Chairman Bruggeman:

America’s Health Insurance Plans (AHIP) and its members appreciate the continuing dedication and diligence that you and your colleagues show in your work to address the pandemic crisis while balancing the regulatory goals of consumer protection and company solvency. It is beyond doubt that these are extraordinary times, and they require extraordinary effort by both the regulatory community and industry.

The Statutory Accounting Principles (E) Working Group (SAPWG) recently exposed five new proposed Interpretations that address various impacts of the pandemic. AHIP is providing the following comments which pertain to one of those five exposures, specifically, INT 20-08T, COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends.

AHIP often signs on to comment letters submitted by a broader group of interested parties (IP), however we have chosen not to do so in this instance. That is not because of any fundamental disagreement per se with the draft of the IP letter that we reviewed. Rather, it is because, as drafted, the IP letter proposes to amend INT 20-08T to address the accounting and reporting for premium refunds, rate reductions, policyholder benefit payments and policyholder dividends attributable to COVID-19 impacts on the private passenger and commercial auto insurance business only. In light of the message we received from NAIC staff yesterday which included staff’s recommended changes to INT 20-08T to specifically scope in health insurance, we believe it is best for AHIP to submit its own comments and focus directly on impacts on health plans.

Also, and given that we have had barely more than one day to review the health-specific amendments provided by NAIC staff, we have had extremely limited time to study those amendments and solicit input from our members. Accordingly, please accept the following comments as preliminary. We hope you will afford us the opportunity to expand upon them if needed in oral comments to SAPWG when it convenes by phone on May 20. With that, we offer the following comments:

1. With regards to paragraphs 1-5, some additional context that is more specific to the health insurance sector may be appropriate. For example, and to the extent known, it would be helpful to include information as to the various ways in which such premium reductions have been made in the health sector.
2. As drafted with the health-related amendments, INT 20-08T calls for “immediate adjustments to premium for voluntary accident and health premium refunds.” It is not clear to us that “immediate” is necessarily appropriate depending, for example, as to whether the subject is written or earned premium. Many health plans are established as 12-month contracts. In some cases the insurer records premiums on a monthly basis as billed, and on others it records written premium for the 12-month period with corresponding unearned premium which are then reduced as premium payments are received and as premiums are earned over the coverage period, respectively. Depending on management’s intent with respect to the premium reduction, it may have an intended immediate impact on earned premium, or be amortized over the remaining term of the contract.
   a. For example, it may depend if the premium reduction is in the context of past business with the insurer (expired portion of the contract or prior contracts) or in the context of continued business (unexpired portion of the contract or future contracts).
   b. Such alternatives are conceptually like the FASB guidance cited by the IPs with respect to INT 20-05T: Investment Income Due and Accrued, and the treatment of an “interest holiday.”
   c. We are aware of one member which has in the past given premium holidays, usually in the first month of the policy period which is then amortized ratably over the policy period.

3. In short, we can see such health premium reductions happening in various ways, and more time is needed to assure that the INT text accommodates those variances and thus maximizing opportunities for such reductions, while at the same time providing sufficient uniformity in reporting across reporting entities in order to meet your objectives.

4. AHIP also has concerns about some aspects of the proposed disclosures proposed by INT 20-08T and references therein to SSAP 66 and experience rated contracts (which includes experience rated health contracts). It provides that “all COVID-19 inspired premium refunds, rate reductions, and policyholder dividends shall be disclosed as unusual or infrequent items.” For experience-based refunds, the amount is based on the group's total experience over the contract period, and it is not practical to parse through claim details to say how much is necessarily related to Covid-19. Moreover, to the extent that claims have not been made (e.g., elective procedures have been deferred) and premiums reduced, a health plan could only surmise the cause of that impact, although certainly a good portion would be related to the pandemic - it just can't be quantified with any precision. We thus suggest the following change:

21. To allow for aggregate, consistent assessment, the Working Group came to a tentative consensus that all COVID-19 inspired premium refunds, rate reductions, and policyholder dividends shall be disclosed as unusual or infrequent items in annual statement 21A. This disclosure is in addition to other existing disclosures on various items related to the policyholder payments. For the avoidance of doubt, refunds required under the policy terms as discussed in paragraph 12 (i.e., policies that require an adjustment to premium based on either...
the level of exposure to insurance risk or the level of losses) are not required to be aggregated in disclosures of COVID-19 inspired premium refunds, rate reductions and policyholder dividends.

* * * * * *

Thank you for the opportunity to comment. We look forward to discussing this with you and addressing any questions you or your colleagues may have.

Kind regards,

Bob Ridgeway
Bridgeway@AHIP.org
501-333-2621
America’s Health Insurance Plans
May 14, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners

Re: SAPWG Proposals Exposed on May 5, 2020

Dear Chairman Bruggeman:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to comment on the items exposed by the Statutory Accounting Principles (E) Working Group on May 5, 2020. APCIA is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

APCIA supports the comment letter from industry interested parties with respect to all issues except for INT 20-08T, which we address below.

INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

The COVID-19 pandemic has introduced unprecedented challenges for the insurance industry and regulators as it has for the entire nation. While changing many aspects of their operations, insurers are undertaking substantial and extraordinary efforts to help policyholders at this challenging time. For example, companies are providing flexible payment options, waiving late fees, and pausing cancellation of coverage due to non-payment of premiums. Most significantly, property casualty insurers are returning billions of dollars to policyholders through a variety of mechanisms—including refunds, discounts, dividends, and credits.

Given the unprecedented nature and scope of this extraordinary industry action, there is understandably limited statutory accounting guidance for reporting the various methods that insurers are implementing to support policyholders. INT 20-08T proposes tentative guidance on how to account for policyholder relief issued in response to COVID-19. The proposed INT concludes that voluntary refunds and rate reductions should be accounted for as an adjustment to premium revenue, and different treatment (e.g., as an expense) must be considered a permitted or prescribed practice.

APCIA’s Financial Management and Regulation Committee voted to support the conclusions reached in the INT. We agree that, under existing accounting guidance, voluntary refunds and rate reductions should be accounted for as an adjustment to premium revenue, and differing
treatment should be considered a permitted or prescribed practice. Consequently, APCIA urges the Working Group to adopt INT 20-08T in order to provide temporary guidance.

While we agree with the proposal’s interpretation of existing statutory accounting principles, APCIA believes that current accounting guidance may not adequately address the wide variety of methods companies are using to deliver policyholder relief. For example, it may be appropriate to amend statutory accounting principles to allow certain types of policyholder relief to be treated as an expense, depending on the circumstances that call for such relief. Some insurers have amended their policies through manual rate filings and endorsements to provide payments or credits to policyholders; however, companies would be unable to report these amounts as an expense unless statutory accounting is amended. Because of the extraordinary circumstances in which we find ourselves as a result of COVID-19, we believe that additional substantive guidance is needed by the end of this year. Therefore, APCIA asks the Working Group to consider—an expedited basis—a Form A containing substantive amendments to statutory accounting regarding the treatment of policyholder relief measures.

Furthermore, accounting and financial reporting issues associated with policyholder relief should be addressed holistically. Although we are experiencing a highly unusual and unexpected situation that has required extraordinary industry and regulatory action, we should not assume new unusual and unexpected situations will not occur in the future. Statutory accounting guidance must be able to adapt to sudden changes in the regulated environment, so we believe the Working Group should consider changes to statutory accounting that would be applicable to future situations where policyholder relief may be a suitable reaction to a future event. This approach would build flexibility into statutory accounting to allow timely development of necessary guidance to suit the exigent and unpredictable needs of a future crisis.

Finally, we note that APCIA agrees with interested parties’ recommendation to add the following sentence to paragraph 21 of the proposed INT: “For the avoidance of doubt, refunds required under the policy terms as discussed in paragraph 12 (i.e., policies that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses) are not required to be aggregated in disclosures of COVID-19 inspired premium refunds, rate reductions and policyholder dividends.”

Thank you for considering the points addressed in this letter, and please do not hesitate to contact us if you have any questions.

Sincerely,

Stephen W. Broadie
Vice President, Financial & Counsel
May 14, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: INT 20-08T- COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

The Cincinnati Insurance Company ("Cincinnati") appreciates the opportunity to provide comments for consideration on the Statutory Accounting Principles Working Group ("SAPWG") interpretation exposure, INT #20-08T: COVID-19 Premium Refunds, Rate Reductions, and Policyholder Dividends ("the Tentative INT"). Cincinnati's property casualty group is among the 25 largest groups in the United States, based upon net written premium.

The Tentative INT contemplates interpretation of policyholder relief payments in reaction to the current COVID-19 pandemic as either premium refunds, rate reductions, or policyholder dividends, and provides statutory accounting and reporting framework as such. Cincinnati supports the comment letter submitted by interested parties in adding a new Issue 4 to the Tentative INT. Cincinnati's position is based on the following:

• This was a one-time action intended to provide immediate relief to policyholders in response to the unusual and unprecedented COVID-19 pandemic.
• Payment amount was determined without specific known loss experience in order to accommodate urgency of the situation.
• Cincinnati revised the impacted policyholder contracts through rule filings to states and company letters to impacted policyholders, allowing this one-time payment benefit with the intent to treat it as a company expense.
• Companies acted with a sense of urgency, notified states of the company payment plan, and proceeded to act, in good faith, in accordance with those plans, absent any state objections.
• The INT as originally drafted does not address the situation where companies utilized rule filings to allow this one-time policyholder relief payment.

In conclusion, Cincinnati supports the comment letter submitted by interested parties, which suggests adding an Issue to the INT where companies utilized rule filings to allow this one-time payment and allow this situation to be reported as an expense following the guidance provided under SSAP 70 - Allocation of Expenses.

Sincerely,

[Signature]
Michael J. Sewell
Chief Financial Officer, Senior Vice President

CC: Julie Gann, NAIC Staff; Robin Marcotte, NAIC Staff; Theresa Hoffer, Senior Vice President and Treasurer; Andrew Schnell, Assistant Vice President; James Sims, Assistant Treasurer; Rachel Underwood, Technical Accounting Manager
May 14, 2020

Mr. Dale Bruggeman, Chair
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: INT 20-08T – COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

Grange Insurance Company (“Grange”) appreciates the opportunity to provide comments for consideration on the exposure drafts released for comment by the Statutory Accounting Principles Working Group (“SAPWG”) on interpretation exposure, INT #20-08T: COVID-19 Premium Refunds, Rate Reductions, and Policyholder Dividends (“the Tentative INT”). Grange’s property & casualty group is among the 75 largest insurance groups in the United States of America, based upon our approximately $1.3 billion in net written premium.

The Tentative INT contemplates classifying policyholder relief payments in reaction to the current COVID-19 pandemic as either premium refunds or policyholder dividends and provides proposed statutory accounting and reporting guidance as such. Grange’s comments will primarily focus on rationale to revise the Tentative INT to allow reporting these payments as other underwriting expenses due to other fact patterns that were not contemplated by the original policy exposure. Grange’s position is based on the following logic:

- The payments were intended to provide immediate financial relief to our policyholders regardless of contractual obligations.
- The payments were made voluntarily in our operating states.
- Loss experience data was mostly unknown at the time of announcing and issuing relief payments, regarding the ultimate impact of federal and state shelter-in-place orders.
- These payments are more in line with a company expense, such as a policyholder dividend.
- Grange revised the impacted policyholder contracts through filing endorsements with certain states and provided company letters to all impacted policyholders to provide the contractual language needed to allow such payments.
- Formal policyholder dividends were not a viable option, as dividends must be paid to all policyholders not just the lines of business expected to be favorably impacted by the shelter-in-place orders. Also, due to required approvals, dividends would not be the most immediate payment option.
- When we looked for relative consistency in reporting treatment for payments made outside of contractual premium refunds, categorizing these payments as an expense was the closest option to policyholder dividend reporting.
Classification as a premium refund will have unintended ancillary financial consequences, such as reducing premium taxes to state agencies. Like many of our competitors, we assured our independent agent partners, many of which are small businesses, that their commissions would not be impacted by these payments. Accordingly, commission ratios will be impacted (elevated) if reporting as a premium refund is required.

- Reporting the payments as an expense brings an advantage to analyzing insurance company results as it will impact only the expense ratio component of the combined ratio.
- Reporting the payments as a premium refund would distort analysis of insurance company results as it will impact all components of the combined ratio: loss, dividend, and expense ratios.
- Premium adjustments, whether contractual refunds or by rate filings, include consideration of actual loss experience, which is not completely available in this situation.
- These payments are the result of an unusual and infrequent event that would be excluded from future rate filing consideration.
- Insurance companies acted with a sense of urgency in light of the pandemic, notified states of the company’s payment plans, and then proceeded to act, in good faith, in accordance with those plans, absent any state objections.
- In addition to these payments to our policyholders for immediate financial relief, actual premium relief could come in the future through normal rate reviews and consideration of actual loss experience.

In light of the COVID-19 pandemic, regulators from a majority of states issued a number of bulletins, orders, advisories, and other guidance (collectively “Bulletins”) urging property & casualty insurance carriers nationwide to provide some means of immediate financial relief to policyholders, at least in private passenger automotive lines. The principle was that insurers should provide immediate financial relief in anticipation of lower than expected loss experience arising from a decrease in driving activity due to federal and state shelter-in-place orders. Such payments needed to be applied reasonably and consistently in order to avoid being considered a rebate or unfair discrimination. Though payments by insurance carriers would be a voluntary action in most states, they were required in the State of California (Bulletin 2020-3). The issuance of Bulletins by each state, each with their own guideline nuances, created uncertainty across insurance carriers of how to accommodate making such payments within applicable compliance standards.

Grange considered the magnitude of the situation and guidance available at the time. A policyholder dividend was deemed inappropriate, at least in part, as it would take longer to enact given the required approval process. A premium refund would create unintended negative financial consequences to state agencies and agents (absent the decision by Grange, like many carriers, to not impact agent compensation) by reducing premium amounts, therefore reducing premium taxes and commissions. Premium refunds also have the negative impact of altering comparability for all components of the combined ratio. Additionally, these policyholder payments were based on the expectation of profits from favorable loss experience, yet the data to determine such experience has not yet occurred. Therefore, Grange communicated to states that the payment program would be treated as an expense when policy endorsements were filed. Grange included that it intends to review the actual loss experience results and adjust premiums as part of regularly planned future rate reviews. These one-time payments would be excluded from future rate calculations and filings. No state rejected Grange’s payment program.

In the absence of any state objections, Grange acted in accordance with the payment program and contends that reporting these pandemic related payments as an expense would fall within the guidance of SSAP 70 – Allocation of Expenses and be disclosed in accordance with SSAP 24 – Discontinued Operations and Unusual or Infrequent
Items. INT 20-08T already includes disclosure guidance under SSAP 24. SSAP 70 – Allocation of Expenses, paragraph 3 states:

3. Allocable expenses for property and casualty insurance companies shall be classified into one of three categories in the Underwriting and Investment Exhibit as follows:

And then goes on to list the three expense categories as a) Loss adjustment expenses, b) Investment expenses, or c) Other underwriting expenses. Other underwriting expenses are defined as allocable expenses other than loss adjustment expenses and investment related expenses. Grange would report the relief payments as a write-in item under other underwriting expenses.

In conclusion, Grange believes that INT 20-08T should provide guidance for companies to report the relief payment as an expense. The payments achieved immediate financial relief for policyholders without unintended negative consequences for state agencies and company agents. Policyholders would see premium relief, as applicable, in future rates. We believe that comparability of insurance company results is least impacted if these payments are recorded as other underwriting expenses.

Sincerely,
Brian Poling
VP - Finance
May 14, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group on May 5 with Comments due May 14

Dear Mr. Bruggeman:

Interested parties thank the NAIC Statutory Accounting Principles (E) Working Group (the “Working Group”) for your continuing effort to address the various statutory accounting issues arising from the ongoing pandemic caused by the novel coronavirus, COVID-19. We appreciate the opportunity to comment on the exposure drafts released for comment the Working Group. We offer the following comments:

**INT 20-05T: Investment Income Due and Accrued**

In response to COVID-19, temporary interpretations have been considered to provide exceptions to existing statutory accounting guidance with regards to the 90-day rule for various receivables, as well as guidance on the assessment of impairment and trouble debt restructurings. In response to these interpretations, a request to provide a temporary exception to SSAP No. 34—Investment Income Due and Accrued was made.

This interpretation is intended to assess the requirements to review investment income due and accrued and consider whether temporary exceptions could be granted in response to COVID-19. Issues addressed in the interpretation include:

a. Recognition and admittance of investment income under SSAP No. 34.

b. Review of FASB staff technical inquiries and responses on investment income.

The Working Group considered limited time collectability assessments and admittance exceptions for investment income due and accrued and reached the following tentative consensus:

a. Continue with existing guidance in SSAP No. 34 that investment income shall be recorded when due (earned and legally due) or accrued (earned but not legally due until after the reporting date). If investments have been impacted by forbearance or other modification provisions, a reporting entity shall assess whether the investment income has been earned in accordance with the modified terms. Investment income shall only be recognized when earned.

b. Continue with existing guidance in SSAP No. 34 to require an assessment of whether recorded investment income due and accrued is uncollectible.
For mortgage loans, bank loans and investment products with underlying mortgage loans impacted by forbearance or modification provisions, reporting entities may presume that borrowers and investments that were current as of Dec. 31, 2019, were not experiencing financial difficulties at the time of the forbearance or modification for purposes of determining collectability. For these investments, further evaluation of collectability is not required for the 1st and 2nd quarter 2020 financial statements unless other indicators that interest would not be collected are known (e.g., the entity has filed for bankruptcy).

For investments not impacted by forbearance or modification provisions, this interpretation does not provide an assumption of collectability and the provisions of SSAP No. 34 shall be followed in evaluating collectability and assessing whether an impairment exists.

c. Provide an exception for the nonadmittance of recorded investment income due and accrued that is deemed collectible and over 90-days past due. With this exception, reported investment income interest due and accrued that becomes over 90-days past due in the 1st or 2nd quarter may continue to be admitted in the June 30th, 2020 (1st and 2nd quarter) financial statements. This exception does not encompass mortgage loans in default. Mortgage loans in default shall continue to follow the SSAP No. 34 guidance.

The Working Group considered the FASB technical guidance and reached a tentative consensus consistent with the FASB staff on how interest should be recognized when a payment holiday is given and interest is not accrued. With this guidance, either of the following methods could be applied:

a. A new effective interest rate is determined that equates the revised remaining cash flows to the carrying amount of the original debt and is applied prospectively for the remaining term. With this approach, interest income is recognized during the payment period holiday.

b. The reporting entity recognizes interest income on the loan in accordance with the contractual terms. Under this view, the reporting entity would recognize no interest income during the payment holiday and would resume recognizing interest income when the payment holiday ends.

The exceptions and provisions detailed in the interpretation are applicable for the June 30th, 2020 (2nd quarter) financial statements. The exceptions provided in this interpretation are not applicable in the September 30, 2020 (3rd quarter) financial statements as the interpretation will automatically expire as of September 29, 2020.

Interested parties note that paragraph 10C of the INT states the following: “Provide an exception for the nonadmittance of recorded investment income due and accrued that is deemed collectible and over 90-days past due. With this exception, reported investment income interest due and accrued that becomes over 90-days past due in the 1st or 2nd quarter may continue to be admitted in the June 30th, 2020 (1st and 2nd quarter) financial statements. This exception does not encompass mortgage loans in default. Mortgage loans in default shall continue to follow the SSAP No. 34 guidance.” (emphasis added by italics)

Interested parties also note that, under certain circumstances, a modified loan (in scope of SSAP No. 34) where the modification is in the scope of INT 20-03, could have an amount due and accrued (deemed collectible) that is 180 days or more past due if the number of days past due is measured in terms of the original contractual terms (prior to the modification). We recommend that INT 20-05T be clarified to state that the determination of whether a loan is in default should be done based on the terms of the modified contractual terms of the loan and not the original contractual terms of the loan (prior to the modification).
INT 20-06T: Participation in the 2020 TALF Program

The Working Group reached a tentative consensus to prescribe statutory accounting guidance for insurance reporting entity involvement in the 2020 TALF Program. Pursuant to this consensus:

a. Reporting entities borrowers who directly receive the TALF loan shall follow guidance in paragraphs 8-14 of this interpretation for the statutory accounting and reporting. As detailed in paragraph 11 of the INT, this interpretation provides an exception to allow admitted asset reporting for the pledged securities although the TALF program does not permit the pledged assets to be generally substitutable.

b. Reporting entities that do not directly receive the TALF loan but are investors to borrowers that receive the TALF loan, shall follow the provisions in paragraphs 15-16 for the statutory accounting and reporting.

The provisions detailed in this interpretation are applicable for the duration of the 2020 TALF loan program.

Interested parties propose the following clarifying edit to paragraph 13 in order to avoid unnecessary confusion for reporting entities and unintended inconsistencies in reporting:

13. Although the transaction is similar to a repurchase agreement accounted for as a secured borrowing, the TALF transaction is not a repurchase transaction. As such, the provisions and disclosures for repurchase agreements are not applicable. Particularly, as each TALF loan will have a three-year maturity, the loan will not be impacted by the statutory accounting provisions that require short-term (less than one year) repurchase agreements for admittance purposes.

Clarification that a TALF transaction is not a repurchase agreement and that, therefore, the repurchase agreement provisions and disclosures are not applicable is sufficient for purposes of providing guidance to financial statement preparers. The sentence we suggest be stricken would not provide additional clarity, and could only serve to create extraneous ambiguities pertaining to requirements that have already been clearly established as non-applicable for the subject of this INT.

INT 20-07T: Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19

The Working Group reached a tentative consensus in response to requests to consider exceptions to statutory accounting guidance for troubled debt restructurings and impairment for all debt instruments. Pursuant to this consensus:

a. This interpretation does not provide exceptions to the recognition of a troubled debt restructuring for debt securities with modifications that result in non-insignificant concessions to a debtor that is experiencing financial difficulties.

b. This interpretation does not provide exceptions to the assessment or recognition of impairment for debt instruments. Pursuant to the guidance in SSAP No. 26R, after a modification for a debt instrument, assessment of OTTI shall be based on the current terms of the debt instrument.

(Exposure Staff Note – This statement corresponds with Agenda Item 2020-14.)

c. This interpretation does not provide exceptions for trouble debt restructuring determination and impairment assessments for situations in which the reporting entity is a direct, active participant in negotiating debt instrument modifications.
In response to assessments on the application of existing SSAP No. 36 provisions, particularly in determining whether a modification is a concession (insignificant), this consensus provides the following limited-time practical expedients in determining whether a modification is a concession under SSAP No. 36:

a. Paragraph 10.a. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay is insignificant to the unpaid principal or collateral value of the debt and will result in an insignificant shortfall in the contractual amount due. For the duration of this interpretation, debt security restructurings in response to COVID-19 are considered to be insignificant if the restructuring results with a change that reflects a 10% or less shortfall amount in the contractual amount due.

b. Paragraph 10.b. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay in timing of the restructured payment period is insignificant to the frequency of payments due under the debt, debt’s original contractual maturity or the debt’s original expected duration. For the duration of this interpretation, debt security restructurings in response to COVID-19 are considered to be insignificant if the restructuring results in a one-time 6-month or less delay in payment receipts. (This timeframe is consistent with the provisions in the interagency statements for loans.)

c. For the duration of this interpretation, debt security restructurings in response to COVID-19 that solely impact covenant requirements are not considered troubled debt restructurings.

In response to assessments on the application of existing SSAP No. 103R provisions, particularly in determining whether a modification that is not a troubled debt restructuring needs to be assessed as an exchange, this consensus provides the following exceptions to SSAP No. 103R:

a. Modifications that reflect a 10% or less change in contractual cash flows considered insignificant under this interpretation do not need to be further evaluated to determine whether the modification is more than minor based on the specific facts and circumstances (and other relevant considerations) surrounding the modification. As such, these investments shall not be reported as an extinguishment and a new debt instrument.

The Working Group highlighted that modifications that would be considered troubled debt restructurings, particularly as they provide a non-insignificant concession, may be presented to the domiciliary state regulatory for a permitted practice exception to prevent troubled debt restructuring recognition and disclosure. However, the Working Group concluded that the need for reliable and accurate financial information does not permit exceptions that would allow wide-spread non-insignificant restructurings to occur and not be recognized on the statutory financial statements.

This interpretation is effective for the specific purpose to provide practical expedients in assessing whether modifications in response to COVID-19 are insignificant under SSAP No. 36 and in assessing whether a change is substantive under SSAP No. 103R. This interpretation will only be applicable for the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates.

Interested parties appreciate your responsiveness by providing accounting relief associated with COVID-19 related modifications we make to borrowers in both our loan and debt security investment portfolios. As significant investors in the capital markets, and as economic conditions have changed rapidly, we believe it is imperative that we respond as quickly as possible to help position our borrowers for financial success post-COVID-19.
For all the reasons conveyed in our April 2nd letter, we believe the same accounting relief provided to mortgage loans and bank loans in INT 20-03 and INT 20-04 should be provided to private placement debt securities. Although the exposed INT 20-07T provides some relief in assessing Troubled-Debt-Restructurings (“TDR”) for private placement debt securities, when applied in practice, we do not expect it to provide sufficient relief (i.e., relief from assessing TDRs) based on the types of modifications we expect. The exposed INT includes a 6-month modification constraint, which is very restrictive since private placement debt modifications may potentially involve periods longer than 6 months and still be considered insignificant relative to the entire debt instrument. Modifications that insurers make for debt securities are intended to provide the borrowers relief due to temporary operational and financial issues because of COVID-19. Providing such relief now will benefit the borrowers and ultimately our policyholders as it reduces the likelihood that the borrowers will have immediate liquidity concerns resulting in longer-term financial issues and ultimately could result in insurers suffering impairments.

The remainder of these comments relate to the proposed INT and recommends some changes we believe will better align with the types of modifications expected in our private placement portfolios, while retaining the integrity and usefulness of our financial statements.

**Clarifications Related to the Proposed INT**

In reviewing the INT, we noted several areas of the INT for which we would like to confirm our interpretation as to how the INT would be applied. The key areas are as follows:

1) Scope- We interpret the INT to be applicable for all debt securities and not to introduce additional restrictions for loans that are in the scope of INT 20-03.

2) How the practical expedients are to be applied- After studying the practical expedients in paragraphs 15 a, b, c and 16 a, we interpret them as follows:

   - An insurer may conclude a modification for a debt security is insignificant if the modification meets the criteria in both 15a and 15b.
   - Paragraph 15a provides that to be considered insignificant, the total modified cash flows, over the remaining life of the asset, may not be more than 10% less than the then current contractual cash flows (prior to the modification) over the remaining life of the asset.
   - Paragraph 15b is simply stating the modification must not result in a delay in payments (either principal or interest) that is more than 6 months.
   - Paragraph 15c provides relief in that all covenant modifications are assumed to not be significant.
   - If either the criteria in paragraph 15 a and 15b are not met, the practical expedients may not be employed, and the modification must be assessed for a TDR based on current practices consistent with SSAP No. 36. That is, it is still possible, based on the application of SSAP No. 36 (not using the practical expedients), that the modification does not meet the conditions to be considered a TDR.
   - If the investor has concluded that the modification is not a TDR and the criteria in paragraph 15a has not been met, it is assumed that the modification would not be considered a new asset via SSAP No. 103R (i.e., not considered more than minor both quantitatively and qualitatively). That is, no additional analysis is required to determine if the modified terms result in a new asset, with a related realized capital gain/loss recorded.

**Recommended Changes to the Proposed INT:**

Assuming our interpretation of the INT as detailed above is accurate, we have the following recommendations:
Criteria for Paragraph 15

In discussing modifications with our private placement investment managers, we expect modifications that provide borrowers delayed payments of principal and/or interest, will likely be for a longer period than 6-months; however, the modification would still be considered insignificant when considering the remaining life of the debt security. As a result, as opposed to focusing the use of the practical expedient on insignificant modifications (determined by ensuring both criteria 15a and 15 b are met), we recommend a form of the “financial difficulty” criteria in paragraph 9 of SSAP No. 36 be introduced into the criteria that must be met for the practical expedients to be used (see recommendation below). Using such an approach introduces a higher standard in ensuring the modifications are only driven by COVID-19 temporary conditions.

We recommend removing paragraph 15b criteria so that the paragraph 15a criteria (i.e., the 10%) would be leveraged to determine if a modification was insignificant. This would allow modifications that are still considered temporary in nature, but longer than 6-months and insignificant to a specific debt security, to be considered insignificant. To introduce the “financial difficulty” criteria into the use of the practical expedient, like INT 20-03 for loans, we recommend a criterion be added (to replace paragraph 15b) to require that the debt security must have not been more than 30 days past due at December 31, 2019. The December 31, 2019 date is important because borrowers likely began to experience temporary operational and financial issues in the 1st Q of 2020. Thus, if the borrower was not more than 30 days past due at December 31, 2019, it is presumed that they are only experiencing temporary issues due to COVID-19. The modifications are intended to help them through those temporary situations.

We also recommend moving item 15c to its own paragraph and not including it with paragraphs 15a and 15b. We believe the intent is that both paragraph 15a and 15b must be met for the practical expedients to be applied. Paragraph 15c criterion is stand-alone and not related to 15a and 15b. That is, all financial covenants are considered insignificant regardless of paragraphs 15a and 15b.

Paragraph 14c:
Paragraph 14c of the INT states “This interpretation does not provide exceptions for troubled debt restructuring determination and impairment assessments for situations in which the reporting entity is a direct, active participant in negotiating debt instrument modifications.” We recommend this paragraph be struck from the final INT as it implies that the practical expedients outlined in the INT do not apply to private placement debt securities, which we believe is not your intent. We believe paragraphs 14a and 14b are enough for what is intended to be conveyed in the INT.

Example 3:
Example 3 discusses a modification related to a SSAP No. 43R investment. In paragraph 3 of the “Example 3-Application of INT 20-07T” section of the document, the example notes that “…assuming there is no collateral, a realized loss shall be recognized for the difference between fair value and amortized cost”. We find the SSAP No. 43R examples to be somewhat complex in terms of conveying the message related to the criteria. We believe the objective of the example is to illustrate the need for both criteria in 15a and 15b to be met to apply the practical expedients. Should a similar example be retained in the final INT, we recommend it be simplified to use a SSAP No. 26R security rather than a SSAP No. 43R security.

Period during which INT 20-07T is effective:
Paragraph 18 of the INT notes that the interpretation would be applicable from March 1, 2020 until the earlier of 12/31/2019 or 60 days after the national emergency expires. Similar to INT 20-03 for loans, we recommend the INT be applied to a modification for the term of the modification.
We appreciate you considering our recommendations summarized above to ensure we may contribute to economic recovery post COVID-19 for the various private placement borrowers in our debt security portfolios.

**INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends**

The Working Group reached a tentative consensus to prescribe statutory accounting guidance for insurance reporting entities providing refunds in response to COVID-19. Pursuant to this consensus:

**Issue 1:** Reporting entities that provide voluntary or jurisdiction-directed refunds which are not required under the policy terms shall follow the guidance in paragraphs 8-11 of this interpretation. This guidance stipulates that such refunds shall be recognized as a reduction of premium. Refunds that are recognized in a different manner (e.g., as an expense), shall be considered a permitted or prescribed practice pursuant to SSAP No. 1.

**Issue 2:** Reporting entities that provide refunds in accordance with insurance policy terms shall follow paragraph 12 of this interpretation. This guidance indicates that existing statutory accounting principles in SSAP No. 53 or SSAP No. 66 shall be followed as applicable.

**Issue 3:** Reporting entities that provide rate reductions shall follow paragraph 13 of this interpretation. This guidance provides direction based on whether the rate reduction is for in-force or future policies.

**Issue 4:** Reporting entities that provide policyholder dividend shall follow the existing guidance for policyholder dividends which is summarized in paragraphs 14-18 and in addition, shall complete the disclosures described in paragraphs 19-21.

**Issue 5:** This interpretation, paragraphs 19-22 indicates that reporting entities shall continue to comply with all statutory accounting disclosure requirements, but also requires that all premium refunds, rate reductions and/or policyholder dividends provided because of the decreased activity due to COVID-19 shall be aggregated and reported in Note 21A.

The Working Group noted that premium taxation requirements vary by jurisdiction. Taxation is determined by the jurisdiction where the premium is written/returned to the policyholder according to the laws of that jurisdiction.

This interpretation will be automatically nullified on January 1, 2021 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

Interested parties offer the following comments on the tentative consensus noted above:

**Issue 1:** Those insurers that provided voluntary or jurisdiction-directed refunds which are not required under the policy terms concluded that guidance similar to that described in paragraphs 8-11 of this interpretation is appropriate and accounted for those amounts accordingly. However, it is noted that the consensus for Issue 1 should be amended to address the effect on the unearned premium reserve by stating: . . . refunds shall be recognized as a reduction of premium and the unearned premium reserve adjusted accordingly.

Other insurers chose to provide funds or credits to policyholders by amending the terms of their policies through manual rate fillings or policy endorsements and reported the amounts provided to policyholders as an expense as part of Other Underwriting Expense based on SSAP No. 70, *Allocation of Expenses*. To address the accounting treatment for policies that were amended to allow for a policy payment in circumstances related to COVID-19, those companies recommend that Issue 1 be modified, and a new issue added to the INT as marked in the attachment.
Issue 2: Interested parties agree with the tentative consensus.

Issue 3: Interested parties agree with the tentative consensus.

Issue 4: Interested parties agree with the tentative consensus.

Issue 5: Interested parties believe it would be cumbersome (and may not be possible) to aggregate workers' compensation audit premium adjustments attributable to COVID-19 with premium adjustments based on either the level of exposure to insurance risk or the level of losses. To address this, we recommend that the tentative consensus be amended as follows:

21. To allow for aggregate, consistent assessment, the Working Group came to a tentative consensus that all COVID-19 inspired premium refunds, rate reductions, and policyholder dividends shall be disclosed as unusual or infrequent items in annual statement 21A. This disclosure is in addition to other existing disclosures on various items related to the policyholder payments. For the avoidance of doubt, refunds required under the policy terms as discussed in paragraph 12 (i.e., policies that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses) are not required to be aggregated in disclosures of COVID-19 inspired premium refunds, rate reductions and policyholder dividends.

Ref# 2020-14: Assessment of OTTI Based on Original Contract Terms

NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and consider revisions to add a new footnote to SSAP No. 26R—Bonds to clarify the interrelationship between SSAP No. 26R, SSAP No. 36 and SSAP No. 103 when there is a modification to a debt instrument.

SSAP No. 26R—Bonds

Impairment

13. An other-than-temporary (INT 06-07) impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of a debt security in effect at the date of acquisition FN. A decline in fair value which is other-than-temporary includes situations where a reporting entity has made a decision to sell a security prior to its maturity at an amount below its carrying value. If it is determined that a decline in the fair value of a bond is other-than-temporary, an impairment loss shall be recognized as a realized loss equal to the entire difference between the bond’s carrying value and its fair value at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR/IMR, the accounting for the entire amount of the realized capital loss shall be in accordance with SSAP No. 7. The other-than-temporary impairment loss shall be recorded entirely to either AVR or IMR (and not bifurcated between credit and non-credit components) in accordance with the annual statement instructions.

New Footnote: If a bond has been modified from original acquisition, the guidance in SSAP No. 36—Troubled Debt Restructuring and paragraph 22 of SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities shall be followed, as applicable. After modification of original terms, future assessments to determine other-than-temporary impairment shall be based on the current contractual terms of the debt instrument.
Interested parties recommend that the new footnote be modified to clarify that after modification of original terms, future assessments to determine other-than-temporary impairment should be based on the modified contractual terms of the debt instrument. Use of the term “current” may not be clear to preparers and auditors.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell

Rose Albrizio
Interpretation of the Statutory Accounting Principles Working Group

INT 20-08T: COVID-19 Premium Refunds, Rate Reductions, Policyholder Benefits and Policyholder Dividends

INT 20-08T Dates Discussed

Email Vote to Expose

INT 20-08T References

SSAP No. 5—Liabilities, Contingencies and Impairments of Assets
SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items
SSAP No. 53—Property Casualty Contracts—Premiums
SSAP No. 65—Property and Casualty Contracts
SSAP No. 66—Retrospectively Rated Contracts
SSAP No. 70—Allocation of Expenses

INT 20-08T Issue

COVID 19

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

Premium Refunds, Rate Reductions, Policyholder Benefits and Policyholder Dividends

2. The federal, state or local government orders requiring non-essential workers to “stay home” caused a significant reduction in commercial and non-commercial activity, including automotive usage. Some consumer groups wrote letters and issued press releases calling for insurance premium refunds or pricing decreases, which included specific comments directed toward consumer automotive lines. The comments presumed that the decrease in activity would result in fewer losses.

3. Many Recognizing the extraordinary economic hardship experienced by their policyholders together with the reduction in auto accident frequency resulting from the decline in economic activity, insurers began issuing designed various programs to provide a portion of the favorable experience realized from reduced accident frequency to policyholders. The underlying objective of the programs is to provide temporary relief to customers during the period that various government-based shelter in place orders remain in effect resulting in a significant decline in general economic activity accident frequency levels remaining significantly below historic levels. The methods utilized to deliver temporary relief to policyholders include voluntary premium refunds, future rate reductions, policyholder benefit payments (in certain instances, based on manual rule filings or policy endorsements) and policyholder dividends because of the decreased activity. The majority of the refunds were related. Most of the relief payments (or programs) relate to automotive lines of business. Insurers have provided the reductions policyholder relief in a variety of ways. Some of the rate reductions were specific including direct relief...
payments for in-force policies, whereas some of the as well as relief payments/programs designed as rate reductions would apply to be applied to future policy renewals.

Voluntary

4. The majority of the refunds or rate reductions company actions taken are being offered voluntarily and are not amounts required under the existing policy terms. The aggregate monetary amount of the return of funds payments and adjustments is considered materially significant.

Jurisdiction Directed

5. In addition, a few jurisdictions have issued bulletins directing refunds and rate reductions on varying lines of property and casualty insurance, including but not limited to: private passenger automobile, commercial automobile, workers’ compensation, commercial multiple peril, commercial liability and medical professional liability. In addition, some jurisdictions have indicated support for refunds, rate reductions, and policyholder benefits but also directed that payment of such amounts require either premium rate filings or policy form amendments.

Accounting Issues

6. The intent of this interpretation is to address questions related to the accounting and reporting for premium refunds, rate reductions, policyholder benefit payments and policyholder dividends in response to the decreased activity related attributable to COVID-19. Because there are a variety of impacts on the private passenger and commercial auto insurance business. Due to the severity of the event and the speed at which it emerged, different insurers designed and implemented policyholder relief programs that reporting entities are accomplishing are fundamentally different even if designed to achieve a similar objective. The intent of returning money or reducing premiums, this guidance is to ensure that for accounting purposes, the programs are accounted for in accordance with their design and execution. Separately, to provide policyholders and other stakeholders with information about the size and scope of the programs, required comprehensive disclosures should be utilized. This interpretation provides guidance on the following issues:

- Issue 1: How to account for premium refunds not required under the existing policy terms.
- Issue 2: How to account for refunds required under the existing policy terms.
- Issue 3: How to account for rate reductions on inforce and renewal business.
- Issue 4: How to account for policyholder benefit payments under modified policy terms (e.g., manual rule filings or certain policy endorsements).
- Issue 5: How to account for policyholder dividends.
- Issue 56: Where to disclose premium refunds, rate reductions, policyholder benefit payments and policyholder dividends related to covid-19 decreases in activity.

INT 20-08T Discussion

7. As an overall guiding principle, the accounting shall follow existing statutory accounting principles and annual statement reporting where feasible consistent with the design and execution of the program.
Issue 1: How to Account for Premium Refunds Not Required Under the Policy Terms

8. The Working Group reached a tentative consensus that company actions whose intent is a voluntary refunds because of premium refund based on reduced auto accident frequency attributed to decreased activity related to COVID-19 and other jurisdiction-directed premium refunds which are not required by the policy terms, are fundamentally a return of premium. Such refunds shall be accounted for as immediate adjustments to premium. The premium refund will be an adjustment to written or earned premium.

9. Premium refunds shall be recognized as a liability when the definition of a liability in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets is met. For example, the declaration of a voluntary dividend by the board of directors will trigger liability recognition. In cases where the refunds are directed by a jurisdiction, the SSAP No. 5 definition of a liability shall be used to determine timing of liability recognition.

10. Immediate adjustment to premium is consistent with the existing guidance in SSAP No. 53—Property Casualty Contracts—Premiums. SSAP No. 53 guidance requires adjustments to the premium charged for changes in the level of exposure to insurance risk. It is also consistent with the treatment of loss sensitive premium adjustments in SSAP No. 66—Retrospectively Rated Contracts. While some of the voluntary or jurisdiction-directed refunds may not be required by the explicit policy terms, the principle of reversing premium in the same way that the premium was originally recognized continues to apply.

11. Reporting the refunded amounts as a miscellaneous underwriting expense is not consistent with the underwriting expense description. This reporting option is inconsistent with the characterization of the amount as a return of premium.

b. Reporting the refunds as premium balances charged off (e.g., bad debt expense) is inconsistent with guidance in 53, paragraph 14, on earned but uncollected premium. It is also inconsistent with the annual statement instructions as the amount is not an uncollectible amount, but rather a voluntary choice by the reporting entity to reduce the amount charged.

Issue 2: How to Account for Premium Refunds Required Under the Policy Terms

12. While most of the premium refunds are voluntary or jurisdiction-directed and not required under the policy terms, some policies have terms that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses. If the policy terms change the amount charged, existing guidance in SSAP No. 53 or SSAP No. 66 continues to apply:

a. SSAP No. 53 provides guidance for policies in which the premium amount is adjusted for changes in the level of exposure to insurance risk. This is often seen in commercial lines of business such as workers’ compensation. The guidance notes that audits often occur after the policy term or mid-term in the policy. SSAP No. 53 refers to the adjustment to premium (either due to the customer or to the insurer) as earned but unbilled (EBUB) premium. SSAP No. 53 requires such adjustment to premium to be made immediately either through written premium or earned premium. SSAP No. 53 also requires recognition of the related liabilities and expenses such as commissions and premium taxes based on when the premium is earned.
b. SSAP No. 66 provides guidance for policies whose terms or legal formulas determine premium based on losses. SSAP No. 66 references other applicable statements based on contract type for the initial accrual of premium. Estimates of premium adjustments are accrued based on activity to date and result in immediate adjustments to premium. SSAP No. 66 guidance specifies the corresponding annual statement reporting lines for different entity types.

**Issue 3: How to Account for Rate Reductions**

13. Some reporting entities are offering rate reductions instead of premium refunds. Some of these rate reductions provide one-time price decreases to future payments on in-force policies. Other reporting entities have provided offers of rate reductions on future renewals. Some of the offers for future rate reductions are only applicable to in-force policyholders as of a specified date. Some reporting entities have offered one-time rate reductions for future renewals for both existing and new policyholders for 2020.

a. Rate reductions on in-force business, shall be recognized as immediate adjustments to premium.

b. Rate reductions on future renewals shall be reflected in the premium rate charged on renewal. This is because it is outside of the policy boundary to require the accrual before contract inception. While the amount of future rate reduction can be estimated, it is not a change to existing policy terms and policyholders are not obligated to renew at the reduced rate, therefore, payment of the amount is avoidable. Such amounts shall be disclosed as discussed in Issue No. 5.

**Issue 4: How to Account for Policyholder Benefit Payments Under Modified Policy Terms (e.g. Manual Rule Filings or Policy Endorsements)**

14. In an effort to expedite relief to policyholders, certain insurers filed manual rule filings or policy endorsements to modify the terms of their insurance contracts to allow for the payment of discretionary policy benefits. In these instances, policy endorsements or manual rule filings were determined to be the most efficient method to provide relief to policyholders.

15. The manual rules filings or policy endorsements in paragraph 14 allowed for discretionary benefit payments to policyholders that were not otherwise provided under the contract (e.g. the payments did not result from an indemnifiable loss or a premium adjustment based on changes in insurance risk attributable to a policy change or cancellation) and were stated to be in response to circumstances surrounding COVID-19. The manual rule filings or policy endorsement was utilized to expedite providing relief to policyholders. As the manual rule filings or policy endorsements would not impact written premium and would, therefore, not result in adjustments to either premium tax returns or agent commissions. The following was considered in determining the appropriate accounting and presentation of discretionary policy benefit payments provided through the manual rule filings or policy endorsements:

a. Accounting for discretionary policy benefits paid in accordance with contract terms modified through a manual rule filing or endorsement authorizing payments to policyholders that are not directly related to a change in the level of insurance risk is not specifically addressed in existing statutory accounting literature.

b. SSAP 70, *Allocation of Expenses*, does however state that allocable expenses for property and casualty insurance companies shall be classified into one of three categories in the Underwriting and Investment Exhibit as follows; loss adjustment expenses, investment expenses, other underwriting
expenses. Other underwriting expenses are defined as allocable expenses other than loss adjustment expenses and investment related expenses.

c. In those circumstances when an insurer modifies the terms of its insurance contracts to allow for discretionary payments that are not directly related to the level of insurance risk under the contract and not designed as a premium refund, the payment shall be accounted for consistent with its nature and design; as an underwriting expense. These payments affect the results of the underwriting activities of the insurer since they are related to the policy and are not precluded in the literature from being classified as underwriting expenses.

16. Policyholder payments shall be recognized as a liability when the definition of a liability in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets is met.

Issue 5: How to Account for Policyholder Dividends

17. SSAP No. 65—Property and Casualty Contracts, paragraph 46 requires that dividends to policyholders immediately become liabilities of the reporting entity when they are declared by the board of directors and shall be recorded as a liability.

18. The Working Group noted that policyholder dividends are typically only provided on participating policies or policies issued by non-stock companies, such as mutual entities and other corporate entity types in which profits are shared with policyholders.

19. Research during the development of this item identified that a small number of jurisdictions have legal restrictions which only allow policyholder dividends to be provided after the expiration of the policy period for which the dividend was earned. This interpretation only addresses policyholder dividends which are permitted by the applicable jurisdiction.

20. The property and casualty annual statement blank provides specific reporting lines for policyholder dividends including, but not limited to a liability line and a line in the income statement and statement of cash flow. For those entities whose policies are participating or whose corporate shell type and/or membership structure allow for policyholder dividends, the accounting for policyholder dividends is unchanged by this interpretation.

21. SSAP No. 72—Surplus and Quasi-Reorganizations, paragraph 22 requires disclosure of dividend amounts and dates. In addition, SSAP No. 65, paragraph 47 also requires disclosure of dividend restrictions. The disclosures from both statements are in annual statement Note 13 Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations. This interpretation does not change the dividend disclosure but provides additional guidance that such policyholder dividends issued in response to COVID-19 decreases in activity shall also be disclosed as discussed in Issue 5.

Issue 56: Where to Disclose Premium Refunds, Rate Reductions, Policyholder Benefit Payments and Policyholder Dividends Related to COVID-19 Decreases in Activity

22. There are various places in the notes to the statutory annual statement where disclosures of various aspects of premium refunds, premium reductions or policyholder dividends are required. This interpretation does not recommend changes to those existing disclosures. This interpretation does, however, recommend a consistent annual statement disclosure for all such amounts to allow for comparable disclosures.

23. SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items requires disclosure of the nature and financial effects of each unusual or infrequent event or transaction. Gains or losses of a similar nature that are
not individually material shall be aggregated. This disclosure shall include the line items which have been affected by the event or transaction considered to be unusual and/or infrequent. This disclosure is currently required to be reported in annual statement Note 21A. (Reporting entities shall maintain jurisdiction-specific information to be made available upon request from department of insurance or revenue regulators.)

24. To allow for aggregate, consistent assessment, the Working Group came to a tentative consensus that all COVID-19 inspired premium refunds, rate reductions, policyholder benefit payments and policyholder dividends shall be disclosed as unusual or infrequent items in annual statement 21A. This disclosure is in addition to other existing disclosures on various items related to the policyholder payments. For the avoidance of doubt, refunds required under the policy terms as discussed in paragraph 12, (i.e., policies that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses) are not required to be aggregated in disclosures of COVID-19 inspired premium refunds, rate reductions, policyholder benefit payments and policyholder dividends.

INT 20-08T Tentative Consensus

25. The Working Group reached a tentative consensus to prescribe statutory accounting guidance for insurance reporting entities providing refunds and discretionary policyholder benefits in response to COVID-19. Pursuant to this consensus:

a. Reporting entities that provide voluntary or jurisdiction-directed premium refunds which are not required under the policy terms shall follow the guidance in paragraphs 8-11 of this interpretation. This guidance stipulates that such premium refunds shall be recognized as a reduction of premium. Premium refunds described in paragraphs 8-11 that are recognized in a different manner (e.g., other than as an expense), a decrease to premium, shall be considered a permitted or prescribed practice pursuant to SSAP No. 1.

b. Reporting entities that provide premium refunds in accordance with insurance policy terms shall follow paragraph 12 of this interpretation. This guidance indicates that existing statutory accounting principles in SSAP No. 53 or SSAP No. 66 shall be followed as applicable.

c. Reporting entities that provide rate reductions shall follow paragraph 13 of this interpretation. This guidance provides direction based on whether the rate reduction is for in-force or future policies.

d. Reporting entities that provide for the payment of discretionary policy benefits through a manual rule filing or policy endorsement that authorizes payments to policyholders not otherwise provided under the contract (e.g., not a payment resulting from an indemnifiable loss or a return of premium based on changes in insurance risk related to the policy or not related to a policy change or cancellation) shall account for the payment in accordance with the guidance in paragraphs 14-16. This INT addresses and is limited to the accounting for the particular circumstance when policyholder payments as specified in the modified policy terms are related to conditions resulting from COVID 19 for manual rule filings or policy endorsements filed in response to COVID 19 activity.

e. Reporting entities that provide policyholder dividend shall follow the existing guidance for policyholder dividends which is summarized in paragraphs 14-18/17-21 and in addition, shall complete the disclosures described in paragraphs 19-24/22-24.
This interpretation, paragraphs 19-22-24 indicates that reporting entities shall continue to comply with all statutory accounting disclosure requirements, but also requires that all premium refunds and payments, rate reductions and/or policyholder dividends provided because of the decreased activity due to COVID-19 shall be aggregated and reported in Note 21A.

26. The Working Group noted that premium taxation requirements vary by jurisdiction. Taxation is determined by the jurisdiction where the premium is written/returned to the policyholder according to the laws of that jurisdiction.

27. This interpretation will be automatically nullified on January 1, 2021 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

INT 20-08T Status

28. Further discussion is planned.
May 14, 2020

Dale Bruggeman
Chair, Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners
VIA Email Transmission: jgann@naic.org; rmarcotte@naic.org

RE: INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

The following comments are submitted on behalf of the member companies of the National Association of Mutual Insurance Companies1 regarding the interpretive reporting guidance issued to account for premium refunds, rate reductions, and policyholder dividends.

As the COVID-19 global pandemic continues to disrupt our national and state economies, insurers are hard at work continuing to adapt and innovate to best serve policyholders in their time of need. Like every other business in America, our members are navigating the new challenges and demands that come from remote work arrangements, implementing business continuity plans, making best efforts to educate and communicate updates to staff, and much more. These complications notwithstanding, our members continue to remain focused on providing regular service to policyholders in addition to taking proactive steps to alleviate the financial hardships facing many consumers, including cancellation suspensions, fee waivers, and premium relief. NAMIC members remain committed to working with all policyholders to provide flexibility where possible for the duration of this crisis.

Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close leading to a significant increase in unemployment and the potential permanent closure of many businesses. The federal, state or local government orders requiring non-essential workers to “stay home” caused a significant reduction in commercial and non-commercial activity, including automotive usage. Many NAMIC members responded proactively and implemented various programs in response to the reduction in auto accident frequency due to the decline in economic activity. These programs were designed to provide relief to policyholders experiencing economic hardship and to recognize the improvement in loss experience due to less miles driven on the roads.

NAMIC members view this issue from many different perspectives, and for some, treating these refunds/credits as a reduction in premium makes the most sense for how the company manages its’ operations and ultimately

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1 NAMIC is the largest property/casualty insurance trade association in the country, with more than 1,400-member companies representing 39 percent of the total market. NAMIC supports regional and local mutual insurance companies on main streets across America and many of the country’s largest national insurers. NAMIC member companies serve more than 170 million policyholders and write more than $230 billion in annual premiums. Our members account for 54 percent of homeowners, 43 percent of automobile, and 32 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
how it reports it in the annual statement. For others, treating these refunds as a policyholder dividend or an expenditure similar to a policyholder dividend is in line with the types of policies they issue. Still others prefer to treat the funds distributed to policyholders as a premium charge-off, as that makes the most sense for the insurer based on their unique circumstances.

The reasons for an accounting interpretation of this nature is to respond to various approaches taken by insurers during these unprecedented times; therefore, NAMIC believes the accounting treatment for these transactions needs to recognize the unusual nature and the infrequency of an event of this scale. The proposed interpretive guidance does not fully consider the nuances of a mutual insurance company’s participating structure, contract form, and financial reporting considerations. NAMIC members respectfully request the working group consider more flexibility in their guidance; this would allow companies to continue classifying funds returned to policyholders in the same consistent manner with how they have done so historically in the financial statements.

**Participating Insurance Contracts**

The payment of a dividend is considered a component of an insurer’s combined ratio and for mutual insurance companies that offer participating policies, a dividend is typically paid to policyholders when favorable operating profits are realized. The proposed interpretation does not consider insurers returning funds to policyholders (other than dividends) for a period of favorable underwriting experience as a similar situation, and therefore the proposal treats all refunds/credits/rate reductions as a return of premium. NAMIC members do not believe that treating funds returned to policyholders as a premium credit is the only way to account for these distributions of funds. Depending on the design of the program, insurers should be afforded the flexibility to account for these refunds similar to a policyholder dividend.

Paragraph 10 of INT 20-08T states that the guidance in SSAP No. 53 – Property Casualty Contracts – Premiums “requires adjustments to the premiums charged for changes in the level of exposure to insurance risk.” Paragraph 7 of SSAP No. 53 also states, “the exposure to insurance risk for most property and casualty insurance contracts does not vary significantly during the contract period.” Mutual insurance companies that provide participating insurance contracts designed to return operating profits resulting from favorable loss experience to policyholders didn’t experience any change in loss exposure, rather it is their loss experience that improved. Because the level of exposure to insurance risk is unchanged and loss experience has improved, many mutual insurers returning money to policyholders do not view these payments as a premium credit, rather they view them very similarly to a dividend payment.

The INT makes reference to certain types of policies that require premium refunds under the policy terms; however, the guidance is nonapplicable to participating insurance contracts. The reference to paragraph 12.b of INT 20-08T is appropriate for retrospectively rated contracts, such as workers compensation polices – these policies are designed to include a return mechanism. For these policies, the INT states that SSAP No. 66 – Retrospective Rated Contracts, “provides guidance for policies whose terms or legal formulas determine premium based on losses” and that “estimates of premium adjustments are accrued based on activity to date and result in immediate adjustments to premium.” For participating insurance contracts, the return mechanism is designed to return shared operating profits to policyholders as a separate payment (usually a dividend), not as a return of premium. Our view is these payments are funds returned to policyholders related to the accelerated recognition of favorable loss experience and are similar to making a dividend payment; therefore, insurers should not be forced to treat these as premium credits.

**Material Unusual and Infrequent Item**

Many mutual insurance companies offering participating policies view the amounts already returned to policyholders as a shared benefit of favorable loss experience and were planning to include them as a component of the combined ratio and treat as an expenditure similar to a policyholder dividend. In this case and
in response to the uniqueness of the COVID-19 situation, the expenditure should be considered a material unusual and infrequent item. The abrupt nature of this refund was unique in circumstance and the sense of urgency to return these funds in an expedient manner was not readily possible within most mutual insurer’s administrative systems. Although in substance these policyholder payments were consistent with the intent of a dividend payment, they were not remitted in the form of a dividend. For these reasons, we believe insurers that offer participating policyholder payments should be afforded the option to account for these policyholder payments similarly to a dividend, so as not to force all insurers to net them within premiums in the annual statement.

The rationale for optionality is supported by paragraph 9 of SSAP No. 24 – Discontinued Operations and Unusual or Infrequent Items, which states, “a material event or transaction that an entity considers to be of an unusual nature or of a type that indicates infrequency of occurrence or both shall be reported consistently with the reporting entity’s reporting of continued operations.”

Premium Balance Charge-Off

Other insurers are looking at this from an entirely different perspective and have made the decision to pay for a percentage of auto premiums for their policyholders for policies in force. This approach has no impact on agents or the insured only that the insurer is helping to pay the policyholder’s bill. These companies were planning to record the total amount in billing assistance as a premium charge-off in their financial statements. These companies are looking to avoid impacting the combined ratio, as these amounts are significant in size and certainly qualify as unusual and infrequent. Availing flexibility for insurers in this situation recognizes the need to call out these unique and unusual transactions in the financial statements, so as not to distort the core operations, assisting regulators in their examination and analysis of the financial results of an impacted company.

Paragraph 11.b of INT 20-08T states that reporting refunds as premium balances charged off is “inconsistent with guidance in SSAP No. 53, paragraph 14, on earned but uncollected premiums.” However, in certain cases the premium was earned and collected. Instead of issuing a refund, some insurers paid off a portion of the policyholders billed premium. Thus, it was collected and the premium was then earned by the company. It makes more sense for companies in this situation to treat the reduction in loss experience as a one-time premium charge-off instead of telling the policyholder to not pay their bill only to then write it off.

Disclosing Premium Refunds, Rate Reductions, and Policyholder Dividends Related to COVID-19

The disclosure of dividend amounts and dates required by SSAP No. 72, paragraph 22, as referenced by paragraph 18 of INT 20-08T, applies to stockholder dividends only, and not policyholder dividends. Therefore, this reference should be removed from INT 20-08T as a requirement for disclosure of policyholder dividends. Note 13 Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations only requires disclosure of policyholder dividend restrictions as required by SSAP 65, paragraph 47.

NAMIC members recommend paragraph 18 of INT 20-08 be reworded as follows to clarify the required disclosure of policyholder dividends:

18. SSAP No. 65, paragraph 47 requires disclosure of dividend restrictions. This disclosure is in annual statement Note 13 Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations. This interpretation does not change the dividend disclosure but provides additional guidance that such policyholder dividends issued in response to COVID-19 decreases in activity shall also be disclosed as discussed in Issue 5.

2 Premium Balances Charge Off – Page 4, Line 12 of the P/C Annual Statement
Thank you for your consideration of these comments on this matter of importance to NAMIC, its member companies and their policyholders. If there are any questions, please feel free to contact me at 317-876-4206.

Sincerely,

Jonathan Rodgers
Director of Financial and Tax Policy
National Association of Mutual Insurance Companies
May 14, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

Thank you, the Working Group and NAIC staff for responding quickly to the issues that are arising as a result of the rapid spread of the Coronavirus Disease 2019 (COVID-19). Travelers appreciates the opportunity to comment on INT 20-08T: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends (INT 20-08T) of the NAIC Statutory Accounting Principles Working Group (the Working Group), which was exposed for comment with comments due May 14.

During the past couple of months, state and/or local government orders requiring non-essential workers to “stay home” caused a significant reduction in economic activity, including automotive usage. As a result, many insurers, including Travelers, began issuing voluntary premium refunds, future rate reductions, or policyholder dividends. As stated in the INT, insurers provided the reductions in a variety of ways. Some of the rate reductions were specific to in-force policies, whereas some of the rate reductions apply to future policy renewals. In most cases, the refunds or rate reductions were not amounts required under the policy terms.

Travelers agrees with the conclusions reached for Issues 1 through 4 of INT 20-08T that adjustments to premium is consistent with the statutory accounting guidance in SSAP No. 53, Property Casualty Contracts – Premiums, SSAP No. 65, Property and Casualty Contracts and SSAP No. 66, Retrospectively Rated Contracts. We also believe that there should be consistent reporting by property and casualty insurers of voluntary premium refunds, temporary future rate reductions, and policyholder dividends resulting from COVID-19.

Other than the treatment of policyholder dividends specifically referenced in Issue 4 of INT-20-08T, we do not believe that payments to policyholders that are based on past or current premiums and are the result of reduced insured exposure due to COVID-19 should be characterized as an expense. SSAP No. 70, Allocation of Expenses, provides for three types of reportable expense classifications for property and casualty insurers: loss adjustment expenses, investment expenses and other underwriting expenses. Premium refunds and temporary future rate reductions to policyholders are clearly not loss adjustment or investment expenses, nor are such payments other underwriting expenses, the latter of which is meant to capture the allocable underwriting expenses of the insurer. Rather, these refunds, payments and credits are the result of changes in insured exposures (such as lower miles driven related to auto policies due to federal, state or local government orders requiring non-essential workers to “stay home”). Additionally, we agree that if such premium refund payments or credits to policyholders are reported as expenses, such treatment should be disclosed as a permitted practice.
Regarding Issue 5 ("Where to Disclose Refunds, Rate Reductions and Policyholder Dividends Related to COVID-19 Decreases in Activity"), Travelers has concerns regarding the proposed disclosure requirement in paragraph 21 that all COVID-19 inspired premium refunds, rate reductions, and policyholder dividends be disclosed as unusual or infrequent items. We believe that this proposed disclosure is not practicable as it concerns certain commercial policies, especially loss sensitive policies and policies subject to retrospective rating or audit adjustment. For such policies, it will not be practical to separate refunds and rate reductions from changes in premium due to loss experience.

Thank you for the opportunity to comment on INT 20-08T. If you have any questions or would like to discuss our comments, please feel free to call me at (860) 277-0537.

Best regards,

D. Keith Bell
May 20, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Addendum to original comments regarding INT 20-08T - COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends

Dear Mr. Bruggeman:

Thank you for this opportunity to share additional comments on INT 20-08T for your consideration. And thank you again to the Working Group for your effort in this endeavor during such extraordinary times. We value and appreciate your partnership and guidance.

The Cincinnati Insurance Company offers the following additional comments:

When a state mandates that companies make a payment, this is typically accounted for as some sort of an expense to the company, such as assessments, surcharges, guaranty funds, fines, taxes.

For purpose of context, I would like to use a general example for comparison:

A state enacts a fee whereby companies are required to pay an amount equal to 5% of premiums for a specific product line. Companies have the option to collect all, or part, of this fee from impacted policyholders. If the company chooses to NOT collect the fee from policyholders, the amount incurred by the company is an expense.

Now, substitute this example with the nature of the current relief payment:

States have strongly encouraged, and in some cases mandated, that companies pay a civic donation to policyholders for, at least, a specific product line. This request, or order, is based on the premise that companies will experience favorable loss experience, but not based on actual loss experience.

Assuming contracts are non-participating and premium refunds are not required under the policy terms, this relief payment should also be an expense.

- Companies are essentially incurring an expense, in place of a loss.
- As an expense, companies bear the majority of the financial burden for the payment. As opposed to the financial burden being shared by further exacerbating revenue shortfalls
  - for state governments through reduced premium taxes and
  - for small businesses through commission clawbacks.
- States allowed payments to be made directly to policyholders, rather than sending payments to the states and the state making payments directly to impacted policyholders.

Whether viewed as most aligned with an assessment, surcharge, donation, or marketing, we propose these payments are appropriately reported as expense. In accounting treatment, reporting payments as an expense limits the combined ratio impact to the expense ratio. Given the fact that some companies have the option of making these payments under normal policyholder dividend guidelines, limiting the impact to dividend and expense ratios provides a level of industry consistency. If treated as premium, all aspects of the combined ratio, including the loss ratio, are impacted, which does not seem appropriate. Given that the premise of the payment request is for companies to share their anticipated favorable loss experience, it seems counterintuitive that loss experience ratios be negatively impacted by the payment.

For these reasons, The Cincinnati Insurance Company respectfully proposes that relief payments made on non-participating contracts, and outside of policy terms that existed at the time of state orders, are fundamentally an expense and should be accounted for as such.
Sincerely,

Andrew Schnell  
Assistant Vice President

CC: Robin Marcotte, NAIC Staff  
    Michael Sewell, Chief Financial Officer and Senior Vice President  
    Theresa Hoffer, Senior Vice President and Treasurer  
    James Sims, Assistant Treasurer  
    Rachel Underwood, Technical Accounting Manager
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Surplus Notes – Enhanced Disclosures

Check (applicable entity):

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<th>Modification of Existing SSAP</th>
<th>P/C</th>
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Description of Issue:
Surplus notes are unique statutory accounting items which have the characteristics of both debt and equity addressed in SSAP No. 41R—Surplus Notes. Surplus notes are debt instruments that are required to be subordinated to policyholders, claimants and all other creditors; with interest and principal repayments requiring approval by the domiciliary commissioner. As such, surplus notes are reported as equity for statutory accounting purposes. (This treatment is specific to statutory accounting. Surplus notes are reported as debt under U.S. GAAP.) Pursuant to the requirements of SSAP No. 41R, proceeds received by the issuer of a surplus note must be in the form of cash or other admitted assets meeting both value and liquidity requirements of the state of domicile's commissioner.

In conjunction with agenda item 2018-07, originally a referral from the Reinsurance (E) Task Force, the Statutory Accounting Principles (E) Working Group has been discussing surplus notes where an “associated” asset is received by the surplus note issuer. These discussions have questions whether a surplus note that does not result with an exchange of cash flows (as the cash flows of offset with an associated asset), shall be considered surplus notes under SSAP No. 41R. Although the discussion on how to treat these surplus notes will occur in agenda item 2018-07, the Working Group has directed that additional disclosures shall be captured in SSAP No. 41R. The intent of this agenda item is to consider new disclosures involving surplus notes to better identify these situations in the statutory financial statements.

Existing Authoritative Literature:
Authoritative guidance is detailed in SSAP No. 41R—Surplus Notes. Current guidance does not require disclosure if a surplus note has been issued with the structure as described where little or no actual cashflows are exchanged.

Current Surplus Note Disclosures under SSAP No 41R:

Disclosures
18. The notes to the financial statements of a reporting entity that issues surplus notes shall disclose the following as long as the surplus notes are outstanding:
   a. Date issued;
   b. Description of the assets received;
   c. Holder of the note or if public the names of the underwriter and trustee;
   d. Amount of note;
   e. Carrying value of note;
   f. The rate at which interest accrues;
   g. Maturity dates or repayment schedules, if stated;
   h. Unapproved interest and/or principal;
i. Interest and/or principal paid in the current year;
j. Total interest and/or principal paid on surplus notes;
k. Subordination terms;
l. Liquidation preference to the reporting entity’s common and preferred shareholders;
m. The repayment conditions and restrictions.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Discussions on linked surplus notes is occurring within agenda item 2018-07. The Working Group directed NAIC staff to collect information via a data-call on “linked” surplus notes as of Sept. 30, 2019. This information is requested by Dec. 31, 2019. Improved disclosures on surplus notes in SSAP No. 41R will reduce the need for subsequent data-call collection.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 41R to provide enhanced disclosures to identify when a surplus note has been issued in which anticipated or typical cashflows have been partially or fully offset through the terms of the asset provided by the note holder.

Disclosures
18. The notes to the financial statements of a reporting entity that issues surplus notes shall disclose the following as long as the surplus notes are outstanding:
a. Date issued;
b. Description and fair value of the assets received;
c. Holder of the note or if public, the names of the underwriter and trustee, with identification on whether the holder of the surplus note is a related party per SSAP No. 25;
d. Original issue amount of note;
e. Carrying value of note;
f. The rate at which interest accrues;
g. Maturity dates or repayment schedules, if stated;
h. Unapproved interest and/or principal;
i. Life-to-date and current year approved interest and/or principal recognized as “paid” with identification of the amount of approved interest and/or principal remitted to the holder of the surplus note (actual transfer of cash / assets) and the amount of approved interest and/or principal not remitted to the holder of the surplus note (no transfer of cash / assets);
j. Information regarding a 3rd party liquidity source including name, identification if a related party, cost of the liquidity guarantee, and maximum amount available should a triggering event occur.
k. Subordination terms;
l. Liquidation preference to the reporting entity’s common and preferred shareholders;
The repayment conditions and restrictions.

19. If a reporting entity is not remitting actual cash or assets to the holder of the surplus note for approved interest or principal (as reported under paragraph 18.h), because the reporting entity is offsetting the amount owed under the surplus note with an amount receivable from a reported asset, the following information shall be disclosed regarding the offsetting asset:

a. Identification of asset, including the investment schedule where the asset is reported and reported NAIC designation.

b. Book/adjusted carrying value of asset and interest income recognized in the current year.

c. Amount of principle return and interest income from the asset not received by the reporting entity as the amounts were offset with approved amounts owed by the reporting entity’s issued surplus note.

20. In addition to the above, a reporting entity shall identify all affiliates that hold any portion of a surplus debenture or similar obligation (including an offering registered under the Securities Act of 1933 or distributed pursuant to rule 144A under the Securities Act of 1933), and any holder of 10% or more of the outstanding amount of any surplus note registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933.

Updates to the Blanks are proposed as a result of the SSAP No. 41R revisions. For readability and due to the amount of proposed changes, both the current and proposed Blanks revisions are detailed below.

**Current Blanks Disclosures:**

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**Proposed Blanks Disclosures:**

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<tr>
<th>Date Issued</th>
<th>Interest Rate</th>
<th>Original Issue Amount of Note</th>
<th>Fair Value of Assets Received Upon Issuance</th>
<th>Type of Assets Received Upon Issuance</th>
<th>Carrying Value of Note Prior Year</th>
<th>Carrying Value of Note Current Year</th>
<th>Unapproved Interest And / Or Principal</th>
<th>Approved Interest Recognized Current Year</th>
<th>Life-To-Date Interest Remitted (Actual Transfer of Cash/Assets) Remitted</th>
<th>Life-To-Date Principal (Actual Transfer of Cash/Assets) Remitted</th>
<th>Date of Maturity</th>
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- **Current Year Approved Interest Remitted (Actual Transfer of Cash/Assets)**
- **Current Year Approved Principal Remitted (Actual Transfer of Cash/Assets)**
- **Current Year Approved Interest Not Remitted Since Issuance (No Transfer of Cash/Assets)***
- **Current Year Approved Principal Not Remitted Since Issuance (No Transfer of Cash/Assets)***
- **Is Non-Remitted Interest or Principal Offset with Amounts Owed from Surplus Note Holder? (Y/N)***
- **Does Remitted Interest or Principal Payments Result with Acquisition of a Source of Liquidity Through the Surplus Note Holder? (Y/N)***
- **Is Surplus Note Holder a Related Party (Y/N)***

*Include amounts offset with amounts owed from the holder of the surplus note.*
<table>
<thead>
<tr>
<th>Name of 3rd Party Liquidity Source Acquired</th>
<th>Is Liquidity Source a Related Party to the Surplus Note Issuer?</th>
<th>Current Year Total Cost of Liquidity Source</th>
<th>Current Year Cost of Liquidity Source Reported as Surplus Note Interest</th>
<th>Total Cost of Liquidity Source Since Acquisition</th>
<th>Total Cost of Liquidity Source Reported as Surplus Note Interest Since Acquisition</th>
<th>Maximum Amount Surplus Note Issuer Can Receive from Liquidity Source</th>
</tr>
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</table>

Staff Review Completed by: Jim Pinegar, October 2019

Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 41—Surplus Notes to provide enhanced disclosures to identify when an issued surplus note’s anticipated or typical cash flows have been partially or fully offset through an asset held by the surplus note issuer.

Spring 2020 National Meeting discussion

Interested Parties submitted comments and suggested edits on the prior exposure; NAIC staff agree that the proposed edits, as they in essence, require disclosure of the desired items as detailed in the original agenda item. Additionally, in some cases, suggested proposed edits expanded surplus note structure disclosures requirements.

NAIC staff added one disclosure item to be data captured in the Blanks

**NAIC staff recommends that the Working Group expose this agenda item, with revisions as proposed by interested parties, and as further modified by NAIC staff. These revisions will require additional disclosures regarding the issuance of Surplus Notes – specifically those that are structured in a manner in which typical cashflows have been reduced or eliminated**

Changes from the original exposure are highlighted in grey below.

Disclosures

18. The notes to the financial statements of a reporting entity that issues surplus notes shall disclose the following as long as the surplus notes are outstanding:

a. Date issued;

b. Description and fair value of the assets received;

c. Holder of the note or if public, the names of the underwriter and trustee, with identification on whether the holder of the surplus note is a related party per SSAP No. 25;

d. Original issue amount of note;

e. Carrying value of note;

f. The rate at which interest accrues;

g. Maturity dates or repayment schedules, if stated;

h. Unapproved interest and/or principal;

i. Life-to-date and current year approved interest recognized and/or principal paid recognized

   i. Percentage interest payments offset through “administrative offsetting” (not inclusive of amounts paid to a 3rd party liquidity provider). I.E. if $100 in interest was recognized through...
the year, $10 of which was remitted to a 3rd party liquidity provider and the reminder $90 was offset, the reporting entity shall report 100% as offset.

j. Disclosure of whether the surplus note was issued as "paid part of a transaction with identification any of the following attributes:
   i. Do surplus note / associated asset terms negate or reduce cash flow exchanges, and/or are amounts payable under surplus note and amounts receivable under other agreements contractually linked (For example, the asset provides amount of approved interest and/or principal remitted payments only when the surplus note provides interest payments).
   ii. Are any amounts due under surplus notes and associated assets netted or offset (partially or in full) thus eliminating or reducing the exchange of cash or assets that would normally occur throughout the duration, or at maturity, of the agreement (This may be referred to as administrative offsetting.)
   iii. Were the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note. (actual transfer of cash / assets) and the amount of approved interest and/or principal not remitted to the holder of the surplus note (no transfer of cash / assets).

h. Information regarding a 3rd party liquidity source including name, identification if a related party, cost of the liquidity guarantee, and maximum amount available should a triggering event occur.

k. Principal amount of assets received upon Surplus Note issuance, if applicable.
   i. Subordination terms;
   j. Liquidation preference to the reporting entity’s common and preferred shareholders;
   n. The repayment conditions and restrictions.
   k. Information about any guarantees, support agreements, or related party transactions associated with the surplus note issuance, and whether payments have been made under such agreements.

19. If a reporting entity has ceded business to a surplus note issuer that is not remitting actual cash or assets to a related party as part of a reinsurance transaction in which the surplus note meets any of the criteria in 18. j above, the ceding entity shall provide a description of the transaction, including whether the criteria in 18. j above were met with respect to the surplus note issuance, as long as the reinsurance agreement remains in force. The ceding entity should provide a description of the risks reinsured, the related party reinsurer, any guarantees or support agreements and the amount of notes outstanding.

19.20. If the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note for approved interest or principal (as reported under paragraph 18.h), because the reporting entity is offsetting the amount owed under the surplus note with an amount receivable from a reported asset, the following information shall be disclosed regarding the offsetting asset/assets received:
   a. Identification of asset, including the investment schedule where the asset is reported and reported NAIC designation.
   b. Book/adjusted carrying value of asset and interest income recognized in as of the current year/reporting date.
   c. Amount of principle return and interest income from the asset not received by the reporting entity as the amounts were offset with approved amounts owed by the reporting entity’s issued surplus note. A description of terms under which liquidity would be provided should a triggering event occur.
20.21. In addition to the above, a reporting entity shall identify all affiliates that hold any portion of a surplus debenture or similar obligation (including an offering registered under the Securities Act of 1933 or distributed pursuant to rule 144A under the Securities Act of 1933), and any holder of 10% or more of the outstanding amount of any surplus note registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933.
## Proposed Blanks Disclosures:

<table>
<thead>
<tr>
<th>Date Issued</th>
<th>Interest Rate</th>
<th>Original Issue Amount of Note</th>
<th>Fair Value of Assets Received Upon Issuance Is Surplus Note Holder a Related Party (Y/N)</th>
<th>Carrying Value of Note Prior Year</th>
<th>Carrying Value of Note Current Year</th>
<th>Unapproved Interest And/or Principal Amount Recognized</th>
<th>Approved Interest Recognized Current Year</th>
<th>Current Year Interest Expense Recognized</th>
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### Life-To-Date Interest Remitted (Actual Transfer of Cash/Assets)

- Current Year Interest Offset Percentage (not including amounts paid to a 3rd party liquidity provider)
- Current Year Principal Paid
- Life-To-Date Principal Paid

### Date of Maturity

- Total Cost of Liquidity Source Since Acquisition
- Unapproved Interest Recognized Current Year
- Current Year Interest Expense Recognized

### Current Year

- Approved Interest Recognized
- Approved Interest Recognized
- Surplus Note Issuer a Related Party (Y/N)
- Total Cost of Liquidity Source Since Acquisition
- Total Cost of Surplus Note Interest Since Acquisition
- Maximum Amount Surplus Note Issuer Can Receive from Liquidity Source

**Note:** Include amounts offset with amounts owed from the holder of the surplus note.

<table>
<thead>
<tr>
<th>Name of 3rd Party Liquidity Source Acquired</th>
<th>Is Liquidity Source a Related Party to the Surplus Note Issuer?</th>
<th>Current Year Total Cost of Liquidity Source</th>
<th>Current Year Cost of Liquidity Source Reported as Surplus Note Interest</th>
<th>Total Cost of Liquidity Source Since Acquisition</th>
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<th>Maximum Amount Surplus Note Issuer Can Receive from Liquidity Source</th>
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On March 18, 2020, the Statutory Accounting Principles (E) Working Group exposed proposed revisions to SSAP No. 41R—Surplus Notes, as illustrated below, with modifications highlighted in gray. A referral will also be sent to the Blanks (E) Working Group for notification of the proposed modifications for its concurrent exposure. This item has a shortened comment period deadline ending May 1, 2020.

Spring 2020 NM Proposed Revisions:

Disclosures
18. The notes to the financial statements of a reporting entity that issues surplus notes shall disclose the following as long as the surplus notes are outstanding:

a. Date issued;
b. Description and fair value of the assets received;
c. Holder of the note or if public, the names of the underwriter and trustee, with identification on whether the holder of the surplus note is a related party per SSAP No. 25;
d. Original issue amount of note;
e. Carrying value of note;
f. The rate at which interest accrues;
g. Maturity dates or repayment schedules, if stated;
h. Unapproved interest and/or principal;
i. Disclosure of whether the surplus note was issued as "paid part of a transaction with identification any of the following attributes:
   i. Do surplus note / associated asset terms negate or reduce cash flow exchanges, and/or are amounts payable under surplus note and amounts receivable under other agreements contractually linked (For example, the asset provides amount of approved interest and/or principal remitted payments only when the surplus note provides interest payments).
   ii. Are any amounts due under surplus notes and associated assets netted or offset (partially or in full) thus eliminating or reducing the exchange of cash or assets that would normally occur throughout the duration, or at maturity, of the agreement (This may be referred to as administrative offsetting.)
   iii. Were the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note, (actual transfer of cash / assets) and the amount of approved interest and/or principal not remitted to the holder of the surplus note (no transfer of cash / assets).
   h. Information regarding a 3rd party liquidity source including name, identification if a related party, cost of the liquidity guarantee, and maximum amount available should a triggering event occur.
   k. Principal amount and fair value of assets received upon Surplus Note issuance, if applicable.
   l. Subordination terms;
   m. Liquidation preference to the reporting entity’s common and preferred shareholders;
   n. The repayment conditions and restrictions.
k-o. Information about any guarantees, support agreements, or related party transactions associated with the surplus note issuance, and whether payments have been made under such agreements.

19. If a reporting entity has ceded business to a surplus note issuer that is not remitting actual cash or assets to a related party as part of a reinsurance transaction in which the surplus note meets any of the criteria in 18. j above, the ceding entity shall provide a description of the transaction, including whether the criteria in 18. j. above were met with respect to the surplus note issuance, as long as the reinsurance agreement remains in force. The ceding entity should provide a description of the risks reinsured, the related party reinsurer, any guarantees or support agreements and the amount of notes outstanding.

20. If the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note for approved interest or principal (as reported under paragraph 18.h), because the reporting entity is offsetting the amount owed under the surplus note with an amount receivable from a reported asset, the following information shall be disclosed regarding the offsetting asset:

   a. Identification of asset, including the investment schedule where the asset is reported and reported NAIC designation.
   b. Book/adjusted carrying value of asset and interest income recognized as of the current year reporting date.
   c. Amount of principle return and interest income from the asset not received by the reporting entity as the amounts were offset with approved amounts owed by the reporting entity's issued surplus note. A description of terms under which liquidity would be provided should a triggering event occur.

21. In addition to the above, a reporting entity shall identify all affiliates that hold any portion of a surplus debenture or similar obligation (including an offering registered under the Securities Act of 1933 or distributed pursuant to rule 144A under the Securities Act of 1933), and any holder of 10% or more of the outstanding amount of any surplus note registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 41R—Surplus Notes, as illustrated above, to require additional disclosures regarding the issuance of surplus notes, specifically those that are structured in a manner in which typical cash flows have been reduced or eliminated.
**Statutory Accounting Principles (E) Working Group**  
**Maintenance Agenda Submission Form**  
**Form A**

**Issue:** Eliminating Financial Modeling Process

**Check (applicable entity):**

<table>
<thead>
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<th>Modification of Existing SSAP</th>
<th>P/C</th>
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<th>Health</th>
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**Description of Issue:** In coordination with a Valuation of Securities (E) Task Force and the Blanks (E) Working Group, this agenda item proposes elimination of the multi-step modeling process (i.e. incorporating breakpoints) to determine final NAIC designations on RMBS and CMBS securities.

Current guidance allows the amortized cost basis to be used in determining the “final” NAIC designation for statutory accounting and reporting - including the assessment of AVR and for risk-based capital (RBC) purposes. By design, this practice allows for reporting diversity as identical securities, purchased at different price points (thus having different amortized/carrying values) may have differing reported NAIC designations. Thus, two identical reporting entities possessing the same security, may have differing NAIC designations.

The current RMBS/CMBS multi-step modeling practice is the only remaining approach that utilizes breakpoints to determine final NAIC designations. In March 2019, agenda item 2018-19 removed the multi-step modeling approach for modified filing exempt (MFE) securities. This change removed the carrying value from the designation determination analysis and accordingly now utilizes the original NAIC designation, without adjustment, to determine the measurement method under SSAP No. 43R and corresponding RBC charges. With this change, identical securities have an identical NAIC designation.

The implemented change for MFE securities is being proposed for expansion to RMBS and CMBS securities for several reasons. In conjunction with the upcoming designation granularity expansion, the cost, complexity and technical issues to maintain the multi-step modeling process will be substantial for reporting entities. Each individual security will be required to develop an additional 19 price breakpoints to correspond with designation granularity reporting; insurance companies will need to substantially modify their investment accounting software to determine designations and designation categories. It is important to note that the current multi-step modeling approach has the potential to increase/improve a security’s NAIC designation – thus reducing RBC and AVR charges, however, could also work in an opposite manner decreasing NAIC designation. Despite the proposal to cease the multi-step model usage, industry appears supportive of the change as the cost and usage in both today’s environment and with the upcoming granularization reporting, does not adequately justify any potential benefit. A RMBS/CMBS security can be appropriately modeled, regardless of the amortized carrying value and will provide a single, nonadjustable NAIC designation. This will provide regulators with increased efficiency of oversight and improved comparability between various reporting entities carrying identical investments.

**Existing Authoritative Literature:**

**SSAP No. 43R—Loan-backed and Structured Securities**

**Reporting Guidance for All Loan-Backed and Structured Securities**

26. Loan-backed and structured securities shall be valued and reported in accordance with this statement, the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and the
designation assigned in the *NAIC Valuations of Securities* product prepared by the NAIC Securities Valuation Office or equivalent specified procedure. The carrying value method shall be determined as follows:

a. For reporting entities that maintain an Asset Valuation Reserve (AVR), loan-backed and structured securities shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value.

b. For reporting entities that do not maintain an AVR, loan-backed and structured securities designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) shall be reported at amortized cost; loan-backed and structured securities that are designated medium quality, low quality, lowest quality and in or near default (NAIC designations 3 to 6, respectively) shall be reported at the lower of amortized cost or fair value.

**Designation Guidance**

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process. The *Purposes and Procedures Manual of the NAIC Investment Analysis Office* provides detailed guidance. A general description of the processes is as follows:

a. Financial Modeling: The NAIC identifies securities where financial modeling must be used to determine the NAIC designation. NAIC designation based on financial modeling incorporates the insurers’ carrying value for the security. For those securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. Securities where modeling results in zero expected loss in all scenarios are automatically considered to have a final NAIC designation of NAIC 1, regardless of the carrying value. The three-step process for modeled securities is as follows:

i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP to establish the initial NAIC designation.

ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. Step 3: Determine Final Designation – The final NAIC designation that shall be used for investment schedule reporting is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP. This final NAIC designation shall be applicable for statutory accounting and reporting purposes (including establishing the AVR charges). The final designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. All Other Loan-Backed and Structured Securities: For loan-backed and structured securities not subject to paragraphs 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26.
these securities include, but are not limited to, mortgage-referenced securities, equipment trust certificates, credit tenant loans (CTL), 5*/6* securities, interest only (IO) securities, securities with CRP ratings (excluding RMBS/CMBS), and loan-backed and structured securities with SVO assigned NAIC designations.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): In accordance with a Valuation of Securities (E) Task Force referral, agenda item 2018-19 eliminated the multi-step designation guidance, utilizing amortized cost basis and breakpoints for the determination of final NAIC designations of MFE securities. The revisions were adopted with an effective date of March 31, 2019, with early adoption permitted for year-end 2018.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation:

NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 43R—Loan-backed and Structured Securities to eliminate the multi-step financial modeling designation guidance in determining final NAIC designations for RMBS/CMBS securities.

Although the Working Group is recommended to proceed with exposure on this agenda item and solicit comments for consideration, final action will not occur on this item until revisions eliminating the RMBS/CMBS multi-step modeling approach has been adopted by the Valuation of Securities (E) Task Force. NAIC SAPWG staff will coordinate with the VOSTF staff to stay current on their discussion and action on this item.

Proposed Revisions to SSAP No. 43R—Loan-backed and Structured Securities

Reporting Guidance for All Loan-Backed and Structured Securities

26. Loan-backed and structured securities shall be valued and reported in accordance with this statement, the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and the designation assigned in the NAIC Valuations of Securities product prepared by the NAIC Securities Valuation Office or equivalent specified procedure. The carrying value method shall be determined as follows:

a. For reporting entities that maintain an Asset Valuation Reserve (AVR), loan-backed and structured securities shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value.

10 Securities within scope of this statement shall be reported with NAIC designations. The process to determine the NAIC designation may vary based on type of underlying investment and is directed in accordance with the Purposes and Procedures Manual of the NAIC Investment Analysis Office. For example, certain investments may use CRP ratings in determining the equivalent NAIC designation, whereas other investments, including, but not limited to, mortgage-referenced securities, equipment trust certificates, credit tenant loans (CTL), and interest only (IO) securities, may be required to obtain the NAIC designation directly from the NAIC Valuation of Securities product. For interim reporting instructions, refer to the Purposes and Procedures Manual of the NAIC Investment Analysis Office.
b. For reporting entities that do not maintain an AVR, loan-backed and structured securities designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) shall be reported at amortized cost; loan-backed and structured securities that are designated medium quality, low quality, lowest quality and in or near default (NAIC designations 3 to 6, respectively) shall be reported at the lower of amortized cost or fair value.

**Designation Guidance**

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process. The *Purposes and Procedures Manual of the NAIC Investment Analysis Office* provides detailed guidance. A general description of the processes is as follows:

a. **Financial Modeling:** The NAIC identifies securities where financial modeling must be used to determine the NAIC designation. NAIC designation based on financial modeling incorporates the insurers’ carrying value for the security. For those securities that are financially modeled, the insurer must use NAIC CUSIP-specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. Securities where modeling results in zero expected loss in all scenarios are automatically considered to have a final NAIC designation of NAIC 1, regardless of the carrying value. The three-step process for modeled securities is as follows:

i. **Step 1: Determine Initial Designation** – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP to establish the initial NAIC designation.

ii. **Step 2: Determine Carrying Value Method** – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. **Step 3: Determine Final Designation** – The final NAIC designation that shall be used for investment schedule reporting is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP. This final NAIC designation shall be applicable for statutory accounting and reporting purposes (including establishing the AVR charges). The final designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. **All Other Loan-Backed and Structured Securities:** For loan-backed and structured securities not subject to paragraphs 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26. Examples of these securities include, but are not limited to, mortgage-referenced securities, equipment trust certificates, credit tenant loans (CTL), 5*/6* securities, interest only (IO) securities, securities with CRP ratings (excluding RMBS/CMBS), and loan-backed and structured securities with SVO assigned NAIC designations.

**Specific Interim Reporting Guidance for RMBS/CMBS Securities**

28. The guidance in this paragraph shall be applied in determining the reporting method for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported...
under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 27, regardless of the quarterly methodology used.

a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 27.a.) for all securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year-end.

b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 27.a.) for those securities acquired subsequent to year-end.

c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPS, and are not captured within paragraphs 28.a. or 28.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b, as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.

d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b, as appropriate).

For brevity, the remaining SSAP has been omitted, however remaining paragraphs will be renumbered accordingly.

**EXHIBIT A – Question and Answer Implementation Guide**

This exhibit addresses common questions regarding the valuation and impairment guidance detailed in SSAP No. 43R.

**Index to Questions**

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Are reporting entities permitted to establish an accounting policy to write down a SSAP No. 43R other-than-temporarily impaired security, for which a “non-interest” related decline exists, to fair-value regardless of whether the reporting entity intends to sell, or has the intent and ability to hold?</td>
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<tr>
<td>2</td>
<td>Can a reporting entity avoid completing a cash-flow assessment or testing for a specific other-than-temporarily impaired security when the entity believes there is a clear cash-flow shortage (i.e., non-interest related impairment) and elect to recognize a full impairment for the SSAP No. 43R security (no impairment bifurcation), with fair value becoming the new amortized cost basis, and recognition of the full other-than-temporary impairment as a realized loss?</td>
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<td>3</td>
<td>Can reporting entities change their “intend to sell” or “unable to hold” assertions and recover previously recognized other-than-temporary impairments?</td>
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<tr>
<td>4</td>
<td>How do the regulators intend the phrase “intent and ability to hold” as used within SSAP No. 43R to be interpreted?</td>
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<tr>
<td>5</td>
<td>How do contractual prepayments affect the determination of credit losses?</td>
</tr>
<tr>
<td>No.</td>
<td>Question</td>
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<tr>
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<tr>
<td>6</td>
<td>Are the disclosure requirements within paragraphs 51.f. and 51.g. of SSAP No. 43R required to be completed for the current reporting quarter only, or as a year-to-date cumulative disclosures?</td>
</tr>
<tr>
<td>7</td>
<td>If an impairment loss is recognized based on the &quot;present value of projected cash flows&quot; in one period is the entity required to get new cash flows every reporting period subsequent or just in the periods where there has been a significant change in the actual cash flows from projected cash flows?</td>
</tr>
</tbody>
</table>

Questions 8-10 are specific to securities subject to the financial modeling process. (This process is limited to qualifying RMBS/CMBS securities reviewed by the NAIC Structured Securities Group.) The guidance in questions 8-10 shall not be inferred to other securities in scope of SSAP No. 43R.

8. **Question** — Do LBSS purchased in different lots result in a different NAIC designation for the same CUSIP? Can reporting entities use a weighted average method determined on a legal entity basis?

8.1 Under the financial modeling process (applicable to qualifying RMBS/CMBS reviewed by the NAIC Structured Securities Group), the amortized cost of the security impacts the “final” NAIC designation used for reporting and RBC purposes. As such, securities subject to the financial modeling process acquired in different lots can result in a different NAIC designation for the same CUSIP. In accordance with the current instructions for calculating AVR and IMR, reporting entities are required to keep track of the different lots separately, which means reporting the different designations. For reporting purposes, if a SSAP No. 43R security (by CUSIP) has different NAIC designations by lot, the reporting entity shall either 1) report the aggregate investment with the lowest applicable NAIC designation, or 2) report the investment separately by purchase lot on the investment schedule. If reporting separately, the investment may be aggregated by NAIC designation. (For example, all acquisitions of the identical CUSIP resulting with an NAIC 1 designation may be aggregated, and all acquisitions of the identical CUSIP resulting with an NAIC 3 designation may be aggregated.)

9. **Question** — The NAIC Designation process for LBSS subject to the financial modeling process may incorporate loss expectations that differ from the reporting entity’s expectations related to OTTI conclusions. Should the reporting entities be required to incorporate recovery values obtained from data provided by the service provider used for the NAIC Designation process for impairment analysis as required by SSAP No. 43R?

9.1 In accordance with INT 06-07: Definition of Phrase “Other Than Temporary,” reporting entities are expected to “consider all available evidence” at their disposal, including the information that can be derived from the NAIC designation.
10. **Question**: For companies that have separate accounts, can the NAIC designation be assigned based upon the total legal entity or whether it needs to be calculated separately for the general account and the total separate account?

10.1 The financial modeling process for qualifying RMBS/CMBS securities is required for applicable securities held in either the general or separate account.

**Staff Review Completed by:** Jim Pinegar, NAIC Staff – September 2019

**Status:**
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to *SSAP No. 43R—Loan-backed and Structured Securities*, as illustrated above, to eliminate the multi-step financial modeling designation guidance in determining final NAIC designations for residential mortgage-backed securities (RMBS) / commercial mortgage-backed securities (CMBS) securities. Exposure was contingent upon the Valuation of Securities (E) Task Force’s concurrent exposure, which occurred on December 8, 2019. The Working Group noted that final action on this would not be taken until the Valuation of Securities (E) Task Force takes action on their related item.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group deferred discussion of this agenda item for a subsequent call or meeting.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group disposed of this agenda item, without statutory revisions.
Issue: Grade in of Variable Annuity Reserves

Check (applicable entity):

- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

P/C | Life | Health
---|---|---

Description of Issue:
At the 2019 Summer National Meeting, the NAIC Executive and Plenary adopted revisions drafted by the Life Actuarial (A) Task Force to Section 21 of the *Valuation Manual Requirements for Principle-Based Reserves for Variable Annuities (VM-21)* which provides comprehensive updates to the Commissioners Annuity Reserve Valuation Method of reserving for variable annuities. The revisions adopted to VM-21 represent an accounting change that must be recognized as a change in valuation basis under *SSAP No. 51R—Life Contracts*. Updates to SSAP No. 51R are needed to coordinate with the recent revisions to the variable annuity reserving methodology. In addition, the proposed revisions recommend deferring to VM-21 regarding future variable annuity reserving methodology phase-ins along with disclosure on phase in details.

The enhancements to the variable annuity framework resulting in revisions to AG 43 and VM-21 centered around the following:

- Reforming the standard scenario to enhance regulatory oversight of companies’ actuarial assumptions
- Mitigating asset-liability accounting mismatch between hedge instruments and statutory liabilities
- Improving interpretability of framework results and simplicity of calculations
- Facilitating greater harmonization across insurers and products for greater comparability

To achieve this focus the determination of the Conditional Tail Expectation (CTE) amount, Standard Scenario and the Standard Scenario amount has changed significantly resulting in the revised variable annuity reserves methodology.

The revisions to VM-21 in combination with the revisions to Actuarial Guideline XLIII CARVM For Variable Annuities (AG 43) applies retroactively to contracts issued between 1981 and Dec. 31, 2019 as follows:

- VM-21 changes affect reserving for contracts issued Jan. 1, 2017 through Dec. 31, 2019
- AG 43 changes affect reserving for contracts issued to 1981 through Dec. 31, 2016

These changes to the variable annuity reserving framework updated the principles and methodology and apply retroactively (see Authoritative Literature). Under SSAP No. 55 a change in valuation basis is recognized as a change in surplus rather than an increase in reserves recognized through income.

The VM-21 allows the following choices for phasing in the change in reserving valuation basis necessitated by variable annuity reserving methodology changes. Early adoption, beginning Dec. 31, 2019

- Adoption in full beginning Jan.1, 2020
- A reporting entity election to grade in over 3 years.
- An election to grade in over 7 years, subject to commissioner discretion.
In addition, it provides the following acceleration provisions:

- Early termination and full recognition,
- If there is a material decrease in the book of business by sale or reinsurance ceded, the company shall adjust the amount of the grade-in provision. The grade-in amount \( C = R_1 R_2 \), as described below) must be scaled down in proportion to the reduction in the excess reserve, measured on the effective transaction date as the reserve amount in excess of cash surrender value before and after the impact of the transaction.
- The company must obtain approval for any other modification of the remaining grade-in amount.

**Existing Authoritative Literature:**

**Valuation Manual – Section 21**

Effective Date and Phase-In These requirements apply for valuation dates on or after Jan. 1, 2020. A company may elect to phase in these requirements over a 36-month period beginning Jan. 1, 2020. A company may elect a longer phase-in period, up to seven years, with approval of the domiciliary commissioner. The election of whether to phase in and the period of phase-in must be made prior to the Dec. 31, 2020, valuation. At the company’s option, a phase-in may be terminated prior to the originally elected end of the phase-in period; the reserve would then be equal to the unadjusted reserve calculated according to the requirements of VM-21 applicable for valuation dates on or after Jan. 1, 2020. If there is a material decrease in the book of business by sale or reinsurance ceded, the company shall adjust the amount of the phase-in provision. The phase-in amount \( C = R_1 - R_2 \), as described below) must be scaled down in proportion to the reduction in the excess reserve, measured on the effective transaction date as the reserve amount in excess of cash surrender value before and after the impact of the transaction. The company must obtain approval for any other modification of the remaining phase-in amount. The method to be used for the phase-in calculation is as follows:

**SSAP No. 51R—Life Contracts**

**Change In Valuation Basis**

36. A change in valuation basis for reserves determined under paragraphs 18-21, except for reserves defined under Actuarial Guideline XLIII—CARVM: For Variable Annuities (AG 43), as detailed in Appendix C of this Manual, shall be defined as a change in the interest rate, mortality assumption, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors (SSAP No. 3).

37. Changes in reserves developed under paragraph 22 or AG 43 shall be reviewed to determine whether the change represents a change in valuation basis and if it meets the definition of a change in accounting as defined in SSAP No. 3.

   a. Changes in principle-based reserving assumptions are often the result of updating assumptions and other factors required by the existing reserving methodology. Reserve changes resulting from the application of principle-based reserving methodology including, but not limited to, updating assumptions based on reporting entity, industry or other experience, and having the reported reserve transition between net premium reserve, deterministic reserve or stochastic reserve, as required under existing guidance, shall not be considered a change in valuation basis. These types of changes also include, but are not limited to, periodic updates in Valuation Manual tables, such as industry valuation basic tables, asset spread tables and default cost tables.
b. A change in valuation basis for principle-based reserves shall include cases where the required reserve methodology has changed or the insurer makes a voluntary decision to choose one allowable reserving method over another. These types of changes include, but are not limited to, new standardized mortality tables such as Commissioners Standard Ordinary tables and regulatory changes in methodology.

38. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus (under changes to surplus in the change in valuation basis annual statement line) rather than as a part of the reserve change recognized in the summary of operations.

39. The impact of a change in valuation basis on surplus is based on the difference between the reported reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless this statement prescribes a new method and a specific transition that allows for grading. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The changes remain subject to the disclosures prescribed in SSAP No. 3. The Valuation Manual is effective prospectively for policies written on or after the operative date. Therefore, upon the initial prospective adoption of principle-based reserving, the change in valuation basis reflected as an adjustment to surplus will be zero. After initial adoption of the Valuation Manual, changes in valuation basis will need to be evaluated to determine the amount of any surplus adjustments.

SSAP No. 3—Accounting Changes and Corrections of Errors

Disclosures

13. Disclosure of material changes in accounting and correction of errors shall include:

   a. A brief description of the change, encompassing a general disclosure of the reason and justification for change or correction;

   b. The impact of the change or correction on net income, surplus, total assets, and total liabilities for the two years presented in the financial statements (i.e., the balance sheet and statement of income and operations); and

   c. The effect on net income of the current period for a change in estimate that affects several future periods, such as a change in the service lives of depreciable assets or actuarial assumptions affecting pension costs. Disclosure of the effect on those income statement amounts is not necessary for estimates made each period in the ordinary course of accounting for items such as uncollectible accounts; however, disclosure is recommended if the effect of a change in the estimate is material; and

   d. When subsequent financial statements are issued containing comparative restated results as a result of the filing of an amended financial statement, the reporting entity shall disclose that the prior period has been restated and the nature and amount of such restatement.

14. Refer to the Preamble for further discussion regarding disclosure requirements.
Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): Not applicable

Staff Review Completed by:
Robin Marcotte, NAIC Staff - November 2019

Staff Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose the revisions described and illustrated below to SSAP No. 51R—Life Contracts, and adding reference to the additional grade-in disclosure requirements in SSAP No. 3—Accounting Changes and Corrections of Errors for reporting years beginning Jan. 1, 2020. In addition, NAIC staff plans a future agenda item regarding exercise of Commissioner Discretion in the VM. Proposed revisions detailed in the current agenda item:

1. Revises the existing guidance, which prohibits grading-in changes in valuation basis unless provided for in the statement, to allow a grade-in for changes in valuation basis if permitted by the statement or the Valuation Manual in section VM-21 Requirements for Principle-Based Reserves for Variable Annuities (VM-21). Historically choosing effective dates for major reserving changes for the Accounting Practices and Procedures Manual has been determined by Working Group, for example the 2001 CSO table (adopted in 2002) was effective for policies January 1, 2004 in Appendix A-820. This has been to promote consistent implementation and reporting. By deferring to the VM-21 on grade-in options with many varied features, there will be less comparability in reporting, because there is more optionality in reserve reporting. Therefore, additional disclosure regarding grade-in has been proposed.

2. A change in valuation basis under SSAP No. 51R is recognized through surplus. As the unrecognized graded-in reserve represents an unrecognized adjustment to surplus, the revisions require the unrecognized grade-in amount from a change in valuation basis, if resulting with an increase in reserves (decrease from surplus), to be reported as an allocation from unassigned funds to special surplus until the amount has been fully graded into unassigned funds. The reclassification from unassigned funds to special surplus does not reduce total surplus. This is to provide transparency regarding the increased reserve amount that has not been reflected into surplus. As amounts are graded-in to reduce surplus, the amount in special surplus is reclassified to unassigned funds.

3. The proposed revisions to SSAP No. 51R expand the disclosure for changes in valuation basis as a change in accounting principle under SSAP No. 3 to also include details regarding grade-ins of changes in valuation basis, including the grade-in period applied, the remaining amount to be graded-in, remaining time for the grade-in period and the initial grade-in amount and any adjustments to the original amount.

4. Adds a reference in SSAP No. 3 regarding additional disclosures of grade-in features.

NAIC staff plans to propose a new agenda item to address commissioner discretion in the VM. The exercise of commissioner discretion has been typically removed from Appendix A – Excerpts of Model Laws so that if it is exercised, it is disclosed as a permitted or prescribed difference in Note 1 to provide transparency and comparability. As the Valuation Manual incorporates Commissioner discretion that might not be reported as a prescribed or permitted practice, NAIC staff also recommends a future agenda item, regarding how to provide transparency on the use of commissioner discretion.
SSAP No. 51R:

Change In Valuation Basis

36. A change in valuation basis for reserves determined under paragraphs 18-21, except for reserves defined under Actuarial Guideline XLIII—CARVM: For Variable Annuities (AG 43), as detailed in Appendix C of this Manual, shall be defined as a change in the interest rate, mortality assumption, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors (SSAP No. 3).

37. Changes in reserves developed under paragraph 22 or AG 43 shall be reviewed to determine whether the change represents a change in valuation basis and if it meets the definition of a change in accounting as defined in SSAP No. 3.

   a. Changes in principle-based reserving assumptions are often the result of updating assumptions and other factors required by the existing reserving methodology. Reserve changes resulting from the application of principle-based reserving methodology including, but not limited to, updating assumptions based on reporting entity, industry or other experience, and having the reported reserve transition between net premium reserve, deterministic reserve or stochastic reserve, as required under existing guidance, shall not be considered a change in valuation basis. These types of changes also include, but are not limited to, periodic updates in Valuation Manual tables, such as industry valuation basic tables, asset spread tables and default cost tables.

   b. A change in valuation basis for principle-based reserves shall include cases where the required reserve methodology has changed, or the insurer makes a voluntary decision to choose one allowable reserving method over another. These types of changes include, but are not limited to, new standardized mortality tables such as Commissioners Standard Ordinary tables and regulatory changes in methodology.

38. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus (under changes to surplus in the change in valuation basis annual statement line) rather than as a part of the reserve change recognized in the summary of operations.

39. The impact of a change in valuation basis on surplus is based on the difference between the reported reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless this statement or the Valuation Manual in section VM-21 Requirements for Principle-Based Reserves for Variable Annuities (VM-21) prescribes a new method and a specific transition that allows for grading. If the grading permitted by this statement or Valuation Manual section VM-21 represents an increase in the reserve liabilities, the unrecognized change in valuation basis reserve increase shall initially be reflected as an allocation from unassigned funds to special surplus until fully recognized in reserving and unassigned funds. The reclassification from unassigned funds to special surplus does not reduce total surplus, but highlights the ungraded in amount for transparency as it represents an unrecognized adjustment (decrease) to total surplus. The allocation to special surplus is reversed to unassigned funds as the grading of the increase in reserving is recognized as a decrease to total surplus. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The changes remain subject to the disclosures prescribed in SSAP No. 3. Effective January 1, 2020, if the Valuation Manual section VM-21 (on variable annuities) or this statement prescribes
or permits a grading in period or provides the option of multiple grading periods, reporting entities shall also include in the change in accounting disclosures required by SSAP No. 3, disclosure of the following:

a. the grade in period being applied, and the remaining time period of the grade in
b. any adjustments to the grade in period.
c. amount of change in valuation basis grade in, which has been recognized in unassigned funds and
d. the remaining amount to be graded-in (reflected in special surplus if the ungraded in amount represents an increase in reserving).

40. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies in force for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The Valuation Manual is effective prospectively for policies written on or after the operative date, however, as the CARVM methodology was already principles based, some changes to the CARVM methodology in section VM-21 (on variable annuities) and to the related AG 43 may result in retroactive application to the reserving for existing contracts. Therefore, upon the initial prospective adoption of principle-based reserving, the change in valuation basis reflected as an adjustment to surplus will be zero. After initial adoption of the Valuation Manual, changes in valuation basis will need to be evaluated to determine the amount of any surplus adjustments.

SSAP No. 3—Accounting Changes and Corrections of Errors

Disclosures

13. Disclosure of material changes in accounting and correction of errors shall include:

a. A brief description of the change, encompassing a general disclosure of the reason and justification for change or correction;

b. The impact of the change or correction on net income, surplus, total assets, and total liabilities for the two years presented in the financial statements (i.e., the balance sheet and statement of income and operations); and

c. The effect on net income of the current period for a change in estimate that affects several future periods, such as a change in the service lives of depreciable assets or actuarial assumptions affecting pension costs. Disclosure of the effect on those income statement amounts is not necessary for estimates made each period in the ordinary course of accounting for items such as uncollectible accounts; however, disclosure is recommended if the effect of a change in the estimate is material;

d. Changes in accounting that are changes in reserve valuation basis as described in SSAP No. 51R—Life Contracts which have grade in or other optional application features, shall also include in the change in accounting disclosures information regarding the application of any grade in as provided for in SSAP No. 51R, and

e. When subsequent financial statements are issued containing comparative restated results as a result of the filing of an amended financial statement, the reporting entity shall disclose that the prior period has been restated and the nature and amount of such restatement.
Ref #2019-47

Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 51R—Life Contracts and SSAP No. 3—Accounting Changes and Corrections of Errors as illustrated above. The revisions add reference, disclosures and accounting for Section 21 of the Valuation Manual, Requirements for Principle-Based Reserves for Variable Annuities, and grade-in requirements for reporting changes in the valuation basis for years beginning January 1, 2020.

For 2020 Spring National Meeting Discussion

NAIC Staff recommends that the Working Group adopt the exposed revisions, incorporating interested parties proposed edits of removing the reclassification to special surplus as summarized and illustrated in the agenda item and below. The proposed text for adoption does not incorporate all of the interested parties’ revisions. If preferred, the Working Group could have a short re-exposure, but such a deferral may raise first quarter reporting concerns.

NAIC Staff does not propose to incorporate the following revisions requested by Interested Parties:

- SSAP No. 51, paragraph 39, 40 and SSAP No. 3 - Keep the exposed grade in guidance as which defers only to the VM 21 CARVM grade in guidance and requires coordination on future VM grade in proposals.
- SSAP No. 51, paragraph 40 – did not add industry proposed language on retroactivity.

NAIC Staff illustration incorporates the following revisions requested by Interested Parties:

- SSAP No. 51, paragraph 39 and subparagraphs c and d – Delete the exposed reclassification to special surplus until the grade in for reserving amount is fully recognized. Most entities will have a short-term impact (three years) and disclosure should be adequate.
- SSAP No. 51, paragraph 39/40 – Maintain the existing language on changes in accounting in paragraph 39 instead of moving it paragraph 40 as proposed in the exposure.
- SSAP No. 51, paragraph subparagraphs and SSAP No. 3 – editorial - Change “grade-in” to “phase in” as suggested by interested parties to maintain consistency with SSAP No. 51 and the Valuation Manual.

Note that Shaded revisions are edits to prior exposure

SSAP No. 51R

39. The impact of a change in valuation basis on surplus is based on the difference between the reported reserve under the old and new methods as of the beginning of the year. This difference shall not be grade phased in over time unless this statement or the Valuation Manual in section VM-21 Requirements for Principle-Based Reserves for Variable Annuities (VM-21) prescribes a new method and a specific transition that allows for grading. If the grading permitted by this statement or Valuation Manual section VM-21 represents an increase in the reserve liabilities, the unrecognized change in valuation basis reserve increase shall initially be reflected as an allocation from unassigned funds to special surplus until fully recognized in reserving and unassigned funds. The reclassification from unassigned funds to special surplus does not reduce total surplus, but highlights the ungraded in amount for transparency as it represents an unrecognized adjustment (decrease) to total surplus. The allocation to special surplus is reversed to unassigned funds as the grading of the increase in reserving is recognized as a decrease to total surplus. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3...
and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The changes remain subject to the disclosures prescribed in SSAP No. 3. Effective January 1, 2020, if the Valuation Manual section VM-21 (on variable annuities) or this statement prescribes or permits a phase in period or provides the option of multiple phase in periods, reporting entities shall also include in the change in accounting disclosures required by SSAP No. 3, disclosure of the following:

a. the phase in period being applied, and the remaining time period of the phase in
b. any adjustments to the phase in period.

c. amount of change in valuation basis phase in, which has been recognized in unassigned funds and

d. the remaining amount to be phased-in (reflected in special surplus if the ungraded in amount represents an increase in reserving).

40. The Valuation Manual is effective prospectively for policies written on or after the operative date, however, as the CARVM methodology was already principles based, some changes to the CARVM methodology in section VM-21 (on variable annuities) and to the related AG 43 may result in retroactive application to the reserving for existing contracts. Therefore, upon the initial prospective adoption of principle-based reserving, the change in valuation basis reflected as an adjustment to surplus for most entities will be zero. After initial adoption of the Valuation Manual, changes in valuation basis will need to be evaluated to determine the amount of any surplus adjustments.

SSAP No. 3—Accounting Changes and Corrections of Errors

13d. Changes in accounting that are changes in reserve valuation basis as described in SSAP No. 51R—Life Contracts which have elected phase in provided for in the Valuation Manual Section VM 21 or other optional application features, shall also include in the change in accounting disclosures information regarding the application of any phase in as provided for in SSAP No. 51R. and

“Clean version” of revisions tracked only to SSAP 51R and SSAP No. 3 with shading new wording

SSAP No. 51R

39. The impact of a change in valuation basis on surplus is based on the difference between the reported reserve under the old and new methods as of the beginning of the year. This difference shall not be graded phased in over time unless this statement or the Valuation Manual in section VM-21 Requirements for Principle-Based Reserves for Variable Annuities (VM-21) prescribes a new method and a specific transition that allows for grading. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The changes remain subject to the disclosures prescribed in SSAP No. 3. Effective January 1, 2020, if the Valuation Manual section VM-21 (on variable annuities) or this statement prescribes or permits a phase in period or provides the option of multiple phase-in periods, reporting entities shall also include in the change in accounting disclosures required by SSAP No. 3, disclosure of the following:

a. the phase in period being applied, and the remaining time period of the phase in
b. any adjustments to the phase in period.

c. amount of change in valuation basis phase in, and

d. the remaining amount to be phased-in.

The Valuation Manual is effective prospectively for policies written on or after the operative date, however, as the CARVM methodology was already principles based, some changes to the CARVM methodology in section VM-21 (on variable annuities) and to the related AG 43 may result in retroactive application to the reserving for existing contracts. Therefore, upon the initial prospective adoption of principle-based reserving, the change in valuation basis reflected as an adjustment to surplus for most entities will be zero. After initial adoption of the Valuation Manual, changes in valuation basis will need to be evaluated to determine the amount of any surplus adjustments.

SSAP No. 3—Accounting Changes and Corrections of Errors

Disclosures

13. Disclosure of material changes in accounting and correction of errors shall include:

a. A brief description of the change, encompassing a general disclosure of the reason and justification for change or correction;

b. The impact of the change or correction on net income, surplus, total assets, and total liabilities for the two years presented in the financial statements (i.e., the balance sheet and statement of income and operations); and

c. The effect on net income of the current period for a change in estimate that affects several future periods, such as a change in the service lives of depreciable assets or actuarial assumptions affecting pension costs. Disclosure of the effect on those income statement amounts is not necessary for estimates made each period in the ordinary course of accounting for items such as uncollectible accounts; however, disclosure is recommended if the effect of a change in the estimate is material;

d. Changes in accounting that are changes in reserve valuation basis as described in SSAP No. 51R—Life Contracts which have elected phase in provided for in the Valuation Manual Section VM 21, shall also include in the change in accounting disclosures information regarding the application of any phase in as provided for in SSAP No. 51R, and

e. When subsequent financial statements are issued containing comparative restated results as a result of the filing of an amended financial statement, the reporting entity shall disclose that the prior period has been restated and the nature and amount of such restatement.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group exposed this agenda item, with revisions as illustrated above under “Spring National Meeting Discussion.” A referral will also be sent to the Life Actuarial (A) Task Force for notification of this exposure. This item has a shortened comment period deadline ending May 1, 2020.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 3—Accounting Changes and Corrections of Errors and SSAP No. 51R—Life Contracts, as illustrated above.
Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual*, such as editorial corrections, reference changes and formatting.

<table>
<thead>
<tr>
<th>SSAP/Appendix</th>
<th>Description/Revision</th>
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<tbody>
<tr>
<td>SSAP No. 21R</td>
<td>In paragraph 2, remove the excerpts from <em>SSAP No. 4—Assets and Nonadmitted Assets</em> regarding the definition and accounting treatment for admitted assets.</td>
</tr>
<tr>
<td>SSAP No. 51R</td>
<td>Update paragraph references in paragraph 36 related to change in valuation basis to be consistent with the originally adopted language in the related issue paper.</td>
</tr>
</tbody>
</table>

**Recommendation:**
NAIC staff recommends that the Statutory Accounting Principles (E) Working Group move this agenda item to the active listing, categorized as nonsubstantive, and expose editorial revisions, as illustrated below.

**SSAP No. 21R**

1. *SSAP No. 21R—Other Admitted Assets* in paragraph 2, remove the excerpts from SSAP No. 4 regarding the definition and accounting treatment for admitted assets.

**SUMMARY CONCLUSION**

2. The definition and accounting treatment for admitted assets is outlined in paragraphs 2 and 3 of *SSAP No. 4—Assets and Nonadmitted Assets* as follows:

   2. For purposes of statutory accounting, an asset shall be defined as: probable future economic benefits obtained or controlled by a particular entity as a result of past transactions or events. An asset has three essential characteristics: (a) it embodies a probable future benefit that involves a capacity, singly or in combination with other assets, to contribute directly or indirectly to future net cash inflows, (b) a particular entity can obtain the benefit and control others’ access to it, and (c) the transaction or other event giving rise to the entity’s right to or control of the benefit has already occurred. These assets shall then be evaluated to determine whether they are admitted. The criteria used is outlined in paragraph 3.

   3. As stated in the Statement of Concepts, “The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet,” and are, therefore, considered nonadmitted. For purposes of statutory accounting principles, a nonadmitted asset shall be defined as an asset meeting the criteria in paragraph 2, which is accorded limited or no value in statutory reporting, and is one which is:
      a. Specifically identified within the Accounting Practices and Procedures Manual as a nonadmitted asset; or

If an asset meets one of these criteria, the asset shall be reported as a nonadmitted asset and charged against surplus unless otherwise specifically addressed within the Accounting Practices and Procedures Manual. The asset shall be depreciated or amortized against net income as the estimated economic benefit expires. In accordance with the reporting entity's written capitalization policy, amounts less than a predefined threshold of furniture, fixtures, equipment, or supplies, can be expensed when purchased.

3. Consistent with paragraph 2, the following assets shall be considered admitted and shall be reported in accordance with SSAP No. 4. These admitted assets are not addressed in other statements.

SSAP No. 51R

SSAP No. 51R—Life Contracts - Update paragraph references in SSAP No. 51R, paragraph 36.

Update paragraph references in paragraph 36 related to changes in valuation basis to be consistent with the originally adopted language in the related issue paper. Paragraph 36 refers to “a change in valuation basis for reserves determined under paragraphs 18-21 and the reference should be updated to be paragraphs 17-21. This edit is consistent with Issue Paper No. 154–Implementation of Principle Based Reserving, Exhibit A, which documents changes to SSAP No. 51, paragraph 36 and includes a reference to paragraphs 17-21.

36. A change in valuation basis for reserves determined under paragraphs 18-21, except for reserves defined under Actuarial Guideline XLIII—CARVM: For Variable Annuities (AG 43), as detailed in Appendix C of this Manual, shall be defined as a change in the interest rate, mortality assumption, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors.

Status:

On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the editorial maintenance revisions to SSAP No. 21R—Other Admitted Assets and SSAP No. 51R—Life Contracts as detailed above. This item has a shortened comment period deadline ending May 1, 2020.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted the exposed editorial revisions to SSAP No. 21R—Other Admitted Assets and SSAP No. 51R—Life Contracts, as final.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Change to the Summary Investment Schedule

Check (applicable entity):

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<tr>
<th>Modification of Existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
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<tr>
<td>Interpretation</td>
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Description of Issue:
SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures requires disclosures as detailed in Appendix A-001: Investments of Reporting Entities (A-001). Section 3 of A-001 requires the Summary Investment Schedule in the statutory annual statements and in the notes to the annual audited financial statements.

NAIC staff support for the Blanks (E) Working Group were notified of a crosscheck error within the Annual Reporting Blanks where total mortgage loans reported on the Summary Investment Schedule do not tie to the amounts reported in Schedule B, Part 1. After research, it was found that this is due to Valuation Allowance not being included on the Summary Investment Schedule. This agenda item will add in Valuation Allowance to ensure that these schedules will tie together.

The purpose of the referral was to allow coordination to update the Appendix A-001 requirements for the Summary Investment Schedule and the related financial statement notes. This agenda item is intended to be exposed concurrently with a Blanks (E) Working Group proposal.

Existing Authoritative Literature:

SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures

Supplemental Investment Disclosure

26. For the current year, reporting entities shall disclose the information required by Appendix A-001, Investments of Reporting Entities. A Summary Investment Schedule and Investment Risk Interrogatories shall be filed with the audited statutory financial statements. The Summary Investment Schedule shall be filed with the Annual Statement whereas the interrogatories shall be filed as a supplement to the Annual Statement by April 1 for the applicable reporting period.

Appendix A-001

The annual statement must include:

- Supplement to Annual Statement filed by April 1 Investment Risk Interrogatories (as specified in A-001, Section 2) and
- Summary Investment Schedule (as specified in A-001, Section 3)

The audited statutory financial statements must include:

- Investment Risk Interrogatories (as specified in A-001, Section 2) and
- Summary Investment Schedule (as specified in A-001, Section 3)
SSAP No. 83—Mezzanine Real Estate Loans

Disclosures

6. The financial statements shall disclose, as applicable, the requirements of SSAP No. 37, paragraphs 25-27. The MREL lender shall report in Appendix A-001 to its annual statement the amount and percentages of its total admitted assets held in MREL and the largest three investments held in MREL except that such detail shall not be required for assets held in MREL totaling less than 2.5% of its total admitted assets.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this agenda item to the active listing, categorized as nonsubstantive, and expose revisions to Appendix A-001, Section 3, Summary Investment Schedule to add a line for Total Valuation Allowance as illustrated below. The updates below match those that will be concurrently exposed by the Blanks (E) Working Group at the Spring National Meeting.

Section 3. Summary Investment Schedule (Revised for reporting periods effective January 1, 2019)

<table>
<thead>
<tr>
<th>Investment Categories</th>
<th>Gross Investment Holdings</th>
<th>Admitted Assets as Reported in the Annual Statement</th>
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<tr>
<td></td>
<td>1</td>
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<tr>
<td>Mortgage Loans (Schedule B)</td>
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<tr>
<td>4.1 Farm Mortgages</td>
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<td>4.2 Residential Mortgages</td>
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<td>4.3 Commercial Loans</td>
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<tr>
<td>4.4 Mezzanine Real Estate Loans</td>
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<tr>
<td>4.5 Total Valuation Allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.56 Total Mortgages</td>
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Staff Review Completed by: Jake Stultz, February 2020

Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix A-001, Section 3, Summary Investment Schedule, as detailed above, to add a line for Total Valuation Allowance. These revisions mirror those that the Blanks (E) Working Group concurrently exposed. This item has a shortened comment period deadline ending May 1, 2020.
On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to Appendix A-001, Section 3, Summary Investment Schedule, as detailed above, to add a line for Total Valuation Allowance.

W:\National Meetings\2020\Summer\TF\App\SAP\Minutes\05_20_2020 Attachments (C)\Att One-C7_20-07 - Change to Summary Investment Schedule.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2016-20, Technical Corrections and Improvements to Topic 606

Check (applicable entity):
- Modification of Existing SSAP: P/C
- Life
- Health
- New Issue or SSAP: P/C
- Life
- Health
- Interpretation: P/C

Description of Issue:
In December 2016, the Financial Accounting Standards Board (FASB) issued ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers, to clarify narrow aspects of the guidance issued in ASU 2014-09, Revenue from Contracts with Customers, which was the result of a joint project between FASB and the International Accounting Standards Board (IASB). This project clarified the principles for recognizing revenue and develop a common revenue standard for U.S. GAAP and IFRS (the IASB issued IFRS 15 – Revenue from Contracts with Customers) and created ASC Topic 606 – Revenue from Contracts with Customers.

In 2018, the Working Group rejected the guidance in ASU 2014-09 and several other ASUs related to Revenue Recognition in SSAP No. 47—Uninsured Plans. The guidance in ASU 2016-20 provides updates and clarifications based on issues that were found during the initial implementation of ASU 2014-09 and ASC Topic 606.

Existing Authoritative Literature:
Premium revenue recognition is detailed throughout the SSAPs, including the following: SSAP No. 51—Life Contracts; SSAP No. 53—Property Casualty Contracts – Premiums; SSAP No. 54—Individual and Group Accident and Health Contracts and SSAP No. 57—Title Insurance. The ASUs related to ASC Topic 606 have been rejected in SSAP No. 47.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Agenda item 2016-19 and 2017-37 address the previous ASUs related to ASC Topic 606.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): ASC Topic 606 and IFRS 15 are the result of the joint project between the FASB and IASB to improve financial reporting by creating common revenue recognition guidance.

Staff Recommendation:
NAIC Staff recommends the Working Group move this agenda item to the active listing, categorized as nonsubstantive and expose revisions to reject ASU 2016-20 in SSAP No. 47—Uninsured Plans. This recommendation is consistent with how the prior ASUs related to Topic 606 have been treated.

Staff Review Completed by: Jake Stultz, February 2020
Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 47—Uninsured Plans, as illustrated below, to reject ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers. This item has a shortened comment period deadline ending May 1, 2020.

Proposed Revisions to SSAP No. 47:

15. This statement rejects ASU 2014-09, Revenue from Contracts with Customers; ASU 2015-14, Revenue From Contracts With Customers; ASU 2016-08, Revenue From Contracts with Customers: Principal versus Agent Considerations (Reporting Revenue Gross versus Net); ASU 2016-10, Revenue from Contracts with Customers: Identifying Performance Obligations and Licensing; and ASU 2016-12, Revenue from Contracts with Customers: Narrow-Scope Improvements and Practical Expedients; and ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to SSAP No. 47—Uninsured Plans, as illustrated above, as final, to reject ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers for statutory accounting.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: **ASU 2018-18, Collaborative Arrangements (Topic 808)**

Check (applicable entity):

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Description of Issue:
FASB issued **ASU 2018-18, Collaborative Arrangements (Topic 808), Clarifying the Interaction between Topic 808 and Topic 606**, which clarifies and aligns revenue recognition under the new Topic 606 for collaborative arrangements. A collaborative arrangement is defined as a contractual arrangement that involves a joint operating activity, involving two (or more) parties that are both: 1) active participants in the activity and 2) are exposed to significant risks and rewards dependent on the commercial success of the activity. The intent of this guidance is to ensure that revenue recognized within a collaborative arrangement is consistent with revenue recognition in Topic 606.

Existing Authoritative Literature:
Collaborative arrangements in Topic 808 are similar in nature to voluntary pooling arrangements that are discussed in **SSAP No. 63—Underwriting Pools**. **ASU 2014-09, Revenue from Contracts with Customers** established ASC Topic 606 with the new revenue recognition guidance and was rejected for statutory accounting in **SSAP No. 47—Uninsured Plans**.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): **ASU 2014-09**, which created ASC Topic 606, and IFRS 15 are the result of the joint project between the FASB and IASB to improve financial reporting by creating common revenue recognition guidance.

Staff Recommendation:
Staff recommends the Working Group move this agenda item to the active listing, categorized as nonsubstantive and expose revisions to reject **ASU 2018-18** in **SSAP No. 47—Uninsured Plans**. This recommendation is consistent with the treatment of prior ASUs related to Topic 606.

Staff Review Completed by: Jake Stultz, February 2020

Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to **SSAP No. 47—Uninsured Plans** to reject **ASU 2018-18, Collaborative Arrangements (Topic 808), Clarifying the Interaction between Topic 808 and Topic 606**. This item has a shortened comment period ending May 1, 2020.

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Proposed Revisions to SSAP No. 47:

15. This statement rejects ASU 2014-09, Revenue from Contracts with Customers; ASU 2015-14, Revenue From Contracts With Customers; ASU 2016-08, Revenue From Contracts with Customers: Principal versus Agent Considerations (Reporting Revenue Gross versus Net); ASU 2016-10, Revenue from Contracts with Customers: Identifying Performance Obligations and Licensing; and ASU 2016-12, Revenue from Contracts with Customers: Narrow-Scope Improvements and Practical Expedients; and ASU 2018-18, Collaborative Arrangements (Topic 808), Clarifying the Interaction between Topic 808 and Topic 606.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to SSAP No. 47—Uninsured Plans, as illustrated above, as final, to reject ASU 2018-18, Collaborative arrangements (Topic 808), Clarifying the Interaction between Topic 808 and Topic 606 for statutory accounting.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topic 605 and Topic 606

Check (applicable entity):

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Description of Issue:
FASB issued *ASU 2017-14, Income Statement—Reporting Comprehensive Income (Topic 220), Revenue Recognition (Topic 605), and Revenue from Contracts with Customers (Topic 606), Amendments to SEC Paragraphs Pursuant to Staff Accounting Bulletin No. 116 and SEC Release No. 33-10403*, which effects only SEC paragraphs in Topic 220, Topic 605 and Topic 606.

The revisions to Topic 220 update references from “income statement” to “statement of comprehensive income” and add a reference to revenue recognition in Topic 606. The revisions to Topic 605 remove guidance from and references to *SEC Staff Accounting Bulletin 13, Revenue Recognition*. The updates to Topic 606 add in guidance from *SEC Release No. 33-10403*, which is guidance for revenue recognition for sales of vaccines and bioterror countermeasures to the federal government for strategic national stockpiles, specifically for SEC registrants.

Existing Authoritative Literature:
Generally, all SEC guidance from ASUs is rejected as not applicable for statutory accounting in Appendix D. The ASUs related to ASC Topic 606 have been rejected in *SSAP No. 47—Uninsured Plans*.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Agenda item 2016-19 and 2017-37 address the previous ASUs related to ASC Topic 606.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): ASC Topic 606 and IFRS 15 are the result of the joint project between the FASB and IASB to improve financial reporting by creating common revenue recognition guidance.

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to *Appendix D—Nonapplicable GAAP Pronouncements* to reject *ASU 2017-14, Income Statement—Reporting Comprehensive Income (Topic 220), Revenue Recognition (Topic 605), and Revenue from Contracts with Customers (Topic 606), Amendments to SEC Paragraphs Pursuant to Staff Accounting Bulletin No. 116 and SEC Release No. 33-10403* as not applicable to statutory accounting.

This item is proposed to be rejected as not applicable as ASU 2017-14 is specific to deletion and modification of SEC paragraphs, which are not applicable for statutory accounting purposes.

Staff Review Completed by: Jake Stultz, February 2020

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Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topics 605 and Topic 606 for statutory accounting. This item has a shortened comment period ending May 1, 2020.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements, as final, to reject ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topics 605 and Topic 606 as not applicable to statutory accounting.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2020-02, Amendments to SEC Paragraphs in Credit Losses (Topic 326) and Leases (Topic 842)

Check (applicable entity):

Modification of Existing SSAP  P/C  Life  Health
New Issue or SSAP
Interpretation

Description of Issue:
FASB issued ASU 2020-02, Financial Instruments—Credit Losses (Topic 326) and Leases (Topic 842), Amendments to SEC Paragraphs Pursuant to SEC Staff Accounting Bulletin No. 119 and Update to SEC Section on Effective Date Related to Accounting Standards Update No. 2016-02, Leases (Topic 842), which effects the codification in Credit Losses (Topic 326) and Leases (Topic 842). The update provides a new SEC section in Topic 326 that clarifies reporting for SEC registrants and updates the effective date for these provisions, and the updates to Topic 842 update the effective dates for the new lease guidance for SEC reporting companies.

Existing Authoritative Literature:
Credit Losses (Topic 326) while not yet addressed, is being actively monitored by the Working Group.

Leases are covered in SSAP No. 22R—Leases. Basic discussion of the nature of assets, and specifically admitted assets, is covered in SSAP No. 4—Assets and Nonadmitted Assets.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): The Working Group adopted substantive revisions to create SSAP No. 22R, which brings in language from Topic 842 but retains the operating lease treatment for statutory accounting.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS):
The leases project began as a joint project with the IASB and many of the requirements in Topic 842 are the same as the requirements in IFRS 16.

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-02, Financial Instruments—Credit Losses (Topic 326) and Leases (Topic 842), Amendments to SEC Paragraphs Pursuant to SEC Staff Accounting Bulletin No. 119 and Update to SEC Section on Effective Date Related to Accounting Standards Update No. 2016-02, Leases (Topic 842) as not applicable to statutory accounting.

This item is proposed to be rejected as not applicable as ASU 2020-02 is specific to deletion of SEC paragraphs, which are not applicable for statutory accounting purposes.

Staff Review Completed by: Jake Stultz – February 2020
Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2020-02—Amendments to SEC Paragraphs in Credit Losses (Topic 326) and Leases (Topics 842) as not applicable for statutory accounting. This item has a shortened comment period ending May 1, 2020.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted the exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements, as final, to reject ASU 2020-02—Amendments to SEC Paragraphs in Credit Losses (Topic 326) and Leases (Topics 842) as not applicable to statutory accounting.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Working Capital Finance Notes

Check (applicable entity):

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Description of Issue:
The Valuation of Securities (E) Task Force has referred to the Working Group industry-prepared tracked revisions to SSAP No. 105—Working Capital Finance Investments and materials produced by the Securities Valuation Office (SVO) staff on the issues raised. The Task Force recommends that the Working Group consider the amendments, which the Task Force has previously exposed. This agenda item has been drafted to address the referral.

The industry-proposed revisions to SSAP No. 105 detailed in the referral can be grouped into the following categories:
1. Changes to program and/or obligor credit quality requirements
2. Changes to program administration and/or documentation
3. Changes to regulatory compliance requirements
4. Changes to statutory reporting requirements.

Existing Authoritative Literature:
SSAP No. 105—Working Capital Finance Investments was originally effective on January 1, 2014.

Purposes and Procedures Manual of the NAIC Investment Analysis Office provides the following on NAIC Designations

NAIC 1 is assigned to obligations exhibiting the highest quality. Credit risk is at its lowest and the issuer’s credit profile is stable. This means that interest, principal or both will be paid in accordance with the contractual agreement and that repayment of principal is well protected. An NAIC 1 obligation should be eligible for the most favorable treatment provided under the NAIC Financial Regulation Standards and Accreditation Program.

NAIC 2 is assigned to obligations of high quality. Credit risk is low but may increase in the intermediate future and the issuer’s credit profile is reasonably stable. This means that for the present, the obligation’s protective elements suggest a high likelihood that interest, principal or both will be paid in accordance with the contractual agreement, but there are suggestions that an adverse change in circumstances or economic, financial or business conditions will affect the degree of protection and lead to a weakened capacity to pay. An NAIC 2 obligation should be eligible for relatively favorable treatment under the NAIC Financial Regulation Standards and Accreditation Program.

NAIC 3 is assigned to obligations of medium quality. Credit risk is intermediate and the issuer’s credit profile has elements of instability. These obligations exhibit speculative elements. This means that the likelihood that interest, principal or both will be paid in accordance with the contractual agreement is reasonable for the present, but an exposure to an adverse change in circumstances or economic, financial or business conditions would create an uncertainty about the issuer’s capacity to make timely payments.
payments. An NAIC 3 obligation should be eligible for less favorable treatment under the NAIC Financial Regulation Standards and Accreditation Program.

NAIC 4 is assigned to obligations of low quality. Credit risk is high and the issuer's credit profile is volatile. These obligations are highly speculative, but currently the issuer has the capacity to meet its obligations. This means that the likelihood that interest, principal or both will be paid in accordance with the contractual agreement is low and that an adverse change in circumstances or business, financial or economic conditions would accelerate credit risk, leading to a significant impairment in the issuer's capacity to make timely payments. An NAIC 4 obligation should be accorded stringent treatment under the NAIC Financial Regulation Standards and Accreditation Program.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

SSAP No. 105 permits admittance of Securities Valuation Office (SVO) designated WCFI programs that meet specific requirements. SSAP No. 105 was originally effective in 2014 and was controversial as it was developed at the request of a single life entity. At that time, some Working Group members objected to the development of a new statement of statutory accounting principles (SSAP), reporting changes and specific asset class risk-based capital (RBC) charges at the behest of a single company. The discussion at that time noted that the permitted practice concept was intended to address such situations.

In 2018, the single reporting entity that participates in these programs requested modifications to the adopted program and submitted a proposal for consideration. The Valuation of Securities (E) Task Force held discussion on the industry proposal in the third quarter of 2018, which was exposed for comment. The Task Force approved the referral at the 2019 Spring National Meeting.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group:

Working Capital Finance Investments (WCFI) reported in the annual statement Schedule BA - Other Invested Assets continues to be limited to investments by the same single life entity that requested the development of SSAP No. 105. This company reported a total of $258 million in a total of seven WCFI programs for 2017 and $224 million in a total of six WCFI programs for 2018. The total of these amounts is immaterial to the reporting entity. No reporting entities disclosed any prescribed or permitted practices varying from SSAP No. 105 in annual statement Note 1 for 2017 or 2018.


Staff Review Completed by:
Robin Marcotte
NAIC Staff

Staff Recommendation:
Staff recommends that the Working Group receive the referral and provide initial direction on the referral, as it is still perceived as primarily impacting a single entity. If consideration of the referral, and revisions to SSAP No. 105 are supported, NAIC staff recommends that the Working Group direct NAIC staff to proceed with drafting revisions to SSAP No. 105, pursuant to the staff recommendations below which include a review of the industry proposed revisions. NAIC staff does support limited revisions to SSAP No. 105, but a few key elements requested by industry are not supported by NAIC staff.
The key industry proposed revisions included in the referral are under the heading “Details for Working Group Discussion.” If consideration of staff recommendations for the revisions to SSAP No. 105 are supported, NAIC staff will prepare updates to the industry proposal for future discussion based on the Working Group direction. Alternatively, the Working Group could choose to hold a separate call on this topic. The industry proposed revisions are substantive, but categorization could change based on the extent of the revisions.

The following is a summary of the NAIC Staff recommendations on the topics for Working Group discussion:

1. NAIC Staff **does not recommend** lowering the credit quality of the acceptable obligors from NAIC 1 (highest quality) and NAIC 2 (high quality) to allow NAIC designations of 3 (medium quality) and NAIC 4 (low quality) in the WCFI programs. The descriptions of NAIC designations in the *Purposes and Procedures Manual of the Investment Analysis Office note* that both NAIC designations of 3 and 4 have speculative elements (see Authoritative Literature and points for consideration). (paragraphs 6 & 7)

2. NAIC Staff **does not recommend** the proposed credit substitution methodology for unrated subsidiaries as it is overly complex, broad and difficult to apply. SVO staff memos also highlighted the difficulty in applying the industry proposed credit substitution methodology. (paragraph 7)

3. NAIC Staff **recommends the Working Group consider** removing the requirement that the SVO determine if the International Finance Agent is the functional equivalent of the US. Regulator. (paragraph 10.a)

4. NAIC Staff **recommends the Working Group consider** if removing the commingling requirements provide the desired degree of protection. In addition, the Working Group should discuss with the Task Force if the program revisions are functional for analysis purposes. The Working Group should also consider the potential impact of other proposed revisions including lower rated key participants and obligors (points for consideration are in the discussion below). (paragraph 10.b)

5. NAIC Staff **recommends the Working Group consider modifying** the finance agent independent review requirements as requested by industry. The industry proposal still provides independent review of the finance agent either by audit or through an internal control report. (paragraph 16)

6. NAIC SAPWG Staff **recommends the Working Group direct staff to prepare minor rewording** to paragraph 11b to improve readability and eliminate redundancy. (paragraph 11.b)

7. NAIC Staff **does not recommend** removing the statement that the reporting entity may need to seek approval from the domestic regulator as this is a statement rather than an explicit requirement and these investments may not fit into the normal investment law categories (points for consideration are in the discussion below). (paragraph 18)

8. NAIC Staff **recommends the Working Group consider modifying** the filing certification requirements and allowing the SVO to determine if a first priority perfected interest has been obtained. (paragraphs 14 & 15)

9. NAIC Staff **recommends the Working Group consider modifying** the default provisions from 15-30 days as it is more practical to have the default date and the cure period be consistent (points for consideration are in the discussion below). (paragraph 28)
10. NAIC Staff **does not recommend** the Working Group change the reporting requirements to move the WCFI investments from Schedule BA – Other Assets, to Schedule DA Short term Investments (points for consideration are in the discussion below). (paragraph 22)

**Details for Working Group Discussion**

**A. Changes to program and or obligor credit quality requirements**

**SSAP No. 105** – Current provisions:

- Allow admitted asset treatment to receivables from WCFI programs that have high quality NAIC designations from the SVO (NAIC 1 or 2).
- Require the direct obligor to have a designation equivalent of NAIC 1 or 2.
- Nonadmits WCFNs if the program or the obligor falls below either credit threshold.

1. **Admit Obligors and Program with Lower Credit Ratings** – (Reference -SSAP No. 105, paragraph 7)

**Industry proposal** – Expand admitted asset treatment to include receivables from WCFI programs with NAIC SVO designations 3 and 4; and direct obligors with designation equivalents of NAIC 3 and 4.

1. NAIC Staff **does not recommend** lowering the credit quality of the acceptable obligors from NAIC 1 (highest quality) and NAIC 2 (high quality) to allow NAIC designations of 3 (medium quality) and NAIC 4 (low quality) in the WCFI programs. The descriptions of NAIC designations in the *Purposes and Procedures Manual of the Investment Analysis Office* note both NAIC designations of 3 and 4 have speculative elements (see Authoritative Literature).

- Assets that reflect “factored receivables” are nonadmitted in statutory accounting. The SAPWG created SSAP No. 105 to allow admission for only high-quality programs, from high quality obligors. Allowing obligors with lower credit assessments would be a fundamental change in program requirements.

- As noted in the P&P Manual:
  - NAIC 3 is assigned to obligations of medium quality. Credit risk is intermediate and the issuer's credit profile has elements of instability. These obligations exhibit speculative elements. This means that the likelihood that interest, principal or both will be paid in accordance with the contractual agreement is reasonable for the present, but an exposure to an adverse change in circumstances or economic, financial or business conditions would create an uncertainty about the issuer's capacity to make timely payments. An NAIC 3 obligation should be eligible for less favorable treatment under the NAIC Financial Regulation Standards and Accreditation Program.

- NAIC 4 is assigned to obligations of low quality. Credit risk is high and the issuer’s credit profile is volatile. These obligations are highly speculative, but currently the issuer has the capacity to meet its obligations. This means that the likelihood that interest, principal or both will be paid in accordance with the contractual agreement is low and that an adverse change in circumstances or business, financial or economic conditions would accelerate credit risk, leading to a significant impairment in the issuer’s capacity to make timely payments. An NAIC 4 obligation should be accorded stringent treatment under the NAIC Financial Regulation Standards and Accreditation Program.
2. **Unrated subsidiaries** – (Reference - SSAP No. 105, paragraph 7)

**Industry proposal has two aspects:**

1. An unrated subsidiary obligor of a rated obligor - Proposes to attribute the credit strength of the rated parent to the unrated subsidiary obligor without the rated parent being a guarantor of the unrated subsidiary’s WCFI obligations. This proposal envisions the rated entity having some of its own obligations in the program.

2. A rated obligor and its unrated subsidiaries which are key transaction participants, but not obligors. The industry proposal is to create criteria to allow the “program” to obtain an acceptable NAIC designation by evaluating if the unrated “key transaction participant” is able to perform its functions.

Industry proposes several different ways to attribute the rated entity’s credit rating to the unrated entity including:

- Documented operational control of unrated obligor, or
- An important inter-relationship with unrated obligor, or
- If the unrated key transaction participants are reasonably expected to perform their functions.

➤ **NAIC Staff does not recommend the proposed credit substitution methodology for unrated subsidiaries** as it is overly complex, broad and difficult to apply. SVO staff memos excerpted below also highlighted the difficulty in applying the industry proposed credit substitution methodology.

**SVO P&P Requirements** – Note that it is possible for the program and the obligor to have different designations. SVO staff, noted that in their analysis key transaction participants could not have a lower designation than the entire program. Essentially their evaluation of a program is downgraded by the “weakest” link.

- Excerpts VOSTF October 2018 memo to the SAPWG:

  SVO evaluated whether analytical discretion would enable it to designate WCFI programs with unrated obligors of a rated or designated parent. SVO evaluated whether operational and strategic linkages between a rated parent and unrated obligor can provide a basis to attribute the credit rating of one entity to the other. It concluded that no principle exists to permit an assumption that a legal entity can be held responsible for the debt of another without having contractually agreed to do so. While WCFI arrangements may be inherently different than the credit situations SVO assesses SVO lacks the experiential basis to opine on the idea that the difference permits attribution.

  The SVO believes that it should be possible to develop performance criteria to evaluate the ability of the unrated entity to perform the functions expected of it. The goal would be to identify performance factors that could be evaluated in the exercise of analytical discretion to determine that the unrated entity could reliably perform the role expected of it.

**B. Changes to Program Administration/ Documentation Requirements**

**SSAP No. 105** – Current provisions:

- Requires the finance agent (bank, financial institution, financial intermediary or service provider) to fall under the jurisdiction of a financial regulator or that the investor be paid directly (No Commingling).
- If the finance agent is domiciled in another country that is on the SVO list of jurisdictions eligible for netting, it can be regulated by an agency that the SVO determines has a functional equivalent to the Board
of Governors of the Federal Reserve System; 2) the Office of the Comptroller of the Currency; or 3) the Federal Deposit Insurance Corporation.

- As an alternative to having a regulated finance agent, SSAP No. 105 allows for the investor to be paid directly without funds flowing through the finance agent. The SSAP program requirements for admission excludes programs which commingle funds of the obligor, supplier, servicers or other investors.


**Industry proposal** – Remove the requirement for the SVO to determine functionally equivalent regulators of finance agents in other countries.

**Excerpts from VOSTF October 2018 memo to the SAPWG:**

The SVO either determines that an international finance agent’s regulator is the functional equivalent of specified US federal bank regulators or verifies that payments due to the investor are not commingled. Determining functional equivalence is not an analytical issue. Therefore, programs are evaluated on the commingling standard. However, the prohibition of commingling is a requirement so the SVO verifies that commingling can never occur or fails the program.

- **NAIC Staff recommends** the Working Group consider removing the requirement that the SVO determine if the International Finance Agent is the functional equivalent of the US. Regulator.

4. Remove finance agent commingling requirements – (Reference SSAP No. 105, paragraph 10.b.)

**Industry proposal** – As an alternative to having a regulated finance agent, allow the payments to be paid directly to the investor or paid into an account maintained by a regulated financial institution for the benefit of investors without the agent being the beneficiary of the payments. This would require removal of the commingling prohibition.

- **NAIC Staff recommends** Working Group consider if removing the commingling requirements provide the desired degree of protection. In addition, the Working Group should discuss with the Task Force if the program revisions are functional for analysis purposes. The Working Group should also consider the potential impact of other proposed revisions including lower rated key participants and obligors. Points for consideration:

  - SVO staff noted in their October 2018 memo that some programs fail the commingling requirement. SVO staff noted if commingling were not a requirement it would consider commingling risk, when present, as a structural deficiency and balance it against the requirement that the Finance Agent be NAIC 1 or NAIC 2.

  - Discussions with SVO staff indicated that although the Finance Agent is not required by SSAP No. 105 to be an NAIC 1 or NAIC 2, that as a key participant, the SVO analysis would require it to have an NAIC 1 or NAIC 2 in order for the program to meet the credit quality requirements. Note that if the program requirements were lowered, presumably the key participants could also have lower designations.

5. Finance agent validation requirements – (Reference SSAP No. 105, paragraph 16)
SSAP No. 105 – Requires that the annual program filing to the SVO include an annual audit which is unqualified related to servicing. In addition, it requires either an independent report on the controls of the finance agent related to the administration of the investment (SSAE 16 report) or an annual audit of the internal controls. Consolidated reports which include the finance agent are acceptable. SSAP No. 105 allows for materiality judgment of the SVO relative to the report findings.

**Industry proposal** – Make the annual audit requirement one of two options, with either a SSAE 16 report (or its functional equivalent), or an annual audit of the financial statements which includes internal controls. Retain the requirement to only permit reports which do not contain qualifications related to servicing of WCFI.

- NAIC Staff recommends the Working Group consider modifying the finance agent independent review requirements as requested by industry. The industry proposal still provides independent review of the finance agent either by audit or through an internal control report.

6. **Confirmed Supplier Receivable** – (Reference SSAP No. 105, paragraph 11b)

SSAP No. 105 – Requires that the ability of the investor to exercise its creditor rights not be subject to the discretion of the finance agent, other lenders or investors. A separate sentence notes the same requirements but allows an exception that a cure period not to exceed 30 days is permissible.

**Industry proposal** – Remove the sentence “shall not be subject to the discretion of the finance agent other lenders or investors” but keep the subsequent sentence.

- NAIC SAPWG Staff recommends that the Working Group direct staff to prepare minor rewording to paragraph 11b to improve readability and eliminate redundancy.

C. **Regulatory Compliance Requirements**

SSAP No. 105 – paragraph 18 provides the following:

18. Reporting entity investors must have the ability to monitor the working capital finance program and the credit-related activities of the obligor. Reporting entity investors must provide information as requested to the state of domicile indicating that they have the ability to monitor on an ongoing basis the activities of the working capital finance program. Initial permission to invest in Working Capital Finance Investment Programs may be required by the domiciliary commissioner.

7. **Domestic Regulator Approval** – (Reference SSAP No. 105, paragraph 18)

**Industry proposal** – Remove reference to the possibility for the need of insurers to seek prior approval from their domestic regulator.

- NAIC Staff does not recommend removing the statement that the reporting entity may need to seek approval from the domestic regulator as this is a statement rather than an explicit requirement. NAIC Staff provides the following points for consideration:
  - Issue Paper No. 147 documents that requiring domestic regulator approval was an intentional decision because of concerns regarding the ability of smaller entities to monitor the investments in such programs on an ongoing basis.
• The current guidance in SSAP No. 105 is not an explicit requirement, but only identifies that a domiciliary commissioner may require a company to receive initial permission before investing in WCFI.
• These investments may not fit into the normal investment law categories.
• The Industry proposal agrees that the asset class is not for most insurers as it requires relationships with finance agents beyond the traditional dealer insurer.
• The Industry proposal notes that the investor needs specialized knowledge, asset management operations and the ability to book and supervise the assets.
• The Industry proposal notes that the filing fees require sizable commitments to justify the costs, which would make it cost prohibitive for smaller players.

8. Filing certification – (Reference SSAP No. 105, paragraphs 14 and 15)

SSAP No. 105 – Program requirements for a confirmed supplier receivable require the investor to certify that they have the commercially reasonable belief that their participation in the WCFI program results in a first priority perfected interest and required meeting Uniform Commercial Code (UCC) requirements in a legalistic manner. Annual filings require the investor to certify that they have a commercially reasonable belief that they have met the standard for creating a first priority security interest. There is also a requirement that the SVO deems the investor’s belief reasonable.

Industry proposal – Remove requirement for legal officer to certify compliance in obtaining a first priority perfected interest in accordance with UCC requirements for each annual submission and related SVO requirements.

• SVO staff has indicated that the criteria in paragraphs 14 and 15 are typically determined when contracting a program and similar objectives can be accomplished in more ways than the UCC lien process. Requiring the UCC lien process is overly prescriptive.
• The definition in SSAP No. 105 of a confirmed supplier receivable requires a first priority perfected interest and, SVO analytical staff should be able to determine if first priority interest has been achieved.

➢ NAIC Staff recommends the Working Group consider modifying the filing certification requirements and allowing the SVO to determine if a first priority perfected interest has been obtained.

9. Default date – (Reference SSAP No. 105, paragraph 28)

SSAP No. 105 – A WCFI program is in default and nonadmitted when payments are uncollected within 15 days.

Industry proposal – Extend default and nonadmission date to 30 days.

➢ NAIC Staff recommends that the Working Group consider modifying the default provisions from 15-30 days as it is more practical to have the default date and the cure period be consistent. Key discussion points are:

• Waiting 30 days for a short-term asset can be material in relation to the life of the asset.
Fifteen (15) days was previously chosen to be consistent with settlement guidance in SSAP No. 21—Other Admitted Assets, which nonadmits and reclassifies receivables for securities not settled within 15 days.

The “cure period” noted in paragraph 11.b on confirmed supplier receivables is not to exceed 30 days so it may make sense for the default date and the end of the cure period to be consistent.

D. Change to Statutory Reporting

10. Change Reporting Category – (Reference SSAP No. 105 – paragraph 22)

SSAP No. 105 – Requires WCFI receivables to be on annual statement Schedule BA- Other Long-term Assets on specifically created reporting lines. Capital Adequacy (E) Task Force reviewed the asset class and requires specific (relatively low) RBC charges based on the NAIC SVO WCFI program designation.

Industry proposal – Move the statutory reporting of Working Capital Finance Investments from Schedule BA-Other Long-term Assets to Schedule DA, Short Term Investments because the receivables within the rated WCFI programs are required to be less than one year.

NAIC Staff does not recommend the Working Group change the reporting requirements to move the WCFI investments from Schedule BA – Other Assets, to Schedule DA Short term Investments (points for consideration are in discussion below). Key reasons include:

- This is an unique class. Issue Paper No. 147, documents the VOSTF recommendation for Schedule BA reporting. The Task Force discussed the relative benefits between Schedule BA and DA and concluded that WCFIs should be reported as Other Invested Assets and therefore Schedule BA provides an enhanced disclosure framework deemed more appropriate for the investment.
- This reporting was intentional because the long-term programs are designated, even though the different investments are short term.
- Annual statement lines and RBC charges have already been established and the current RBC charges based on program designation would not be functional if the reporting was on Schedule DA, because that schedule does not include designations.

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group received a referral from the Valuation of Securities (E) Task Force and directed staff to proceed with drafting revisions for subsequent exposure using the staff Summer 2019 recommendations. During this discussion additional industry proposed revisions were presented, but not captured in the direction for initial revisions to SSAP No. 105.

For Fall 2019 National Meeting Discussion:

NAIC staff recommends exposing the substantive revisions to SSAP No. 105—Working Capital Finance Investments incorporating the industry proposed language for the specific items directed by the Working Group and illustrated in the attached. The revisions in response to the industry request are summarized below. NAIC staff recommends directing Staff to prepare an issue paper for discussion at the 2020 Spring National Meeting.
1. **Functionally Equivalent Foreign Regulators** - Removed the requirement that the SVO determine if the International Finance Agent is the functional equivalent of the U.S. Regulator. (paragraph 10.a)

2. **Commingling Prohibitions** - Removed the finance agent prohibitions on commingling. (paragraph 10.b)

3. **Investor Rights Edit** - Removed duplicative text regarding exercise of investor rights. (paragraph 11.b)

4. **Requirements for filer to Certify Perfected Interest** – Removed requirements, with revisions allowing the SVO to determine if a first priority perfected interest has been obtained. (paragraphs 14 & 15)

5. **Finance Agent Validation Requirements** – The independent review requirements were broadened to allow independent review of the finance agent by either audit or through an internal control report. (paragraph 16)

6. **Default Date** - Changed the default provisions from 15 to 30 days so the default date and the cure period are consistent. This has the effect of changing the date of nonadmission for an investment in default for a period up to 30 days instead of up to 15 days. (paragraph 28)

**In accordance with the Working Group direction, the following industry requested revisions were not incorporated:**

1. **Possible Domestic Regulator Approval** - The statement that the reporting entity may need to seek approval from the domestic regulator was maintained (paragraph 18). **Points for consideration:**
   - Issue Paper No. 147 documents that requiring domestic regulator approval was an intentional decision because of concerns regarding the ability of smaller entities to monitor the investments in such programs on an ongoing basis.
   - The current guidance in SSAP No. 105 is not an explicit requirement, but only identifies that a domiciliary commissioner may require a company to receive initial permission.
   - These investments may not fit into the normal investment law categories.
   - The industry proposal notes:
     - the asset class is not for most insurers as it requires relationships with finance agents beyond the traditional dealer insurer.
     - the investor needs specialized knowledge, asset management operations and the ability to book and supervise the assets.
     - the filing fees require sizable commitments to justify the costs, which would make it cost prohibitive for smaller players.
   - Fall 2019 industry comments noted that state approval is not a practical risk mitigant. In addition, the speaker commented that he questioned the evaluation criteria that would be used by a state.

2. **Only High-Quality Obligors** – The current requirement which restricts designations of programs and obligors to being of high quality was maintained. NAIC Staff continues to not recommend lowering the credit quality of the acceptable obligors from NAIC 1 (highest quality) and NAIC 2 (high quality) to allow NAIC designations of 3 (medium quality) and NAIC 4 (low quality). **Points for consideration:**
   - The descriptions of NAIC designations in the *Purposes and Procedures Manual of the Investment Analysis Office* note that both NAIC designations of 3 and 4 have speculative elements (see Authoritative Literature).
   - Assets that reflect “factored receivables” are nonadmitted in statutory accounting. This program is the sole exception to the factored receivable rule. By lowering the allowable credit standards,
an expanded class of factored receivables would be admitted, further deviating from statutory accounting concepts.

- The SAPWG created SSAP No. 105 to allow admission for only high-quality programs, from high quality obligors. Allowing obligors with lower credit assessments would be a fundamental change in program requirements. (paragraphs 6 & 7)

3. **Unrated subsidiaries / Credit substitution** - NAIC Staff does not recommend the proposed credit substitution methodology for unrated subsidiaries as it is overly complex, broad and difficult to apply. Further, credit substitution does not adequately address credit risk for an unrated affiliate. SVO staff memos also highlighted the difficulty in applying the industry proposed credit substitution methodology (paragraph 7). Excerpts VOSTF October 2018 memo to the SAPWG:

SVO evaluated whether analytical discretion would enable it to designate WCFI programs with unrated obligors of a rated or designated parent. SVO evaluated whether operational and strategic linkages between a rated parent and unrated obligor can provide a basis to attribute the credit rating of one entity to the other. **It concluded that no principle exists to permit an assumption that a legal entity can be held responsible for the debt of another without having contractually agreed to do so.** While WCFI arrangements may be inherently different than the credit situations SVO assesses SVO lacks the experiential basis to opine on the idea that the difference permits attribution.

**Industry proposal for credit substitution has two aspects:**

a. **Credit substitution for unrated subsidiary obligors of a rated obligor** – Industry proposes to attribute the credit strength of the rated parent to the unrated subsidiary obligor without the rated parent being a guarantor of the unrated subsidiary’s WCFI obligations. This aspect envisions the rated entity having some of its own obligations in the program

b. **Credit Substitution of rated obligor for its unrated subsidiaries which are key transaction participants, but not obligors.** The industry proposal is to create criteria to allow the “program” to obtain an acceptable NAIC designation by evaluating if the unrated “key transaction participant” is able to perform its functions. Industry proposes several different ways to attribute the rated entity’s credit rating to the unrated entity including:

- Documented operational control of unrated obligor, or
- An important inter-relationship with unrated obligor, or
- If the unrated key transaction participants are reasonably expected to perform their functions.

**NAIC Staff Credit Substitution Recommendation – Reference SVO P&P Requirements** – The Practices and Procedures Manual of the Investment Analysis Office (P&P) contains existing credit substitution methodology, however the industry is proposing to diverge from the existing methodology for this asset class. **NAIC staff recommends referencing the existing credit substitution methodology in the P&P.**

4. **Change Reporting Schedule** - NAIC Staff does not recommend the Working Group change the reporting requirements to move the WCFI investments from Schedule BA – Other Assets, to Schedule DA – Short term Investments (paragraph 22). Points for consideration:

- This reporting was intentional because the long-term programs are designated, even though the different investments are short term. Issue Paper No. 147, documents the VOSTF recommendation for Schedule BA reporting. The Task Force discussed the relative benefits between Schedule BA and
DA and concluded that WCFIs should be reported as Other Invested Assets and that Schedule BA provides an enhanced disclosure framework deemed more appropriate for the investment.

- Annual statement lines and RBC charges have already been established on Schedule BA.

- Capital Adequacy (E) Task Force reviewed the asset class and requires specific designations (relatively low - just slightly higher than a bond of similar credit risk). RBC charges are based on the NAIC SVO WCFI program designation. The current RBC charges based on program designation would not be functional if the reporting was moved to Schedule DA, because that schedule does not include designations.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group exposed substantive revisions to SSAP No. 105—Working Capital Finance Investments to incorporate industry revisions to program requirements, as previously directed by the Working Group during the Summer National Meeting. The Working Group directed NAIC staff to prepare an issue paper.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group re-exposed SSAP No. 105—Working Capital Finance Investments with a proposed/anticipated effective date of June 30, 2020 and exposed Issue Paper 16X: Working Capital Finance Investment Updates for comment. This item was exposed with a May 1, 2020 comment period deadline.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 105—Working Capital Finance Investments and Issue Paper 163: Working Capital Finance Investment Updates with an additional modification discussed on the call. The modification removed this sentence from SSAP No. 105R, paragraph 16, “Initial permission to invest in Working Capital Finance Investment Programs may be required by the domiciliary commissioner.” Accordingly, the related discussion in Issue Paper No. 163 was also updated.

This modification was part of the original request from industry and was recommended by a regulator member of the Working Group who noted that it may be confusing to regulators and cause extra work which would be duplicative since these programs are also subject to SVO office review. Therefore, the Working Group adopted 7 of the 10 industry modifications with a June 30, 2020 effective date.

The Working Group also directed notification of the revisions to the Valuation of Securities (E) Task Force.

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Statutory Issue Paper No. 163

Working Capital Finance Investment Updates

STATUS
Finalized May 20, 2020

Original SSAP: 105; Current Authoritative Guidance: SSAP No. 105R

Type of Issue:
Common Area

SUMMARY OF ISSUE

1. This issue paper introduces substantive revisions to SSAP No. 105—Working Capital Finance Investments to change some of the existing accounting and program requirements. This item is specific for Working Capital Finance investments (WCFI) which comply with the program requirements and have been designated by the NAIC Securities Valuation Office (SVO).

SUMMARY CONCLUSION

2. The substantive revisions to SSAP No. 105 (illustrated in Exhibit A), reflect the following elements:
   a. Functionally Equivalent Foreign Regulators – Removed the requirement that the SVO determine if the International Finance Agent is the functional equivalent of the U.S. Regulator.
   b. Commingling Prohibitions – Removed the finance agent prohibitions on commingling.
   c. Requirements for Filer to Certify First Priority Perfected Interest – Removed requirements, with revisions allowing the SVO to determine if first priority perfected interest has been obtained.
   d. Finance Agent Validation Requirements – The independent review requirements were broadened to allow independent review of the finance agent by either audit or through an internal control report.
   e. Default Date – Changed the default provisions from 15 to 30 days so the default date and the cure period are consistent. This has the effect of changing the date of nonadmission for an investment in default for a period up to 30 days instead of up to 15 days.
   f. Investor Rights Edit – Removed duplicative text regarding exercise of investor rights.

3. This issue paper provides historical information on the consideration of revisions for working capital finance program issuances acquired as investments, as well as some of the initially adopted guidance. SSAP No. 105 permits admittance of NAIC Securities Valuation Office designated WCFI programs that meet specific requirements.

Working Capital Finance Investments Overview

4. Bills receivable, in general, are an asset class that has been historically nonadmitted by statutory accounting. They were nonadmitted prior to codification and explicitly nonadmitted in SSAP No. 20—Nonadmitted Assets.
5. When SSAP No. 105 was developed, SSAP No. 20 was amended to allow working capital finance investments as admitted assets to the extent they conform to the requirements of SSAP No. 105 (see Relevant Statutory Accounting). Some of the WCFI program requirements are to provide protections that help to distinguish these programs from factoring, forfaiting, invoice discounting and other similar programs which have been historically nonadmitted in SSAP No. 20. SSAP No. 105 details that eligible confirmed supplier receivables must not: include insurance or insurance related assets; be impaired or in default at the time of purchase; or have a maturity longer than one year from the date of invoice. In addition, there are restrictions that preclude admission of affiliated WCFI investments.

6. SSAP No. 105 provides that working capital finance investments represent a confirmed short-term obligation\(^1\) to pay a specified amount owed by one party (the obligor) to another (typically a supplier of goods), generated as a part of a working capital finance investment program currently designated by the NAIC Securities Valuation Office (SVO). Pursuant to the long-term working capital finance investment program, a short-term obligation has been transferred by the entity entitled to payment (typically a supplier of goods) to a third-party investor.

7. Working capital finance investments held by a reporting entity represent a right for the reporting entity to receive future payments. This issue paper provides details on the updates to the SSAP No. 105 accounting and reporting guidelines for the right to receive payment under working capital finance programs that meet particular criteria.

**Background**

8. SSAP No. 105 requires an SVO program designation of NAIC 1 or NAIC 2 (See definitions in relevant statutory accounting) in order to admit working capital finance investments. This was an intentional choice by the Working Group and the Valuation of Securities (E) Task Force during the initial development of guidance in 2012 to limit the admissibility to high quality programs and obligors. High quality programs in existence at the time of the original development of SSAP No. 105 and the some of the requirements of these programs which were administered by larger banks were reviewed.

9. During the original development of SSAP No. 105, the single group reporting entities that had been successfully investing in these types of assets for a number of years, agreed that a high level of investor sophistication to enter and monitor the transactions is required. Also, during the original development of SSAP No. 105, some regulators expressed concerns regarding the ability of smaller entities to monitor the investments in such programs on an ongoing basis. That concern was the basis of the recommendation reflected in the original Issue Paper No. 147 presented to the Working Group to note that such investments which do not fit into traditional categories, may require department of insurance approval.

10. When SSAP No. 105 was developed, the Capital Adequacy (E) Task Force also determined a capital charge for the receivables which varied based on the NAIC designations on the new Schedule BA reporting lines which were developed for these investments.

11. The subsequent industry 2019 proposal developed under discussion by the Working Group proposed to move the investments to Schedule DA — Short-term Investments. During the subsequent review, the Working Group indicated a preference to maintain the long-term programs on annual statement BA where lines and columns would allow proper reporting of the risk-based capital charge. While the program issuances are limited to short-term investments, the long-term program which continually has new balances is what receives the designation.

\(^1\) All references to short-term obligations in this issue paper refer to obligations not exceeding one year.

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DISCUSSION

Development of Statutory Accounting Guidance

12. SSAP No. 105 was originally effective in 2014 and was controversial as it was developed at the request of a single life entity. At that time, some Working Group members objected to the development of a new SSAP, reporting changes and specific asset class risk-based capital (RBC) charges at the behest of a single company. The discussion at that time noted that the permitted practice concept was intended to address such situations.

13. In 2018, the reporting entity that participates in these programs requested modifications to the adopted program and submitted a proposal for consideration.

14. As of year-end 2018, WCFI reported in the annual statement Schedule BA - Other Invested Assets was limited to the same life entity that originally requested the development of SSAP No. 105. This company reported a total of $258 million in a total of seven WCFI programs for 2017 and $224 million in a total of six WCFI programs for 2018. The total of these amounts is immaterial to the reporting entity. No reporting entities disclosed any prescribed or permitted practices varying from SSAP No. 105 in annual statement Note 1 for 2017 or 2018.

15. The Valuation of Securities (E) Task Force exposed the industry proposal and held discussion on in the third quarter of 2018. The Task Force approved referral to the Statutory Accounting Principles (E) Working Group, which was also supported by the life industry at the 2019 Spring National Meeting. The referral was also forwarded to the Working Group with Valuation of Securities (E) Task Force Memos.

16. The industry proposed ten revisions to SSAP No. 105 affecting the following key aspects:
   a. Changes to program and or obligor credit quality requirements
   b. Changes to program administration and/or documentation
   c. Changes to regulatory compliance requirements
   d. Changes to statutory reporting requirements.

17. On August 3, 2019, the Working Group received the referral from the Task Force and directed NAIC staff to proceed with drafting revisions for subsequent exposure using six of the ten industry recommendations.

Review of Items Not Supported by the Working Group:

18. During the August 2019 discussion the following four industry proposed revisions were presented, but not captured in the direction for revisions to SSAP No. 105.
   a. Possible Domestic Regulator Approval – The statement that the reporting entity may need to seek approval from the domestic regulator was maintained.
   b. Only High-Quality Obligors – The current requirement which restricts designations of programs and obligors to being of high quality (NAIC 1 or NAIC 2) was maintained.
   c. Unrated subsidiaries / Credit substitution - The industry proposed credit substitution methodology for unrated subsidiaries was not incorporated in the exposed revisions. The industry proposal had two aspects:
Ref #2019-25
IP No. 163

i. Credit substitution for unrated subsidiary obligors of a rated obligor – Industry proposed to attribute the credit strength of the rated parent to the unrated subsidiary obligor without the rated parent being a guarantor of the unrated subsidiary’s WCFI obligations. This aspect envisions the rated entity having some of its own obligations in the program.

ii. Credit Substitution of rated obligor for its unrated subsidiaries which are key transaction participants, but not obligors. The industry proposal was to create criteria to allow the “program” to obtain an acceptable NAIC designation by evaluating if the unrated “key transaction participant” is able to perform its functions. Industry proposed several different ways to attribute the rated entity’s credit rating to the unrated entity including:

(a) Documented operational control of unrated obligor, or
(b) An important inter-relationship with unrated obligor, or
(c) If the unrated key transaction participants are reasonably expected to perform their functions.

d. Change Reporting Schedule - The Working Group did not change the reporting requirements to move the WCFI investments from Schedule BA – Other Assets, to Schedule DA – Short term Investments.

19. Some of the discussion points that were discussed which resulted in the Working Group not directing the inclusion of four of the industry proposed revisions were as follows:

a. Possible Domestic Regulator Approval – The statement that the reporting entity may need to seek approval from the domestic regulator was maintained as previously noted in Issue Paper No. 147. The Issue Paper documents the possible requirement for domestic regulator approval was an intentional decision because of concerns regarding the ability of smaller entities to monitor the investments in such programs on an ongoing basis.

i. It was also noted that the current guidance in SSAP No. 105 is not an explicit requirement, but only identifies that a domiciliary commissioner may require a company to receive initial permission (see final action in paragraph 23).

ii. The agenda item noted that the industry proposal noted:

(a) that these investments may not fit into the normal investment law categories.
(b) the asset class is not for most insurers as it requires relationships with finance agents beyond the traditional dealer insurer.
(c) the investor needs specialized knowledge, asset management operations and the ability to book and supervise the assets.
(d) the filing fees require sizable commitments to justify the costs, which would make it cost prohibitive for smaller players.

iii. As a counterpoint to the decision not to change the guidance in the SSAP No. 105, the Fall 2019 industry comments noted that state approval is not a practical risk mitigant. In
addition, the speaker present at the meeting commented that he questioned the evaluation criteria that would be used by a state.

b. Only High-Quality Obligors – The current requirement which restricts designations of programs and obligors to being of high quality was maintained. The Working Group was not in favor of lowering the credit quality of the acceptable obligors from NAIC 1 (highest quality) and NAIC 2 (high quality) to allow NAIC designations of 3 (medium quality) and NAIC 4 (low quality) (See definitions in relevant statutory accounting).

i. The descriptions of NAIC designations in the *Purposes and Procedures Manual of the Investment Analysis Office* note that both NAIC designations of 3 and 4 have speculative elements.

ii. Assets that reflect “factored receivables” are nonadmitted in statutory accounting. This program is the sole exception to the factored receivable rule. By lowering the allowable credit standards, an expanded class of factored receivables would be admitted, further deviating from statutory accounting concepts.

iii. The SAPWG created SSAP No. 105 to allow admission for only high-quality programs, from high quality obligors. Allowing obligors with lower credit assessments would be a fundamental change in program requirements.

c. Unrated subsidiaries / Credit substitution – The industry proposed credit substitution methodology for unrated subsidiaries was not incorporated in the exposed revisions. The industry proposal was noted in the discussion as complex, broad and difficult to apply. Further, credit substitution does not adequately address credit risk for an unrated affiliate. SVO staff memos also highlighted the difficulty in applying the industry proposed credit substitution methodology. Excerpts from the Valuation of Securities (E) Task Force October 2018 memo to the Working Group note the following:

SVO evaluated whether analytical discretion would enable it to designate WCFI programs with unrated obligors of a rated or designated parent. SVO evaluated whether operational and strategic linkages between a rated parent and unrated obligor can provide a basis to attribute the credit rating of one entity to the other. *It concluded that no principle exists to permit an assumption that a legal entity can be held responsible for the debt of another without having contractually agreed to do so. While WCFI arrangements may be inherently different than the credit situations SVO assesses SVO lacks the experiential basis to opine on the idea that the difference permits attribution.*

d. Change Reporting Schedule – The Working Group did not change the reporting requirements to move the WCFI investments from Schedule BA – Other Assets, to Schedule DA – Short term Investments. Key points noted were:

i. Reporting on Schedule BA was intentional because the long-term programs are designated, even though the different investments are short-term. Issue Paper No. 147, documents the VOSTF recommendation for Schedule BA reporting. The Task Force discussed the relative benefits between Schedule BA and DA and concluded that WCFIs should be reported as Other Invested Assets and that Schedule BA provides an enhanced disclosure framework deemed more appropriate for the investment.

ii. Annual statement lines and RBC charges have already been established on Schedule BA.
iii. Capital Adequacy (E) Task Force reviewed the asset class and requires specific designations (relatively low - just slightly higher than a bond of similar credit risk). RBC charges are based on the NAIC SVO WCFI program designation. The current RBC charges based on program designation would not be functional if the reporting was moved to Schedule DA, because that schedule does not include designations which are needed for RBC.

Review of Items Proposed for Inclusion in SSAP No. 105:

20. On December 7, 2019, the Working Group exposed substantive revisions to SSAP No. 105 to incorporate industry revisions to program requirements, as previously directed by the Working Group during the 2019 Summer National Meeting.

21. The substantive revisions to SSAP No. 105 that were exposed for comment reflected the following elements:

a. Functionally Equivalent Foreign Regulators - Removed the requirement that the SVO determine if the International Finance Agent is the functional equivalent of the U.S. Regulator. Removing this element was supported by the SVO, which noted that determining functional equivalence is not an analytical issue.

b. Commingling Prohibitions - Removed the finance agent prohibitions on commingling. Removal of this requirement was supported by the SVO. SVO staff noted if commingling were not a requirement it would consider commingling risk, when present, as a structural deficiency and balance it against the requirement that the Finance Agent be NAIC 1 or NAIC 2.

c. Investor Rights Edit - Removed duplicative text regarding exercise of investor rights. This revision was to improve readability and eliminate redundancy.

d. Requirements for filer to Certify Perfected Interest – Removed requirements, with revisions allowing the SVO to determine if a first priority perfected interest in accordance with uniform commercial code (UCC) requirements for each annual submission has been obtained. In deciding to make this revision the following key points were deemed relevant:

i. It was noted that the SVO staff has indicated that UCC first priority perfected interest criteria are typically determined when contracting a program and similar objectives can be accomplished in more ways than the UCC lien process. Requiring the UCC lien process was viewed as overly prescriptive.

ii. The definition in SSAP No. 105 of a confirmed supplier receivable requires a first priority perfected interest and, SVO analytical staff should be able to determine if first priority interest has been achieved

e. Finance Agent Validation Requirements – The independent review requirements were broadened to allow independent review of the finance agent by either audit or through one of two types of internal control report. This is a lower threshold, than the existing requirements, but one that still provides some type of independent program review.
f. Default Date - Changed the default provisions from 15 to 30 days so the default date and the cure period are consistent. This has the effect of changing the date of nonadmission for an investment in default for a period up to 30 days instead of up to 15 days. Key discussion points are:

i. Waiting 30 days for a short-term asset can be material in relation to the life of the asset.

ii. Fifteen (15) days was previously chosen to be consistent with settlement guidance in SSAP No. 21—Other Admitted Assets, which nonadmits and reclassifies receivables for securities not settled within 15 days.

iii. The “cure period” on confirmed supplier receivables is not to exceed 30 days, therefore, the Working Group agreed that it may make sense for the default date and the end of the cure period to be consistent.

22. At the 2020 Spring National Meeting, the Working Group reviewed the issue paper and the January 2020 comments on the exposed item. Comments received from industry advocated for inclusion of the four items that the Working Group opted to exclude from the additional revisions to the revised Statement. Key elements noted in the industry comments included the following:

a. Absent all 10 of the industry proposed revisions, investments in working capital finance programs will remain low.

b. Industry advocated that its proposed credit substitution mechanism to allow unrated subsidiaries was suitable for NAIC implementation to allow not only lower rated subsidiaries but also un-rated subsidiaries. The commenters maintained that the absence of mention of non-rated subsidiaries as acceptable obligors, did not preclude them from allowing unrated obligors. However, the current SSAP No. 105 program requirements explicitly require obligors to be of high credit quality.

c. The industry comments advocated that lower rated investments should be allowed as the statutory risk-based capital requirements reflect investment quality decisions in capital calculations.

d. The industry comments advocated that domiciliary regulator prior approval for investment is a transfer of transaction review from staff to state insurance departments. The commenters noted that when, if regulators are concerned about the asset class, they can uniformly limit investment as a whole. Given the high costs to a small industry investor, coupled with the fact that dealers would unlikely choose to document such investments bilaterally with small industry investors, already limits access to the assets to large industry investors (see final action in paragraph 23).

e. The industry commented that Schedule BA reporting is both cumbersome and expensive and in the view of the industry commenters, the more appropriate schedule would be Schedule DA.

23. During the 2020 Spring National Meeting, after considering the interested parties’ comments, the Working Group identified the revisions as a substantive change, re-exposed revisions to SSAP No. 105, and exposed this Issue Paper. On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 105—Working Capital Finance Investments and Issue Paper 163: Working Capital Finance Investment Updates with an additional modification discussed on the call. As part of the May 20, 2020 adoption action, the Working Group and designated an effective date for the revisions of June 30, 2020.
a. The modification removed this sentence from SSAP No. 105R, paragraph 16, “Initial permission to invest in Working Capital Finance Investment Programs may be required by the domiciliary commissioner.” Accordingly, the related discussion in Issue Paper No. 163 was also updated.

b. This modification was part of the original request from industry and was recommended by a regulator member of the Working Group who noted that it may be confusing to regulators and cause extra work which would be duplicative since these programs are also subject to SVO office review. Therefore, the Working Group adopted 7 of the 10 industry modifications.

c. The Working Group also directed notification of the revisions to the Valuation of Securities (E) Task Force.

RELEVANT STATUTORY ACCOUNTING


25. SSAP No. 20—Nonadmitted Assets was amended by SSAP No. 105 to allow working capital finance investments as admitted assets to the extent they conform to the requirements of SSAP No. 105.

4. Consistent with paragraph 2, the following assets shall be nonadmitted:

   a. Deposits in Suspended Depositories—Amounts on deposit with suspended depositories may not be fully recoverable. Any amounts not reasonably expected to be recovered shall be written off in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R). Amounts in excess of that written off shall be nonadmitted as they are not available to satisfy obligations to policyholders;

   b. Bills Receivable Not for Premium and Loans Unsecured or Secured by Assets That Do Not Qualify As Investments—In accordance with SSAP No. 5R, amounts determined to be uncollectible or otherwise impaired shall be written off. Amounts in excess of that written off are not considered to be properly collateralized as there are no underlying assets which would otherwise be admitted assets. Such amounts shall be nonadmitted as they may be of questionable economic value if needed to fulfill policyholder obligations. Receivables arising from working capital finance programs designated by the Securities Valuation Office are subject to the guidance in SSAP No. 105;

   (Rest of paragraph omitted for brevity)

26. Purposes and Procedures Manual of the NAIC Investment Analysis Office provides the following on NAIC Designations:

   a. NAIC 1 is assigned to obligations exhibiting the highest quality. Credit risk is at its lowest and the issuer’s credit profile is stable. This means that interest, principal or both will be paid in accordance with the contractual agreement and that repayment of principal is well protected. An NAIC 1 obligation should be eligible for the most favorable treatment provided under the NAIC Financial Regulation Standards and Accreditation Program.

   b. NAIC 2 is assigned to obligations of high quality. Credit risk is low but may increase in the intermediate future and the issuer’s credit profile is reasonably stable. This means that for the present, the obligation’s protective elements suggest a high likelihood that interest, principal or both will be paid in accordance with the contractual agreement, but there are suggestions that an adverse change in circumstances or economic, financial or business conditions will affect the degree of protection and lead to a weakened capacity to pay. An NAIC 2 obligation should be
eligible for relatively favorable treatment under the NAIC Financial Regulation Standards and Accreditation Program.

c. NAIC 3 is assigned to obligations of medium quality. Credit risk is intermediate and the issuer’s credit profile has elements of instability. These obligations exhibit speculative elements. This means that the likelihood that interest, principal or both will be paid in accordance with the contractual agreement is reasonable for the present, but an exposure to an adverse change in circumstances or economic, financial or business conditions would create an uncertainty about the issuer’s capacity to make timely payments. An NAIC 3 obligation should be eligible for less favorable treatment under the NAIC Financial Regulation Standards and Accreditation Program.

d. NAIC 4 is assigned to obligations of low quality. Credit risk is high and the issuer’s credit profile is volatile. These obligations are highly speculative, but currently the issuer has the capacity to meet its obligations. This means that the likelihood that interest, principal or both will be paid in accordance with the contractual agreement is low and that an adverse change in circumstances or business, financial or economic conditions would accelerate credit risk, leading to a significant impairment in the issuer’s capacity to make timely payments. An NAIC 4 obligation should be accorded stringent treatment under the NAIC Financial Regulation Standards and Accreditation Program.

Effective Date

27. As issue papers are not represented in the Statutory Hierarchy (see Section IV of the Preamble), the subsequent consideration and adoption of this issue paper will not have any impact of the effective date of the substantive revisions adopted to SSAP No. 105 by the Working Group on May 20, 2020.

Statement of Statutory Accounting Principles No. 105

Working Capital Finance Investments

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for working capital finance investments held by reporting entities. This statement amends SSAP No. 20—Nonadmitted Assets (SSAP No. 20) to allow working capital finance investments as admitted assets to the extent they conform to the requirements of this statement.

SUMMARY CONCLUSION

2. Working capital finance investments represent a confirmed short-term obligation\(^1\) to pay a specified amount owed by one party (the obligor) to another (typically a supplier of goods), generated as a part of a working capital finance investment program currently designated by the NAIC Securities Valuation Office. Pursuant to the working capital finance investment program, this short-term obligation has been transferred by the entity entitled to payment (typically a supplier of goods) to a third-party investor.

3. Working capital finance investments held by a reporting entity represent a right of the reporting entity to receive future payment. This Statement provides accounting and reporting guidelines for the right to receive payment under working capital finance programs that meet particular criteria.

Working Capital Finance Program - Definitions and Conditions

4. A “working capital finance program” is an open account program under which an investor may purchase interests, or evidence thereof, in commercial non-insurance receivables. A working capital finance program is created for the benefit of a commercial investment-grade obligor and its suppliers of goods or services, and facilitated by a finance agent.

5. A working capital finance program transfers a right to payment to an investor from a short term obligation and arises from transactions among:
   a. a buyer of goods or services that becomes an obligor to the supplier of goods or services,
   b. the supplier(s) of those goods or services,
   c. a finance agent, and
   d. an investor.

6. A “working capital finance investment” is an interest in payment(s) from a confirmed supplier receivable issued pursuant to a working capital finance program. The payment (maturity) date must not exceed one year from

\(^1\) All references to short-term obligations in this statement to refer to obligations not exceeding one year.
the date of invoice from the supplier to the obligor. This investment is created when the investor purchases from a working capital finance program that is currently designated as NAIC “1” or “2” by the NAIC Securities Valuation Office, any of the following:

a. One or more confirmed supplier receivables;

b. in case of a participation, a participation interest in one or more confirmed supplier receivables issued by the finance agent or lead lender holding confirmed supplier receivables; or

c. a certificate, note or other interest manifestation, documented in a way that is verifiable by regulators, representing a legally enforceable interest in a right to payment either directly to the investor or from a trust, other special purpose entity or pool holding confirmed supplier receivables.

7. “Obligor” is the party that purchases the goods or services that generates the original supplier receivable (and which is the payable for the Obligor). The obligor must be a single entity, which has an NAIC designation of “1” or “2” or a Credit Rating Provider equivalent. The obligor must confirm the supplier receivable described in paragraph 11 as described in the confirmation process in paragraphs 12-13.

8. “Supplier” is the party that sells the goods or services to the obligor. The supplier sells the confirmed supplier receivable in accordance with the terms of the working capital finance program designated by the NAIC Securities Valuation Office at a price agreed to by the finance agent and/or investor.

9. “Investor” is the party purchasing a working capital finance investment in accordance with the terms of the working capital finance program designated by the NAIC Securities Valuation Office.

10. The “finance agent” is a bank, financial institution, other financial intermediary, or service provider that facilitates the working capital finance program, arranges the sale, assignment or transfer of the confirmed supplier receivable to the investor for a fee and administers the payment mechanism. In the case of participation, the finance agent must inform the reporting entity investor of a default or event of default as soon as it becomes aware of such default or event of default. For the working capital finance program to qualify under this SSAP, the finance agent must meet the requirements of either paragraph 10.a. or 10.b.:

a. The finance agent is directly regulated by, or falls under the supervision of, a financial regulator of its domiciliary country provided that such country appears on the Purposes and Procedures Manual of the NAIC Investment Analysis Office List of Jurisdictions Eligible for Netting and that the Securities Valuation Office determines that the regulator is the functional equivalent of the Board of Governors of the Federal Reserve System, the Office of the Comptroller of the Currency, or the Federal Deposit Insurance Corporation; or

b. Payments from the obligor must be paid directly to the reporting entity (investor) or into an account maintained by a regulated financial institution for the benefit of investors in the working capital finance program and, in either case, cannot flow through the finance agent and cannot be the beneficiary of such payment. There can be no commingling of payments or assets with those of the obligor, supplier, servicer or trust administrator or other investors.

11. A “confirmed supplier receivable” is a first priority perfected security interest or right to payment of a monetary obligation from the obligor arising from the sale of goods or services from the supplier to the obligor the payment of which has been confirmed by the obligor committing and stating that the obligations under the agreement and any payment shall not be affected by the invalidity, unenforceability, existence, performance or non-performance of the underlying commercial trade transaction or any related contract or undertaking nor that it will
not protest, delay, or deny, nor offer nor assert any defenses, personal or otherwise, against payment to the supplier or any party taking claims, interests, or rights to payments made by the supplier.

a. The confirmed supplier receivable must be sold, assigned or otherwise transferred in a manner that results in an absolute, irrevocable and legally enforceable obligation that has been confirmed by the Obligor.

b. In the case of a participation, the certificates or other evidence of participation provide an absolute, irrevocable, and legally enforceable obligation of the finance agent or holder of the confirmed supplier receivable to pay to the reporting entity investor all of the amounts due to it under the confirmed supplier receivable, without reduction or delay arising from any claims that the finance agent may have against the reporting entity investor. The reporting entity investor’s ability to exercise its rights as creditor, or to direct the finance agent to exercise the rights of a creditor on its behalf, shall not be subject to the discretion of the finance agent or other lenders or investors. The reporting entity investor’s ability to exercise its rights as creditor, or to direct the finance agent to exercise the rights of a creditor on its behalf, shall not be subject to, other than during a cure period not to exceed thirty days, the discretion of the finance agent or other lenders or investors.

Confirmation Process

12. In the case of a purchase, the investor shall verify, prior to the sale that the obligor has confirmed the respective amounts, payment dates and related invoice numbers’ specified dates and has waived all defenses to payment. In the case of a participation, the finance agent must verify that the obligor has confirmed the respective amounts, payment dates and related invoice reference numbers’ specified due dates, and has waived all defenses to payment in accordance with the confirmation process.

13. The obligor must commit and state that upon confirmation of a supplier receivable it is obligated to pay to the investor, the finance agent, or any third party acting as agent or trustee for the investor, a sum equal to the full amount of that confirmed supplier receivable(s) on a date certain stated in the confirmation and that it waives any right of setoff or other defenses to avoid or delay the full and timely payment of that Confirmed Supplier Receivable. The documents establishing the working capital finance program or the confirmation must state and confirm that the obligation to pay must be independent of any other contracts or claims that might be raised in defense arising from any transaction financed in connection with the WCFPWCFI program, the confirmed supplier receivable, or any other courses of performance or courses of dealing with the supplier.

14. In the case of participation, the investor must certify that it has a commercially reasonable belief that its participation interest meets the Uniform Commercial Code’s standards for creating and preserving first priority security interests in the payments due and in the confirmed supplier receivables. Commercially reasonable belief shall mean the SVO deems the investor’s belief reasonable in light of the systems, policies, or practices commonly recognized in the field of investing in participations. The investor must be able to demonstrate to a regulator or to the SVO, upon either’s request, the basis for its commercially reasonable belief that the WCFP creates and preserves the investor’s ability to enforce a first priority perfected security interest in the confirmed supplier receivables.

15. In the case of a certificate, note, or other manifestation, capable of verification, representing a right to payment from a trust, other special purpose entity, or special purpose pool holding confirmed supplier receivables, the investor must certify that it has a commercially reasonable belief that the documents establishing and governing the working capital finance program create and preserve interests in the confirmed supplier receivables capable of being enforced by the trustee or other entity holding confirmed supplier receivables as first priority perfected security interests under the Uniform Commercial Code. The investor must be able to demonstrate the basis for such belief to a regulator or to the SVO upon either’s request. Commercially reasonable belief shall mean the SVO
Program Requirements

46.14. The working capital finance program investor must provide in its annual filing with the Securities Valuation Office an annual audit of the consolidated financial statements of which the finance agent is part, which does not report any qualifications related to servicing, and one of the following:

   a. An annual independent report according to Statement on Standards for Attestation Engagements (SSAE) No. 16 (or functional equivalent), reporting on controls at a service organization related to the administration of the investment; or

   b. An annual audit of the financial statements and internal controls of the consolidated group of which the finance agent is part, which does not note any material weaknesses related to servicing working capital financial investments.

The NAIC Securities Valuation Office would review the materiality of the report findings in making their determination of the assignment of a designation.

47.15. If the credit rating of the working capital finance program or obligor falls to non-investment grade (below the equivalent of NAIC designation “1” or “2”), the reporting entity shall nonadmit, the working capital finance investments obtained under the related working capital finance program and/or the related obligor. Due to the short-term nature of these investments, once an investment is nonadmitted due to the credit rating of the working capital finance program or the obligor, those investments will continue to be nonadmitted.

48.16. Reporting entity investors must have the ability to monitor the working capital finance program and the credit-related activities of the obligor. Reporting entity investors must provide information as requested to the state of domicile indicating that they have the ability to monitor on an ongoing basis the activities of the working capital finance program. Initial permission to invest in Working Capital Finance Investment Programs may be required by the domiciliary commissioner.

49.17. All contracts or agreements that are a part of or that together constitute a working capital finance program must provide that if a dispute arises among any of the parties under any of the contracts or agreements that are a part of or that together constitute the working capital finance program, each party agrees that the dispute will be submitted to a court of competent jurisdiction in the United States or a constituent state thereof or of an alternative dispute resolution process recognized thereby. All contracts or agreements that are a part of or that together constitute a working capital finance program must provide that any dispute arising under any of the contracts or agreements that are a part of or that together constitute the working capital finance program must be resolved pursuant to the laws of the United States or a constituent state thereof that address the substance of the dispute but excluding those laws addressing conflicts of law.

Exclusions

20.18. A working capital finance investment excludes any receivables financed through:

   a. Factoring: the purchase of receivables in bulk from a supplier where the receivables represent the payment obligations of potentially thousands of buyers to a single supplier, in which the buyers have no relationship with or contractual obligation to pay the factor and retain all legal defenses to payment they may have against the supplier;
b. Forfaiting: the purchase of one or a series of receivables from exporters by a forfaiter to enable the exporter (seller) to finance a commercial transaction with a buyer in which the Obligor has no relationship with or contractual obligation to pay the forfaiter and retains all legal defenses to pay it may have against the seller; or

c. Invoice discounting: the advancement of funds by a finance company to a business entity with the funds advanced limited to a defined percentage of the business entity’s eligible and outstanding receivables.

21.19. Eligible Confirmed Supplier Receivables must not:

   a. Include insurance or insurance related assets;

   b. Be impaired or in default at the time of purchase;

   c. Have a payment (maturity) date longer than one year from the date of the invoice from the Supplier to the Obligor giving rise to the confirmed supplier receivable, and the maturity date must not be subject to change or rolling; nor

   d. Include any receivable of any parent or affiliate of the reporting entity investor, and neither the Obligor nor any Supplier may be affiliated with the reporting entity investor. Working Capital Finance Investments that have obligors or vendors that are affiliated with the investor are ineligible, and therefore, nonadmitted assets.

Accounting and Reporting

22.20. The right to receive payment generated by a working capital finance investment issued under a working capital finance program is considered to meet the definition of an asset as defined in SSAP No. 4—Assets and Nonadmitted Assets, and is an admitted asset to the extent the investment conforms to the requirements set forth in this Statement and the Purposes and Procedures Manual of the NAIC Investment Analysis Office. For programs that comply with all of these elements, working capital finance investments shall be valued and reported in accordance with this Statement, the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and the designation assigned in the NAIC Valuations of Securities product. Programs that do not comply with the elements set forth in this Statement, or the provisions set forth in the Purposes and Procedures Manual of the NAIC Investment Analysis Office are nonadmitted. Working capital finance investments are reported as other invested assets in the financial statements.

23.21. A working capital finance investment shall be recorded on the trade date. At acquisition, the Working Capital Finance Investment shall be initially reported at cost, excluding brokerage and other related fees, and all other costs (internal costs, or costs paid for origination, purchase or commitment to purchase such investments), which shall be expensed as incurred.

24.22. After initial acquisition, the Working Capital Finance Investment shall be reported at amortized cost until the specified maturity date, unless the investment, or a portion thereof, is deemed uncollectible or when an other-than-temporary impairment has occurred. In the event that a working capital finance investment is purchased by a reporting entity investor at a premium (amount to be received by the entity under the confirmed supplier receivable is less than the price paid for the investment), the excess paid by the reporting entity investor in comparison to the amount receivable under the confirmed supplier receivable must be immediately expensed.
25.23. For reporting entities required to maintain an Interest Maintenance Reserve (IMR), the accounting for realized capital gains and losses from working capital finance investments shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve (SSAP No. 7). For reporting entities not required to maintain an IMR, realized gains and losses from working capital finance investments shall be reported as net realized capital gains or losses in the statement of income. For reporting entities not required to maintain an AVR, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus).

26.24. A Working Capital Finance Investment may provide for a prepayment penalty or acceleration fee in the event the working capital finance investment is liquidated prior to its scheduled termination date. Such fees shall be reported as investment income when received.

27.25. SSAP No. 34—Investment Income Due and Accrued shall be followed for determining and recording investment income earned on working capital finance investments acquired at a discount. In accordance with SSAP No. 34—Investment Income Due and Accrued, investment income shall be reduced for amounts that have been determined to be uncollectible, however amounts more than 15 days overdue are nonadmitted.

Default

28.26. A working capital finance investment payment that is uncollected by the reporting entity within fifteen thirty days after the due date shall be considered in default and nonadmitted. If the reporting entity has any other working capital finance investment assets from the same defaulting counterparty, all other working capital finance investments from that counterparty shall be nonadmitted. All working capital finance investments from a counterparty identified in default shall be evaluated for impairment.

Impairment

29.27. An other-than-temporary impairment (INT 06-07) shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of a confirmed supplier receivable including the payment on the established due date. Pursuant to this guidance, assessment of other-than-temporary impairment shall include an evaluation of the financial condition and short-term prospects of the obligor. If it is determined that a decline in the fair value of a working capital finance investment below book/adjusted carrying value is due to an other-than-temporary impairment, an impairment loss shall be recognized as a realized loss equal to the entire difference between the working capital finance investment’s carrying value and fair value as of the reporting period for which the assessment is made. Fair value shall be determined in accordance with SSAP No. 100R—Fair Value (SSAP No. 100R), and reflect the price to sell the asset in an orderly market between market participants. As such, the fair value shall reflect the assumptions market participants will use in pricing the asset, including assumptions about risk.

30.28. For reporting entities required to maintain an AVR/IMR, the entire amount of the realized loss from the other-than-temporary impairment shall be recorded through the AVR, in accordance with SSAP No. 7.

31.29. Upon recognition of an other-than-temporary impairment, the fair value of the working capital finance investment on the measurement date shall become the new cost basis of the working capital finance investment and the new cost basis shall not be adjusted for subsequent recoveries in fair value. Once an investment is determined to be other-than-temporarily impaired, until all expected payments are received, the reporting entity must re-evaluate the investment quarterly and reassess fair value, with recognized realized losses for the difference between the book/adjusted carrying value and the current fair value. This process shall continue until either all expected payments are received, or the entity has recognized a realized loss for the entire uncollected carrying value.
Disclosures

32.30. The financial statements shall include the following disclosures:

a. Fair value in accordance with SSAP No. 100R.

b. Concentrations of credit risk in accordance with SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures (SSAP No. 27) in the annual audited statutory financial reports only.

c. Information regarding the aggregate book/adjusted carrying value of working capital finance investment by designation including gross assets with nonadmitted and net admitted amounts annually. (Note that programs designated 3-6 are nonadmitted.)

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d. Annual and quarterly information regarding the aggregate book/adjusted carrying value maturity distribution on the underlying working capital finance investments by the categories of maturities up to 180 days and 181 to 365 days.

e. Any events of default of working capital finance investments during the reporting period.

32.31. Refer to the Preamble for further discussion regarding disclosure requirements.

Effective Date and Transition

This statement is effective for years on or after January 1, 2014. Substantive revisions documented in Issue Paper No. 163—Working Capital Finance Investments Updates are effective for financial reporting periods on or after June 30, 2020. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors.

- Issue Paper No. 147—Working Capital Finance Investments
- Issue Paper No. 163—Working Capital Finance Investments Updates
Statement of Statutory Accounting Principles No. 105R

Working Capital Finance Investments

STATUS

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<th>Type of Issue</th>
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<tr>
<td>Issued</td>
<td>December 15, 2013; Substantively revised May 20, 2020</td>
</tr>
<tr>
<td>Effective Date</td>
<td>January 1, 2014; Substantive revisions documented in Issue Paper No. 163 effective June 30, 2020</td>
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<td>Relevant Appendix A Guidance</td>
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REFERENCES

Relevant Issue Papers

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SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for working capital finance investments held by reporting entities. This statement amends SSAP No. 20—Nonadmitted Assets (SSAP No. 20) to allow working capital finance investments as admitted assets to the extent they conform to the requirements of this statement.

SUMMARY CONCLUSION

2. Working capital finance investments represent a confirmed short-term obligation\(^1\) to pay a specified amount owed by one party (the obligor) to another (typically a supplier of goods), generated as a part of a working capital finance investment program currently designated by the NAIC Securities Valuation Office. Pursuant to the working capital finance investment program, this short-term obligation has been transferred by the entity entitled to payment (typically a supplier of goods) to a third party investor.

3. Working capital finance investments held by a reporting entity represent a right of the reporting entity to receive future payment. This Statement provides accounting and reporting guidelines for the right to receive payment under working capital finance programs that meet particular criteria.

Working Capital Finance Program - Definitions and Conditions

4. A “working capital finance program” is an open account program under which an investor may purchase interests, or evidence thereof, in commercial non-insurance receivables. A working capital finance program is created for the benefit of a commercial investment-grade obligor and its suppliers of goods or services, and facilitated by a finance agent.

5. A working capital finance program transfers a right to payment to an investor from a short term obligation and arises from transactions among:
   a. a buyer of goods or services that becomes an obligor to the supplier of goods or services,
   b. the supplier(s) of those goods or services,
   c. a finance agent, and
   d. an investor.

6. A “working capital finance investment” is an interest in payment(s) from a confirmed supplier receivable issued pursuant to a working capital finance program. The payment (maturity) date must not exceed one year from the date of invoice from the supplier to the obligor. This investment is created when the investor purchases from a working capital finance program that is currently designated as NAIC “1” or “2” by the NAIC Securities Valuation Office, any of the following:
   a. One or more confirmed supplier receivables;
   b. in case of a participation, a participation interest in one or more confirmed supplier receivables issued by the finance agent or lead lender holding confirmed supplier receivables; or

\(^1\) All references to short-term obligations in this statement to refer to obligations not exceeding one year.
c. a certificate, note or other interest manifestation, documented in a way that is verifiable by regulators, representing a legally enforceable interest in a right to payment either directly to the investor or from a trust, other special purpose entity or pool holding confirmed supplier receivables.

7. “Obligor” is the party that purchases the goods or services that generates the original supplier receivable (and which is the payable for that Obligor). The obligor must be a single entity, which has an NAIC designation of “1” or “2” or a Credit Rating Provider equivalent. The obligor must confirm the supplier receivable described in paragraph 11 as described in the confirmation process in paragraphs 12-13.

8. “Supplier” is the party that sells the goods or services to the obligor. The supplier sells the confirmed supplier receivable in accordance with the terms of the working capital finance program designated by the NAIC Securities Valuation Office at a price agreed to by the finance agent and/or investor.

9. “Investor” is the party purchasing a working capital finance investment in accordance with the terms of the working capital finance program designated by the NAIC Securities Valuation Office.

10. The “finance agent” is a bank, financial institution, other financial intermediary, or service provider that facilitates the working capital finance program, arranges the sale, assignment or transfer of the confirmed supplier receivable to the investor for a fee and administers the payment mechanism. In the case of participation, the finance agent must inform the reporting entity investor of a default or event of default as soon as it becomes aware of such default or event of default. For the working capital finance program to qualify under this SSAP, the finance agent must meet the requirements of either paragraph 10.a. or 10.b.:

a. The finance agent is directly regulated by, or falls under the supervision of, a financial regulator of its domiciliary country provided that such country appears on the Purposes and Procedures Manual of the NAIC Investment Analysis Office List of Jurisdictions Eligible for Netting and that the Securities Valuation Office determines that the regulator is the functional equivalent of the Board of Governors of the Federal Reserve System, the Office of the Comptroller of the Currency, or the Federal Deposit Insurance Corporation; or

b. Payments from the obligor must be paid directly to the reporting entity (investor) or into an account maintained by a regulated financial institution for the benefit of investors in the working capital finance program and, in either case, cannot flow through the finance agent cannot be the beneficiary of such payment and 2) there can be no commingling of payments or assets with those of the obligor, supplier, servicer or trust administrator or other investors.

11. A “confirmed supplier receivable” is a first priority perfected security interest or right to payment of a monetary obligation from the obligor arising from the sale of goods or services from the supplier to the obligor the payment of which has been confirmed by the obligor committing and stating that the obligations under the agreement and any payment shall not be affected by the invalidity, unenforceability, existence, performance or non-performance of the underlying commercial trade transaction or any related contract or undertaking nor that it will not protest, delay, or deny, nor offer nor assert any defenses, personal or otherwise, against payment to the supplier or any party taking claims, interests, or rights to payments made by the supplier.

a. The confirmed supplier receivable must be sold, assigned or otherwise transferred in a manner that results in an absolute, irrevocable and legally enforceable obligation that has been confirmed by the Obligor.
b. In the case of a participation, the certificates or other evidence of participation provide an absolute, irrevocable, and legally enforceable obligation of the finance agent or holder of the confirmed supplier receivable to pay to the reporting entity investor all of the amounts due to it under the confirmed supplier receivable, without reduction or delay arising from any claims that the finance agent may have against the reporting entity investor. The reporting entity investor’s ability to exercise its rights as creditor, or to direct the finance agent to exercise the rights of a creditor on its behalf, shall not be subject to the discretion of the finance agent or other lenders or investors. The reporting entity investor’s ability to exercise its rights as creditor, or to direct the finance agent to exercise the rights of a creditor on its behalf, shall not be subject to, other than during a cure period not to exceed thirty days, the discretion of the finance agent or other lenders or investors.

Confirmation Process

12. In the case of a purchase, the investor shall verify, prior to the sale that the obligor has confirmed the respective amounts, payment dates and related invoice numbers’ specified dates and has waived all defenses to payment. In the case of a participation, the finance agent must verify that the obligor has confirmed the respective amounts, payment dates and related invoice reference numbers’ specified due dates, and has waived all defenses to payment in accordance with the confirmation process.

13. The obligor must commit and state that upon confirmation of a supplier receivable it is obligated to pay to the investor, the finance agent, or any third party acting as agent or trustee for the investor, a sum equal to the full amount of that confirmed supplier receivable(s) on a date certain stated in the confirmation and that it waives any right of setoff or other defenses to avoid or delay the full and timely payment of that Confirmed Supplier Receivable. The documents establishing the working capital finance program or the confirmation must state and confirm that the obligation to pay must be independent of any other contracts or claims that might be raised in defense arising from any transaction financed in connection with the WCFP/WCFI program, the confirmed supplier receivable, or any other courses of performance or courses of dealing with the supplier.

14. In the case of participation, the investor must certify that it has a commercially reasonable belief that its participation interest meets the Uniform Commercial Code’s standards for creating and preserving first priority security interests in the payments due and in the confirmed supplier receivables. Commercially reasonable belief shall mean the SVO deems the investor’s belief reasonable in light of the systems, policies, or practices commonly recognized in the field of investing in participations. The investor must be able to demonstrate to a regulator or to the SVO, upon either’s request, the basis for its commercially reasonable belief that the WCFP creates and preserves the investor’s ability to enforce a first priority perfected security interest in the confirmed supplier receivables.

15. In the case of a certificate, note, or other manifestation, capable of verification, representing a right to payment from a trust, other special purpose entity, or special purpose pool holding confirmed supplier receivables, the investor must certify that it has a commercially reasonable belief that the documents establishing and governing the working capital finance program create and preserve interests in the confirmed supplier receivables capable of being enforced by the trustee or other entity holding confirmed supplier receivables as first priority perfected security interests under the Uniform Commercial Code. The investor must be able to demonstrate the basis for such belief to a regulator or to the SVO upon either’s request. Commercially reasonable belief shall mean the SVO deems the investor’s belief reasonable in light of the systems, policies, and practices commonly recognized in the field of investing in securitizations, loan-backed, structured, or trust-issued securities.
Program Requirements

46.14. The working capital finance program investor must provide in its annual filing with the Securities Valuation Office an annual audit of the consolidated financial statements of which the finance agent is part, which does not report any qualifications related to servicing, and one of the following:

   a. An annual independent report according to Statement on Standards for Attestation Engagements (SSAE) No. 16 (or functional equivalent), reporting on controls at a service organization related to the administration of the investment; or

   b. An annual audit of the financial statements and internal controls of the consolidated group of which the finance agent is part, which does not note any material weaknesses related to servicing working capital financial investments.

The NAIC Securities Valuation Office would review the materiality of the report findings in making their determination of the assignment of a designation.

47.15. If the credit rating of the working capital finance program or obligor falls to non-investment grade (below the equivalent of NAIC designation “1” or “2”), the reporting entity shall nonadmit, the working capital finance investments obtained under the related working capital finance program and/or the related obligor. Due to the short-term nature of these investments, once an investment is nonadmitted due to the credit rating of the working capital finance program or the obligor, those investments will continue to be nonadmitted.

48.16. Reporting entity investors must have the ability to monitor the working capital finance program and the credit-related activities of the obligor. Reporting entity investors must provide information as requested to the state of domicile indicating that they have the ability to monitor on an ongoing basis the activities of the working capital finance program. Initial permission to invest in Working Capital Finance Investment Programs may be required by the domiciliary commissioner.

49.17. All contracts or agreements that are a part of or that together constitute a working capital finance program must provide that if a dispute arises among any of the parties under any of the contracts or agreements that are a part of or that together constitute the working capital finance program, each party agrees that the dispute will be submitted to a court of competent jurisdiction in the United States or a constituent state thereof or of an alternative dispute resolution process recognized thereby. All contracts or agreements that are a part of or that together constitute a working capital finance program must provide that any dispute arising under any of the contracts or agreements that are a part of or that together constitute the working capital finance program must be resolved pursuant to the laws of the United States or a constituent state thereof that address the substance of the dispute but excluding those laws addressing conflicts of law.

Exclusions

20.18. A working capital finance investment excludes any receivables financed through:

   a. Factoring: the purchase of receivables in bulk from a supplier where the receivables represent the payment obligations of potentially thousands of buyers to a single supplier, in which the buyers have no relationship with or contractual obligation to pay the factor and retain all legal defenses to payment they may have against the supplier;

   b. Forfaiting: the purchase of one or a series of receivables from exporters by a forfaire to enable the exporter (seller) to finance a commercial transaction with a buyer in which the Obligor has no
relationship with or contractual obligation to pay the forfaiter and retains all legal defenses to pay it may have against the seller; or

c. Invoice discounting: the advancement of funds by a finance company to a business entity with the funds advanced limited to a defined percentage of the business entity’s eligible and outstanding receivables.

21. Eligible Confirmed Supplier Receivables must not:

a. Include insurance or insurance related assets;

b. Be impaired or in default at the time of purchase;

c. Have a payment (maturity) date longer than one year from the date of the invoice from the Supplier to the Obligor giving rise to the confirmed supplier receivable, and the maturity date must not be subject to change or rolling; nor

d. Include any receivable of any parent or affiliate of the reporting entity investor, and neither the Obligor nor any Supplier may be affiliated with the reporting entity investor. Working Capital Finance Investments that have obligors or vendors that are affiliated with the investor are ineligible, and therefore, nonadmitted assets.

Accounting and Reporting

22. The right to receive payment generated by a working capital finance investment issued under a working capital finance program is considered to meet the definition of an asset as defined in SSAP No. 4—Assets and Nonadmitted Assets, and is an admitted asset to the extent the investment conforms to the requirements set forth in this Statement and the Purposes and Procedures Manual of the NAIC Investment Analysis Office. For programs that comply with all of these elements, working capital finance investments shall be valued and reported in accordance with this Statement, the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and the designation assigned in the NAIC Valuations of Securities product. Programs that do not comply with the elements set forth in this Statement, or the provisions set forth in the Purposes and Procedures Manual of the NAIC Investment Analysis Office are nonadmitted. Working capital finance investments are reported as other invested assets in the financial statements.

23. A working capital finance investment shall be recorded on the trade date. At acquisition, the Working Capital Finance Investment shall be initially reported at cost, excluding brokerage and other related fees, and all other costs (internal costs, or costs paid for origination, purchase or commitment to purchase such investments), which shall be expensed as incurred.

24. After initial acquisition, the Working Capital Finance Investment shall be reported at amortized cost until the specified maturity date, unless the investment, or a portion thereof, is deemed uncollectible or when an other-than-temporary impairment has occurred. In the event that a working capital finance investment is purchased by a reporting entity investor at a premium (amount to be received by the entity under the confirmed supplier receivable is less than the price paid for the investment), the excess paid by the reporting entity investor in comparison to the amount receivable under the confirmed supplier receivable must be immediately expensed.

25. For reporting entities required to maintain an Interest Maintenance Reserve (IMR), the accounting for realized capital gains and losses from working capital finance investments shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve (SSAP No. 7). For reporting entities not required to
maintain an IMR, realized gains and losses from working capital finance investments shall be reported as net realized capital gains or losses in the statement of income. For reporting entities not required to maintain an AVR, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus).

26.24. A Working Capital Finance Investment may provide for a prepayment penalty or acceleration fee in the event the working capital finance investment is liquidated prior to its scheduled termination date. Such fees shall be reported as investment income when received.

27.25. SSAP No. 34—Investment Income Due and Accrued shall be followed for determining and recording investment income earned on working capital finance investments acquired at a discount. In accordance with SSAP No. 34—Investment Income Due and Accrued, investment income shall be reduced for amounts that have been determined to be uncollectible, however amounts more than 15 days overdue are nonadmitted.

Default

28.26. A working capital finance investment payment that is uncollected by the reporting entity within fifteen thirty days after the due date shall be considered in default and nonadmitted. If the reporting entity has any other working capital finance investment assets from the same defaulting counterparty, all other working capital finance investments from that counterparty shall be nonadmitted. All working capital finance investments from a counterparty identified in default shall be evaluated for impairment.

Impairment

29.27. An other-than-temporary impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of a confirmed supplier receivable including the payment on the established due date. Pursuant to this guidance, assessment of other-than-temporary impairment shall include an evaluation of the financial condition and short-term prospects of the obligor. If it is determined that a decline in the fair value of a working capital finance investment below book/adjusted carrying value is due to an other-than-temporary impairment, an impairment loss shall be recognized as a realized loss equal to the entire difference between the working capital finance investment’s carrying value and fair value as of the reporting period for which the assessment is made. Fair value shall be determined in accordance with SSAP No. 100R—Fair Value (SSAP No. 100R), and reflect the price to sell the asset in an orderly market between market participants. As such, the fair value shall reflect the assumptions market participants will use in pricing the asset, including assumptions about risk.

30.28. For reporting entities required to maintain an AVR/IMR, the entire amount of the realized loss from the other-than-temporary impairment shall be recorded through the AVR, in accordance with SSAP No. 7.

31.29. Upon recognition of an other-than-temporary impairment, the fair value of the working capital finance investment on the measurement date shall become the new cost basis of the working capital finance investment and the new cost basis shall not be adjusted for subsequent recoveries in fair value. Once an investment is determined to be other-than-temporarily impaired, until all expected payments are received, the reporting entity must reevaluate the investment quarterly and reassess fair value, with recognized realized losses for the difference between the book/adjusted carrying value and the current fair value. This process shall continue until either all expected payments are received, or the entity has recognized a realized loss for the entire uncollected carrying value.

Disclosures

32.30. The financial statements shall include the following disclosures:
a. Fair value in accordance with SSAP No. 100R.

b. Concentrations of credit risk in accordance with SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures (SSAP No. 27) in the annual audited statutory financial reports only.

c. Information regarding the aggregate book/adjusted carrying value of working capital finance investment by designation including gross assets with nonadmitted and net admitted amounts annually. (Note that programs designated 3-6 are nonadmitted.)

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d. Annual and quarterly information regarding the aggregate book/adjusted carrying value maturity distribution on the underlying working capital finance investments by the categories of maturities up to 180 days and 181 to 365 days.

e. Any events of default of working capital finance investments during the reporting period.

33.31. Refer to the Preamble for further discussion regarding disclosure requirements.

**Effective Date and Transition**

34.32. This statement is effective for years on or after January 1, 2014. Substantive revisions documented in Issue Paper No. 163—Working Capital Finance Investments Updates are effective for financial reporting periods on or after June 30, 2020. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors.

**REFERENCES**

**Relevant Issue Papers**

- Issue Paper No. 147—Working Capital Finance Investments
- Issue Paper No. 163—Working Capital Finance Investments Updates
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Inclusion of Cash / Liquidity Pools - Cash Equivalents as Defined in SSAP No. 2R.

Check (applicable entity):

| Description of Issue: Cash pooling, also known as liquidity bundling or liquidity pools, is a special form of liquidity management in which groups combine resources in order to make a more efficient use of idle cash. A cash pool is typically a structure in which several entities’ cash accounts are aggregated for numerous purposes, including optimizing earned interest, accessing additional short-term investments markets, and improving liquidity management. The investment goal is to optimize financial results by increasing investment access and lower transaction costs that would be incurred by each individual pool participant.

Contributed cash is typically placed in short-term investments, which may not have been previously available to a single affiliated reporting entity that possesses a lower cash balance. Affiliates with lower cash balances can leverage the financial strength of other related affiliates in order to access certain markets that contain significant initial investment requirements. Additionally, by pooling resources and making fewer (and larger) investments, transaction costs are reduced, thus giving the participants a more efficient use of cash resources.

In general, pooling is restricted to groups in which several companies are organized under the management of a single corporate entity. Individual participating companies may be legally independent, however the group acts as a strategic unit, for the purposes of cash management.

Cash pooling structures are not a new market development; however, their potential uses and organizational structures can vary significantly. Under certain pool structures, positive cash balances of one member could cover the deficit cash balance of another member. In this type of structure, surplus funds are physically concentrated into a single account in order to maximize investment return while deficit accounts are covered by transfers from the cash pool. Within these structures, individual participants lose economic independence as the cash is managed centrally and may not be available to the extent desired by the participating entity. Pooling structures have also been formed for internal financing purposes as “sharing of cash” can be used to reduce reliance on external borrowing for short-term working capital needs, again potentially reducing the cash available by certain participants.

This agenda item recommends revisions to allow specific structures that strictly hold cash, cash equivalents and short-term investments and other certain criteria, but do not meet the current requirements for cash equivalent reporting, to be reported as cash equivalents under SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments.

Existing Authoritative Literature:

SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments

Cash Equivalents

Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in
value because of changes in interest rates. Only investments with original maturities of three months or less qualify under this definition, with the exception of money market mutual funds, as detailed in paragraph 7. Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

7. Money market mutual funds registered under the Investment Company Act of 1940 and regulated under rule 2a-7 of the Act shall be accounted for and reported as cash equivalents for statutory accounting. Investments in money market mutual funds shall be valued at fair value or net asset value (NAV) as a practical expedient. For reporting entities required to maintain an asset valuation reserve (AVR), the accounting for unrealized capital gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve. For reporting entities not required to maintain an AVR, unrealized capital gains and losses shall be recorded as a direct credit or charge to surplus. Sales/reinvestments in money market mutual funds are excluded from the wash sale disclosure in SSAP No. 103R.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): A question regarding cash pools was raised under the proposed short-term rolling provisions captured in agenda item 2019-20. With this question, it was noted that cash pools are not specifically addressed in SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments. This agenda item proposes to incorporate specific guidance for these instruments. If revisions are adopted to clarify cash pools in scope of SSAP No. 2R, it is anticipated that revisions will also be proposed to exclude cash pools from the short-term rolling provisions, allowing qualifying cash pools to be continually reported as cash equivalents.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation:

NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments to specify the types of cash pooling organization structures and the investments they are required to maintain in order to qualify as cash equivalents.

NAIC staff is aware a circumstance where a Limited Liability Company was used as the primary structure for a Cash / Liquidity Pool. However, NAIC staff is not proposing changes to SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies as the legal structure of such pools will vary. Comments are requested regarding the need for a Cash / Liquidity Pool reference in SSAP No. 48.

1 Original maturity means original maturity to the entity holding the investment. For example, both a three-month U.S. Treasury bill and a three-year Treasury note purchased three months from maturity qualify as cash equivalents. However, a Treasury note purchased three years ago does not become a cash equivalent when its remaining maturity is three months.
Cash Equivalents

6. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Only investments with original maturities of three months or less qualify under this definition, with the exception of cash pools that meet the requirements of paragraph 8 and money market mutual funds described in paragraph 7. Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

7. Money market mutual funds registered under the Investment Company Act of 1940 and regulated under rule 2a-7 of the Act shall be accounted for and reported as cash equivalents for statutory accounting. Investments in money market mutual funds shall be valued at fair value or net asset value (NAV) as a practical expedient. For reporting entities required to maintain an asset valuation reserve (AVR), the accounting for unrealized capital gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve. For reporting entities not required to maintain an AVR, unrealized capital gains and losses shall be recorded as a direct credit or charge to surplus. Sales/reinvestments in money market mutual funds are excluded from the wash sale disclosure in SSAP No. 103R.

8. Cash pooling is a technique, utilized by some companies under common control by which several entities’ cash accounts are aggregated for numerous purposes, including liquidity management, optimizing interest or investment returns and reducing investment or banking transaction fees. Cash pools can have numerous functions and structures, however only those that have obtained domiciliary regulator approval and meet the requirements may look through the ownership structure to report the assets held as cash equivalents.

   a. Members or participants in the pool are limited to affiliated entities as defined in SSAP No. 25.

   b. Investments held by the pool are limited to non-affiliated investments.

   c. The pool must permit each participant to withdraw, at any time, cash up to the amount it has contributed to the pool. Each participant must own an undivided interest in the underlying assets of the pool in proportion to the aggregate amount of cash contributed. All affiliates’ interests in the pool shall be of the same class, with equal rights, preferences and privileges. All membership interests shall be fully paid and non-assessable and shall have no preemptive, conversion or exchange rights. The liability of a participant’s debts and obligations of the pool shall be limited to the amount of its contributions and no participant shall be obligated to contribute money to the pool for any reason other than to participate in the pool’s investments. Additionally, participants shall not cover the debits or credits of another participant (commonly referred to as notional cash pooling).

   a-d. An audited U.S. GAAP annual report of the cash pool and schedules showing each affiliate’s prorated share of investments shall be provided annually to each participant as of December 31. The reporting entity shall determine if the investments would have qualified as cash, cash equivalents or short-term investments had the entity independently acquired the investments. To the extent the pool holds investments that do not meet the...
Disclosures
15. The following disclosures shall be made for short-term investments in the financial statements:

   a. Fair values in accordance with SSAP No. 100R—Fair Value;
   b. Concentrations of credit risk in accordance with SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures;
   c. Basis at which the short-term investments are stated.
   d. The items in the scope of this statement are also subject to the annual audited disclosures in SSAP No. 26R—Bonds, paragraph 30.f.

16. The financial statements shall disclose the reporting entity's share of the cash pool by asset type (cash, cash equivalents, or short-term investments).

For brevity, the remaining paragraphs of SSAP No. 2R have been omitted but will be renumbered accordingly.

Staff Review Completed by:
NAIC Staff – Jim Pinegar, September 2019

Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions, as illustrated above, to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments to specify that cash pooling structures that meet specified criteria qualify as cash equivalents.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group exposed this agenda item, with revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, as illustrated below, with revisions from the prior exposure shaded in gray, to reflect that certain cash / liquidity pools, meeting defined criteria, may be reported as cash, cash equivalents, or short-term investments. This item has a shortened comment period deadline ending May 1, 2020.

Cash Equivalents

7.9. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Only investments with original maturities of three months or less qualify under this definition, with the exception of cash pools that meet the requirements of paragraph 8 and money market mutual funds described in paragraph 7. Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

10. Money market mutual funds registered under the Investment Company Act of 1940 and regulated under rule 2a-7 of the Act shall be accounted for and reported as cash equivalents for statutory accounting.
Investments in money market mutual funds shall be valued at fair value or net asset value (NAV) as a practical expedient. For reporting entities required to maintain an asset valuation reserve (AVR), the accounting for unrealized capital gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve. For reporting entities not required to maintain an AVR, unrealized capital gains and losses shall be recorded as a direct credit or charge to surplus. Sales/reinvestments in money market mutual funds are excluded from the wash sale disclosure in SSAP No. 103R.

11. Cash pooling is a technique, utilized by some companies under common control by which several entities’ cash accounts are aggregated for numerous purposes, including liquidity management, optimizing interest or investment returns and reducing investment or banking transaction fees. Cash pools can have numerous functions and structures, however only those that have obtained domiciliary regulator approval and meet the requirements may look through the ownership structure to report the assets held as cash, cash equivalents, or short-term investments:

   a. Members or participants in the pool are limited to affiliated entities as defined in SSAP No. 25.
   b. Investments held by the pool are limited to non-affiliated investments.
   c. The pool must permit each participant to withdraw, at any time, cash up to the amount it has contributed to the pool. Each participant must own an undivided interest in the underlying assets of the pool in proportion to the aggregate amount of cash contributed. All affiliates’ interests in the pool shall be of the same class, with equal rights, preferences and privileges. All membership interests shall be fully paid and non-assessable and shall have no preemptive, conversion or exchange rights. The liability of a participant’s debts and obligations of the pool shall be limited to the amount of its contributions and no participant shall be obligated to contribute money to the pool for any reason other than to participate in the pool’s investments. Additionally, participants shall not cover the debits or credits of another participant (commonly referred to as notional cash pooling).
   d. A reporting entity shall receive an annual report from the pool manager, which identifies the participant’s investment (share) in the cash pool and the dollar value of its share of cash, cash equivalents and short-term investments. The reporting entity shall report their total balances in the cash pool on the schedule which represents a majority of the held assets. An audited U.S.-GAAP annual report of the cash pool and schedules showing each affiliate’s prorated share of investments shall be provided annually to each participant as of December 31. The reporting entity shall independently determine if the investments would have qualified as cash, cash equivalents or short-term investments had the entity independently acquired the investments. To the extent the pool holds investments that do not meet the definition of cash, cash equivalents, short-term investments, or if the cash pool is not supported by an audited statement, the pool does not qualify within scope of this statement.
   e. Valuation of the assets in the pool shall remain consistent with the valuations required by reported asset type as stipulated in SSAP No. 2R.

Disclosures

16. The following disclosures shall be made for short-term investments in the financial statements:

   a. Fair values in accordance with SSAP No. 100R—Fair Value;
Ref #2019-42

b. Concentrations of credit risk in accordance with SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures;

c. Basis at which the short-term investments are stated.

d. The items in the scope of this statement are also subject to the annual audited disclosures in SSAP No. 26R—Bonds, paragraph 30.f.

**17.18.** The financial statements shall disclose the reporting entity’s share of the cash pool by asset type (cash, cash equivalents, or short-term investments).

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, as illustrated below, with revisions from the prior exposure shaded in gray, to reflect that certain cash / liquidity pools, meeting defined criteria, may be reported as cash equivalents.

### Cash Equivalents

6. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Only investments with original maturities of three months or less qualify under this definition, with the exception of money market mutual funds, as detailed in paragraph 7, and cash pooling, as detailed in paragraph 9 [the verbiage highlighted in italics and underlined, reference guidance expected to be adopted in agenda item 2019-20: Rolling Short-Term Investments] and. Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

8. Money market mutual funds registered under the Investment Company Act of 1940 and regulated under rule 2a-7 of the Act shall be accounted for and reported as cash equivalents for statutory accounting. Investments in money market mutual funds shall be valued at fair value or net asset value (NAV) as a practical expedient. For reporting entities required to maintain an asset valuation reserve (AVR), the accounting for unrealized capital gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve. For reporting entities not required to maintain an AVR, unrealized capital gains and losses shall be recorded as a direct credit or charge to surplus. Sales/reinvestments in money market mutual funds are excluded from the wash sale disclosure in SSAP No. 103R.

9. Cash pooling is a technique, utilized by some companies under common control by which several entities’ cash accounts are aggregated for numerous purposes, including liquidity management, optimizing interest or investment returns and reducing investment or banking transaction fees. Cash pools can have numerous functions and structures, however only those that have obtained domiciliary regulator approval and meet the following requirements are in scope of this statement, may look through the ownership structure to report the assets held as cash, cash equivalents, or short-term investments.

a. Members or participants in the pool are limited to affiliated entities as defined in SSAP No. 25.

b. Investments held by the pool are limited to non-affiliated investments [non-affiliated to the insurance reporting entity].
c. The pool must permit each participant to withdraw, at any time, cash up to the amount it has contributed to the pool. Each participant must own an undivided interest in the underlying assets of the pool in proportion to the aggregate amount of cash contributed. All affiliates’ interests in the pool shall be of the same class, with equal rights, preferences and privileges. All membership interests shall be fully paid and non-assessable and shall have no preemptive, conversion or exchange rights. The liability of a participant’s debts and obligations of the pool shall be limited to the amount of its contributions and no participant shall be obligated to contribute money to the pool for any reason other than to participate in the pool’s investments. Additionally, participants shall not cover the debits or credits of another participant (commonly referred to as notional cash pooling).

d. A reporting entity shall receive an annual monthly reports from the pool manager, which identifies the participant’s investment (share) in the cash pool and the dollar value of its share of cash, cash equivalents and short-term investments. The reporting entity shall report their total balances in the cash pool on the Schedule E – Part 2, utilizing the line number specified for “Other Cash Equivalents,” as a which represents a majority of the held assets (For example, a qualifying cash pool that contains 20% cash, 70% cash equivalents, and 10% short-term investments, the reporting entity would report their entire balance invested as a cash equivalent). The reporting entity shall independently determine if the investments would have qualified as cash, cash equivalents or short-term investments had the entity independently acquired the investments. To the extent the pool holds investments that do not meet the definition of cash, cash equivalents, short-term investments, the pool does not qualify within scope of this statement.

a-e. Valuation of the assets in the pool shall remain consistent with the valuations required by reported asset type as stipulated in SSAP No. 2R.

Disclosures

17. The following disclosures shall be made for short-term investments in the financial statements:

e. Fair values in accordance with SSAP No. 100R—Fair Value;

f. Concentrations of credit risk in accordance with SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures;

g. Basis at which the short-term investments are stated.

h. The items in the scope of this statement are also subject to the annual audited disclosures in SSAP No. 26R—Bonds, paragraph 30.f.

18. The financial statements shall disclose the reporting entity’s share of the cash pool by asset type (cash, cash equivalents, or short-term investments).

Effective Date and Transition

19. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3. Guidance in paragraph 6 of this statement related to terms reset at predefined dates was previously included within INT 08-10: Contractual Terms of Investments and Investor Intent and was effective for periods beginning December 5, 2008. This substantively revised statement, as detailed in Issue Paper No. 155 regarding treatment of money market mutual funds as cash equivalents, is effective on a prospective basis beginning December 31, 2017.
49.20. Revisions permitting cash liquidity pools that meet the specific criteria are effective May 20, 2020 for reporting entities with qualifying cash pools. Reporting entities with cash liquidity pools that do not meet the requirements for reporting within scope of this standard are not permitted to be reported as cash equivalents or short-term investments and shall be reported as a prescribed or permitted practice. (Prior to this adoption date, there was no guidance permitting cash liquidity pools to be captured in scope of this standard.) For reporting entities that will have to reclassify qualifying cash liquidity pools to a cash equivalent from a different investment schedule, the reporting entity may elect to complete these reclassifications effective January 1, 2021, with early adoption permitted.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Rolling Short-Term Investments

Check (applicable entity):

- Modification of existing SSAP
- New Issue or SSAP
- Interpretation

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Description of Issue:
This agenda item has been drafted to consider statutory accounting guidance for short-term investment structures that are being purposely designed to mature at or around 364 days (often with affiliates), with the full expectation that the investment structure would be renewed (rolled) continuously for subsequent years. This agenda item also addresses investments reported as cash equivalents, with the same dynamic, but structured to comply with the cash equivalent timeframes. It is believed these structures occur because reporting as short-term investments (or cash equivalents) results with the following benefits:

1) More-desirable risk-based capital (RBC) charge.
2) To avoid filing with either the SVO or to avoid obtaining a rating from a credit rating provider.
3) Limited affiliate reporting.

Although there are investments (e.g., repurchase and reverse repurchase) transactions that are often expected to renew, it is not appropriate to purposely structure investments to qualify for short-term or cash equivalent reporting, with an anticipation that the investment will continuously roll forward, potentially for many years and avoid filing the security for an NAIC designation and/or reporting on the schedule with more appropriate RBC charges as a long-term investment. In order to avoid unintended consequences for desirable short-term investments, the provisions of this agenda item have been structured to specifically apply to the following:

- All affiliated SSAP No. 26R investments.
- All SSAP No. 43R investments.
- All investments that would be reported on Schedule BA if they did not qualify for cash equivalent or short-term reporting. (This includes both affiliated and non-affiliated investments.)

With these restrictions, any non-affiliated investment that would qualify within *SSAP No. 26R—Bonds* as a long-term investment would be exempt from the proposed new concepts in determining cash equivalent / short-term investment reporting. This scope of the revisions intend to prevent inadvertent application to Treasury-bills, commercial paper, certificates of deposit, etc., where a reporting entity may continuously reacquire the same, or substantially similar short-term investment immediately after maturity of a prior short-term investment. However, any affiliated SSAP No. 26R and any investment (affiliated or non-affiliated) that would be in scope of *SSAP No. 43R—Loan-Backed and Structured Securities*, or that would be reported as an “other invested asset” on Schedule BA is proposed to be subject to the additional concepts for reporting as a cash equivalent / short-term investment. (Repurchase and reverse repurchase transactions are also specifically excluded if they are admitted in accordance with SSAP No. 103R collateral requirements.)
Proposed additional concepts for Cash Equivalents and Short-Term Investments Captured in Scope:

- An overall principle that investments are permitted for short-term and cash equivalent reporting only if the reporting entity reasonably expects the investment duration to be realized (e.g., terminate / mature) on the designated maturity date. If the reporting entity does not expect that the investment will terminate or mature on the designated date but will be renewed / rolled beyond the cash equivalent / short-term maturity deadlines, then the investment shall not be classified within scope of SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments. Such investments shall be reported as long-term investments on the applicable reporting schedule and shall follow the provisions (including NAIC designations and RBC calculations) for a long-term investment. (Although SAP and U.S. GAAP have different definitions for “short-term” / “current asset” reporting, the concept that the duration is “reasonably expected to be realized” is consistent with the “current asset” definition under U.S. GAAP.)

- Provisions that a cash equivalent / short-term investment (unless specifically exempted) is only permitted to be reported within those classifications for one applicable reporting period. As such, if an investment is reported as a short-term investment as of Dec. 31, 2018, and the investment does not mature on the original scheduled maturity date, the reporting entity shall not be permitted to report the investment as a short-term investment on Dec. 31, 2019. (A cash equivalent would only be permitted to be reported with that distinction for one quarter, before moving to a long-term investment schedule.) For these situations, if a security is held after the initial maturity timeframes have passed, the reporting entity shall report the investment as a long-term investment on the applicable schedule and follow all provisions (including NAIC designations and RBC calculations as required) for a long-term investment. (By default, this provision incorporates a quarter (90-day) grace period, because if the security is sold in the quarter following the initial reporting date, it will not subsequently be reported as an invested asset.)

- The sale or maturity of an investment, with a reacquisition of the same or substantially similar security within a 1-year timeframe shall preclude the reporting entity from reporting the currently held security as a cash equivalent or short-term investment regardless of the maturity date. (This one-year timeframe prevents reporting of recurring “re-acquisitions” as cash equivalents or short-term investments.)

- Although wash sales, which are sales and reacquisitions within a 30-day timeframe, of cash-equivalents and short-term investments with credit assessments of NAIC 1-2 are currently excluded from the wash-sale disclosure, modifications have been proposed to require disclosure of all wash sales, regardless of NAIC designation, if the investment or transaction involves an affiliate.

RBC Assessment of Proposed Revisions:

Life Reporting Entities: For life reporting entities, if the investment is a bond, RBC is similar between all reporting schedules in accordance with NAIC designations. If the investment is not a bond, and does not have an NAIC 1 designation, and/or is not permitted to be reported as an “underlying fixed income security” pursuant to the requirements of Schedule BA, a reporting entity receives an RBC benefit by reporting the investment as a cash equivalent or short-term investment rather than as a BA investment. Also, if a reporting entity reports a “credit assessment” for short-term or cash equivalent bonds that is a better assessment than would be received if they had received an NAIC designation, a reporting entity would receive an RBC benefit by reporting the investment as a cash equivalent or short-term investment.
Bonds that are reported as cash equivalents or short-term investments receive RBC charges based on the “credit assessment” in accordance with how the company reports the investment in the Asset Valuation Reserve calculation. Although NAIC designations are not required for these investments, reporting entities are required to report them based on their own credit assessment. If a bond was reported with a higher credit assessment than what it would receive based on NAIC designation (which is required for long-term investments), then a movement from cash equivalent / short-term reporting to a long-term schedule (Schedule D-1 or Schedule BA) would have an RBC impact.

Property / Casualty and Health Reporting Entities: For property/casualty and health reporting entities, if the investment is a bond, RBC is similar between all reporting schedules in accordance with NAIC designations. If the investment is not a bond, a reporting entity receives an RBC benefit by reporting the investment as a cash equivalent or short-term investment rather than a BA investment. (P/C entities do not have the ability to report NAIC designations on Schedule BA investments for RBC purposes.) Also, if a reporting entity reports a “credit assessment” for short-term or cash equivalent bonds that is a better assessment than would be received if they had reported an NAIC designation, a reporting entity would receive an RBC benefit by reporting the investment as a cash equivalent or short-term investment.
Bonds that are reported as cash equivalents or short-term investments receive RBC charges based on the “credit assessment” assigned in Schedule D-Part 1A. Although NAIC designations are not required for these investments, reporting entities are required to report them based on their own credit assessment. If a bond was reported with a higher credit assessment than what it would receive based on NAIC designation (which is required for long-term investments), then a movement from cash equivalent / short-term reporting to a long-term schedule (Schedule D-1 or Schedule BA) would have an RBC impact.

Existing Authoritative Literature:

**SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments**

**Cash Equivalents**

6. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Only investments with original maturities of three months or less qualify under this definition, with the exception of money market mutual funds, as detailed in paragraph 7. Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

7. Money market mutual funds registered under the Investment Company Act of 1940 and regulated under rule 2a-7 of the Act shall be accounted for and reported as cash equivalents for statutory accounting. Investments in money market mutual funds shall be valued at fair value or net asset value (NAV) as a practical expedient. For reporting entities required to maintain an asset valuation reserve (AVR), the accounting for unrealized capital gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve (SSAP No. 7). For reporting entities not required to maintain an AVR, unrealized capital gains and losses shall be recorded as a direct credit or charge to surplus. Sales/reinvestments in money market mutual funds are excluded from the wash sale disclosure in SSAP No. 103R.

**Footnote 1:** Original maturity means original maturity to the entity holding the investment. For example, both a three-month U.S. Treasury bill and a three-year Treasury note purchased three months from maturity qualify as cash equivalents. However, a Treasury note purchased three years ago does not become a cash equivalent when its remaining maturity is three months.

**Short-Term Investments**

12. All investments with remaining maturities (or repurchase dates under repurchase agreements) of one year or less at the time of acquisition (excluding derivatives and those investments classified as cash equivalents) are required to be reported as short-term investments. If a bond was reported with a higher credit assessment than what it would receive based on NAIC designation, then a movement from short-term reporting to a long-term schedule (Schedule D-1 or Schedule BA) would have an RBC impact.
equivalents as defined in this statement) shall be considered short-term investments. Short-term investments include, but are not limited to, bonds, commercial paper, repurchase agreements, and collateral and mortgage loans which meet the noted criteria. Short-term investments shall not include certificates of deposit. Regardless of maturity date, derivative instruments shall not be reported as short-term investments and shall be reported as derivatives on Schedule DB.

13. All short-term investments shall be accounted for in the same manner as similar long-term investments.

14. Short-term investments meet the definition of assets as defined in SSAP No. 4 and are admitted assets to the extent they conform to the requirements of this statement.

SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities (bolding and underlining added for emphasis)

28.I. A reporting entity shall disclose the following information for wash sales, as defined in paragraph 12, involving transactions for securities with an NAIC designation of 3 or below, or that do not have an NAIC designation (excluding all cash equivalents, derivative instruments as well as short-term investments with credit assessments equivalent to an NAIC 1-2 designation). This disclosure shall be included in the financial statements for when the investment was initially sold. For example, if the investment was sold December 20, 2017, and reacquired on January 10, 2018, the transaction shall be captured in the wash sale disclosure included in the year-end 2017 financial statements:

i. A description of the reporting entity’s objectives regarding these transactions;

ii. An aggregation of transactions by NAIC designation 3 or below, or that do not have an NAIC designation;

iii. The number of transactions involved during the reporting period;

iv. The book value of securities sold;

v. The cost of securities repurchased; and

vi. The realized gains/losses associated with the securities involved.

U.S. GAAP – FASB Codification

Master Glossary of “Current Assets”

Current assets is used to designate cash and other assets or resources commonly identified as those that are reasonably expected to be realized in cash or sold or consumed during the normal operating cycle of the business.

Activity to Date (issues previously addressed by the Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS) and U.S. GAAP:
Not Applicable – NAIC staff highlights that the distinction of “short-term” under SAP is distinctly different from U.S. GAAP. Under U.S. GAAP, a “current asset” is one that is reasonably expected to be realized in case or sold...
or consumed during the normal operating cycle of a business. As such, under U.S. GAAP investments move from a non-current (long-term) to current (short-term) classification. This does not occur under SAP, as the distinction of short-term is based on the maturity timeframe at the time of acquisition.

**Staff Recommendation:** NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments to incorporate additional principle concepts in classifying investments as cash equivalents or short-term investments.

As detailed within this agenda item, the proposed revisions will restrict classification as a cash equivalent or short-term investment for all affiliated SSAP No. 26R—Bond investments, all affiliated and nonaffiliated investments in scope of SSAP No. 43R—Loan-Backed and Structured Securities and all affiliated and nonaffiliated investments that would be reported on Schedule BA in accordance with the following provisions:

- The reporting entity does not reasonably expect that the investment will actually terminate or mature within the timeframe permitted for cash equivalent or short-term investment classification.

- The investment was previously reported as a cash equivalent / short-term investment and the initial maturity timeframes have passed. For example, if an investment was reported as a short-term investment as of Dec. 31, 2018, and the investment was rolled / renewed, the reporting entity will not be permitted to report the investment as a short-term investment on Dec. 31, 2019. (A cash equivalent would only be permitted to be reported for one quarter, before moving to a long-term investment schedule.) For these situations, if a security is held after the initial maturity timeframes have passed, the reporting entity shall report the investment as a long-term investment on the applicable schedule and follow all provisions (including NAIC designations and RBC calculations as required) for a long-term investment.

- The sale or maturity of an investment, with a reacquisition of the same or substantially similar security within a 1-year timeframe would preclude the reporting entity from reporting the currently held security as a cash equivalent or short-term investment regardless of the maturity date. (This one-year timeframe prevents reporting of recurring “re-acquisitions” as cash equivalents or short-term investments.) (This provision is similar to the one regarding “rolled” securities but clarifies that the “settlement” of a security with a reacquisition does not prevent application of the new concepts in determining cash equivalent or short-term reporting. (NAIC staff highlights that this restriction is necessary particularly with the use of “net settlement” structures with affiliates in which no cash is exchanged.)

- Wash sales, regardless of NAIC designation, that involve affiliated investments shall be disclosed.

The proposed revisions in this agenda item have been drafted to focus on affiliated bond investments (SSAP No. 26R), all loan-backed and structured security investments (SSAP No. 43R) and all investments that would be captured on Schedule BA. This approach has been used to exclude a variety of cash equivalent / short-term investments that are often purposely rolled / reacquired to ensure a continuous balance of available short-term liquidity (e.g., Treasury-bills, commercial paper, certificates of deposit, etc.) By excluding all non-affiliated “bonds” from the new guidance, the “normal” recurring short-term / cash equivalent investments are not expected to be impacted. The revisions capture both affiliated and nonaffiliated Schedule BA items, as the short-term structuring is more of an RBC focus. (NAIC staff does not believe there are many SSAP No. 43R securities that qualify as cash equivalents or short-term investments, but they have been specifically identified to prevent such classifications if the noted conditions are met.)
As a key item to note, the proposed revisions permit reporting entities that acquire short-term investments (based on maturity date) that are captured in scope and that they expect to roll (such as an affiliated short-term bond), to report the security as a long-term investment at acquisition. (With this approach, the investment would not have to change reporting schedules once it is rolled after initial acquisition.)

**Proposed Revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments:**

**Cash Equivalents**

6. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Only investments with original maturities\(^1\) of three months or less can qualify under this definition, with the exception of money market mutual funds, as detailed in paragraph 75. Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

7. Regardless of maturity date, affiliated investments that would be in scope of SSAP No. 26R—Bonds and all investments that would be in scope of SSAP No. 43R—Loan-Backed and Structured Securities or that would be reported as “Other Invested Assets” shall be reported as long-term investments if any of the following conditions apply:\(^2\):

   a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial 90-day timeframe.

   b. The investment was previously reported as a cash equivalent investment and the initial maturity timeframe has passed. If an investment is reported as a cash equivalent and it is unexpectedly renewed / rolled, the reporting entity is not permitted to continue to report the held security as a cash equivalent regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a cash equivalent for one quarter reporting period. Meaning, if an investment was reported as a cash equivalent in the first quarter, it is not permitted to be reported as a cash equivalent in the second quarter.

   c. The reporting entity reacquired the investment (or a substantially similar investment) within 1 year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as short-term investments regardless of the maturity date of the reacquired investment.)

**New Footnote 1:** Repurchase and reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. Cash equivalents subject to the provisions of paragraph 7 are not permitted to be subsequently reported as short-term investments.

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\(^1\) Original maturity means original maturity to the entity holding the investment. For example, both a three-month U.S. Treasury bill and a three-year Treasury note purchased three months from maturity qualify as cash equivalents. However, a Treasury note purchased three years ago does not become a cash equivalent when its remaining maturity is three months.
investments, even if the updated / reacquired maturity date is within 1 year. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

**Short-Term Investments**

12. Short-term investments are investments that do not qualify as cash equivalents with remaining maturities (or repurchase dates under repurchase agreements) of one year or less at the time of acquisition. (excluding derivatives and those investments classified as cash equivalents as defined in this statement) shall be considered short-term investments. Short-term investments can include, but are not limited to, bonds, commercial paper, repurchase agreements, and collateral and mortgage loans. which meet the noted criteria. Short-term investments shall not include certificates of deposit. Regardless of maturity date, derivative instruments shall not be reported as short-term investments and shall be reported as derivatives on Schedule DB.

13. Regardless of maturity date, affiliated investments in scope of SSAP No. 26R—Bonds and all investments that would be in scope of SSAP No. 43R—Loan-Backed and Structured Securities or that would be reported as "Other Invested Assets" shall be reported as long-term investments if any of the following conditions apply:

   a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial “less than one year” timeframe.

   b. The investment was previously reported as a short-term investment and the initial maturity timeframe has passed. If an investment is reported as a short-term investment and it is unexpectedly renewed / rolled, the reporting entity is not permitted to continue to report the held security as a short-term investment (or as a cash equivalent) regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a short-term investment for one annual reporting period. Meaning, if an investment was reported as a short-term investment as of December 31, 2018, it is not permitted to be reported as short-term investment as of December 31, 2019.

   c. The reporting entity reacquired the investment (or a substantially similar investment) within 1 year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as cash equivalent investments regardless of the maturity date of the reacquired investment.)

New Footnote 1: Repurchase and reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. Short-term investments subject to the provisions of paragraph 13 are not permitted to be subsequently reported as cash equivalents, even if the updated / reacquired maturity date is within 90-days. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

42. All short-term investments shall be accounted for in the same manner as similar long-term investments.

43. Short-term investments meet the definition of assets as defined in SSAP No. 4 and are admitted assets to the extent they conform to the requirements of this statement.
Proposed Revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities:

28.l. A reporting entity shall disclose the following information for wash sales, as defined in paragraph 12, for all affiliated investment transactions (including items originally classified as cash equivalents and short-term investments) and for non-affiliated involving investment transactions for securities with an NAIC designation of 3 or below, or that do not have an NAIC designation. (For non-affiliated investments, excluding all cash equivalents, derivative instruments as well as short-term investments with credit assessments equivalent to an NAIC 1-2 designation are excluded from this disclosure.) This disclosure shall be included in the financial statements for when the investment was initially sold. For example, if the investment was sold December 20, 2017, and reacquired on January 10, 2018, the transaction shall be captured in the wash sale disclosure included in the year-end 2017 financial statements:

i. A description of the reporting entity’s objectives regarding these transactions;

ii. An aggregation of transactions by NAIC designation 3 or below, or that do not have an NAIC designation;

iii. The number of transactions involved during the reporting period;

iv. The book value of securities sold;

v. The cost of securities repurchased; and

vi. The realized gains/losses associated with the securities involved.

Staff Review Completed by: Julie Gann – May 2019

Status:
On August 3, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 2R—Cash, Drafts and Short-term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, as illustrated above, to incorporate additional principle concepts in classifying investments as cash equivalents or short-term investments.

NAIC staff recommends exposure of proposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, which incorporate additional principle concepts in classifying investments as cash equivalents or short-term investments. Items from the original August 3, 2019 exposure are highlighted below and exclude certain qualified cash pooling arrangements (as proposed in agenda item 2019-42) from the restricted cash equivalent reporting detailed in this agenda item. Note: both agenda items (2019-20 and 2019-42) are concurrently exposed and if adopted in their current form, must be adopted simultaneously. Additionally, paragraph 8 as referenced below for cash pooling reflects the modifications proposed in agenda item 2019-42.

Proposed Revisions for Fall 2019 Discussion: to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments:

Cash Equivalents

6. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in
value because of changes in interest rates. Only investments with original maturities\(^2\) of three months or less can qualify under this definition, with the exception of money market mutual funds, as detailed in paragraph 78.\(^2\) and cash pooling, as detailed in paragraph 8.\(^2\) Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

7. Regardless of maturity date, affiliated investments that would be in scope of SSAP No. 26R—Bonds and all investments that would be in scope of SSAP No. 43R—Loan-Backed and Structured Securities or that would be reported as “Other Invested Assets” shall be reported as long-term investments if any of the following conditions apply:\(^N\):

   a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial 90-day timeframe.

   b. The investment was previously reported as a cash equivalent investment and the initial maturity timeframe has passed. If an investment is reported as a cash equivalent and it is unexpectedly renewed / rolled, the reporting entity is not permitted to continue to report the held security as a cash equivalent regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a cash equivalent for one quarter reporting period. Meaning, if an investment was reported as a cash equivalent in the first quarter, it is not permitted to be reported as a cash equivalent in the second quarter.

   c. The reporting entity reacquired the investment (or a substantially similar investment) within 1 year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as short-term investments regardless of the maturity date of the reacquired investment.)

New Footnote 1: Repurchase and reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. Additional exclusions include cash pooling arrangements permitted under paragraph 8. Cash equivalents subject to the provisions of paragraph 7 are not permitted to be subsequently reported as short-term investments, even if the updated / reacquired maturity date is within 1 year. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

Short-Term Investments

12. **Short-term** investments are investments that do not qualify as cash equivalents, with remaining maturities (or repurchase dates under repurchase agreements) of one year or less at the time of acquisition. (excluding derivatives and those investments classified as cash equivalents as defined in this statement) shall be considered short-term investments. Short-term investments can include, but are

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\(^2\) Original maturity means original maturity to the entity holding the investment. For example, both a three-month U.S. Treasury bill and a three-year Treasury note purchased three months from maturity qualify as cash equivalents. However, a Treasury note purchased three years ago does not become a cash equivalent when its remaining maturity is three months.
not limited to, bonds, commercial paper, repurchase agreements, and collateral and mortgage loans. which meet the noted criteria. Short-term investments shall not include certificates of deposit. Regardless of maturity date, derivative instruments shall not be reported as short-term investments and shall be reported as derivatives on Schedule DB.

13. Regardless of maturity date, affiliated investments in scope of SSAP No. 26R—Bonds and all investments that would be in scope of SSAP No. 43R—Loan-Backed and Structured Securities or that would be reported as “Other Invested Assets” shall be reported as long-term investments if any of the following conditions applyFN:

   a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial “less than one year” timeframe.

   b. The investment was previously reported as a short-term investment and the initial maturity timeframe has passed. If an investment is reported as a short-term investment and it is unexpectedly renewed / rolled, the reporting entity is not permitted to continue to report the held security as a short-term investment (or as a cash equivalent) regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a short-term investment for one annual reporting period. Meaning, if an investment was reported as a short-term investment as of December 31, 2018, it is not permitted to be reported as short-term investment as of December 31, 2019.

   c. The reporting entity reacquired the investment (or a substantially similar investment) within 1 year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as cash equivalent investments regardless of the maturity date of the reacquired investment.)

New Footnote 1: Repurchase and reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. Short-term investments subject to the provisions of paragraph 13 are not permitted to be subsequently reported as cash equivalents, even if the updated / reacquired maturity date is within 90-days. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

42.14. All short-term investments shall be accounted for in the same manner as similar long-term investments.

43.15. Short-term investments meet the definition of assets as defined in SSAP No. 4 and are admitted assets to the extent they conform to the requirements of this statement.

Proposed Revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities:

28.l. A reporting entity shall disclose the following information for wash sales, as defined in paragraph 12, for all affiliated investment transactions (including items originally classified as cash equivalents and short-term investments) and for non-affiliated involving investment transactions for securities with a NAIC designation of 3 or below, or that do not have a NAIC designation. (For non-affiliated investments, excluding all cash equivalents, derivative instruments as well as short-term investments with credit assessments equivalent to an NAIC 1-2 designation, are excluded from this disclosure.) This disclosure shall be included in the financial statements for when the investment was initially sold. For example, if the
investment was sold December 20, 2017, and reacquired on January 10, 2018, the transaction shall be captured in the wash sale disclosure included in the year-end 2017 financial statements:

i. A description of the reporting entity’s objectives regarding these transactions;

ii. An aggregation of transactions by NAIC designation 3 or below, or that do not have an NAIC designation;

iii. The number of transactions involved during the reporting period;

iv. The book value of securities sold;

v. The cost of securities repurchased; and

vi. The realized gains/losses associated with the securities involved.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, as shown above in the “Proposed Revisions for Fall 2019 Discussion” to incorporate additional principle concepts in classifying investments as cash equivalents or short-term investments to prevent the “rolling” of certain investments. Fall revisions to the prior Summer National Meeting exposure incorporate guidance to exclude qualifying cash pools from the short-term rolling provisions.

With the Fall exposure, comments were requested from regulators and industry representatives on whether other investments should be included / excluded from the short-term rolling provisions. In particular, comments are requested on whether short-term lending (both collateral loans and affiliated loans) should be permitted to be continuously rolled/renewed as short-term, whether non-affiliated SSAP No. 26R investments should be subject to the short-term rolling restrictions, and whether an assessment of “re-underwriting” could be used as support to allow the rolling of short-term investments.

Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, as illustrated below, with modifications from the prior exposure shown as gray shading. This item has a shortened comment period deadline ending May 1, 2020.

The revisions incorporate additional principle concepts, if certain criteria are not met, that will restrict the classification of related party or affiliated investments as a cash equivalent or short-term investment in the scope of SSAP No. 26R—Bonds, SSAP No. 43R—Loan-Backed and Structured Securities, or that would be reported as “Other Invested Assets.”

An additional disclosure has also been proposed to identify short-term investments (or substantially similar investments) which remain on the short-term schedule for more than one consecutive year (i.e. a re-underwritten investment that is renewed). A concurrent blanks proposal will recommend a reporting code for renewed short-term investments as well as a new general interrogatory to certify that re-underwriting has occurred. (This code will also apply to nonaffiliated non-related party transactions for identification purposes.)
Proposed Revisions for Spring 2020 Discussion: to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments:

Cash Equivalents

6. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Only investments with original maturities of three months or less can qualify under this definition, with the exception of money market mutual funds, as detailed in paragraph 787, and cash pooling, as detailed in paragraph 8. Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

7. Regardless of maturity date, related party or affiliated investments that would be in scope of SSAP No. 26R—Bonds, and all investments that would be in the scope of SSAP No. 43R—Loan-Backed and Structured Securities, or that would be reported as "Other Invested Assets" shall be reported as long-term investments if any of the following conditions apply, unless the reporting entity has re-underwritten the investment, maintained appropriate re-underwriting documentation, and each participating party had the ability to independently review the terms and can terminate the transaction prior to renewal.

a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial 90-day timeframe.

b. The investment was previously reported as a cash equivalent investment and the initial maturity timeframe has passed. If an investment is reported as a cash equivalent and it is unexpectedly renewed / rolled, the reporting entity is not permitted to continue to report the held security as a cash equivalent regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a cash equivalent for one quarter reporting period. Meaning, if an investment was reported as a cash equivalent in the first quarter, it is not permitted to be reported as a cash equivalent in the second quarter.

c. The reporting entity reacquired the investment (or a substantially similar investment) within 1 year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as short-term investments regardless of the maturity date of the reacquired investment.)

New Footnote 1: Repurchase and reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities permitted under Cash equivalents subject to the provisions of paragraph 7 are not permitted to be subsequently reported as short-term investments, even if the updated / reacquired maturity date is within 1 year. These

3 Original maturity means original maturity to the entity holding the investment. For example, both a three-month U.S. Treasury bill and a three-year Treasury note purchased three months from maturity qualify as cash equivalents. However, a Treasury note purchased three years ago does not become a cash equivalent when its remaining maturity is three months.
investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

Short-Term Investments

12. Short-term investments are investments that do not qualify as cash equivalents with remaining maturities (or repurchase dates under repurchase agreements) of one year or less at the time of acquisition (excluding derivatives and those investments classified as cash equivalents as defined in this statement) shall be considered short-term investments. Short-term investments can include, but are not limited to, bonds, commercial paper, repurchase agreements, and collateral and mortgage loans. Regardless of maturity date, derivative instruments shall not be reported as short-term investments and shall be reported as derivatives on Schedule DB.

13. Regardless of maturity date, related party or affiliated investments in scope of SSAP No. 26R—Bonds, and all investments that would be in scope of SSAP No. 43R—Loan-Backed and Structured Securities, or that would be reported as “Other Invested Assets” shall be reported as long-term investments if any of the following conditions apply, unless the reporting entity has re-underwritten the investment, maintained appropriate re-underwriting documentation, and each participating party had the ability to independently review the terms and can terminate the transaction prior to renewal.

a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial “less than one year” timeframe.

b. The investment was previously reported as a short-term investment and the initial maturity timeframe has passed. If an investment is reported as a short-term investment and it is unexpectedly renewed / rolled, the reporting entity is not permitted to continue to report the held security as a short-term investment (or as a cash equivalent) regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a short-term investment for one annual reporting period. Meaning, if an investment was reported as a short-term investment as of December 31, 2018, it is not permitted to be reported as short-term investment as of December 31, 2019.

c. The reporting entity reacquired the investment (or a substantially similar investment) within 1 year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as cash equivalent investments regardless of the maturity date of the reacquired investment.)

New Footnote 1: Repurchase and reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. Short-term investments subject to the provisions of paragraph 13 are not permitted to be subsequently reported as cash equivalents, even if the updated / reacquired maturity date is within 90-days. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

14. All short-term investments shall be accounted for in the same manner as similar long-term investments.

15. Short-term investments meet the definition of assets as defined in SSAP No. 4 and are admitted assets to the extent they conform to the requirements of this statement.
Disclosures

14.16. The following disclosures shall be made for short-term investments in the financial statements:

a. Fair values in accordance with SSAP No. 100R—Fair Value;

b. Concentrations of credit risk in accordance with SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures;

c. Basis at which the short-term investments are stated.

d. The items in the scope of this statement are also subject to the annual audited disclosures in SSAP No. 26R—Bonds, paragraph 30.f.

d-e. Identification of short-term investments or substantially similar investments in which remain on the short-term schedule for more than one year

Proposed Revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities: (No changes to prior exposure.)

28.l. A reporting entity shall disclose the following information for wash sales, as defined in paragraph 12, for all affiliated investment transactions (including items originally classified as cash equivalents and short-term investments) and for non-affiliated involving-investment transactions for securities with an NAIC designation of 3 or below, or that do not have an NAIC designation. (For non-affiliated investments, excluding all cash equivalents, derivative instruments as well as short-term investments with credit assessments equivalent to an NAIC 1-2 designation are excluded from this disclosure.) This disclosure shall be included in the financial statements for when the investment was initially sold. For example, if the investment was sold December 20, 2017, and reacquired on January 10, 2018, the transaction shall be captured in the wash sale disclosure included in the year-end 2017 financial statements:

vii. A description of the reporting entity’s objectives regarding these transactions;

viii. An aggregation of transactions by NAIC designation 3 or below, or that do not have an NAIC designation;

ix. The number of transactions involved during the reporting period;

x. The book value of securities sold;

xi. The cost of securities repurchased; and

xii. The realized gains/losses associated with the securities involved.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, the revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, as illustrated below, with modifications from the prior exposure shown as gray shading, to incorporate additional principle concepts, that if certain criteria are not met, that will restrict the classification of related party or affiliated investments as a cash equivalent or short-term investment in the scope of SSAP No. 26R—Bonds, SSAP No. 43R—Loan-Backed and Structured Securities, or that would be reported as “Other Invested Assets.” An additional disclosure identifies short-term investments (or substantially similar investments) which remain on the short-term schedule for more than one consecutive year (i.e. a re-underwritten investment that is renewed).
Cash Equivalents

6. Cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash, and (b) so near their maturity that they present insignificant risk of changes in value because of changes in interest rates. Only investments with original maturities of three months or less can qualify under this definition, with the exception of money market mutual funds, as detailed in paragraph 79, and cash pooling, as detailed in paragraph 80. Regardless of maturity date, derivative instruments shall not be reported as cash equivalents and shall be reported as derivatives on Schedule DB. Securities with terms that are reset at predefined dates (e.g., an auction-rate security that has a long-term maturity and an interest rate that is regularly reset through a Dutch auction) or have other features an investor may believe results in a different term than the related contractual maturity shall be accounted for based on the contractual maturity at the date of acquisition, except where other specific rules within the statutory accounting framework currently exist.

7. Regardless of maturity date, related party or affiliated investments that would be in scope of SSAP No. 26R—Bonds of SSAP No. 43R—Loan-backed and Structured Securities, or that would be reported as "Other Invested Assets" shall be reported as long-term investments if any of the following conditions apply, FN, unless the reporting entity has re-underwritten the investment, maintained appropriate re-underwriting documentation, and each participating party had the ability to independently review the terms and can terminate the transaction prior to renewal.

a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial 90-day timeframe.

b. The investment was previously reported as a cash equivalent investment and the initial maturity timeframe has passed. If an investment is reported as a cash equivalent and it is unexpectedly renewed / rolled, the reporting entity is not permitted to continue to report the held security as a cash equivalent regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a cash equivalent for one quarter reporting period. Meaning, if an investment was reported as a cash equivalent in the first quarter, it is not permitted to be reported as a cash equivalent in the second quarter.

c. The reporting entity reacquired the investment (or a substantially similar investment) within 1 year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as short-term investments regardless of the maturity date of the reacquired investment.)

New Footnote 1: Repurchase and reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities permitted under Cash equivalents subject to the provisions of paragraph 7 are not permitted to be subsequently reported as short-term investments, even if the updated / reacquired maturity date is within 1 year. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

Short-Term Investments

12. Short-term investments are investments that do not qualify as cash equivalents with remaining maturities (or repurchase dates under reverse repurchase agreements) of one year or less at the time of acquisition (excluding derivatives and those investments classified as cash equivalents as defined in this statement) shall be considered short-term investments. Short-term investments can include, but are not limited to, bonds, commercial paper, reverse repurchase agreements, and
collateral and mortgage loans, which meet the noted criteria. Short-term investments shall not include certificates of deposit. Regardless of maturity date, derivative instruments shall not be reported as short-term investments and shall be reported as derivatives on Schedule DB.

13. Regardless of maturity date, related party or affiliated investments in scope of SSAP No. 26R—Bonds, SSAP No. 43R—Loan-backed and Structured Securities, or that would be reported as “Other Invested Assets” shall be reported as long-term investments if any of the following conditions apply unless the reporting entity has re-underwritten the investment, maintained appropriate re-underwriting documentation, and each participating party had the ability to independently review the terms and can terminate the transaction prior to renewal.

a. The reporting entity does not reasonably expect the investment to terminate on the maturity date. This provision includes investments that are expected to be renewed (or rolled) with a maturity date that ends subsequent to the initial “less than one year” timeframe.

b. The investment was previously reported as a short-term investment and the initial maturity timeframe has passed. If an investment is reported as a short-term investment and it is unexpectedly renewed / rolled, the reporting entity is not permitted to continue to report the held security as a short-term investment (or as a cash equivalent) regardless of the updated maturity date and shall report the security as a long-term investment. An investment is only permitted to be reported as a short-term investment for one annual reporting period. Meaning, if an investment was reported as a short-term investment as of December 31, 2018, it is not permitted to be reported as short-term investment as of December 31, 2019.

c. The reporting entity reacquired the investment (or a substantially similar investment) within 1 year after the original security matured or was terminated. These reacquired securities shall be reported as long-term investments. (These securities are also not permitted to be reported as cash equivalent investments regardless of the maturity date of the reacquired investment.)

New Footnote 1: Repurchase and reverse repurchase transactions are excluded from these provisions if admitted in accordance with collateral requirements pursuant to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities.

New Footnote 2: Short-term investments subject to the provisions of paragraph 13 are not permitted to be subsequently reported as cash equivalents, even if the updated / reacquired maturity date is within 90-days. These investments shall be reported as long-term investments. To avoid changes in reporting schedules, reporting entities are permitted to report securities as long-term investments at initial acquisition regardless of the initial maturity date.

42. All short-term investments shall be accounted for in the same manner as similar long-term investments.

43. Short-term investments meet the definition of assets as defined in SSAP No. 4 and are admitted assets to the extent they conform to the requirements of this statement.

Disclosures

44. The following disclosures shall be made for short-term investments in the financial statements:

a. Fair values in accordance with SSAP No. 100R—Fair Value;
b. Concentrations of credit risk in accordance with SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures;

c. Basis at which the short-term investments are stated.

d. The items in the scope of this statement are also subject to the annual audited disclosures in SSAP No. 26R—Bonds, paragraph 30.f.

d.e. Identification of short-term investments or substantially similar investments in which remain on the short-term schedule for more than one year.

Proposed Revisions to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities: (No changes to prior exposure.)

28.l. A reporting entity shall disclose the following information for wash sales, as defined in paragraph 12, for all affiliated investment transactions (including items originally classified as cash equivalents and short-term investments) and for non-affiliated involving investment transactions for securities with an NAIC designation of 3 or below, or that do not have an NAIC designation. (For non-affiliated investments, excluding all cash equivalents, derivative instruments and short-term investments with credit assessments equivalent to an NAIC 1-2 designation are excluded from this disclosure.) This disclosure shall be included in the financial statements for when the investment was initially sold. For example, if the investment was sold December 20, 2017, and reacquired on January 10, 2018, the transaction shall be captured in the wash sale disclosure included in the year-end 2017 financial statements:

xiii. A description of the reporting entity’s objectives regarding these transactions;

xiv. An aggregation of transactions by NAIC designation 3 or below, or that do not have an NAIC designation;

xv. The number of transactions involved during the reporting period;

xvi. The book value of securities sold;

xvii. The cost of securities repurchased; and

xviii. The realized gains/losses associated with the securities involved.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Assessment of OTTI Based on Original Contract Terms

Check (applicable entity):

- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

P/C Life Health

Description of Issue:
This agenda item intends to clarify the assessment of other than temporary impairment (OTTI) guidance in SSAP No. 26R—Bonds. It has been identified that there is a disconnect between SSAP No. 26R, SSAP No. 36R—Troubled Debt Restructuring and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities with how modifications to debt instruments are considered for OTTI. It has been noted that this is a long-standing disconnect that has recently been identified as a result of the number of debt restructurings that have occurred in response to COVID-19.

In short summary, existing guidance in SSAP No. 26R identifies that OTTI assessments are based on the contractual terms of a debt security in effect at the date of acquisition. However, if a debt instrument has been modified pursuant to SSAP No. 36 or SSAP No. 103 (nontroubled situations), subsequent assessments of OTTI shall be based on the modified contractual terms of the debt instrument, and not revert back to the original acquisition terms.

This agenda item intends to correct this disconnect between SSAP No. 26R, SSAP No. 36 and SSAP No. 103R.

Existing Authoritative Literature:

**SSAP No. 26R—Bonds**

**Impairment**

13. An other-than-temporary (INT 06-07) impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of a debt security in effect at the date of acquisition. A decline in fair value which is other-than-temporary includes situations where a reporting entity has made a decision to sell a security prior to its maturity at an amount below its carrying value. If it is determined that a decline in the fair value of a bond is other-than-temporary, an impairment loss shall be recognized as a realized loss equal to the entire difference between the bond’s carrying value and its fair value at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR/IMR, the accounting for the entire amount of the realized capital loss shall be in accordance with SSAP No. 7. The other-than-temporary impairment loss shall be recorded entirely to either AVR or IMR (and not bifurcated between credit and non-credit components) in accordance with the annual statement instructions.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None
Staff Recommendation:
NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and consider revisions to SSAP No. 26R—Bonds to clarify the interrelationship between SSAP No. 26R, SSAP No. 36 and SSAP No. 103 when there is a modification to a debt instrument.

SSAP No. 26R—Bonds

Impairment
13. An other-than-temporary (INT 06-07) impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of a debt security in effect at the date of acquisition. A decline in fair value which is other-than-temporary includes situations where a reporting entity has made a decision to sell a security prior to its maturity at an amount below its carrying value. If it is determined that a decline in the fair value of a bond is other-than-temporary, an impairment loss shall be recognized as a realized loss equal to the entire difference between the bond’s carrying value and its fair value at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR/IMR, the accounting for the entire amount of the realized capital loss shall be in accordance with SSAP No. 7. The other-than-temporary impairment loss shall be recorded entirely to either AVR or IMR (and not bifurcated between credit and non-credit components) in accordance with the annual statement instructions.

New Footnote: If a bond has been modified from original acquisition, the guidance in SSAP No. 36—Troubled Debt Restructuring and paragraph 22 of SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities shall be followed, as applicable. After modification of original terms, future assessments to determine other-than-temporary impairment shall be based on the current contractual terms of the debt instrument.

Proposed edit for discussion on the May 20, 2020 conference call:

New Footnote: If a bond has been modified from original acquisition, the guidance in SSAP No. 36—Troubled Debt Restructuring and paragraph 22 of SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities shall be followed, as applicable. After modification of original terms, future assessments to determine other-than-temporary impairment shall be based on the modified current contractual terms of the debt instrument.

Staff Review Completed by:
Julie Gann - NAIC Staff, May 2020

Status:
On May 5, 2020, the Statutory Accounting Principles (E) Working Group exposed nonsubstantive revisions to incorporate a new footnote to SSAP No. 26R to clarify that if a debt instrument has been modified in accordance with SSAP No. 36—Troubled Debt Restructuring or SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, the assessment of other-than-temporary impairment shall be based on current contractual terms of the debt instrument.

On May 20, 2020, the Statutory Accounting Principles (E) Working Group adopted nonsubstantive revisions, as final, to incorporate a new footnote to SSAP No. 26R—Bonds, clarifying that if a debt instrument has been modified in accordance with SSAP No. 36—Troubled Debt Restructuring or SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, the assessment of other-than-temporary impairment shall be
based on modified contractual terms of the debt instrument. (The adopted language is shown above with a noted edit to replace the word “current” with “modified” as discussed on the May 20, 2020 conference call.)
Interpretation of the Statutory Accounting Principles Working Group

INT 20-05: Investment Income Due and Accrued

INT 20-05 Dates Discussed

Email Vote to Expose May 5, 2020; May 20, 2020

INT 20-05 References

- SSAP No. 34—Investment Income Due and Accrued

INT 20-05 Issue

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

2. In response to COVID-19, temporary interpretations have been considered to provide exceptions to existing statutory accounting guidance with regards to the 90-day rule for various receivables, as well as guidance on the assessment of impairment and trouble debt restructurings. In response to these interpretations, a request to provide a temporary exception to SSAP No. 34—Investment Income Due and Accrued has been requested.

3. This interpretation intends to assess the requirements to review investment income due and accrued and consider whether temporary exceptions could be granted in response to COVID-19. Issues addressed within this interpretation include:

   a. Recognition and admittance of investment income under SSAP No. 34.
   b. Review of FASB staff technical inquiries and responses on investment income.

INT 20-05 Discussion

SSAP No. 34 Provisions

4. Investment income due is defined in SSAP No. 34 as the investment income earned and legally due to be paid to the reporting entity as of the reporting date. Investment income accrued is defined as investment income earned as of the reported date but not legally due to be paid to the reporting entity until subsequent to the reporting date.

5. Pursuant to SSAP No. 34, investment income due and accrued shall be recorded as an asset and assessed for impairment in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets. Amounts determined to be uncollectible shall be written off, and then an assessment shall be made of the remaining balance to determine nonadmitted amounts. SSAP No. 34 identifies this as a two-step process as follows:

   a. Investment income due and accrued is assessed for collectibility. If in accordance with SSAP No. 5R, it is probable the investment income due and accrued balance is uncollectible, the amount
shall be written off and shall be charged against investment income in the period the determination was made.

b. Any remaining investment income due and accrued (amounts considered probable for collection) representing either 1) amounts that are over 90-days past due (generated by any assets except mortgage loans in default) or 2) amounts designated elsewhere in the *NAIC Accounting Practices and Procedures Manual* as nonadmitted shall be considered nonadmitted. These items shall be subject to continuing assessments of collectibility and, if determined to be uncollectible, a write-off shall be recorded in the period such determination is made.

6. Pursuant to SSAP No. 34, accrued interest on mortgage loans in default shall only be recorded if deemed collectible. If uncollectible, accrued interest shall not be recorded and any previously accrued amounts shall be written off. If a mortgage loan in default has interest 180-days past due, which is assessed as collectible, all interest shall be recorded as a nonadmitted asset.

**FASB Staff Technical Inquiry**

7. The FASB staff received a technical inquiry regarding the recognition of interest income in response to COVID-19 when a “loan payment holiday” is provided that allows the borrowers to temporarily stop payments. The FASB Staff technical inquiry on interest income recognition was discussed April 17, 2020. In the scenario considered by the FASB staff:

   a. Interest is not accrued when the loan payment holiday is in effect.

   b. The loan modification did not represent a troubled debt restructuring.

   c. The loan modification would be accounted for as a continuation of the original lending arrangement (not as an extinguishment with a new loan recognized).

8. With this inquiry two views were presented in how interest should be recognized when a payment holiday is given and interest is not accrued:

   a. View 1 – Upon modification, a new effective interest rate is determined that equates to the revised remaining cash flows to the carrying amount of the original debt and is applied prospectively for the remaining term. That is, interest income is recognized during the payment period holiday.

   b. View 2 – Upon modification, the institution should recognize interest income on the loan in accordance with the contractual terms. Under this view, the institution would not recognize interest income during the payment holiday and would resume recognizing interest income when the payment holiday.

9. The FASB staff reviewed the submission and concluded both views to be appropriate.

**INT 20-05 Consensus**

10. The Working Group considered limited time collectibility assessments and admittance exceptions for investment income due and accrued and reached the following consensus:
INT 20-05

a. Continue with existing guidance in SSAP No. 34 that investment income shall be recorded when due (earned and legally due) or accrued (earned but not legally due until after the reporting date). If investments have been impacted by forbearance or other modification provisions, a reporting entity shall assess whether the investment income has been earned in accordance with the modified terms. Investment income shall only be recognized when earned.

b. Continue with existing guidance in SSAP No. 34 to require an assessment of whether recorded investment income due and accrued is uncollectible.

i. For mortgage loans, bank loans and investment products with underlying mortgage loans impacted by forbearance or modification provisions, reporting entities may presume that borrowers and investments that were current as of Dec. 31, 2019, were not experiencing financial difficulties at the time of the forbearance or modification for purposes of determining collectibility. For these investments, further evaluation of collectibility is not required for the 1st and 2nd quarter 2020 financial statements unless other indicators that interest would not be collected are known (e.g., the entity has filed for bankruptcy).

ii. For investments not impacted by forbearance or modification provisions, this interpretation does not provide an assumption of collectibility and the provisions of SSAP No. 34 shall be followed in evaluating collectibility and assessing whether an impairment exists.

c. Provide an exception for the nonadmittance of recorded investment income due and accrued that is deemed collectible and over 90-days past due. With this exception, reported investment income interest due and accrued that becomes over 90-days past due in the 1st or 2nd quarter may continue to be admitted in the June 30th, 2020 (1st and 2nd quarter) financial statements. This exception does not encompass accrued interest on mortgage loans that are in default. Mortgage loans in default shall continue to follow the SSAP No. 34 guidance. SSAP No. 37—Mortgage Loans identifies that determining that a loan is in default is per the contractual terms of the loan. For mortgage loans modified, determination of default shall be based on the modified contractual terms.

11. The Working Group considered the FASB technical guidance and reached a consensus consistent with the FASB staff on how interest should be recognized when a payment holiday is given and interest is not accrued. With this guidance, either of the following methods could be applied:

a. A new effective interest rate is determined that equates the revised remaining cash flows to the carrying amount of the original debt and is applied prospectively for the remaining term. With this approach, interest income is recognized during the payment period holiday.

b. The reporting entity should recognize interest income on the loan in accordance with the contractual terms. Under this view, the reporting entity would recognize no interest income during the payment holiday and would resume recognizing interest income when the payment holiday ends.

12. The exceptions and provisions detailed in this interpretation are applicable for the June 30th, 2020 (2nd quarter) financial statements. As the exceptions provided in this interpretation are not applicable in the September 30, 2020 (3rd quarter) financial statements, as this interpretation will automatically expire as of September 29, 2020. This interpretation will be publicly posted on the Statutory Accounting Principles (E) Working Group’s website. This interpretation will be automatically nullified on September 29, 2020 and will be included as a

INT 20-05 Status

13. The Statutory Accounting Principles (E) Working Group will subsequently review this interpretation to determine if an extension is needed to the effective date.
Interpretation of the Statutory Accounting Principles Working Group  

INT 20-06: Participation in the 2020 TALF Program  

INT 20-06 Dates Discussed  
Email Vote to Expose May 5, 2020; May 20, 2020  

INT 20-06 References  
SSAP No. 64—Offsetting and Netting of Liabilities  
SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities  
INT 01-31: Assets Pledged as Collateral  

INT 20-06 Issue  

1. The Federal Reserve reestablished the Term Asset-Backed Securities Loan Facility (TALF) on March 23, 2020, to support the flow of credit to consumers and businesses. The TALF program will enable the issuance of asset-backed securities (ABS) backed by student loans, auto loans, credit card loans, loans guaranteed by the Small Business Administration (SBA), and certain other assets.  

2. Under the TALF program, the Federal Reserve will lend on a non-recourse basis to holders of certain AAA-rated ABS backed by newly and recently originated consumer and small business loans. The Federal Reserve will lend an amount equal to the market value of the ABS less a haircut and will be secured at all times by the ABS. Treasury, using the Exchange Stabilization Fund (ESF), will also make an equity investment in the special purpose vehicle (SPV) established by the Federal Reserve for this facility.  

3. The TALF is established by the Federal Reserve under the authority of Section 13(3) of the Federal Reserve Act, with approval of the Treasury Secretary.  

4. Per review of public data available from the prior 2009 TALF program, there were a limited number of insurance reporting entities that were the actual borrower (entity that directly received the loan) under the TALF program. Rather, in most instances, insurance reporting entities were a material investor to the actual borrower. Per the TALF data, a material investor reflects the entity or individual with 10 percent or greater beneficial ownership interest in any class of securities of a borrower. Such ownership interest may be a direct, intermediate or ultimate interest. Due to the different methods of participating in the TALF program, this interpretation focuses on both reporting entity borrowers and reporting entity investors.  

5. For reporting entity borrowers (entity that directly received the loan), the accounting issues addressed in this interpretation include:  

a. How the loan received, and collateral provided shall be reported within the statutory financial statements.  

b. Whether the pledged assets shall be reported as admitted assets as the collateral pledged to the TALF program is not permitted to be substituted.
6. For reporting entities that are not the direct borrowers, but represent investors to the direct borrower, the accounting issues addressed in this interpretation include:

   a. How the reporting entity shall report their investment to a TALF borrower.
   b. Whether the reporting entity investor is permitted to pledge assets under the TALF program, and retain admittance, when the reporting entity is not the direct borrower under the TALF program.

7. The April 9, 2020 term sheet for the 2020 TALF program:


   Term Asset-Backed Securities Loan Facility

   Effective April 9, 2020
   (The Board of Governors of the Federal Reserve System (“Board”) and Secretary of the Treasury may make adjustments to the terms and conditions described in this term sheet. Any changes will be announced on the Board’s website.)

   Facility:
   The TALF is a credit facility authorized under section 13(3) of the Federal Reserve Act intended to help meet the credit needs of consumers and businesses by facilitating the issuance of asset-backed securities (“ABS”) and improving the market conditions for ABS more generally.

   The TALF will serve as a funding backstop to facilitate the issuance of eligible ABS on or after March 23, 2020. Under the TALF, the Federal Reserve Bank of New York (“Reserve Bank”) will commit to lend to a special purpose vehicle (“SPV”) on a recourse basis. The Department of the Treasury will make an equity investment of $10 billion in the SPV, as described below.

   The TALF SPV initially will make up to $100 billion of loans available. The loans will have a term of three years; will be nonrecourse to the borrower; and will be fully secured by eligible ABS.

   Eligible Borrowers:
   All U.S. companies that own eligible collateral and maintain an account relationship with a primary dealer are eligible to borrow under the TALF. For the purpose of this document, a U.S. company is defined as a business that is created or organized in the United States or under the laws of the United States and that has significant operations in and a majority of its employees based in the United States.

   Eligible Collateral:
   Eligible collateral includes U.S. dollar denominated cash (that is, not synthetic) ABS that have a credit rating in the highest long-term or, in the case of non-mortgage backed ABS, the highest short-term investment-grade rating category from at least two eligible nationally recognized statistical rating organizations (“NRSROs”) and do not have a credit rating below the highest investment-grade rating category from an eligible NRSRO. All or substantially all of the credit exposures underlying eligible ABS must have been originated by a U.S. company, and the issuer of eligible collateral must be a U.S. company. With the exception of commercial mortgage-backed securities (“CMBS”), eligible ABS must be issued on or after March 23, 2020. CMBS issued on or after March 23, 2020, will not be eligible. For CMBS, the underlying credit exposures must be to real property located in the United States or one of its territories. Eligible collateral must be ABS where the underlying credit exposures are one of the following:

   1) Auto loans and leases;
   2) Student loans;
   3) Credit card receivables (both consumer and corporate);
   4) Equipment loans and leases;
5) Floorplan loans;
6) Insurance premium finance loans;
7) Certain small business loans that are guaranteed by the Small Business Administration;
8) Leveraged loans; or
9) Commercial mortgages.

Eligible collateral will not include ABS that bear interest payments that step up or step down to predetermined levels on specific dates. In addition, the underlying credit exposures of eligible collateral must not include exposures that are themselves cash ABS or synthetic ABS.

To be eligible collateral, all or substantially all of the underlying credit exposures must be newly issued, except for legacy CMBS.

The feasibility of adding other asset classes to the facility or expanding the scope of existing asset classes will be considered in the future.

Conflicts of interest: Eligible borrowers and issuers of eligible collateral will be subject to the conflicts of interest requirements of section 4019 of the CARES Act.

Restriction on single-asset single-borrower (“SASB”) CMBS and commercial real estate collateralized loan obligations (“CRE CLOs”): SASB CMBS and CRE CLOs will not be eligible collateral.

Restrictions on CLO loan substitution: Only static CLOs will be eligible collateral.

Collateral Valuation: Haircut schedule is below. The haircut schedule is consistent with the haircut schedule used for the TALF established in 2008.

Pricing: For CLOs, the interest rate will be 150 basis points over the 30-day average secured overnight financing rate (“SOFR”). For SBA Pool Certificates (7(a) loans), the interest rate will be the top of the federal funds target range plus 75 basis points. For SBA Development Company Participation Certificates (504 loans), the interest rate will be 75 basis points over the 3-year fed funds overnight index swap (“OIS”) rate. For all other eligible ABS with underlying credit exposures that do not have a government guarantee, the interest rate will be 125 basis points over the 2-year OIS rate for securities with a weighted average life less than two years, or 125 basis points over the 3-year OIS rate for securities with a weighted average life of two years or greater. The pricing for other eligible ABS will be set forth in the detailed terms and conditions. Fees: The SPV will assess an administrative fee equal to 10 basis points of the loan amount on the settlement date for collateral.

Maturity: Each loan provided under this facility will have a maturity of three years.

Investment by the Department of the Treasury: The Department of the Treasury, using the Exchange Stabilization Fund, will make an equity investment of $10 billion in the SPV.

Non-Recourse: Loans made under the TALF are made without recourse to the borrower, provided the requirements of the TALF are met.

Prepayment: Loans made under the TALF will be pre-payable in whole or in part at the option of the borrower, but substitution of collateral during the term of the loan generally will not be allowed.

Program Termination: No new credit extensions will be made after September 30, 2020, unless the TALF is extended by the Board of Governors of the Federal Reserve System and the Department of the Treasury.

Other Terms and Conditions: More detailed terms and conditions will be provided at a later date, primarily based off of the terms and conditions used for the 2008 TALF. In addition, the Federal Reserve reserves
the right to review and make adjustments to these terms and conditions – including size of program, pricing, loan maturity, collateral haircuts, and asset and borrower eligibility requirements – consistent with the policy objectives of the TALF.

INT 20-06 Discussion

For Reporting Entity Borrowers - Insurance Reporting Entity Received the Loan

8. Reporting entity borrowers shall report the cash received under the TALF program with a corresponding liability. The liability shall be captured in scope of SSAP No. 15—Debt and Holding Company Obligations and reported as “borrowed money.” The disclosures in SSAP No. 15 shall be completed. Once the cash received has been reinvested, the reporting entity shall report the acquired asset in accordance with the applicable statement of statutory accounting principle.

9. Reporting entity borrowers shall report asset-backed securities pledged to the TALF program as restricted assets with the appropriate code in the investment schedules and disclosed in accordance with SSAP No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures, and in General Interrogatory, Part 1: 25.30 – Pledged as Collateral. Assets pledged to the TALF program are subject to the underlying asset risk-based capital charge but are excluded from an additional “restricted asset” risk-based capital charge. (As a carryover from the 2009 TALF Program, existing provisions in the risk-based capital instructions instruct the removal of assets pledged to the TALF program reported as restricted assets in the General Interrogatories.)

10. Reporting entity borrowers are permitted to continue reporting pledged asset-backed securities as admitted assets in the statutory financial statements if the following two conditions are met:
   a. Asset qualified as an admitted asset before it was pledged to the TALF program.
   b. The reporting entity has not committed an uncured contract default.

11. As the TALF program specifically identifies that substitution of pledged collateral during the term of the loan will generally not be allowed, this interpretation provides an exception to existing statutory accounting requirements. Pursuant to INT 01-31: Assets Pledged as Collateral, a pledged asset shall be readily substitutable in order to be admitted in the statutory financial statements. With the exception in this interpretation, assets held by the insurance reporting entity (borrower) that are pledged to the TALF program can be admitted even though they are not generally substitutable.

12. Reporting entity borrowers shall not net the obligation to return the liability and the pledged collateral in the statutory financial statements. The criteria for a valid right of offset in SSAP No. 64—Offsetting and Netting of Assets and Liabilities has not been met for these transactions. Specifically, the reporting entity does not have the right to offset the amount owed under the TALF program and the reporting entity does not intend to setoff the amount owed. Although the collateral pledged could be claimed under the TALF program in the event that the insurer reporting entity commits a loan repayment default, the ability to claim pledged collateral does not represent a “right of setoff” with the counterparty.

13. Although the transaction is similar to a repurchase agreement accounted for as a secured borrowing, the TALF transaction is not a repurchase transaction. As such, the provisions and disclosures for repurchase agreements are not applicable.
14. In the event that a reporting entity commits a contract default, and the pledged collateral is retained under the TALF program, the reporting entity shall follow the guidance in SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, paragraph 20, in removing the pledged assets and liability from the statutory financial statements.

For Reporting Entity Investors - Insurance Reporting Entity Does Not Receive the Loan but is an “Investor” to an Entity that was the Direct TALF Borrower

15. Reporting entity investors shall report the investment in the borrower in accordance with the underlying nature of the investment and the relationship with the borrower. The underlying investments will be subject to the reporting and RBC requirements for the applicable SSAP and reporting schedule:

a. If the borrower is a limited liability company (LLC), the investment shall be reported in accordance with SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies.

b. If the borrower is a private equity fund (e.g., joint venture), the investment shall be reported in accordance with SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies.

c. If the borrower is an affiliate, the investment shall be reported in accordance with SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

16. Reporting entity investors are not permitted to admit assets pledged to the TALF program if they are not the direct borrower. This is because the return of the assets would be contingent on the action of the actual borrower to the TALF program and not the reporting entity. This provision is consistent with SSAP No. 4—Assets and Nonadmitted Assets, footnote 2:

If assets of an insurance entity are pledged or otherwise restricted by the action of a related party, the assets are not under the exclusive control of the insurance entity and are not available to satisfy policyholder obligations due to these encumbrances or other third-party interests. Thus, pursuant to SSAP No. 4, paragraph 2(c), such assets shall not be recognized as an admitted asset on the balance sheet. Additional guidance for assets pledged as collateral is included in INT 01-31.

INT 20-06 Consensus

17. The Working Group reached a consensus to prescribe statutory accounting guidance for insurance reporting entity involvement in the 2020 TALF Program. Pursuant to this consensus:

a. Reporting entities borrowers who directly receive the TALF loan shall follow guidance in paragraphs 8-14 of this interpretation for the statutory accounting and reporting. As detailed in paragraph 11, this interpretation provides an exception to allow admitted asset reporting for the pledged securities although the TALF program does not permit the pledged assets to be generally substitutable.

b. Reporting entities that do not directly receive the TALF loan, but are investors to borrowers that receive the TALF loan, shall follow the provisions in paragraphs 15-16 for the statutory accounting and reporting.
18. The provisions detailed in this interpretation are applicable for the duration of the 2020 TALF loan program.

**INT 20-06 Status**

19. No further discussion planned.
Interpretation of the Statutory Accounting Principles Working Group

INT 20-07: Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19

INT 20-07 Dates Discussed

Email: Vote to Expose May 5, 2020; May 20, 2020

INT 20-07 References

SSAP No. 26R—Bonds
SSAP No. 36—Troubled Debt Restructuring
SSAP No. 43R—Loan-Backed and Structured Securities
SSAP No. 103R—Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

INT 20-07 Issue

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay at home” orders and forced non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

2. In response to COVID-19, Congress and federal and state prudential banking regulators issued provisions pertaining to loan modifications as a result of the effects of COVID-19. These provisions are intended to be applicable for the term of the loan modification, but solely with respect to a modification, including a forbearance arrangement, interest rate modification, repayment plan, or other similar arrangements that defers or delays the repayment of principal and/or interest, that occurs during the applicable period for a loan that was not more than 30 days past due as of December 31, 2019.

3. On April 15, the Statutory Accounting Principles (E) Working Group issued INT 20-03T: Troubled Debt Restructuring Due to COVID-19. This interpretation provides guidance for mortgage loans and bank loans, consistent with the CARES Act and an April 7 interagency statement in recognizing troubled debt restructurings in response to COVID-19. Although the original comment letter received from interested parties proposed an expansion to all SSAP No. 26R and SSAP No. 43R debt securities, during the April 15 discussion, the comments presented from interested parties clarified their request to expand the interpretation was primarily related to private placement debt securities. The Working Group requested that interested parties provide more detail on this request.

4. On April 23, the interested parties submitted a comment letter requesting expansion consideration to all debt instruments in scope of SSAP No. 26R and SSAP No. 43R. In making these expanded requests, the interested parties’ comment letter stated that from a practical standpoint, actual relief will almost exclusively apply to private placement debt securities. However, by referencing “all debt securities,” it will not be necessary to provide a precise definition of a private placement debt security. In addition to considering edits for troubled debt restructuring, the comment letter also requested exceptions to impairment recognition for these securities.

5. The issues addressed in this interpretation include:

a. Should exceptions be provided to the determination of troubled debt restructurings and impairment for all debt securities in response to COVID-19?
b. Should exceptions be considered in the determination of troubled debt restructurings for non-public debt instruments in which the reporting entity is a direct, active, participant in the modification negotiations?

c. Should exceptions be considered to assist with the determination of insignificant modifications in accordance with SSAP No. 36, paragraph 10?

INT 20-07 Discussion

Consideration of Exceptions for All Debt Securities

6. After evaluating the April 23 interested parties’ comment letter, this interpretation considers statutory accounting exceptions to minimize documentation and assessment requirements for specific debt securities. However, due to the importance of state regulators having accurate and reliable financial statement information, this interpretation does not propose the following:

a. Exceptions to the recognition of a troubled debt restructuring for debt securities with modifications that result in non-insignificant concessions to a debtor that is experiencing financial difficulties.

b. Exceptions to the assessment or recognition of impairment for debt instruments.

7. With the conclusion in paragraph 6, this interpretation does not eliminate a reporting entity’s responsibility to recognize modifications in debt instruments that to a debtor that is experiencing financial difficulties that qualify as concessions under SSAP No. 36. Furthermore, this interpretation does not delay the assessment and recognition of impairment for debt instruments that are not captured in scope of INT 20-04. As detailed above, these exceptions are not granted due to the importance of state regulators having timely, accurate and reliable financial information.

Consideration of Exceptions if the Reporting Entity is a Direct, Active Participant in Negotiating Modifications

8. Consideration was given as to whether exceptions should be provided for troubled debt restructuring and impairment assessments for situations in which the reporting entity is a direct, active participant in negotiating debt instrument modifications. However, due to the vast nature of non-public instruments that are currently classified as debt instruments that are designed in response to specific insurance reporting entity needs (such as collateralized fund obligations, principal protected notes, and other non-traditional securitizations), using direct, active participation as the sole threshold in determining whether exceptions should be granted was viewed as too expansive to ensure appropriate recognition of non-insignificant concessions and/or known impairments in the statutory financial statements.

Consideration of Provisions to Assist with Existing Troubled Debt Restructuring Guidance

9. Pursuant to existing guidance in SSAP No. 36, not all modifications are considered a troubled debt restructuring. In order to be troubled debt restructuring, a creditor, for economic or legal reasons related to the debtor’s financial difficulties, grants a concession to the debtor that it would not otherwise. As such, in order to be considered a troubled debt restructuring, the debtor must be having financial difficulties and the modification must be considered a concession. Pursuant to paragraph 10 of SSAP No. 36, a restructuring that results in only a delay in payment that is insignificant is not a concession. The guidance also indicates that the following factors, when considered together, may indicate that a restructuring results in a delay in payment that is insignificant:
a. The amount of the restructured payments subject to the delay is insignificant relative to the unpaid principal or collateral value of the debt and will result in an insignificant shortfall in the contractual amount due.

b. The delay in timing of the restructured payment period is insignificant to any one of the following:
   i. frequency of payments due under the debt
   ii. debt’s original contractual maturity,
   iii. debt’s original expected duration.

10. Although this interpretation does not support exceptions that would result with “significant” modifications (concessions) not being recognized, from information received, differing assessments of what could be considered insignificant, and the required documentation, may be prohibitive in providing modifications. Particularly, it has been noted that the assessments are subject to auditor assessment and there are concerns that a modification considered insignificant by a reporting entity may be subsequently assessed as a significant modification by the reporting entity’s auditor.

Practical Expedients to Assessing Concessions

11. This interpretation, as a means of assisting with troubled debt restructuring assessments, provides limited-time practical-expedient determinants that can be used in accordance with existing SSAP No. 36 provisions in determining whether a modification shall be considered a troubled debt restructuring. These provisions are intended to assist reporting entities and auditors when considering whether a modification is insignificant. If a modification is considered insignificant, then the modification is not a concession, and recognition of a troubled debt restructuring, and disclosure is not required. If a modification does not meet the practical expedient provisions provided within this interpretation, the modification shall not automatically be considered a “non-insignificant” modification (concession). Rather, the reporting entity can continue to apply the existing guidance in SSAP No. 36 in assessing whether the modification is insignificant and is therefore not a concession. Modifications that qualify as concessions (do not qualify as insignificant) are required to follow the existing guidance in SSAP No. 36 as a troubled debt restructuring.

12. Specifically, this interpretation provides the following limited-time practical expedients:

   a. Paragraph 10.a. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay is insignificant to the unpaid principal or collateral value of the debt and will result in an insignificant shortfall in the contractual amount due. For the duration of this interpretation, debt security restructurings in response to COVID-19 are considered to be insignificant if the restructuring results with a change that reflects a 10% or less shortfall amount in the contractual amount due.

   b. Paragraph 10.b. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay in timing of the restructured payment period is insignificant to the frequency of payments due under the debt, debt’s original contractual maturity or the debt’s original expected duration. For the duration of this interpretation, debt security restructurings in response to COVID-19 are considered to be insignificant if the restructuring does not result in an extension of the maturity of the debt by more than three years.
13. For the duration of this interpretation, debt security restructurings in response to COVID-19 that solely impact covenant requirements are not considered troubled debt restructurings.

**Practical Expedients on Debt Extinguishments and Exchanges**

14. In addition to the limited-time practical expedients to SSAP No. 36, this interpretation provides an exception to assess modifications as an exchange of debt instruments under paragraph 22 of SSAP No. 103R—Transfer and Servicing of Financial Assets and Extinguishments of Liabilities. Pursuant to the guidance in SSAP No. 103, debt instruments that are exchanged with substantially different terms are reported as an extinguishment and a new debt instrument. Pursuant to the provisions in this interpretation:

a. Modifications that reflect a 10% or less change in contractual cash flows considered insignificant pursuant to paragraph 12.a. do not need to be further evaluated to determine whether the modification is more than minor based on the specific facts and circumstances (and other relevant considerations) surrounding the modification. As such, these investments shall not be reported as an extinguishment and a new debt instrument.

**INT 20-07 Consensus**

15. The Working Group reached a consensus in response to requests to consider exceptions to statutory accounting guidance for troubled debt restructurings and impairment for all debt instruments. Pursuant to this consensus:

a. This interpretation does not provide exceptions to the recognition of a troubled debt restructuring for debt securities with modifications that result in non-insignificant concessions to a debtor that is experiencing financial difficulties.

b. This interpretation does not provide exceptions to the assessment or recognition of impairment for debt instruments. Pursuant to the guidance in SSAP No. 26R, after a modification for a debt instrument, assessment of OTTI shall be based on the current terms of the debt instrument.

16. In response to assessments on the application of existing SSAP No. 36 provisions, particularly in determining whether a modification is a concession (insignificant), this consensus provides the following limited-time practical expedients in determining whether a modification is a concession under SSAP No. 36:

a. Paragraph 10.a. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay is insignificant to the unpaid principal or collateral value of the debt and will result in an insignificant shortfall in the contractual amount due. For the duration of this interpretation, debt security restructurings in response to COVID-19 are considered to be insignificant if the restructuring results with a change that reflects a 10% or less shortfall amount in the contractual amount due.

b. Paragraph 10.b. of SSAP No. 36 identifies that restructured payments are considered insignificant if the delay in timing of the restructured payment period is insignificant to the frequency of payments due under the debt, debt’s original contractual maturity or the debt’s original expected duration. For the duration of this interpretation, debt security restructurings in response to COVID-19 are considered to be insignificant if the restructuring does not result in an extension of the maturity of the debt by more than three years.
17. For the duration of this interpretation, debt security restructurings in response to COVID-19 that solely impact covenant requirements are not considered troubled debt restructurings.

18. In response to assessments on the application of existing SSAP No. 103R provisions, particularly in determining whether a modification that is not a troubled debt restructuring needs to be assessed as an exchange, this consensus provides the following exceptions to SSAP No. 103R:

   a. Modifications that reflect a 10% or less change in contractual cash flows considered insignificant under this interpretation do not need to be further evaluated to determine whether the modification is more than minor based on the specific facts and circumstances (and other relevant considerations) surrounding the modification. As such, these investments shall not be reported as an extinguishment and a new debt instrument.

   b. Modifications in response to COVID-19 that exceed the practical expedient of a 10% shortfall in contractual cash flows permitted in this interpretation that were assessed and deemed insignificant under paragraph 10 of SSAP No. 36 shall not be considered an exchange of debt instruments with substantially different terms under SSAP No. 103, paragraph 22. (Under SSAP No. 103, an exchange of debt instruments (in a nontroubled debt situation) is accomplished with debt instruments that are substantially different if the present value of cash flows under the terms of the new instruments is at least 10% different from the present value of the remaining cash flows under the terms of the original instrument.) Reporting entities shall work with auditors and regulators with the application of paragraph 10 of SSAP No. 36 to confirm that a change in contractual cash flows in excess of 10% qualifies as insignificant.

19. The Working Group highlights that modifications that would be considered troubled debt restructurings, particularly as they provide a non-insignificant concession, may be presented to the domiciliary state regulatory for a permitted practice exception to prevent troubled debt restructuring recognition and disclosure. However, the Working Group concluded that the need for reliable and accurate financial information does not permit exceptions that would allow widespread non-insignificant restructurings to occur and not be recognized on the statutory financial statements.

20. This interpretation is effective for the specific purpose to provide practical expedients in assessing whether modifications in response to COVID-19 are insignificant under SSAP No. 36 and in assessing whether a change is substantive under SSAP No. 103R. This interpretation will only be applicable for the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates. For clarity, this effective timeframe specifies when modifications in response to COVID-19 can be incorporated using the provisions of this interpretation. Once incorporated, the provisions of this interpretation will continue for the duration of the modification.

**INT 20-07 Status**

21. The Statutory Accounting Principles (E) Working Group will subsequently review this interpretation to determine if an extension is needed to the effective date.
Application of the INT 20-07 Consensus

Example 1: Payment Holiday with Extension of Payment Term for SSAP No. 26R Instrument

A. Insurer modifies a debt instrument captured in scope of SSAP No. 26R to provide a payment holiday for 6-months in response to COVID-19. For the duration of the payment holiday, no payments are due, however the original maturity of the debt instrument has been extended from 10 years to 10 years and 6 months, with all terms and conditions remaining the same except for the payment holiday.

B. The amount of restructuring is considered insignificant as it results in a less than 10% shortfall in the contractual amount due.

C. At the time of the restructuring, fair value has dropped below amortized cost.

D. At the time of the restructuring, the reporting entity believes it is probable that the reporting entity will collect all amounts due in accordance with the modified terms of the debt instrument. Furthermore, the reporting entity does not intend to sell the instrument.

Example 1 - Application of INT 20-07

1. As this modification only extends the duration 6-months and results in a less than 10% shortfall in the contractual amount due, pursuant to the practical expedients in INT 20-07, the modification is considered insignificant and not a concession under SSAP No. 36. As this modification is not a concession, accounting and reporting as a troubled debt restructuring is not required.

2. As this modification is less than 10% of the contractual cash flows, pursuant to the practical expedients in INT 20-07, further assessment is not required to determine whether the modification is more than minor under SSAP No. 103R. As such, the modification shall not be reported as an extinguishment and a new debt instrument.

3. As the reporting entity believes it is probable that they will collect all amounts due in accordance with the modified terms of the debt instrument, no other-than-temporary impairment recognition is required under SSAP No. 26R. Future assessments of impairment will be based on the modified terms of the debt instrument.

Example 2: Reduction of Covenant Terms for SSAP No. 43R Instrument

A. Insurer modifies a debt instrument captured in scope of SSAP No. 43R to eliminate covenant terms in response to COVID-19. For the remainder of the maturity of the debt instrument, the covenant terms will reflect the modification incorporated in response to COVID-19. There has been no changes to the debt instrument with the exception of the covenant requirements.

B. At the time of the restructuring, fair value has dropped below amortized cost.

C. At the time of the restructuring, the reporting entity has the intent and ability to hold debt instrument to recover the amortized cost basis. Additionally, the reporting entity has not identified that a non-interest related decline exists.
Example 2 - Application of INT 20-07

1. As this modification only pertains to covenant components (and not the amount or timing of payments), pursuant to the practical expedients in INT 20-07, the modification is considered insignificant and not a concession under SSAP No. 36. As this modification is not a concession, accounting and reporting as a troubled debt restructuring is not required.

2. As this modification does not change the contractual cash flows, pursuant to the practical expedients INT 20-07, further assessment is not required to determine whether the modification is more than minor under SSAP No. 103R. As such, the modification shall not be reported as an extinguishment and a new debt instrument.

3. As the reporting entity has the intent and ability to hold the debt security to recover the amortized cost basis, and they have not identified a non-interest related decline, an other-than-temporary impairment is not required under SSAP No. 43R.

Example 3: Reduction in Interest Rate and Covenants for SSAP No. 26R Debt Security

A. Insurer modifies a debt instrument captured in scope of SSAP No. 26R in response to COVID-19 to eliminate interest payments for a 12-month timeframe, and to eliminate covenant requirements for the same 12-month timeframe. This change will represent an 11% shortfall of the contractual amount due.

B. At the time of the restructuring, fair value has dropped below amortized cost.

C. At the time of the restructuring, the reporting entity believes it is probable that the reporting entity will collect all amounts due in accordance with the modified terms of the debt instrument. Furthermore, the reporting entity does not intend to sell the instrument.

Example 3 - Application of INT 20-07

1. As this modification results with a 11% shortfall in the contractual amount due, the reporting entity cannot assume the change is insignificant, and therefore not a concession, under the practical expedients provided within this interpretation.

2. The reporting entity may continue to assess whether this modification is an insignificant change under paragraph 10 of SSAP No. 36. (If the reporting entity elects not to further assess for insignificance, then would proceed with considering the change as a concession.) If the reporting entity concludes that the change is insignificant, and therefore not a concession, then recognition as a troubled debt restructuring is not required. If the change is assessed as insignificant, although the change in cash flows exceeds 10%, the instrument does not need to be assessed as an exchange of debt instruments pursuant to SSAP No. 103R, paragraph 22. An OTTI is not required at the time of the modification if the reporting entity has the intent and ability to hold to recover the modified amortized cost basis and if the reporting entity has not identified that a non-interest related decline exists. Future assessments of impairment will be based on the modified terms of the debt instrument.

3. If the reporting entity concludes that the change is not insignificant under paragraph 10 of SSAP No. 36, then the modification is a concession and further assessment as a troubled debt restructuring is required. Assuming there is no collateral, a realized loss shall be recognized for the difference between fair value and amortized cost. Subsequent to this realized loss recognition, future assessments of impairment will be based on the modified terms of the debt security.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded May 5, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Tom Dudek (NY); Joe DiMemmo (PA); Jamie Walker (TX); and Amy Malm (WI).

1. Exposed Agenda Item 2020-14, INT 20-05, INT 20-06, INT 20-07 and INT 20-08

The Working Group conducted an e-vote to consider exposure of agenda item 2020-14: Assessment of OTTI Based on Original Contract Terms; Interpretation (INT) 20-05: Investment Income Due and Accrued; INT 20-06: Participation in the 2020 TALF Program; INT 20-07: Troubled Debt Restructuring for Certain Debt Instruments Due to COVID-19; and INT 20-08: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends for a one-week public comment period ending May 14. A summary of the exposed interpretations is as follows:

1) Agenda Item 2020-14 – This agenda item proposes nonsubstantive revisions to address a long-standing disconnect in the assessment of other-than-temporary impairment (OTTI) after there has been a modification to a debt security captured in scope of SSAP No. 26R—Bonds. The current guidance requires OTTI assessment based on contract terms at the date of acquisition. This agenda item incorporates minor revisions to clarify that subsequent to modification under SSAP No. 36—Troubled Debt Restructuring or SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, future assessments of OTTI shall be based on the current contractual terms of the debt instrument.

2) INT 20-05 – This guidance proposes limited-time exceptions to the collectability and nonadmittance guidance in SSAP No. 34—Investment Income Due and Accrued, and it also considers technical guidance for the recognition of investment income issued by the Financial Accounting Standards Board (FASB) when there is a payment holiday and interest is not accrued. The proposed exceptions provide a collectability assessment exception for certain items modified in response to COVID-19, and it proposes an exception to the nonadmittance provisions for all items that are deemed collectable and are over 90 days past due.

3) INT 20-06 – This guidance proposes provisions for reporting entities participating in the federal Term Asset-Backed Securities Lending Facility (TALF) program. The guidance addresses both direct borrowers and reporting entities that participate as an investor to a direct borrower. The guidance proposes a statutory accounting exception for direct borrowers who pledge assets to the TALF program to allow admittance of the pledged assets, as the TALF program does not permit substitutions to the collateral.

4) INT 20-07 – This guidance proposes limited-time practical expedients in determining whether a restructuring reflects a “concession” under paragraph 10 of SSAP No. 36. Under existing statutory accounting guidance, a restructuring that is insignificant is not a concession; therefore, it is not a troubled debt restructuring. The guidance proposes a 10% threshold for the shortfall in the contractual amount due and a 6-month delay in payments as practical expedients for the existing guidance. Under the proposed provisions, if a modification falls within these parameters, it would be considered insignificant and not a concession. The guidance also proposes to clarify that if a modification is below 10%, then further analysis would not be needed under SSAP No. 103R to determine if the modification is substantive and does not require extinguishment with recognition of a new security.

5) INT 20-08 – This guidance proposes provisions on how to account for premium refunds in response to COVID-19. Due to the different ways in which these refunds can be provided, the proposed guidance addresses a variety of methods. For premium refunds that are outside policy terms, the proposed guidance identifies that these shall be reported as a reduction of premium and not as an expense. The proposed guidance also directs an aggregate disclosure of all refunds in response to COVID-19 to allow for easy identification of the full impact in the statutory financial statements.
Ms. Walker made a motion, seconded by Ms. Mears, to expose agenda item 2020-14, INT 20-05, INT 20-06, INT 20-07 and INT 20-08. The motion passed without opposition, with 12 members voting.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded April 17, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair (IA); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Eric Moser (IL); Stewart Guerin (LA); Doug Bartlett (NH); Joe DiMemmo (PA); Jamie Walker (TX); David Smith (VA); and Amy Malm (WI).

1. Exposed Agenda Item 2020-13

The Working Group conducted an e-vote to consider exposure of agenda item 2020-13: Health Industry Request on 2020 Health Insurance Assessment, for a one-week public comment period ending April 24. Agenda item 2020-13 addresses an April 2020 request from America's Health Insurance Plans (AHIP) (Attachment One-E1) to the Working Group regarding SSAP No. 106—Affordable Care Act Section 9010 Assessment. The federal Affordable Care Act (ACA) Section 9010 fee is also known as the health insurance tax (HIT). The payable amount is assessed on applicable 2019 premium, and it is due once the reporting entity provides health insurance in January 2020. The amount due is then remitted in September 2020 to the U.S. Department of the Treasury.

The exposed recommendation is to reject the request to defer liability recognition of the ACA fee due in September 2020 and move the agenda item to the rejected listing. The rejection would not result in any statutory accounting revisions.

The agenda item notes, “This request has the potential to materially distort the financial statements, as a known liability would not be fully recognized. In times of financial stress, it is important to be able to accurately assess the financial solvency of reporting entities. With the potential impact of the financial statements, any consideration for such a request warrants domiciliary state regulator review. Any state specific considerations would be either permitted practices (individual requests) or prescribed practices (state bulletins, etc.). If granted by the domestic state, such practices would be disclosed in the financial statements.”

Ms. Mears made a motion, seconded by Ms. Walker, to expose agenda item 2020-13. The motion passed unanimously, with 11 members voting.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
SSAP 106 – Affordable Care Act Section 9010 Assessment
AHIP Request to Amend due to Covid-19

• SSAP 106 relates to what has been known as the health insurance tax (HIT); with changes in law, the tax was paid in 2014-2016, 2018, and is to be paid for the last time in 2020; it will be repealed in 2021 and, as a result, SAPWG has a pending proposal to supersede SSAP 2016 effective in 2021

• In the meantime, for amounts to be paid in 2020 based on data collected in 2019, SSAP 106 requires the following:
  - In 2019, insurers reflect the estimate to be paid in 2020 by a monthly reclassification from unassigned surplus to special surplus (i.e., total surplus is not reduced)
  - At the beginning of 2020, the entire balance in the special surplus is reclassified back to unassigned surplus with no effect on total surplus; that amount is then accrued as a liability and a corresponding expense, which reduces unassigned (and total) surplus
  - After items 1. and 2. above have been accomplished, the special surplus account has a zero balance; unassigned surplus is reduced by the full amount of the tax, which will remain as a liability on the balance sheet until it is paid to the government in September 2020

• The concern: AHIP members anticipate surplus strain due to the pandemic and its work with providers and subscribers to support their efforts to alleviate its impacts, which will be exacerbated by the mismatch in the timing of revenue and expense for 2020 interim reporting:
  - Insurers will show the full expense and resulting surplus hit of the tax at the beginning of 2020
  - But they will not realize the revenues and profits from the business that is subject of the tax until they are earned pro rata throughout the year (the HIT is priced into rates)
  - Magnitude: for some members, can be 10% of group-wide surplus during early 2020; would gradually diminish over the year

• Proposal:
  - Amend SSAP 106 to permit insurers to accrue the tax liability on a monthly or quarterly basis; during interim months of 2020, the portion of the estimated tax that has not yet been accrued would remain in special surplus to clearly document its designated purpose
  - Alternatively, to defer the expense until payment is made

• Additional considerations:
  - Impacts interim results for 2020 only; no impact on year-end reporting or RBC
  - Sets no precedent for SSAP 106; the tax is (and the SSAP will be) repealed effective 2021
  - Urgency in that the current filing deadline for 1Q 2020 is May 15, and next SAPWG call is currently scheduled for May 20
1. Reviewed Comments and Considered Adoption of Temporary Exceptions to Statutory Accounting

Julie Gann (NAIC) stated that the intention of this call is to consider four interpretations that provide exceptions to current statutory accounting guidance and require a super majority vote for adoption.

The Working Group held a public hearing to review comments on previously exposed items (Attachment One-F1).

a. Agenda Item 2020-12 and INT 2020-01T

Mr. Bruggeman directed the Working Group to agenda item 2020-12 and Interpretation (INT) 2020-01T: Reference Rate Reform. Jim Pinegar (NAIC) stated that this non-substantive agenda item is a result of Accounting Standards Update (ASU) 2020-04, Reference Rate Reform, which provides optional expedient guidance, allowing for the continuation of certain contracts that are modified in response to reference rate reform. Additionally, it provides waivers from derecognizing hedging transactions, and it provides some exceptions for assessing hedge effectiveness as a result of transitioning away from certain interbank offering rates. Mr. Pinegar stated that interested parties commented on two items. Interested parties wanted to ensure that ASU 2020-04 was broadly adopted, and they expressed concerns regarding the sunset date of Dec. 31, 2022. Mr. Pinegar stated that additional language was proposed affirming that all contracts within the scope of ASU 2020-04, which allows for modifications due to reference rate reform and provides for the optional expedient to be accounted for as a continuation of the existing contract, shall apply to all Statements of Statutory Accounting Principles (SSAPs). He stated that the sunset date matched the date in ASU 2020-04; however, the Financial Accounting Standards Board (FASB) continues to monitor the transition, and it may modify its guidance, if needed. If the FASB takes such action, it is anticipated that the Working Group will consider a similar response.

Angelica Tamayo-Sanchez (New York Life Insurance Company), representing interested parties, stated appreciation for ensuring that INT 2020-01T was consistent with ASU 2020-04, as the potential contract modifications are broad and may encompass all SSAPs. She stated that in terms of the sunset date, the FASB indicates that it will review for possible modifications, and it appreciates that the Working Group will review if a similar action is necessary.

Mr. Hudson made a motion, seconded by Ms. Weaver, to adopt agenda item 2020-12 and INT 2020-01T, with the modification as proposed by NAIC staff, for statutory accounting (Attachment One-F2 and Attachment One-F3). The motion passed unanimously.

b. INT 2020-02T

Mr. Bruggeman directed the Working Group to INT 2020-02T: Extension of Ninety-Day Rule for the Impact of COVID-19. Jake Stultz (NAIC) stated in response to COVID-19 that this nonsubstantive interpretation provides exceptions to the 90-day rule for uncollected premium balances, bills receivable and amounts due from agents under SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers, and high deductible policies under SSAP No. 65—Property and Casualty Contracts. He stated that previous extensions to SSAP No. 6 in response to catastrophes have generally been for an additional 60 days, resulting in a total of 150 days before nonadmission. However, due to the fact that COVID-19 is a longer lasting and broader catastrophe, the recommendation proposed allows a total of approximately 200 days before requiring nonadmission. The 200-day allowance would apply to the first and second quarters of 2020, as the interpretation would expire prior to third quarter financial reporting.
Robin Marcotte (NAIC) stated that interested parties requested the scope of INT 2020-02T be expanded to include SSAP No. 51R—Life Contracts regarding life deferred and uncollected premiums, SSAP No. 47—Uninsured Plans for uninsured plan receivables, such as administrative services contracts, and SSAP No. 84—Health Care and Government Insured Plan Receivables regarding pharmaceutical rebate receivables and risk sharing receivables. She stated that additional interested party requests included: 1) extending the exception to the 90-day rule from the end of the second quarter to the end of the third quarter; 2) including policies written or renewed after the declaration of emergency, and not only to the policies that were current as of the date of emergency; and 3) allowing the extension of the 90-day rule to apply to polices in effect prior to the expiration of the state of emergency that later become past due for 180 days before non-admission. She stated that NAIC staff did not recommend extending INT 2020-02T through the third quarter, but they recommend that the Working Group retain the existing first and second quarter timeframe with an assurance to consider whether an extension is necessary in August 2020. She stated that NAIC staff also did not recommend that the interpretation provide provisions allowing the admittance of a receivable that was previously nonadmitted because it was 90 days past due prior to the COVID-19 pandemic. Additionally, if the Working Group supports consideration of exceptions for SSAP No. 84, specifically risk sharing and pharmacy rebates, it is recommended that a separate discussion occur, as the admittance process and calculation of those items is significantly different than receivables from policyholders, and the admissibility criteria for these items is more complex.

Mr. Stultz stated that upon review of the feedback from interested parties, NAIC staff support including SSAP No. 47 and SSAP No. 51R in the interpretative accounting guidance. Clarifying language was also suggested to include policies written or renewed on or after March 13 in paragraphs 3.a. and 3.c. Additional modified language was proposed to ensure that INT 2020-02T would have consistent expiration language with INT 2020-04T: Mortgage Loan Impairment Assessment due to COVID-19. Mr. Stultz stated that while the interpretation is written to expire prior to the third quarter, it is anticipated that future discussions will occur regarding possible extensions.

D. Keith Bell (Travelers Insurance), representing interested parties, stated their appreciation for the quick issuance of this interpretation and the Working Group’s commitment to review in August for a possible extension. He stated that other areas, including paragraphs 3.b. and 3.d., within the interpretation should have similar language to include other policies written or renewed on or after March 13. Mr. Bruggeman stated that the phrase, “on or after March 13, 2020,” would be included in paragraphs 3.a through 3.d. Mr. Stultz and Ms. Marcotte concurred with adding the language to ensure consistency throughout the guidance.

Albert Thomas Finnell (Finnell & Company), representing America’s Health Insurance Plans (AHIP), stated that due to the COVID-19 pandemic, health insurers are facing financial strain through waiving copays, deductibles, and covering COVID-19 testing. These issues affect the timeliness and ultimate collectability of certain receivables. Mr. Finnell stated that while health insurers are requesting relief regarding pharmaceutical rebate and risk sharing receivables covered in SSAP No. 84, addressing those issues in a separate agenda item would be more appropriate. He stated that additional data will be gathered, and relief will likely be requested in terms of loans and advances to providers, which is also addressed in SSAP No. 84. He stated that a letter has been submitted requesting relief on SSAP No. 106—Affordable Care Act Section 9010 Assessment, and he noted that interested parties are prepared to discuss those proposed edits with the Working Group once it has considered the request.

Ms. Malm made a motion, seconded by Ms. Belfi, to adopt INT 2020-02T, with the modifications to add certain receivables from SSAP No. 47 and SSAP No. 51R to the scope of the standard and include language confirming that policies written or renewed on or after March 13 are in scope of the interpretation (Attachment One-F4). The motion passed unanimously. Additionally, direction was given to NAIC staff to collaborate with industry on an agenda item covering SSAP No. 84.

c. INT 2020-03T

Mr. Bruggeman directed the Working Group to INT 2020-03T: Troubled Debt Restructuring Due to COVID-19. Julie Gann (NAIC) stated that this interpretation clarified that modifying mortgage loan terms in response to COVID-19 shall follow the provisions detailed in the March 22, “Joint Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus,” in determining whether the modification shall be reported as a troubled debt restructuring within SSAP No. 36—Troubled Debt Restructuring. Subsequent to the initial exposure, the proposed interpretation was revised to include the provisions from Section 4013 of the March 27 Coronavirus Aid, Relief, and Economic Security (CARES) Act, which affirmed that the interpretation is only applicable for the term of the loan modification. Additionally, the exposed interpretation was revised to reflect the updated interagency statement issued after the CARES Act on April 7. Ms. Gann stated that the CARES Act and proposed interpretation provide guidance for modifications that include a forbearance arrangement, interest rate modification, a repayment plan, and other similar arrangements that defer or delay the
payment of principal or interest. She stated that under existing U.S. generally accepted accounting principles (GAAP) and SSAP No. 36, a restructuring of a mortgage loan does not automatically result in the classification of a troubled debt restructuring. SSAP No. 36 defines the criteria for troubled debt restructuring, which generally includes the requirement of the borrower experiencing financial difficulties and the loan modification resulting in a significant change in terms. Ms. Gann stated that the proposed interpretation was initially exposed to only include mortgage loans. She stated that interested parties requested the expansion of the scope to include all debt instruments in SSAP No. 26R—Bonds and SSAP No. 43R—Loan-Backed and Structured Securities. She, in response to these comments, stated that proposed revisions include bank loans as defined in SSAP No. 26R; however, NAIC staff did not recommend including all debt instruments within scope of the interpretation. She stated that the CARES Act and the interagency statement is specific in that the loans addressed within their guidance are from financial institutions, and they are specific to loans from borrowers. She stated that the CARES Act and interagency statements reference banking agencies in collecting data on modified loans for regulatory purposes. She stated, in response to additional industry comments, that additional edits were proposed to clarify that the troubled debt restructuring relief is only applicable for the term of the modification. Additionally, in response to comments by interested parties regarding SSAP No. 34—Investment Income Due and Accrued, NAIC staff are awaiting additional technical guidance from the FASB; as such, NAIC staff have not yet proposed interpretative guidance to SSAP No. 34. Ms. Gann stated that the proposed effective date is consistent with the CARES Act, and it would be applicable for the period beginning on March 1 and ending on either Dec. 31 or the date that is 60 days after the date on which the national emergency concerning COVID-19 has terminated.

Bob Ridgeway (AHIP) inquired as to whether an extension would be possible in the event that COVID-19 loan modification occurred after Dec. 31. Ms. Gann stated that regardless if the CARES act is extended, the Working Group has the option to review this interpretation for possible extension. Mr. Bruggeman stated that due to the unknown end date of COVID-19, all related interpretations will be continually reviewed for possible extension.

Diane Bellas (Allstate), representing interested parties, stated that while insurance companies can assist with the economic recovery, additional accounting and reporting obstacles remain. She stated that the relief provided in the interpretations do provide some capital relief necessary to assist with the long-term economic recovery. She stated that while the revised interpretations were helpful, additional barriers within the regulatory framework should be reviewed. She stated that interested parties wish to review risk-based capital (RBC) and the asset valuation reserve (AVR) with the Capital Adequacy (E) Task Force. She stated that interested parties wish to discuss admissibility of investments with a going concern with the Working Group.

Daniel P. Allen (MassMutual), representing interested parties, expressed agreement with the recent modifications to the interpretation, which incorporate the revised April 7 joint interagency statement as a result of the CARES Act. He stated that while the scope of the interpretation covered mortgage loans, additional consideration should be considered to include all debt instruments covered in SSAP No. 26R and SSAP No. 43R, as these investments will likely require modifications as a result of COVID-19. He stated that interested parties were pleased to see that bank loans were included in the revised interpretation; however, due to insurers having significant private placement debt portfolios, temporary relief should be extended to include these investment classes, as these items will likely require similar loan modifications. He stated that the effective date of INT 2020-03T does match the CARES Act, but he requested clarification as to whether the exceptions for loan modifications would extend beyond the projected scheduled termination date. Mr. Bruggeman inquired as to whether there was any specific language or request regarding the expansion of scope or timing of the interpretation. Mr. Allen stated that private placement loans were a significant concern, but he requested clarification regarding whether a modification would remain exempt from SSAP No. 36 in the event that it was extended beyond the effective date of the interpretation. Mr. Bruggeman stated that the scope of this interpretation was to clarify mortgage loans modified as a result of COVID-19, and they were not to be considered a troubled debt restructuring. Ms. Gann stated that the effective dates match the CARES Act; however, the modification must occur in the defined time frame.

Bruce Oliver (Mortgage Bankers Association) stated that the interpretation adopts the CARES Act’s effective date; however, the joint interagency statement does not have an effective date. He stated that clarification should be added since the interpretation references both items. Mr. Bruggeman stated that this interpretation is in response to the national emergency, and should any modifications be required 60 days after the termination of national emergency, an insurer should consult with his/her domestic regulator for possible exception allowance.

Brian Keating (Guardian Life Insurance), representing interested parties, stated that private placement loans represent a significant portion of an insurance company’s portfolio, at times up to 15–20% of invested assets. Due to the COVID-19 pandemic, several requests for loan relief or modifications have been received, especially those from the hospitality industry. Mr. Keating stated that in an effort to be equitable, the bank loan relief provided in the interpretation should be extended to
insurance lenders despite the joint interagency statement not specifically referencing private placement loans. The interagency statement covers loan modifications as a result of the COVID-19 pandemic, and it would presumably allow insurance companies to apply such guidance for investments covered in SSAP No. 26R and SSAP No. 43R. Mr. Keating stated that modification requests include covenant waivers, delayed payment schedules, and that insurers have a direct relationship with the borrowers, which is similar to a typical financial institution.

Ms. Gann stated that, consistent with the interagency statement, several loan modifications are anticipated in response to the COVID-19 pandemic, and they would likely not fall into the scope of troubled debt restructuring as defined in SSAP No. 36. This is because a loan modification that is insignificant, or if the borrower is not experiencing financial difficulty, is not considered as troubled debt restructuring under existing guidance. Ms. Gann stated that the interpretation removes the analysis requirement to determine if a troubled debt restructuring has occurred. She stated that if private placement loans were to be considered for exception guidance, information would be requested from interested parties regarding the scope of loan modifications being requested and granted. Particularly, she inquired as to whether the private placement modifications would likely be considered troubled debt restructurings because they would be significant to the original loan terms. Mr. Bruggeman stated that the interpretation does not prohibit loan modification from being granted, and since insurance companies are typically issuing long-term debt, it is possible that a modification would likely not be significant enough to be determined a restructured troubled debt.

Ms. Sanchez stated that the U.S. GAAP troubled debt restructuring guidance covers both mortgage loans and debt instruments, and the joint interagency statement would presumably apply to both asset classes. However, the interpretation only applies to mortgage and bank loans. Ms. Gann stated that the troubled debt restructuring guidance in SSAP No. 36 is consistent with U.S. GAAP; however, the focus of INT 2020-03T, which provides exceptions to the requirements of SSAP No. 36, is specific to mortgage and bank loans. However, if requested by industry or the Working Group, a separate agenda item could be prepared to review other types of asset classes, specifically private placement debt. Ms. Gann stated that if a private placement modification was to occur, without the interpretation exception, the lender would follow the provisions of SSAP No. 36 to determine whether the modification should be considered a troubled debt restructuring. As noted, the guidance in SSAP No. 36 does not automatically result in a troubled debt restructuring, but assessment has to occur regarding whether the borrower is experiencing financial difficulties and whether the modification is considered insignificant.

Mr. Hudson made a motion, seconded by Ms. Mears, to adopt INT 2020-03T with the modifications to: 1) include the CARES Act, the April 7 updated joint interagency statement, and a reference to bank loans; and 2) clarify that the effective date of the interpretation mirrors the timeframe of the CARES Act (Attachment One-F5). In addition, direction was given to NAIC staff to collaborate with interested parties to evaluate potential temporary troubled debt restructuring relief guidance for private placement loans and other similar debt products. The motion passed unanimously.

d. INT 2020-04T

Mr. Bruggeman directed the Working Group to INT 2020-04T. Ms. Gann stated that INT 2020-04T addresses the impact of mortgage loan forbearance or prudent modifications on the statutory accounting and reporting requirements for mortgage loans, as well as investments with underlying mortgage loans. INT 2020-04T allows for a temporary, limited-time statutory exception for the assessment of impairment due to loan modifications being granted for mortgage loans and investment products with underlying mortgage loans. This exception would only defer the assessment of impairment due to situations caused by the forbearance or modification of mortgage loan payments, and it would not delay the recognition of other-than-temporary impairments if the entity decided to sell the investment and/or if provisions other than the limited-time forbearance or modifications of mortgage loans payments caused the entity to identify that they would not recover the reported carrying value of the investment. Ms. Gann stated that in response to industry comments, revisions have been proposed to include bank loans in scope of INT 2020-04T; however, all other debt instruments covered in SSAP No. 26R and SSAP No. 43R were not added. She stated that additional comments were received regarding the applicability to SSAP No. 34, but NAIC staff proposed waiting on expected FASB technical guidance on the topic. Similar to INT 2020-02T, INT 2020-04T is effective for the first and second quarters of 2020. However, the Working Group will assess in August 2020 to determine if an extension if necessary. She stated, in response to industry questions, that an edit has been proposed to clarify that impairment assessments after the effective date of INT 2020-04T would be based on the contractual terms of the mortgage loan or investment after reflecting any modification. Mr. Bruggeman confirmed that while INT 2020-02T and INT 2020-04T cover the first and second quarters of 2020, it is the intent of the Working Group to review both for possible extensions.

Ms. Sanchez stated that additional consideration is requested on all debt instruments, especially private placement loans. She stated that insurance companies could be giving forbearances to debt holders due to the COVID-19 pandemic which, without
temporary relief, could require impairment assessments. She inquired as to why the effective date of INT 2020-04T did not match INT 2020-03T, which allows modifications 60 days after the end of the national emergency. Mr. Bruggeman stated that impairment assessments are performed at a certain point in time, and rather than extending the temporary relief granted in INT 2020-04T at this time, the Working Group will review for possible extension in August. The effective dates in INT 2020-04T are more in line with the evaluations required for financial statement reporting. Ms. Gann stated that INT 2020-03T was in direct response to the CARES Act, and the effective dates of INT 2020-02T and INT 2020-04T are flexible, allowing for earlier or later termination depending on the timing of the national emergency. Ms. Sanchez stated interested parties stand ready to work with NAIC staff and the Working Group on an agenda item regarding SSAP No. 34, concerning interest due and accrued. She stated that every investment class will likely be affected by variations in cash flow due to the COVID-19 pandemic and interpretative guidance would be beneficial.

Mr. Lathrop stated that Oregon is supportive of extending the effective dates of INT 2020-02T and INT 2020-04T to include the third and fourth quarters of 2020. He stated that several states have issued moratoriums on tenant evictions, and they may issue moratoriums on foreclosures. He stated Oregon’s Insurance Division believes there will be an extended economic recovery, likely warranting extension of the temporary exceptions provided in these interpretations.

Ms. Belfi made a motion, seconded by Ms. Weaver, to adopt INT 2020-04T, with the modifications to include bank loans as proposed by NAIC staff, for statutory accounting (Attachment One-F6). The motion passed unanimously.

2. Discussed Other Matters
   a. Premium Refunds

Ms. Marcotte stated that in response to questions from industry and state insurance regulators, NAIC staff are planning an agenda item to discuss the accounting and reporting of premium refunds due to the COVID-19 pandemic. Birny Birnbaum (Center for Economic Justice [CEJ] and the Consumer Federation of America [CFA]) stated that insurance companies are utilizing a variety of techniques to issue refunds, ranging from a premium credit to a cash refund. Due to these variations, uniform reporting is encouraged.

   b. SSAP No. 106

Mr. Bruggeman stated that NAIC staff have prepared an agenda item in response to a request received from industry regarding the insurer provider fee captured in SSAP No. 106. A subsequent e-vote to expose the agenda item is anticipated.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
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April 2, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Interpretations (INTs) of the NAIC Statutory Accounting Principles Working Group (the Working Group) Exposed for Comment with Comments due April 2

Dear Mr. Bruggeman:

Interested parties thank you, the Working Group and NAIC staff for responding quickly to the issues that are arising as a result of the rapid spread of the Coronavirus Disease 2019 (COVID-19). As several states and cities have issued “stay at home” orders and forced all non-essential businesses to temporarily close, there has been a significant increase in unemployment and the potential permanent closure of many businesses. We appreciate the Working Group’s efforts to head-off problems resulting from the impact of COVID-19 on economic conditions and for the opportunity to comment on the draft INTs that were exposed for comment to address these issues via email vote on March 26, 2020.

INT 20-01T: ASU 2020-04 - Reference Rate Reform

This interpretation has been issued to provide statutory accounting and reporting guidance for the adoption with modification of ASU 2020-04 – Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting for applicable statutory accounting principles. The Financial Accounting Standards Board (FASB) issued ASU 2020-04 in March 2020 as optional, transitional and expedient guidance as a result of reference rate reform.

The accounting issues are:

Issue 1: Should a reporting entity interpret the guidance in ASU 2020-04 as broadly accepted for statutory accounting?

Issue 2: Should the optional, expedient and exception guidance in ASU 2020-04 apply to debt and other service agreements addressed in SSAP No. 15?

Issue 3: Should the optional, expedient and exception guidance in ASU 2020-04 apply to lease transactions addressed in SSAP No. 22R?
Issue 4: Should the optional, expedient and exception guidance in ASU 2020-04 apply to derivative transactions addressed in SSAP No. 86?

For Issue 1, the Working Group came to the tentative consensus that ASU 2020-04 shall be adopted for statutory accounting with only minor modifications noted below. The Working Group tentatively agreed the amendments provide appropriate temporary guidance that alleviate the following concerns due to reference rate reform:

a. Simplifies accounting analyses under current GAAP and statutory accounting principles (SAP) for contract modifications.
b. Allows hedging relationships to continue without de-designation upon a change in certain critical terms.
c. Allows a change in the designated benchmark interest rate to a different eligible benchmark interest rate in a fair value hedging relationship.
d. Suspends the assessment of certain qualifying conditions for fair value hedging relationships for which the shortcut method for assuming perfect hedge effectiveness is applied.
e. Simplifies or temporarily suspends the assessment of hedge effectiveness for cash flow hedging relationships.
f. The only SAP modification to this ASU is related to the option to sell debt currently classified held-to-maturity. This concept is not employed by statutory accounting and thus is not applicable.

For Issue 2, the Working Group came to the tentative consensus that debt and service agreement modifications, as a result of reference rate reform, should not typically rise to the level of requiring a reversal and rebooking of the liability, as SSAP No. 15 states such liabilities should only be derecognized if extinguished. A reference rate modification should not generally require de-recognition and re-recognition under statutory accounting. Nonetheless, for clarity and consistency with ASU 2020-04, the Working Group came to the tentative consensus that should an eligible contract be affected by reference rate reform, then the temporary guidance in ASU 2020-04 shall apply.

For Issue 3, the Working Group came to the tentative consensus that lease modifications, solely caused by reference rate reform and ones eligible for optional expedience, likely do not rise to the level of a modification requiring re-recognition as a new lease under statutory accounting. SSAP No. 22R, paragraph 17 states that only modifications which grant the lessee additional rights shall be accounted for as a new lease. These changes are outside the scope allowed for optional expedience in ASU 2020-04. Nonetheless, for clarity and consistency with ASU 2020-04, the Working Group came to a tentative consensus that if an eligible lease is affected by reference rate reform, then the temporary guidance in ASU 2020-04 shall apply.

For Issue 4, the Working Group came to the tentative consensus that ASU 2020-04 shall be applied to derivative transactions as the following considerations provided in the ASU are appropriate for statutory accounting:
a. For any hedging relationship, upon a change to the critical terms of the hedging relationship, allow a reporting entity to continue hedge accounting rather than de-designate the hedging relationship.

b. For any hedging relationship, upon a change to the terms of the designated hedging instrument, allow an entity to change its systematic and rational method used to recognize the excluded component into earnings and adjust the fair value of the excluded component through earnings.

c. For fair value hedges, allow a reporting entity to change the designated hedged benchmark interest rate and continue fair value hedge accounting.

d. For cash flow hedges, adjust the guidance for assessment of hedge effectiveness to allow an entity to continue to apply cash flow hedge accounting.

Additionally, for GAAP purposes, if an entity has not adopted the amendments in ASU 2017-12, Derivatives and Hedging, it is precluded from being able to utilize certain expedients for hedge accounting. For statutory accounting purposes, only the hedge documentation requirements were adopted from ASU 2017-12, while the remainder of the items are pending statutory accounting review. The Working Group tentatively concluded that all allowed expedient methods are permitted as elections for all reporting entities under statutory accounting. However, if a reporting entity is a U.S. GAAP filer, the reporting entity may only make elections under ASU 2017-12 if such elections were also made for their U.S. GAAP financials.

Interested parties agree with the concepts proposed in item 2020-04 on Reference Rate Reform (the “exposure draft”) and we believe that it will provide significant relief to all companies that have entered into contracts that reference LIBOR (or another reference rate expected to be discontinued due to reference rate reform).

We recommend that Issues 2 and 3 be combined into a single broad consensus that applies to all contract modifications due to reference rate reform and allows the optional expedient to be accounted for as continuations of existing contracts without requiring remeasurement of the contracts. ASU 2020-04 did this with examples at ASC 848-20-35-3 and then broadly at ASC 848-20-35-4:

848-20-35-3 This Subtopic provides optional expedients for accounting for modifications of contracts accounted for in accordance with the following Topics that meet the scope of paragraphs 848-20-15-2 through 15-3:

   a. Topic 310 on receivables
   b. Topic 470 on debt
   c. Topic 840 or 842 on leases.

848-20-35-4 If a contract is not within the scope of the Topics referenced in paragraph 848-20-35-3, an entity shall have the option to account for and present a modification that meets the scope of paragraphs 848-20-15-2 through 15-3 as an event that does not require contract remeasurement at the modification date or reassessment of a previous accounting determination required under the relevant Topic or Industry Subtopic. Paragraph 848-20-55-2 includes examples that illustrate the application of that guidance.
Adopting the ASU broadly for contract modifications will prevent unintentionally omitting optional expedients. For example, interested parties noted SSAP 26R Bonds, paragraph 22 addresses exchanges and conversions and requires the fair value of a bond surrendered be the cost basis of the new contract. SSAP 103R Transfers and Extinguishments, paragraph 130 notes that “exchanges of debt instruments or...modifications are considered extinguishments if the exchange or modification results with substantially different terms or is considered more than minor.” Modifications of bonds' contractual interest rates due to rate reform should not result in remeasurement. This is one example of an unintentional omission that can result without a broad provision for contract modifications.

A specific area of concern for all insurers, which was expressed to the FASB as well, is related to the sunset provision in the exposure draft, which terminates the relief outlined in the exposure draft after December 31, 2022. We are concerned that including a hard termination date after which the relief outlined in the exposure draft would not be available would put significant pressure on the markets unnecessarily. We do not believe that the December 31, 2022 deadline for all market participants to complete the modification of all contracts that reference LIBOR (or another reference rate expected to be discontinued due to reference rate reform) is realistic, or necessary. Although the FASB did not change the date of the sunset provision, they did state in the Basis for Conclusion that the FASB will monitor the market-wide IBOR transitions and will consider whether future developments warrant any changes, including changes to the end date of the application of the amendments in the ASU.

Interested parties request the NAIC to consider extending the date or allowing for future changes to the end date due to the uncertainty regarding when LIBOR will cease.

**INT 20-02T: Extension of Ninety-Day Rule for the Impact of COVID-19**

The emergence of a previously unknown virus began spreading among humans between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay at home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

In response to the sudden impact to the economy and its effect on the timeliness of payments by policyholders, the Working Group considered whether a temporary extension of the 90-day rule, extending the nonadmission guidance for premium receivables due from policyholders or agents and for amounts due from policyholders for high deductible policies to September 28, 2020, for policies in U.S. jurisdictions that have been impacted by COVID-19 should be granted.

The Working Group reached a tentative consensus for a one-time optional extension of the ninety-day rule for uncollected premium balances, bills receivable for premiums and amounts due from agents and policyholders and for amounts due from policyholders for high deductible policies, as follows:

a. For policies in effect and current prior to the date as of the declaration of a state of emergency by the U.S. federal government on March 13, 2020, insurers may wait until September 28, 2020 before nonadmitting premiums receivable from policyholders or
agents as required per SSAP No. 6, paragraph 9.

b. For high deductible policies in effect and current prior to the date as of the declaration of a state of emergency by the U.S. federal government on March 13, 2020, insurers may wait until September 28, 2020 before nonadmitting amounts due from policyholders for high deductible policies as required per SSAP No. 65, paragraph 37.

c. Existing impairment analysis remains in effect for these affected policies.

Due to the short-term nature of the applicability of this extension, which expires September 28, 2020, this interpretation will be publicly posted on the Statutory Accounting Principles (E) Working Group’s website. This interpretation will be automatically nullified on September 29, 2020 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

In discussing the draft wording of INT 20-02, interested parties focused on two areas of concern: scope of the items covered by the INT and timing of the extension of the 90-day rule. We discuss each separately below.

Scope of Items Covered by the INT

We note that the proposed INT 20-02 “scopes-in” certain types of receivables subject to the 90-day rule to which the extension will apply by reference to SSAPs, specifically, SSAP No. 6, Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers, and SSAP No. 65, Property and Casualty Contracts. However, there are other receivables which are only covered in other SSAPs which are relevant and significant to health plans and which are also subject to the 90-day rule:

a. SSAP No. 47, Uninsured Plans. For Administrative Services Contract (ASC) business, health carriers have separate contracts with providers and customers and are obligated to pay providers out of their own funds before receiving reimbursement from the group. The provider contracts specifically state that health carriers will reimburse providers for services rendered regardless if the subscriber is covered by a self-funded or underwritten plan. Many health care providers have already received requests from their large ASC customers to allow them to delay payment to the carrier for claim reimbursements for up to 90 days.

b. SSAP No. 84, Health Care and Government Insured Plan Receivables. This SSAP provides accounting guidance relative to a number of types of receivables that are relevant and significant for health plans, of which three types are subject to the 90-day rule for purposes of determining if the asset will be treated as an admitted asset in statutory reporting. Interested parties request that two of those types of receivables, Pharmaceutical Rebate Receivables and Risk-Sharing Receivables, be “scoped-in” to INT 20-02. Anticipated changes in subscriber needs and utilization, combined with sub-optimal working environments at home for many health carriers’ staff who are involved with accounting and billing matters, presages difficulties in assuring that these receivables will hew to normal levels seen in non-crisis times.

c. SSAP No.6 paragraph 2 states that “This statement does not address uncollected and deferred premiums for Life considerations”. Interested parties request that life premiums be included in the scope.
Bringing the items specified in each of paragraphs a, b and c above in scope would then subject them to the same 90-day extension as other premium receivables currently described in the proposed INT 2020-02, and for which the same edits suggested by interested parties in the section below, *Timing of the Extension of the 90-Day Rule*, would apply.

**Timing of the Extension of the 90-Day Rule**

Interested parties spent some time discussing the wording that addresses how the extension of the 90-day rule is to be applied. Some interpreted the wording to only allow an extension of the rule for contracts that are issued between the date of the declaration of a state of emergency (March 13, 2020) and March 30, 2020, approximately 180 days before the final date of September 28, 2020 allowed for the extension in the draft INT.

To clarify the intent of allowing an extension of the 90-day rule for receivables that become over 90 days past due during the state of emergency, we recommend the following edits as marked below:

As a result of the declaration of a state of emergency by the U.S. federal government on March 13, 2020, the Working Group reached a tentative consensus for a one-time optional extension of the ninety-day rule for uncollected premium balances, bills receivable for premiums and amounts due from agents and policyholders and for amounts due from policyholders for high deductible policies, as follows:

a. For policies in effect and current prior to the expiration date as of the declaration of a state of emergency declared by the U.S. federal government on March 13, 2020 and that later become past due, insurers may wait until September 28, 2020 an additional 90 days over and above the 90 days before nonadmitting premiums receivable from policyholders or agents as required per SSAP No. 6, paragraph 9 before nonadmitting premiums receivable from policyholders or agents.

b. For high deductible policies in effect and current prior to the expiration date as of the declaration of a state of emergency declared by the U.S. federal government on March 13, 2020 and that later become past due, insurers may wait until September 28, 2020 an additional 90 days over and above the 90 days before nonadmitting as amounts due from policyholders for high deductible policies required per SSAP No. 65, paragraph 37 before nonadmitting amounts due from policyholders for high deductible policies.

c. Existing impairment analysis remains in effect for these affected policies.

Interested parties recommend similar wording be added to include SSAP Nos. 47 and 84 in the scope of the INT 20-02 as well as life premiums.

Given the complexity of describing how the extension of the 90-day rule is to be applied and companies’ ability to apply an overly prescriptive extension, we ask the Working Group to consider a more practical approach that would suspend the 90-day rule for the identified SSAPs for 2nd and 3rd quarter 2020 reporting, or longer depending on the impact of COVID-19. This approach would be easier for all to understand and companies to apply.
INT 20-03T: Troubled Debt Restructuring Due to COVID-19

The Working Group reached a tentative consensus to clarify that a modification of mortgage loan terms in response to COVID-19 shall follow the provisions detailed in the March 22, 2020 “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus” (detailed in paragraph 6) in determining whether the modification shall be reported as a troubled debt restructuring within SSAP No. 36.

This interpretation is effective for the specific purpose to address loan modifications in response to COVID-19. This interpretation will be considered for nullification when no longer applicable.

INT 20-04T: Mortgage Loan Impairment Assessment Due to COVID-19

In response to COVID-19, Congress and Federal and state prudential banking regulators have considered provisions pertaining to mortgage loans as a result of the effects of the COVID-19. These provisions are intended to be applicable for the term of the loan modification, but solely with respect to a modification, including a forbearance arrangement, an interest rate modification, a repayment plan, and any other similar arrangement that defers or delays the payment of principal or interest, that occurs during the applicable period for a loan that was not more than 30 days past due as of December 31, 2019.

The Working Group reached a tentative consensus for limited time exceptions to defer assessments of impairment for mortgage loans and investments which predominantly hold underlying mortgage loans which are impacted by forbearance or modifications in response to COVID-19. These exceptions are applicable for the March 31st and June 30th, 2020 (1st and 2nd quarter) financial statements and only in response to mortgage loan forbearance or modifications granted in response to COVID-19. As such, the exceptions provided in this interpretation are not applicable in the September 30, 2020 (3rd quarter) financial statements.

For modification programs designed to provide temporary relief for borrowers current as of December 31, 2019, the reporting entities may presume that borrowers are current on payments are not experiencing financial difficulties at the time of the modification for purposes of determining impairment status and thus no further impairment analysis is required for each loan modification in the program. The exceptions granted in this interpretation are detailed as follows:

a. **SSAP No. 37—Mortgage Loans**: Provide a limited-time exception for assessing impairment under SSAP No. 37, paragraph 16, for mortgage loans with payments (either principal or interest) that have short-term deferrals or modifications in response to COVID-19. This interpretation shall not delay impairment assessments for reasons other than the short-term deferral or modification of interest or principal payments in response to COVID-19 and shall not delay recognition of realized losses if a reporting entity believes a mortgage loan is OTTI.

b. **SSAP No. 30—Common Stock**: Provide a limited-time exception for assessing OTTI under SSAP No. 30, paragraph 10, and INT 06-07 due to fair value declines for SEC registered
funds that have underlying mortgage loans that have been deferred or modified in response to COVID-19 unless the reporting entity intends to sell the security. If the entity has made a decision to sell the security, recognition of the OTTI shall continue to be required. As these investments are reported at fair value, declines in fair value would continue to be reported as unrealized losses.

c. **SSAP No. 43R—Loan-backed and Structured Securities:** Provide a limited-time exception for assessing OTTI under SSAP No. 43R, paragraphs 30-36, due to fair value declines in investments that have underlying mortgage loans deferred or modified in response to COVID-19 unless the reporting entity intends to sell the security. If the entity has made a decision to sell the security, then recognition of an OTTI shall continue to be required.

d. **SSAP No. 48—Joint Ventures, Partnerships and Limited Liabilities Companies:** Provide a limited-time exception for assessing OTTI under SSAP No. 48 due to fair value declines in investments that have underlying mortgage loans deferred or modified in response to COVID-19 unless the entity intends to sell the security. Additionally, an OTTI shall be assessed if factors other than the mortgage loan forbearance or modification have resulted with a decline that is considered other than temporary, or the reporting entity does not believe it is probable they will collect the carrying amount of the investment.

As detailed in paragraph 10, the exceptions granted in this interpretation are applicable for the March 31st and June 30th, 2020 (1st and 2nd quarter) financial statements and only in response to mortgage loan forbearance or modifications granted in response to COVID-19. As the exceptions provided in this interpretation are not applicable in the September 30, 2020 (3rd quarter) financial statements, this interpretation will automatically expire as of September 29, 2020. This interpretation will be publicly posted on the Statutory Accounting Principles (E) Working Group’s website. This interpretation will be automatically nullified on September 29, 2020 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

Interested parties appreciate the opportunity to comment on INT 20-03T, *Troubled Debt Restructuring Due to Covid-19*, and INT 02-04T, *Mortgage Loan Impairment Assessment Due to COVID-19*. We also appreciate the NAIC addressing these important topics so quickly given the effects COVID-19 has had on the economy and your consideration of how insurers may modify investments in their portfolios to mitigate adverse effects on borrowers. Given that insurers are large investors in the capital markets, we believe it is imperative that we be provided similar accounting relief for our investment portfolios as banks have been afforded in order to contribute to the ultimate economic recovery after COVID-19.

We agree that the relief provided by the various Banking regulators, and affirmed by the FASB, in their “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus” (“Interagency Statement”) should be applicable to insurers for statutory reporting. Since U.S. GAAP accounting rules on troubled debt restructurings apply to debt investments as well, industry’s interpretation is that the Interagency Statement applies to debt investments and not just loans.
We note that Section 4013 of the “Coronavirus Aid, Relief, and Economic Security Act” or “CARES Act” seems to provide relief from the requirements of U.S. GAAP with respect to modifications which goes beyond the relief provided in the Interagency Statement. Additional clarity is needed with respect to the scope and application of the provisions in Section 4013 of the CARES Act. To the extent the provisions of this Federal Law change or supersede the guidance provided in the Interagency Statement, we believe the NAIC should amend or replace the guidance in INT 20-03T and 20-04T to align with such enacted law.

Because we view INT 20-03T and INT 20-04T to be interrelated, we offer the following comments for both INTs:

**Scope of the INTs:**

Interested parties believe the scope of both INT’s should be expanded to include debt investments (i.e., all those investments in the scope of SSAP No. 26R and SSAP 43R). Debt investments are a significant portion of insurers’ investment portfolios and we believe including them in the scope of the INTs will afford companies more of an opportunity to contribute to economic recovery after COVID-19.

The intent of the Interagency Statement was to encourage financial institutions to work prudently with borrowers who are or may be unable to meet their contractual payment obligations because they are experiencing short-term financial or operational problems due to the effects of COVID-19. Industry’s interpretation is that the scope of the Interagency Statement applied to debt investments, not just loans, since debt instruments, such as bonds, are also within the scope of ASC Subtopic 310-40, Receivables – Troubled Debt Restructurings by Creditors. As currently drafted, INT 20-03T is limited to mortgage loans, which is inconsistent with the scope of SSAP No. 36, Troubled Debt Restructuring. When insurers apply SSAP No. 36 today they apply it not only to loans, but also to debt investments. Interested parties request that the scope of INT 20-03T be broadened to include all lending activity in the scope of SSAP No. 36, which for insurers include debt investments (SSAP No. 26R and SSAP 43R) that are a significant portion of insurers’ investment portfolios, as long as a borrower was current on amounts due at the time of the modifications, relief provided by a lender was temporary and directly related to COVID-19, and the relief provided was insignificant. This is also consistent with U.S. GAAP, which requires FASB Topic 310-40 (Troubled Debt Restructurings for Creditors) to be applied to loans and debt. In summary, broadening the scope of INT 20-03T would be consistent with how insurers apply SSAP 36 and with the requirements of U.S. GAAP.

In addition, INT 20-04T, as currently written, is limited to mortgage loans or investments that are predominantly impacted by underlying mortgage loans. Insurers may provide the same type of temporary relief to various borrowers in other areas of their investment portfolios (i.e., non-mortgage loan related), including bank loans and debt investments. The intent of such modifications or relief is to mitigate adverse effects on borrowers due to COVID-19. As a result, we believe the scope of INT 20-04T also should be expanded to all investments in the scope of SSAP No. 26R and SSAP 43R.

Including SSAP No. 26R and SSAP 43R investments in the scope of both INTs would result in insignificant modifications for borrowers that are current at the time of the modification and that provide relief due to COVID-19 not being considered TDRs. Additionally, such modifications should not
trigger impairments; however, impairment assessments should not be delayed if relief/modifications provided by lenders are not directly related to COVID-19.

We would also like to confirm that any COVID-19 related modifications entered into while the Interpretation is in effect (at least until December 31, 2020) will not be considered TDRs or impairments for as long as the modification is in force.

Non-admitting Accrued Interest:

The Interagency Statement also discusses “past due” amounts and notes that amounts should not be reported as past due if the lender has granted a deferral or forbearance due to COVID-19 modifications discussed above. We believe that the relief in the Interagency Statement should be applicable to insurers for statutory reporting. Interested parties believe INT 20-04T should be expanded to address accrued interest income. That is, interest amounts accrued for mortgage loans that are deemed collectible, however are 180 days past due (based on the past due definition in SSAP No. 37) because of modifications discussed in this letter, should continue to be admitted assets. Additionally, accrued interest related to SSAP No. 26R and SSAP 43R investments where relief was provided due to COVID-19 also would continue to be admitted if more than 90 days past due (as defined in SSAP No. 34).

As the Interpretation is effective until nullified by the NAIC, interested parties seek to clarify that loans granted a short-term payment deferral that ends after the nullification would be admitted during the entire term of the short-term payment deferral, even if the deferral period ends after the Interpretation is nullified.

Limited Exception: 1st and 2nd Quarter- INT 20-04T

INT 20-04T provides for a limited exception for considering whether it is “probable” an investor would receive its contractual principal and interest payments when the investor provides temporary relief related to COVID-19. The limited exception is for only 1st and 2nd quarter statutory reporting. As insurers are a key lender to many businesses through commercial mortgage loans, bank loans, other SSAP No. 26R investments, SSAP 43R, and the many other types of investments discussed in INT 20-04T, to mitigate adverse effects to borrowers and help future recovery in the economy after COVID-19, interested parties believe relief should be provided beyond the 1st and 2nd quarters. As no one is able to predict the length of economic recovery, we believe providing an exception until at least 12/31/2020 would match the expected timeframe that insurers believe they will be addressing issues.”. At the very least, we believe the limited exception period should be revisited and re-assessed with industry prior to the date expiring.

In addition, interested parties interpreted INT 20-04T to mean that, if a modification were made in the 1st or 2nd quarter, and, the modified terms are insignificant and extend beyond the 2nd quarter, the 9/30/2020 expiration date in the INT would not be relevant. That is, IPs seek to clarify that loans granted a temporary modification during the exception period, but such modification period extends beyond the exception would continue to have the INT applied. We suggest clarification be provided in the INT to this point.

*   *   *
Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell       Rose Albrizio
April 2, 2020

Dale Bruggeman
Chair, Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners

By e-mail to Julie Gann, Robin Marcotte, Jim Pinegar, Fatima Sediqzad and Jake Stultz


Dear Chairman Bruggeman:

America’s Health Insurance Plans (AHIP) is pleased to comment on the above referenced proposed Interpretation of the NAIC’s Statutory Accounting Principles Working Group (SAPWG).

First, we would like to take the opportunity to commend the NAIC and SAPWG on their swift action in dealing with the COVID-19 pandemic. We thank you for recognizing the difficulties with which consumers and insurance carriers are grappling, as well as the critical need for regulatory flexibility in these uncertain times. State regulators are being stretched to the limit, as are our members. We wanted to express our appreciation for your continued recognition of these difficulties and efforts to streamline and coordinate, even as you deal with the same inordinate time and resource challenges in the regulatory community.

We also want to thank you and NAIC staff for your time in conferring with us by phone on March 30. As we indicated on that call, and while AHIP is responding to INT 20-02 herein, we do not plan to respond to the other proposed SAPWG interpretations currently out for exposure which pertain to COVID-19, i.e., INT 20-01, INT 20-03 and INT 20-04. Also to follow-up on our call, AHIP will be providing you with separate letters in the near term with respect to concerns presented to health insurance plans from COVID-19 and the related impact of certain provisions of SSAP No. 84, Health Care and Government Insured Plan Receivables, and SSAP No. 106, Affordable Care Act Section 9010 Assessment.

With that, we have the following comments regarding the proposed extension of the Ninety-Day Rule:

- Given the pervasive economic impacts the crisis is having on firms and individuals, we expect temporary but potentially significant increases in past due receivables of health plans. Thus, AHIP strongly supports the concept of an extension of the Ninety-Day Rule due to COVID-19.
While AHIP desires an extension that will remain in place longer than the proposed September 28 expiration of INT 20-02 as a “just-in-case measure”, we understand that SAPWG anticipates gauging the necessity for further extension as the expiration date nears and, if necessary, will consider at that time. We believe that such monitoring and willingness to consider a further extension in light of circumstances seen on the ground at that time to be imperative.

We note that the proposed INT 20-02 “scopes-in” certain types of receivables subject to the Ninety-Day Rule to which the extension will apply by reference to SSAPs, specifically, SSAP No. 6, Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers, and SSAP No. 65, Property and Casualty Contracts. However, there are other receivables which are only covered in other SSAPs which are relevant and significant to health plans and which are also subject to the Ninety-Day Rule:

i. SSAP No. 47, Uninsured Plans: For Administrative Services Contract (ASC) business, health carriers have separate contracts with providers and customers and are obligated to pay providers out of their own funds before receiving reimbursement from the group. The provider contracts specifically state that health carriers will reimburse providers for services rendered regardless of whether the subscriber is covered by a self-funded or underwritten plan. Some AHIP members have already received requests from their large ASC customers to allow them to delay payment to the carrier for claim reimbursements for up to 90 days.

ii. SSAP No. 84, Health Care and Government Insured Plan Receivables: This SSAP provides accounting guidance relative to a number of types of receivables that are relevant and significant for health plans, of which three types are subject to the Ninety-Day Rule for purposes of determining if the asset will be treated as an admitted asset in statutory reporting. AHIP requests that two of those types of receivables, Pharmaceutical Rebate Receivables and Risk-Sharing Receivables, be “scoped-in” to INT 20-02.1

Anticipated changes in subscriber needs and utilization, combined with sub-optimal working environments at home for many of our members’ staff who are involved with accounting and billing matters, presage difficulties in assuring that these receivables will hew to normal levels seen in non-crisis times. With these receivables scoped-in to INT 20-02, they would be subject to the same proposed extension provisions as for other receivables applicable to the Ninety-Day Rule.

1 The third type of receivable covered by SSAP No. 84 which is also subject to the Ninety-Day Rule is Loans and Advances to Providers. AHIP is not requesting that such balances be scoped-in to the proposed INT 20-02 at this time. However, AHIP has other comments unrelated to the application of the Ninety-Day Rule to Loans and Advances to Providers which we will forward in a separate letter.
Finally, AHIP has concerns with the Staff-drafted language in paragraphs 3a and 3b of INT 20-02. AHIP supports the substance of the Industry Interested Parties group’s suggested language, and would propose language consistent with theirs, such as the following:

For policies in effect and current prior to the expiration date as of the declaration of a state of emergency declared by the U.S. federal government on March 13, 2020 and that later become past due, insurers may wait until September 28, 2020 an additional 90 days over and above the 90 days before nonadmitting premiums receivable from policyholders or agents as required per SSAP No. 6, paragraph 9 before nonadmitting premiums receivable from policyholders or agents.

* * * * * * *

AHIP appreciates this opportunity to comment and would be glad to address any questions you or other SAPWG members may have at your convenience.

Sincerely,

America’s Health Insurance Plans

Bob Ridgeway
Bridgeway@AHIP.org
501-333-2621
April 2, 2020

Mr. Dale Bruggeman  
Chairman, Statutory Accounting Principles (E) Working Group  
Sent via e-mail: jgann@naic.org, jpinegar@naic.org, fseiqzad@naic.org, jstultz@naic.org

Dear Chairman Bruggeman:

On behalf of the undersigned companies, thank you for your leadership in exposing INT 20-02, which extends the 90-day rule for admitted assets. As you are aware, dozens of states have issued guidance designed to give premium relief for their customers during the COVID-19 pandemic. Consequently, health insurers will experience delays in securing payment from our customers. We hope that this working group can give us the support we need to adequately plan for late premium payments.

While our companies are doing everything it can ease the financial impact of the pandemic to our clients and customers, we should not be penalized for receivables paid in excess of 90-days. While relief through the end of second quarter could be helpful, we believe that date will not give us sufficient time to admit expected assets. Therefore, we request that SAPWG extend the time frame contemplated in INT 20-02 from the end of the second quarter to the end of the third quarter. We believe this is the most likely scenario based on current estimates and will give our companies the certainty and direction it needs to plan during this pandemic. We hope you will agree this is a reasonable solution to unprecedented circumstances, and we strongly encourage the adoption of INT 20-02 with the amendment suggested by the undersigned insurers.

Thank you for considering our comments, as well as the comments of America’s Health Insurance Plans with which we are aligned. If you need additional information, please feel free to contact us.

Sincerely,

Amy Lazzaro  
VP, Regulatory Affairs, Cigna  
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VP, Regulatory Affairs, Aetna  
MartinoG@aetna.com
March 30, 2020

Statutory Accounting Principles (E) Working Group
Attn: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group

Re: Response to Exposure Draft INT 20-04T

Dear Mr. Bruggeman:

I am reaching out in response to the SAPWG’s Exposure Draft INT 20-4: Mortgage Loan Impairment Assessment Due to COVID-19. Specifically, I have a clarifying question and observation.

The Exposure Draft states the exceptions granted are applicable for the March 31st and June 30th, 2020 (1st and 2nd quarter) financial statements. Further, it states the exceptions are not applicable in the September 30, 2020 (3rd quarter) financial statements and the interpretation will automatically expire as of September 29, 2020.

As such, as impairment is a ‘point-in-time’ assessment as of the balance sheet date, it is my understanding that loan modifications meeting the conditions set out in this Exposure Draft can therefore be modified up to September 29, 2020 in order for these exceptions to apply (i.e., not cut-off post June 30, 2020).

Further, we expect that certain of our impacted borrowers may not proactively request relief (modification) in the next few months. As such, if we believe it is possible that a borrower would not ask for relief until after the cut-off date above (e.g., during Q4 2020), it would seem this would encourage companies to proactively modify a larger number of loans now to avoid a more problematic accounting implication later. Any guidance or clarification on this observation would be appreciated. In addition, we would ask that you consider extending the guidance until the later of the cut-off date above or until COVID-19 is no longer considered a national emergency.

Thanks for your attention and consideration to these observations.

Sincerely,

Bud Graessle
VP, Controller, Treasurer, and Senior Accounting Officer
Bud.Graessle@OneAmerica.com

Cc: Steven Holland, OneAmerica VP of Commercial Mortgage Loans and Real Estate
**Statutory Accounting Principles (E) Working Group**  
**Maintenance Agenda Submission Form**  
**Form A**

**Issue: Reference Rate Reform**

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**Description of Issue:**

The Financial Accounting Standards Board (FASB) issued ASU 2020-04 *Reference Rate Reform (Topic 848) Facilitation of the Effects of Reference Rate Reform on Financial Reporting* as a method to ensure that the financial reporting results would continue to reflect the intended continuation of contracts and hedging relationships during the period of the market-wide transition to alternative reference rates – thus, generally not requiring remeasurement or redesignation if certain criteria are met.

Reference rate reform typically refers to the transition away from referencing the London Interbank Offered Rate (LIBOR), and other interbank offered rates (IBORs), and moving toward alternative reference rates that are more observable or transaction based. In July 2017, the governing body responsible for regulating LIBOR announced it would no longer require banks to continue rate submissions after 2021 – thus, likely sunsetting both the use and publication of LIBOR. An important item to note is that while LIBOR is the primary interbank offering rate, other similar rates are potentially affected by reference rate reform. For simplicity, LIBOR will be the sole IBOR referenced throughout this agenda item.

With a significant number of financial contracts referencing LIBOR, its discontinuance will require organizations to reevaluate and modify any contract which does not contain a substitute reference rate. A large volume of contracts and other arrangements, such as debt agreements, lease agreements, and derivative instruments, will likely need to be modified to replace all references of interbank offering rates that are expected to be discontinued. While operational, logistical, and legal challenges exist due to the sheer volume of contracts that will require modification, accounting challenges were presented as contract modifications typically require an evaluation to determine whether the modifications result in the establishment of a new contract or the continuation of an existing contract. As is often the case, a change to the critical terms (including reference rate modifications) typically requires remeasurement of the contract, or in the case of a hedging relationship, a redesignation of the transaction.

The overall guidance in ASU 2020-04 is that a qualifying modification (as a result of reference rate reform) should not be considered an event that requires contract remeasurement at the modification date or reassessment of a previous accounting determination. FASB concluded that as reference rate changes are a market-wide initiative, one that is required primarily due to the discontinuance of LIBOR, it is outside the control of an entity and is the sole reason compelling an entity to make modifications to contracts or hedging strategies. As such, FASB determined that the traditional financial reporting requirements of discontinuing such contracts and treating the modified contract as an entirely new contract or hedging relationship would 1) not provide decision-useful information to financial statement users and 2) require a reporting entity to incur significant costs in the financial statement preparation and potentially reflect an adverse financial statement impact, one of which may not accurately reflect the intent or economics of a modification to a contract or hedging transaction.

Stakeholders indicated that due to the significant volume of affected contracts and other arrangements, together with a compressed time frame for making contract modifications, the application of existing accounting standards...
on assessing modifications versus extinguishments could be costly and burdensome and financial reporting results should reflect the intended continuation and true economics of such arrangements. It is important to note this as the optional, expedient and exceptions guidance provided by the amendments in ASU 2020-04 are applicable for all entities, however, are only effective as of March 12, 2020 through December 31, 2022.

Finally, while numerous alternative reference rates are available, the Federal Reserve has identified the Secured Overnight Financing Rate (SOFR) as its preferred alternative to LIBOR. SOFR is calculated using actual transactions and is considered a broad measure of the cost of borrowing cash overnight, fully collateralized by risk-free treasury securities. LIBOR, on the other hand, is set by a panel of banks submitting estimates of what they think their borrowing costs are and represents a benchmark rate that leading global banks charge each other for short-term loans, thus incorporating a degree of credit risk into the reference rate. Unlike SOFR, LIBOR is determined by the equilibrium between supply and demand in the funds market.

**General Principles:**

For contract modifications, hedging relationships, and other transactions affected by reference rate reform, the amendments provide temporary guidance that achieves the following:

1. Simplifies accounting analyses under current GAAP for contract modifications.
2. Allows hedging relationships to continue without redesignation upon a change in certain critical terms.
3. Allows a change in the designated benchmark interest rate to a different eligible benchmark interest rate in a fair value hedging relationship.
4. Suspends the assessment of certain qualifying conditions for fair value hedging relationships for which the shortcut method for assuming perfect hedge effectiveness is applied.
5. Simplifies or temporarily suspends the assessment of hedge effectiveness for cash flow hedging relationships.

The overall scope is that for the modification of a contract (hedging or other) to be eligible for the accounting exceptions provided in ASU 2020-04, the contract must reference LIBOR, or a reference rate that is expected to be discontinued as a result of reference rate reform.

In relation to hedge accounting, without this accounting exception, a change in a contract’s reference rate could disallow the application of certain hedge accounting guidance, and certain hedging relationships may not qualify as highly effective during the period of the market-wide transition to a replacement rate. The inability to apply hedge accounting solely because of reference rate reform would result in financial reporting outcomes that do not reflect entities’ intended hedging strategies when those strategies continue to operate as effective hedges. ASU 2020-04 provides optional expedients that enable reporting entities to continue to apply hedge accounting for hedging relationships in which the critical terms change, but due to reference rate reform may no longer indicate the hedge is effective. The relief is temporary and cannot be applied to contract modifications that occur after December 31, 2022, or hedging relationships initiated or evaluated after that date. This is because the amendments in ASU 2020-04 are intended to provide relief related to the accounting requirements in GAAP due to the effects of the market-wide transition away from IBORs, the relief provided by the amendments is temporary in its application in alignment with the expected market transition period.

**Contract Modifications:**

First, the scope of ASU 2020-04 is intended to distinguish contract modifications that occur solely because of reference rate reform from other contract modifications that occur in the ordinary course of business, or for reasons unrelated to reference rate reform. Again, the scope of contract modifications that are eligible for the optional expedience (and not required to be remeasured) shall only include changes that are being made to the terms that
include the direct replacement of a reference rate or the potential to replace a reference rate from one variable rate to another variable rate. Other contemporaneously modified terms must also be related to the replacement of a reference rate because of reference rate reform. Solely modifying a term or a reference rate not affected by reference rate reform does not qualify for the expedience or the accounting exceptions provided in this update. For qualifying contract modifications, the guidance generally allows a reporting entity to account for and report such modifications as an event that does not require the contract termination and remeasurement – **thus the modifications are to be reported as a continuation of the existing contract.** For the purpose of the amendments in ASU 2020-04, the terms that are permitted to be modified could be those in which affect or have the potential to affect the amount or timing of future cash flows or may include modifications of terms such as fallback provisions in a contract that are triggered upon a contingent event (such as the discontinuance of a reference rate). However, accounting for these changes as a continuation of the existing contract is only allowed if the modifications were required as a result of reference rate reform. Finally, minor contemporaneous changes to terms that do not affect or have the potential to affect the amount or timing of future cash flows are also permitted by ASU 2020-04.

**For Receivable or Debt Contracts** – A reporting entity shall account for the qualified contract modifications as a minor change, resulting in the modification being **accounted for prospectively** as a continuation of the exiting contract, while using the new reference rate/terms in the agreement.

**For Leases** – A reporting entity shall not reassess the lease classification, remeasure lease payments, or make other assessment, but rather the lease is **accounted for prospectively** as a continuation of the existing contract.

**Overall Hedge Accounting:**

The amendments in ASU 2020-04 provide several exceptions and optional expedients for applying hedge accounting guidance. If certain criteria are met, for hedging relationships, the guidance in ASU 2020-04 allows an entity to change the reference rate and certain other critical terms related to reference rate reform without having to redesiginate the relationship and hedging transaction.

Summarized below are the four primary considerations for hedge accounting. Note, the exceptions noted below only relate to critical term changes as a result of reference rate reform. Thus, a contemporaneous change in other terms, not as a result of reference rate reform, does not qualify for the exception and optional expedient guidance herein.

1. For any hedging relationship, upon a change to the critical terms of the hedging relationship, allow a reporting entity to continue hedge accounting rather than redesignate the hedging relationship.
2. For any hedging relationship, upon a change to the terms of the designated hedging instrument, allow an entity to change its systematic and rational method used to recognize the excluded component into earnings and adjust the fair value of the excluded component through earnings.
3. For fair value hedges, allow a reporting entity to change the designated hedged benchmark interest rate and continue fair value hedge accounting.
4. For cash flow hedges, adjust the guidance for assessment of hedge effectiveness to allow an entity to continue to apply cash flow hedge accounting.

The temporary guidance in ASU 2020-04 only applies to eligible hedging relationships that currently exist or are entered into prior to December 31, 2022.

**Fair Value Hedges**

For fair value hedges, in which the designated benchmark interest rate is LIBOR, a reporting entity may change the hedged risk to another permitted benchmark interest rate without redesiginating the relationship, as long as the
hedge is expected to remain highly effective in offsetting changes in fair value attributed to the revised hedged risk. The amendments in ASU 2020-04 require that an entity recognize in current earnings any change in fair value attributable to a change in an eligible benchmark interest rate.

Current GAAP allows an entity to apply the shortcut method for assessing hedge effectiveness of fair value hedges if certain conditions are met. For fair value hedges applying the shortcut method, the amendments in ASU 2020-04 provide an optional expedient to allow an entity to continue to use the shortcut method if the reference rate in the hedging instrument is replaced by another eligible benchmark interest rate. For an entity that qualifies for and elects to use the optional expedient, the entity would continue to use the shortcut method and recognize the changes in fair value of the hedging instrument as a fair value hedge basis adjustment of the hedged asset or hedged liability.

**Cash Flow Hedges**

For a cash flow hedge to qualify for hedge accounting, an entity must assert that the hedged forecasted transaction is probable of occurring. A change in the probability of the forecasted transaction may require that an entity discontinue hedge accounting and may affect the timing of recognizing in current earnings amounts previously deferred in accumulated other comprehensive income.

The amendments in ASU 2020-04 clarify that if the designated hedged risk in a hedged forecasted transaction references LIBOR or another rate that is expected to be discontinued because of reference rate reform, an entity may assert that the hedged forecasted transaction remains probable of occurring if the reference rate is replaced with another rate. However, the amendments require that an entity assess whether the underlying hedged forecasted transaction remains probable of occurring. A change to the designated hedged interest rate risk does not require a redesignation of a cash flow hedge of a forecasted transaction if the hedge is remains highly effective – that is if the entity can assert that the underlying cash flows remain probable, regardless of how the hedged risk and hedged forecasted transaction are documented.

Additionally, there may be periods of time during the transition to replacement rates in which a cash flow hedge would not be considered highly effective because of the basis differences between the reference rates in the hedging instrument and the reference rates in the hedged forecasted transaction. In these cases, if a hedging relationship qualifies for cash flow hedge accounting, all changes in the fair value of the derivative designated as the hedging instrument shall be deferred into accumulated other comprehensive income and recognized in earnings when the hedged forecasted transaction affects earnings. Despite the potential of a hedge not being considered highly effective (solely as a result of reference rate reform), the ASU designates that the reporting entity shall not discontinue hedge accounting and redesignate the hedging transaction. Again, the temporary relief provided cannot be applied to contract modifications after December 31, 2022, or with hedging relationships entered into or evaluated after that date.

NAIC Staff Final Hedge Comments:
For GAAP purposes, if an entity has not adopted the amendments in *ASU 2017-12, Derivatives and Hedging*, it is precluded from being able to utilize certain expedients for hedge accounting. Only the hedge documentation requirements were adopted for statutory accounting purposes, while the remainder of the items are still outstanding. **For statutory accounting, NAIC staff support allowing all available expedient methods permitted if an entity has elected ASU 2017-12 for GAAP purposes.**

**Other Items:**

ASU 2020-04 also allows an entity to make a one-time election to sell, transfer, or both sell and transfer debt securities classified as held-to-maturity that reference a rate affected by reference rate reform and that are classified as held to maturity before January 1, 2020.
Note that, debt classification such as held-to-maturity, available-for-sale, or trading are not concepts employed by statutory accounting and thus are not applicable.

Existing Authoritative Literature:
ASU 2020-04 has affects related to several different Statements of Statutory Accounting Principles, each will be individually addressed.

SSAP No. 15—Debt and Holding Company Obligations

NAIC Staff comment – Debt and service agreement modifications as a result of reference rate reform should not rise to the level requiring a reversal and rebooking of the liability. SSAP No. 15, states such liabilities should only be derecognized if extinguished. A reference rate modification should not be interpreted as necessarily requiring re-recognition. Nonetheless, for clarity and consistency with ASU 2020-04, NAIC staff recommend the Working Group adopt this temporary guidance as appropriate for SSAP No. 15.

11. A reporting entity shall derecognize a liability if, and only if, it has been extinguished. A liability has been extinguished if either of the following conditions is met:
   a. The reporting entity pays the creditor and is relieved of its obligation for the liability. Paying the creditor includes delivery of cash, other financial assets, goods or services, or reacquisition by the debtor of its outstanding debt securities; or
   b. The reporting entity is legally released from being the primary obligor under the liability, either judicially or by the creditor.

15. Modifications to or exchanges of line-of-credit or revolving-debt arrangements, including the accounting for unamortized costs at the time of the change, fees paid to or received from the creditor and third-party costs incurred shall be expensed when incurred.

SSAP No. 22R—Leases

NAIC Staff comment – lease modifications, solely caused by reference rate reform and ones eligible for optional expedience (modifications only being made to the terms that include the direct replacement of a reference rate or the potential to replace a reference rate from one variable rate to another variable rate) likely do not rise to the level of a modification requiring recognition as a new lease under statutory accounting. SSAP No. 22R, paragraph 17 states only modifications in which grant the lessee additional rights shall be accounted for as a new lease. These changes are outside the scope allowed for optional expedience in ASU 2020-04. Nonetheless, for clarity and consistency with ASU 2020-04, NAIC staff recommend the Working Group adopt this temporary guidance as appropriate for SSAP No. 22R.

Modification
17. An entity shall account for a modification to a contract as a separate contract (that is, separate from the original contract) when both of the following conditions are present:
   a. The modification grants the lessee an additional right of use not included in the original lease (for example, the right to use an additional asset).
   b. The lease payments increase commensurate with the standalone price for the additional right of use, adjusted for the circumstances of the particular contract. For example, the standalone price for the lease of one floor of an office building in which the lessee already leases other floors in that building may be different from the standalone price of a similar floor.
18. An entity shall account for initial direct costs, lease incentives and any other payments made to or by the entity in connection with a modification to a lease in the same manner as those items would be accounted for in connection with a new lease.

Accounting and Reporting by Lessees

19. All leases shall be considered operating leases, which means that rental expense is recognized over the lease term, without recognition of a right-to-use asset or lease liability. Rent on operating leases, reflecting all lease considerations in paragraph 20, shall be charged to expense on a straight-line basis over the lease term. Statutory accounting rejects the recognition of a right-to-use lease asset and the associated lease liabilities.

20. The consideration in the contract for a lessee includes all of the following payments that will be made during the lease term:

   a. Any fixed payments (for example, monthly service charges) or in substance fixed payments, less any incentives paid or payable to the lessee.

   b. Any other variable payments that depend on an index or a rate, initially measured using the index or rate at the commencement date.

SSAP No. 86—Derivatives

NAIC Staff comment – The modifications in ASU 2020-04 most primarily address hedge accounting and the allowance for a reporting entity to change the reference rate and other critical terms related to reference rate reform without having it redesignate the hedging relationship. While alternative benchmark interest rates were previously addressed in agenda item 2018-46 – Benchmark Interest Rate, the accounting for hedged transactions is noted below, with applicable areas bolded for emphasis.

Relevant/Applicable of Overview of existing SAP Accounting – SSAP No. 86

12. “Benchmark Interest Rate” is a widely recognized and quoted rate in an active financial market that is broadly indicative of the overall level of interest rates attributable to high-credit-quality obligors in that market. It is a rate that is widely used in a given financial market as an underlying basis for determining the interest rates of individual financial instruments and commonly referenced in interest-rate-related transactions. In theory, the benchmark interest rate should be a risk-free rate (that is, has no risk of default). In some markets, government borrowing rates may serve as a benchmark. In other markets, the benchmark interest rate may be an interbank offered rate. In the United States, the interest rates on direct Treasury obligations of the U.S. government, the London Interbank Offered Rate (LIBOR) swap rate, the Fed Funds Effective Rate Overnight Index Swap Rate, the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Rate, and the Secured Overnight Financing Rate (SOFR) Overnight Index Swap Rate are considered to be benchmark interest rates.

Derivatives Used in Hedging Transactions

20. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and are permitted to be valued and reported in a manner that is consistent with the hedged asset or liability (referred to as hedge accounting). For instance, assume an entity has a financial instrument on which it is currently receiving income at a variable rate but wishes to receive income at a fixed rate and thus enters into a swap agreement to exchange the cash flows. If the transaction qualifies as an effective hedge and a financial instrument on a statutory basis is valued and reported at amortized cost, then the swap would also be valued and reported at amortized cost. Derivative instruments used in hedging transactions that do not meet or no longer meet
the criteria of an effective hedge, or that meet the required criteria but the entity has chosen not to apply hedge accounting, shall be accounted for at fair value and the changes in the fair value shall be recorded as unrealized gains or unrealized losses (referred to as fair value accounting).

21. Entities shall not bifurcate the effectiveness of derivatives. A derivative instrument is either classified as an effective hedge or an ineffective hedge. Entities must account for the derivative using fair value accounting if it is deemed to be ineffective or becomes ineffective. Entities may redesignate a derivative in a hedging relationship even though the derivative was used in a previous hedging relationship that proved to be ineffective. A change in the counterparty to a derivative instrument that has been designated as the hedging instrument in an existing hedging relationship would not, in and of itself, be considered a termination of the derivative instrument. An entity shall prospectively discontinue hedge accounting for an existing hedge if any one of the following occurs:

- Any criterion in paragraphs 24-36 is no longer met;
- The derivative expires or is sold, terminated, or exercised (the effect is recorded as realized gains or losses or, for effective hedges of firm commitments or forecasted transactions, in a manner that is consistent with the hedged transaction – see paragraph 22);
- The entity removes the designation of the hedge; or
- The derivative is deemed to be impaired in accordance with paragraph 17. A permanent decline in a counterparty’s credit quality/rating is one example of impairment required by paragraph 17, for derivatives used in hedging transactions.

22. For those derivatives which qualify for hedge accounting, the change in the carrying value or cash flow of the derivative shall be recorded consistently with how the changes in the carrying value or cash flow of the hedged asset, liability, firm commitment or forecasted transaction are recorded. Upon termination of a derivative that qualified for hedge accounting, the gain or loss shall adjust the basis of the hedged item and be recognized in income in a manner that is consistent with the hedged item (alternatively, if the item being hedged is subject to IMR, the gain or loss on the hedging derivative may be realized and shall be subject to IMR upon termination.) Entities who choose the alternative method shall apply it consistently thereafter.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Agenda item 2018-46 – Benchmark Interest Rate, incorporated revisions to SSAP No. 86, adding the Securities Industry and Financial Markets (SIFMA) Municipal Swap Rate and the Secured Overnight Financing Rate (SOFR) Overnight Index Swap (OIS) Rate as acceptable benchmark interest rates for hedge accounting. Prior to this change, only LIBOR and the Fed Funds Effective Swap Rate (also referred to as the Overnight Index Swap Rate) were considered acceptable benchmark interest rates.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: N/A

Convergence with International Financial Reporting Standards (IFRS): IFRS has taken a similar approach when considering Reference Rate Reform’s impact on IFRS 9 (Financial Instruments), IAS 39 (Recognition and Measurement), and IFRS 7 (Financial Instruments – Disclosures).

Staff Recommendation: Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose temporary (optional) expedient and exception interpretative guidance, with a sunset date of December 31, 2022. These optional expedients would allow entities (under certain circumstances) to avoid having to remeasure contracts or reassess a previous accounting
**determination for hedged items.** With this guidance, reporting entities would be allowed to make specific contract modifications and account for them on a prospective basis. Further, entities would be allowed to continue applying hedge accounting for hedging relationships affected by reference rate reform. Note: NAIC staff support adoption of this ASU, with the only modification related to the option to sell debt currently classified held-to-maturity. This concept is not employed by statutory accounting and thus is not applicable.

The proposed extension temporarily overrides guidance in SSAP No. 15, SSAP No. 22R and SSAP No. 86 for affected policies, therefore the policy statement in Appendix F requires 2/3rd (two-thirds) of the Working Group members to be present and voting and a supermajority of the Working Group members present to vote in support of the interpretation before it can be finalized.

Feedback is requested from regulators if a disclosure of the volume of contracts affected by LIBOR would be beneficial. While ASU 2020-04 did not contain significant disclosure requirements, the results of any SAP disclosure would not be able to ascertain the magnitude of the contract value affected by electing the optional expedient and exception guidance, however, could contain the items such as contact count and notional value.

**Staff Review Completed by:** Jim Pinegar, NAIC Staff – March 2020

**Status:**
On March 26, 2020, the Statutory Accounting Principles (E) Working Group conducted an email vote to expose INT 20-01T: *ASU 2020-04 - Reference Rate Reform*.

On April 15, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, Interpretation 20-01: *ASU 2020-04 – Reference Rate Reform* allowing temporary (optional) expedient and exception interpretative guidance, with a sunset date of December 31, 2022. These optional expedients would allow entities (under certain circumstances) to avoid having to remeasure contracts or reassess a previous accounting determination for hedged items.
Interpretation of the Statutory Accounting Principles (E) Working Group

INT 20-01: ASU 2020-04 - Reference Rate Reform

INT 20-01 Dates Discussed

Email Vote to Expose March 26, 2020; April 15, 2020

INT 20-01 References

Current:
- SSAP No. 15—Debt and Holding Company Obligations
- SSAP No. 22R—Leases
- SSAP No. 86—Derivatives

This INT applies to all SSAPs with contracts within scope of ASU 2020-04, which allows for modifications due to reference rate reform and provides for the optional expedient to be accounted for as a continuation of the existing contract.

INT 20-01 Issue

1. This interpretation has been issued to provide statutory accounting and reporting guidance for the adoption with modification of ASU 2020-04 – Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting for applicable statutory accounting principles. The Financial Accounting Standards Board (FASB) issued ASU 2020-04 in March 2020 as optional, transitional and expedient guidance as a result of reference rate reform.

2. Reference rate reform typically refers to the transition away from referencing the London Interbank Offered Rate (LIBOR), and other interbank offered rates (IBORs), and moving toward alternative reference rates that are more observable or transaction based. In July 2017, the governing body responsible for regulating LIBOR announced it will no longer require banks to continue LIBOR submissions after 2021 – likely sunsetting both the use and publication of LIBOR. An important note is that while LIBOR is the primary interbank offering rate, other similar rates are potentially affected by reference rate reform.

3. With a significant number of financial contracts solely referencing IBORs, their discontinuance will require organizations to reevaluate and modify any contract that does not contain a substitute reference rate. A large volume of contracts and other arrangements, such as debt agreements, lease agreements, and derivative instruments, will likely need to be modified to replace all references of interbank offering rates that are expected to be discontinued. While operational, logistical, and legal challenges exist due to the sheer volume of contracts that will require modification, accounting challenges were presented as contract modifications typically require an evaluation to determine whether the modifications result in the establishment of a new contract or the continuation of an existing contract. As is often the case, a change to the critical terms (including reference rate modifications) typically requires remeasurement of the contract, or in the case of a hedging relationship, a dedesignation of the transaction.

4. The overall guidance in ASU 2020-04 is that a qualifying modification (as a result of reference rate reform) should not be considered an event that requires contract remeasurement at the modification date or reassessment of a previous accounting determination. FASB concluded that as reference rate changes are a market-wide initiative, one that is required primarily due to the discontinuance of LIBOR, it is outside the control of an entity and is the sole reason compelling an entity to make modifications to contracts or hedging strategies. As such, FASB determined that the traditional financial reporting requirements of discontinuing such contracts and treating the modified contract as an entirely new contract or hedging relationship would
1) not provide decision-useful information to financial statement users and 2) require a reporting entity to incur significant costs in the financial statement preparation and potentially reflect an adverse financial statement impact, one of which may not accurately reflect the intent or economics of a modification to a contract or hedging transaction.

5. Guidance in ASU 2020-04 allows a method to ensure that the financial reporting results would continue to reflect the intended continuation of contracts and hedging relationships during the period of the market-wide transition to alternative reference rates – thus, generally not requiring remeasurement or redesignation if certain criteria are met.

6. The optional, expedient and exceptions guidance provided by the amendments in ASU 2020-04 are applicable for all entities. However, they are only effective as of March 12, 2020 through December 31, 2022. This is because the amendments in ASU 2020-04 are intended to provide relief related to the accounting requirements in generally accepted accounting principles (GAAP) due to the effects of the market-wide transition away from IBORs. The relief provided by the amendments is temporary in its application in alignment with the expected market transition period. However, the FASB will monitor the market-wide IBOR transition to determine whether future developments warrant any changes, including changes to the end date of the application of the amendments in this ASU. If such an update occurs, the Working Group may also consider similar action. It is not expected that the Working Group will take action prior to or in the absence of a FASB amendment.

7. The accounting issues are:
   a. Issue 1: Should a reporting entity interpret the guidance in ASU 2020-04 as broadly accepted for statutory accounting?
   b. Issue 2: Should the optional, expedient and exception guidance in ASU 2020-04 apply to debt and other service agreements addressed in SSAP No. 15?
   c. Issue 3: Should the optional, expedient and exception guidance in ASU 2020-04 apply to lease transactions addressed in SSAP No. 22R?
   d. Issue 4: Should the optional, expedient and exception guidance in ASU 2020-04 apply to derivative transactions addressed in SSAP No. 86?

INT 20-01 Discussion

8. For Issue 1, the Working Group came to the consensus that ASU 2020-04 shall be adopted, to include the same scope of applicable contracts or transactions for statutory accounting with the only modification related to a concept not utilized by statutory accounting, as noted below. The Working Group agreed the amendments provide appropriate temporary guidance that alleviate the following concerns due to reference rate reform:
   a. Simplifies accounting analyses under current GAAP and statutory accounting principles (SAP) for contract modifications.
      i. All contracts within scope of ASU 2020-04, which allows for modifications due to reference rate reform and provides for the optional expedient to be accounted for as a continuation of the existing contract.
   b. Allows hedging relationships to continue without redesignation upon a change in certain critical terms.
   c. Allows a change in the designated benchmark interest rate to a different eligible benchmark interest rate in a fair value hedging relationship.
d. Suspends the assessment of certain qualifying conditions for fair value hedging 
relationships for which the shortcut method for assuming perfect hedge effectiveness is 
applied.

e. Simplifies or temporarily suspends the assessment of hedge effectiveness for cash flow 
hedging relationships.

f. The only SAP modification to this ASU is related to the option to sell debt currently 
classified held-to-maturity. This concept is not employed by statutory accounting and thus 
is not applicable.

9. For Issue 2, the Working Group came to the consensus that debt and service agreement 
modifications, as a result of reference rate reform, should not typically rise to the level of requiring a 
reversal and rebooking of the liability, as SSAP No. 15 states such liabilities should only be derecognized 
if extinguished. A reference rate modification should not generally require de-recognition and re-
recognition under statutory accounting. Nonetheless, for clarity and consistency with ASU 2020-04, the 
Working Group came to the consensus that should an eligible contract be affected by reference rate reform, 
then the temporary guidance in ASU 2020-04 shall apply.

10. For Issue 3, the Working Group came to the consensus that lease modifications, solely caused by 
reference rate reform and ones eligible for optional expedience, likely do not rise to the level of a 
modification requiring re-recognition as a new lease under statutory accounting. SSAP No. 22R, paragraph 
17 states only modifications in which grant the lessee additional rights shall be accounted for as a new lease.
These changes are outside the scope allowed for optional expedience in ASU 2020-04. Nonetheless, for 
clarity and consistency with ASU 2020-04, the Working Group came to a consensus that if an eligible lease 
affected by reference rate reform, then the temporary guidance in ASU 2020-04 shall apply.

11. For Issue 4, the Working Group came to the consensus that ASU 2020-04 shall be applied to 
derivative transactions as the following considerations provided in the ASU are appropriate for statutory 
accounting:

a. For any hedging relationship, upon a change to the critical terms of the hedging 
relationship, allow a reporting entity to continue hedge accounting rather than dedesignate 
the hedging relationship.

b. For any hedging relationship, upon a change to the terms of the designated hedging 
instrument, allow an entity to change its systematic and rational method used to recognize 
the excluded component into earnings and adjust the fair value of the excluded component 
through earnings.

c. For fair value hedges, allow a reporting entity to change the designated hedged benchmark 
interest rate and continue fair value hedge accounting.

d. For cash flow hedges, adjust the guidance for assessment of hedge effectiveness to allow 
an entity to continue to apply cash flow hedge accounting.

12. Additionally, for GAAP purposes, if an entity has not adopted the amendments in ASU 2017-12, 
Derivatives and Hedging, it is precluded from being able to utilize certain expedients for hedge accounting. 
For statutory accounting purposes, only the hedge documentation requirements were adopted from ASU 
2017-12, while the remainder of the items are pending statutory accounting review. The Working Group 
concluded that all allowed expedient methods are permitted as elections for all reporting entities under 
statutory accounting. However, if a reporting entity is a U.S. GAAP filer, the reporting entity may only 
make elections under ASU 2017-12 if such elections were also made for their U.S. GAAP financials.
INT 20-01 Status

13. No further discussion is planned.
Interpretation of the Statutory Accounting Principles Working Group


INT 20-02 Dates Discussed

Email Vote to Expose March 26, 2020; April 15, 2020

INT 20-02 References

SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers (SSAP No. 6)
SSAP No. 47—Uninsured Plans (SSAP No. 47)
SSAP No. 51—Life Contracts (SSAP No. 51)
SSAP No. 65—Property and Casualty Contracts (SSAP No. 65)

INT 20-02 Issue

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This has led to a significant increase in unemployment and, in certain states, mandatory closure of many businesses. Total economic damage is still being assessed however, the total impact is likely to exceed $1 trillion in the U.S. alone. This interpretation is intended to cover policies impacted by COVID-19.

2. Should a temporary extension of the 90-day rule, extending the nonadmission guidance for premium receivables due from policyholders or agents and for amounts due from policyholders for high deductible policies, and for uncollected uninsured plan receivables (excluding Medicare and similar government plans) be granted for the March 31st and June 30th, 2020 (1st and 2nd quarter) financial statements, for policies in U.S. jurisdictions that have been impacted by COVID-19?

INT 20-02 Discussion

3. The Working Group reached a consensus for a one-time optional extension of the ninety-day rule for uncollected premium balances, bills receivable for premiums and amounts due from agents and policyholders and for amounts due from policyholders for high deductible policies and amounts due from non-government uninsured plans, as follows:

   a. For policies in effect and current prior to the date as of the declaration of a state of emergency by the U.S. federal government on March 13, 2020 and policies written or renewed on or after March 13, insurers may follow the timeline described in paragraph 5 before nonadmitting premiums receivable from policyholders or agents as required per SSAP No. 6, paragraph 9.

   b. For uncollected uninsured plan receivables (excluding Medicare and similar government plans) which were current prior to the date of the declaration of a state of emergency by the U.S. federal government on March 13, 2020 and policies written or renewed on or after March 13, insurers may follow the timeline described in paragraph 5 before nonadmitting these balances as required per SSAP No. 47, paragraph 10.a.
c. For life premium due and uncollected which were current prior to the date of the declaration of a state of emergency by the U.S. federal government on March 13, 2020, and policies written or renewed on or after March 13, insurers may follow the timeline described in paragraph 5 before nonadmitting these balances as required per SSAP No. 51R, paragraph 12.

d. For high deductible policies in effect and current prior to the date as of the declaration of a state of emergency by the U.S. federal government on March 13, 2020 and policies written or renewed on or after March 13, insurers may follow the timeline described in paragraph 5 before nonadmitting amounts due from policyholders for high deductible policies as required per SSAP No. 65, paragraph 37.

e. Existing impairment analysis remains in effect for these affected policies.

4. The Working Group noted that a 60-day extension had been granted previously for regionally significant catastrophes, including INT 13-01: Extension of Ninety-Day Rule for the Impact of Hurricane/Superstorm Sandy; and INT 05-04: Extension of Ninety-day Rule for the Impact of Hurricane Katrina, Hurricane Rita and Hurricane Wilma, INT 17-01: Extension of Ninety-Day Rule for the Impact of Hurricane Harvey, Hurricane Irma and Hurricane Maria, and INT 18-04: Extension of Ninety-Day Rule for the Impact of Hurricane Florence and Hurricane Michael. This recommendation is for a longer period than the extensions that have been granted in the past as COVID-19 is a nationally significant event due to the expected overall impact to the U.S. economy.

5. Due to the short-term nature of this extension, which is only applicable for the March 31st and June 30th, 2020 (1st and 2nd quarter) financial statements and only for the categories of assets listed in paragraph 3, this interpretation will be publicly posted on the Statutory Accounting Principles (E) Working Group’s website. This INT will allow assets that meet the definition of paragraph 3 to be admitted assets even if they are greater than 90 days past due. As the exceptions provided in this interpretation are not applicable in the September 30, 2020 (3rd quarter) financial statements, this interpretation will automatically expire as of September 29, 2020. This interpretation will be automatically nullified on September 29, 2020 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

INT 20-02 Status

6. The Statutory Accounting Principles (E) Working Group will subsequently review this interpretation to determine if an extension is needed to the effective date.
Interpretation of the Statutory Accounting Principles Working Group

INT 20-03: Troubled Debt Restructuring Due to COVID-19

INT 20-03 Dates Discussed
Email Vote to Expose March 26, 2020; April 15, 2020

INT 20-03 References
SSAP No. 36—Troubled Debt Restructuring

INT 20-03 Issue

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

2. In response to COVID-19, Congress and Federal and state prudential banking regulators have considered provisions pertaining to mortgage loans as a result of the effects of the COVID-19. These provisions are intended to be applicable for the term of the loan modification, but solely with respect to a modification, including a forbearance arrangement, an interest rate modification, a repayment plan, and any other similar arrangement that defers or delays the payment of principal or interest, that occurs during the applicable period for a loan that was not more than 30 days past due as of December 31, 2019.

3. Furthermore, guidance has been issued by the Financial Condition (E) Committee to all U.S. insurers filing with the NAIC in an effort to encourage insurers to work with borrowers who are unable to, or may become unable to meet their contractual payment obligations because of the effects of COVID-19. As detailed in that guidance, the Committee, which is the NAIC parent committee of all the solvency policy making task forces and working groups of the NAIC, supports the use of prudent loan modifications that can mitigate the impact of COVID-19.

4. This interpretation considers the interagency guidance issued by Federal and state prudential banking regulators on March 22, 2020 addressing whether the modification of mortgage loan or bank loan terms in response to COVID-19 shall be considered a troubled debt restructuring.

INT 20-03 Discussion

5. SSAP No. 36—Troubled Debt Restructuring provides guidance, predominantly adopted from U.S. GAAP, in determining whether a debt restructuring is considered a troubled debt restructuring. Additionally, SSAP No. 36 provides accounting and disclosure guidance when a troubled debt restructuring has been deemed to occur. Pursuant to existing guidance in SSAP No. 36, a debt restructuring is not necessarily considered a troubled debt restructuring and a creditor must assess whether the debtor is experiencing financial difficulties. The guidance also indicates that a delay in payment that is insignificant is not a concession.

6. On March 22, 2020, the Federal and state prudential banking regulators issued a joint statement that included guidance on their approach to the accounting for loan modifications in light of the economic impact of the...
The guidance was developed in consultation with the staff of the FASB who concur with the approach and indicated that they stand ready to assist stakeholders with any questions. This interagency statement is provided below and is accessible through the FASB response via the following link:

https://fasb.org/cs/Satellite?c=FASBContent_C&cid=1176174374016&pagename=FASB%2FFASBContent_C%2FNewsPage

Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus

The Board of Governors of the Federal Reserve System (FRB), the Federal Deposit Insurance Corporation (FDIC), the National Credit Union Administration (NCUA), the Office of the Comptroller of the Currency (OCC), the Consumer Financial Protection Bureau (CFPB), and the State Banking Regulators (hereafter, the agencies), are issuing this interagency statement to provide additional information to financial institutions who are working with borrowers affected by the Coronavirus Disease 2019 (also referred to as COVID-19). The United States has been operating under a presidentially declared emergency since March 13, 2020, and financial institutions and their customers are affected by COVID-19. The agencies understand that this unique and evolving situation could pose temporary business disruptions and challenges that affect banks, credit unions, businesses, borrowers, and the economy. The agencies will continue to communicate with the industry as this situation unfolds, including through additional statements, webinars, frequently asked questions, and other means, as appropriate.

Working with Customers

The agencies encourage financial institutions to work prudently with borrowers who are or may be unable to meet their contractual payment obligations because of the effects of COVID-19. The agencies view loan modification programs as positive actions that can mitigate adverse affects on borrowers due to COVID-19. The agencies will not criticize institutions for working with borrowers and will not direct supervised institutions to automatically categorize all COVID-19 related loan modifications as troubled debt restructurings (TDRs). The agencies will not criticize financial institutions that mitigate credit risk through prudent actions consistent with safe and sound practices. The agencies consider such proactive actions to be in the best interest of institutions, their borrowers, and the economy. This approach is consistent with the agencies’ longstanding practice of encouraging financial institutions to assist borrowers in times of natural disaster and other extreme events. The agencies also will not criticize institutions that work with borrowers as part of a risk mitigation strategy intended to improve an existing non-pass loan.

Accounting for Loan Modifications

Modifications of loan terms do not automatically result in TDRs. According to U.S. GAAP, a restructuring of a debt constitutes a TDR if the creditor, for economic or legal reasons related to the debtor’s financial difficulties, grants a concession to the debtor that it would not otherwise consider. The agencies have confirmed with staff of the Financial Accounting Standards Board (FASB) that short-term modifications made on a good faith basis in response to COVID-19 to borrowers who were current prior to any relief, are not TDRs. This includes short-term (e.g., six months) modifications such as payment deferrals, fee waivers, extensions of repayment terms, or other delays in payment that are insignificant. Borrowers considered current are those that are less than 30 days past due on their contractual payments at the time a modification program is implemented.

Working with borrowers that are current on existing loans, either individually or as part of a program for creditworthy borrowers who are experiencing short-term financial or operational problems as a result of COVID-19, generally would not be considered TDRs. For modification programs designed to provide temporary relief for current borrowers affected by COVID-19, financial institutions may presume that borrowers that are current on payments are not experiencing financial difficulties at the time of the modification for purposes of determining TDR status, and thus no further TDR analysis is required for each loan modification in the program.
Modification or deferral programs mandated by the federal or a state government related to COVID-19 would not be in the scope of ASC 310-40, e.g., a state program that requires all institutions within that state to suspend mortgage payments for a specified period.

The agencies’ examiners will exercise judgment in reviewing loan modifications, including TDRs, and will not automatically adversely risk rate credits that are affected by COVID-19, including those considered TDRs. Regardless of whether modifications result in loans that are considered TDRs or are adversely classified, agency examiners will not criticize prudent efforts to modify the terms on existing loans to affected customers.

In addition, the FRB, the FDIC, and the OCC note that efforts to work with borrowers of one-to four family residential mortgages as described in the modification section of this document, where the loans are prudently underwritten, and not past due or carried in nonaccrual status, will not result in the loans being considered restructured or modified for the purposes of their respective risk-based capital rules.

Past Due Reporting

With regard to loans not otherwise reportable as past due, financial institutions are not expected to designate loans with deferrals granted due to COVID-19 as past due because of the deferral. A loan’s payment date is governed by the due date stipulated in the legal loan documents. If a financial institution agrees to a payment deferral, this may result in no contractual payments being past due, and these loans are not considered past due during the period of the deferral.

Nonaccrual Status and Charge-offs

Each financial institution should refer to the applicable regulatory reporting instructions, as well as its internal accounting policies, to determine if loans to stressed borrowers should be reported as nonaccrual assets in regulatory reports. However, during the short-term arrangements discussed in this statement, these loans generally should not be reported as nonaccrual. As more information becomes available indicating a specific loan will not be repaid, institutions should refer to the charge-off guidance in the instructions for the Consolidated Reports of Condition and Income.

Discount Window Eligibility

Institutions are reminded that loans that have been restructured as described under this statement will continue to be eligible as collateral at the FRB’s discount window based on the usual criteria.

On March 27, 2020, President Trump signed into law the Coronavirus Aid, Relief and Economic Security Act (CARES Act). The provisions in Section 4013 specifically address temporary relief from troubled debt restructurings:

SEC. 4013. TEMPORARY RELIEF FROM TROUBLED DEBT RESTRUCTURINGS.

(a) DEFINITIONS.—In this section:

(1) APPLICABLE PERIOD.—The term “applicable period” means the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID–19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates.

(2) APPROPRIATE FEDERAL BANKING AGENCY.—The term “appropriate Federal banking agency”—(A) has the meaning given the term in section 3 of the Federal Deposit Insurance Act (12 U.S.C. 1813); and (B) includes the National Credit Union Administration.
(b) SUSPENSION.—

(1) IN GENERAL.—During the applicable period, a financial institution may elect to— (A) suspend the requirements under United States generally accepted accounting principles for loan modifications related to the coronavirus disease 2019 (COVID–19) pandemic that would otherwise be categorized as a troubled debt restructuring; and (B) suspend any determination of a loan modified as a result of the effects of the coronavirus disease 2019 (COVID–19) pandemic as being a troubled debt restructuring, including impairment for accounting purposes.

(2) APPLICABILITY.—Any suspension under paragraph (1)—

(A) shall be applicable for the term of the loan modification, but solely with respect to any modification, including a forbearance arrangement, an interest rate modification, a repayment plan, and any other similar arrangement that defers or delays the payment of principal or interest, that occurs during the applicable period for a loan that was not more than 30 days past due as of December 31, 2019; and

(B) shall not apply to any adverse impact on the credit of a borrower that is not related to the coronavirus disease 2019 (COVID–19) pandemic.

(c) DEFERENCE.—The appropriate Federal banking agency of the financial institution shall defer to the determination of the financial institution to make a suspension under this section.

(d) RECORDS.—For modified loans for which suspensions under subsection (a) apply—

(1) financial institutions should continue to maintain records of the volume of loans involved; and

(2) the appropriate Federal banking agencies may collect data about such loans for supervisory purposes.

8. On April 7, 2020, the Federal and state prudential banking regulators issued a revised joint statement to reflect the issuance of the CARES Act:


Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus (Revised)

The Board of Governors of the Federal Reserve System (FRB), the Federal Deposit Insurance Corporation (FDIC), the National Credit Union Administration (NCUA), the Office of the Comptroller of the Currency (OCC), and the Consumer Financial Protection Bureau (CFPB) (hereafter, the agencies), in consultation with the state financial regulators, are issuing this revised interagency statement to provide additional information to financial institutions that are working with borrowers affected by the Coronavirus Disease 2019 (also referred to as COVID19). The United States has been operating under a presidentially declared emergency since March 13, 2020 (National Emergency). The agencies understand that this unique and evolving situation could pose temporary business disruptions and challenges that affect banks, credit unions, businesses, borrowers, and the economy.

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. As discussed in more detail below, the CARES Act creates a forbearance program for federally backed mortgage loans, protects borrowers from negative credit reporting due to loan accommodations related to the National Emergency, and provides financial institutions the option to temporarily suspend certain requirements under U.S. generally accepted accounting principles (GAAP) related to troubled debt restructurings (TDR) for a limited period of time to account for the effects of COVID-19.
The agencies originally issued a statement on March 22, 2020, to encourage financial institutions to work prudently with borrowers and to describe the agencies’ interpretation of how current accounting rules under U.S. GAAP apply to certain COVID-19-related modifications. This revised interagency statement clarifies the interaction between the March 22, 2020, interagency statement and section 4013 of the CARES Act, Temporary Relief from Troubled Debt Restructurings (section 4013), as well as the agencies’ views on consumer protection considerations. The agencies will continue to communicate with the industry as this situation unfolds, including through additional statements, webinars, frequently asked questions, and other means, as appropriate.

Working with Customers: General Safety and Soundness Considerations

The agencies encourage financial institutions to work prudently with borrowers who are or may be unable to meet their contractual payment obligations because of the effects of COVID-19. The agencies view loan modification programs as positive actions that can mitigate adverse effects on borrowers due to COVID-19. The agencies will not criticize institutions for working with borrowers in a safe and sound manner. As described below, institutions generally do not need to categorize COVID-19-related modifications as TDRs, and the agencies will not direct supervised institutions to automatically categorize all COVID-19 related loan modifications as TDRs.

The agencies will not criticize financial institutions that mitigate credit risk through prudent actions consistent with safe and sound practices. The agencies consider such proactive measures to be in the best interest of institutions, their borrowers, and the economy. This approach is consistent with the agencies’ longstanding practice of encouraging financial institutions to assist borrowers in times of natural disaster and other extreme events although the agencies recognize that the effects of this event are particularly extreme and broad-based. The agencies also will not criticize institutions that work with borrowers as part of a risk mitigation strategy intended to improve an existing non-pass loan.

Financial institutions have broad discretion to implement prudent modification programs consistent with the framework included in this statement.

Accounting and Reporting Considerations

As provided for under the CARES Act, a financial institution may account for an eligible loan modification either under section 4013 or in accordance with ASC Subtopic 310-40. If a loan modification is not eligible under section 4013, or if the institution elects not to account for the loan modification under section 4013, the financial institution should evaluate whether the modified loan is a TDR.

Accounting for Loan Modifications under Section 4013

To be an eligible loan under section 4013 (section 4013 loan), a loan modification must be (1) related to COVID-19; (2) executed on a loan that was not more than 30 days past due as of December 31, 2019; and (3) executed between March 1, 2020, and the earlier of (A) 60 days after the date of termination of the National Emergency or (B) December 31, 2020 (applicable period).

Financial institutions accounting for eligible loans under section 4013 are not required to apply ASC Subtopic 310-40 to the section 4013 loans for the term of the loan modification. Financial institutions do not have to report section 4013 loans as TDRs in regulatory reports. However, consistent with section 4013, financial institutions should maintain records of the volume of section 4013 loans. Data about section 4013 loans may be collected for supervisory purposes. Institutions do not need to determine impairment associated with certain loan concessions that would otherwise have been required for TDRs (e.g., interest rate concessions, payment deferrals, or loan extensions). For the most recent information on reporting requirements for section 4013 loans, refer to the Federal Financial Institutions Examination Council Instructions.
Accounting for other Loan Modifications Not under Section 4013

There are circumstances in which a loan modification may not be eligible under Section 4013 or in which an institution elects not to apply Section 4013. For example, a loan that is modified after the end of the applicable period would not be eligible under Section 4013. For such loans, the guidance below applies.

Modifications of loan terms do not automatically result in TDRs. According to ASC Subtopic 310-40, a restructuring of a debt constitutes a TDR if the creditor, for economic or legal reasons related to the debtor’s financial difficulties, grants a concession to the debtor that it would not otherwise consider. The agencies have confirmed with staff of the Financial Accounting Standards Board (FASB) that short-term modifications made on a good faith basis in response to COVID-19 to borrowers who were current prior to any relief are not TDRs under ASC Subtopic 310-40. This includes short-term (e.g., six months) modifications such as payment deferrals, fee waivers, extensions of repayment terms, or delays in payment that are insignificant. Borrowers considered current are those that are less than 30 days past due on their contractual payments at the time a modification program is implemented.

Accordingly, working with borrowers who are current on existing loans, either individually or as part of a program for creditworthy borrowers who are experiencing short-term financial or operational problems as a result of COVID-19 generally would not be considered TDRs. More specifically, financial institutions may presume that borrowers are not experiencing financial difficulties at the time of the modification for purposes of determining TDR status, and thus no further TDR analysis is required for each loan modification in the program, if:

- The modification is in response to the National Emergency;
- The borrower was current on payments at the time the modification program is implemented; and
- The modification is short-term (e.g., six months).

Government-mandated modification or deferral programs related to COVID-19 would not be in the scope of ASC Subtopic 310-40, for example, a state program that requires institutions to suspend mortgage payments within that state for a specified period.

Credit Risk

The agencies’ examiners will exercise judgment in reviewing loan modifications and will not automatically adversely risk rate credits that are affected by COVID-19. All loan modifications should comply with applicable laws and regulations and be consistent with safe and sound practices (including maintenance of appropriate allowances for loan and lease losses or allowances for credit losses, as applicable). Regardless of whether modifications result in loans that are considered TDRs, section 4013 loans, or are adversely classified, agency examiners will not criticize prudent efforts to modify the terms on existing loans to affected customers.

Regulatory Capital

The FRB, the FDIC, and the OCC note that efforts to work with borrowers of one-to-four family residential mortgages as described above, where the loans are prudently underwritten, and not 90 days or more past due or carried in nonaccrual status, will not result in the loans being considered restructured or modified for the purposes of their respective risk-based capital rules.

Past Due Reporting

With regard to loans not otherwise reportable as past due, financial institutions are not expected to designate loans with deferrals granted due to COVID-19 as past due because of the deferral. A loan’s payment date is governed by the due date stipulated in the legal agreement. If a financial institution agrees to a payment deferral, this may result in no contractual payments being past due, and these loans are not considered past due during the period of the deferral.
Nonaccrual Status and Charge-offs

Each financial institution should refer to the applicable regulatory reporting instructions, as well as its internal accounting policies, to determine if loans to stressed borrowers should be reported as nonaccrual assets in regulatory reports. However, during the short-term arrangements discussed in this statement, these loans generally should not be reported as nonaccrual. As more information becomes available indicating a specific loan will not be repaid, institutions should refer to the charge-off guidance in the instructions for the Consolidated Reports of Condition and Income.

Discount Window Eligibility

Institutions are reminded that loans that have been restructured as described under this statement will generally continue to be eligible as collateral at the FRB’s discount window based on the usual criteria.

Working with Customers: Consumer Protection Considerations

The agencies encourage financial institutions to consider prudent arrangements that can ease cash flow pressures on affected borrowers, improve their capacity to service debt, increase the potential for financially stressed residential borrowers to keep their homes, and facilitate the financial institution’s ability to collect on its loans. Additionally, such prudent arrangements may mitigate the long-term impact of this emergency on consumers by avoiding delinquencies and other adverse consequences.

When working with borrowers, lenders and servicers should adhere to consumer protection requirements, including fair lending laws, to provide the opportunity for all borrowers to benefit from these arrangements. When exercising supervisory and enforcement responsibilities, the agencies will take into account the unique circumstances impacting borrowers and institutions resulting from the National Emergency. The agencies will take into account an institution's good-faith efforts demonstrably designed to support consumers and comply with consumer protection laws. The agencies expect that supervisory feedback for institutions will be focused on identifying issues, correcting deficiencies, and ensuring appropriate remediation to consumers. The agencies do not expect to take a consumer compliance public enforcement action against an institution, provided that the circumstances were related to the National Emergency and that the institution made good faith efforts to support borrowers and comply with the consumer protection requirements, as well as responded to any needed corrective action.

INT 20-03 Consensus

9. The Working Group reached a consensus to clarify that a modification of mortgage loan or bank loan terms in response to COVID-19 shall follow the provisions detailed in the April 7, 2020 “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus” (detailed in paragraph 8) and the provisions of the CARES Act (detailed in paragraph 7) in determining whether the modification shall be reported as a troubled debt restructuring within SSAP No. 36.

10. This interpretation is effective for the specific purpose to address loan modifications in response to COVID-19. Consistent with the CARES act, this interpretation is only applicable for the term of the loan modification, but solely with respect to any modification, including a forbearance arrangement, interest rate modification, a repayment plan and other similar arrangement that defer or delays the payment of principal or interest for a loan that was not more than 30 days past due as of December 31, 2019. As determined in the CARES Act, this interpretation will only be applicable for the period beginning on March 1, 2020 and ending on the earlier of December 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the novel coronavirus disease (COVID-19) outbreak declared by the President on March 13, 2020 under the National Emergencies Act (50 U.S.C. 1601 et seq.) terminates.
INT 20-03 Status

11. The Statutory Accounting Principles (E) Working Group will subsequently review this interpretation to determine if an extension is needed to the effective date.
**Interpretation of the Statutory Accounting Principles Working Group**

**INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19**

**INT 20-04 Dates Discussed**

Email Vote to Expose March 26, 2020; April 15, 2020

**INT 20-04 References**

SSAP No. 26R—Bonds  
SSAP No. 30—Common Stock  
SSAP No. 37—Mortgage Loans  
SSAP No. 43R—Loan-backed and Structured Securities  
SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies

**INT 20-04 Issue**

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

2. In response to COVID-19, Congress and Federal and state prudential banking regulators have considered provisions pertaining to loans as a result of the effects of the COVID-19. While primarily related to mortgage loans, these provisions are intended to be applicable for the term of a loan modification, but solely with respect to a modification, including a forbearance arrangement, an interest rate modification, a repayment plan, and any other similar arrangement that defers or delays the payment of principal or interest, that occurs during the applicable period for a loan that was not more than 30 days past due as of December 31, 2019.

3. Furthermore, guidance has been issued by the Financial Condition (E) Committee to all U.S. insurers filing with the NAIC in an effort to encourage insurers to work with borrowers who are unable to, or may become unable to meet their contractual payment obligations because of the effects of COVID-19. As detailed in that guidance, the Committee, which is the NAIC parent committee of all the solvency policy making task forces and working groups of the NAIC, supports the use of prudent loan modifications that can mitigate the impact of COVID-19.

4. This interpretation intends to address the impact of loan forbearance or prudent modifications on the statutory accounting and reporting requirements for bank loans, mortgage loans, as well as investments with underlying mortgage loans. Particularly, this interpretation considers whether a temporary, limited-time statutory exception for the assessment of impairment shall be granted for bank loans, mortgage loans and investment products with underlying mortgage loans. This exception would only defer the assessment of impairment due to situations caused by the forbearance or modification of mortgage loan payments and would not delay the recognition of other than temporary impairments if the entity made a decision to sell the investment and/or if provisions other than the limited-time forbearance or modifications of mortgage loans payments caused the entity to identify that they would not recover the reported carrying value of the investment.
INT 20-04 Discussion

5. Although a variety of structures have the potential to be impacted by the economic stimulus provisions, this interpretation is limited to investments specifically identified. Except for the specific inclusion of bank loans, this interpretation does not include investments captured in scope of SSAP No. 26R—Bonds or investments captured in the identified standards that are not predominantly impacted by underlying mortgage loans with forbearance or modification provisions in response to COVID-19. Investments in scope of this interpretation include:

   a. SSAP No. 26R—Bonds: Bank loans in scope of SSAP No. 26R

   b. SSAP No. 37—Mortgage Loans: All mortgage loans in scope of SSAP No. 37.

   c. SSAP No. 30—Common Stock: SEC registered investments with underlying mortgage loans (e.g., mortgage-backed mutual funds).

   d. SSAP No. 43R—Loan-backed and Structured Securities: Securities in scope of SSAP No. 43R with underlying mortgage loans. This includes residential and commercial mortgage backed securities (RMBS & CMBS), and credit risk transfers (CRTs) issued through government sponsored enterprises (GSEs). Other investments in scope of SSAP No. 43R are also captured within this interpretation if the underlying investments predominantly reflect mortgage loan products.

   e. SSAP No. 48—Joint Ventures, Partnerships and Limited Liabilities Companies: Investments in scope of SSAP No. 48 that have underlying characteristics of mortgage loans. These investments could include private equity mortgage loan funds.

Bank Loans

6. Bank loans, if meeting certain parameters, are in scope of SSAP No. 26R—Bonds. Bank loans per SSAP No. 26R, are defined as fixed-income instruments, representing indebtedness of a borrower, made by a financial institution. Bank loans can be issued directly by a reporting entity or acquired through an assignment, participation or syndication. The guidance in SSAP No. 26R states an other-than-temporary impairment shall be considered to have occurred if it is probable the reporting entity will be unable to collect amounts due according to the contract terms of a debt security in effect at the date of issue/acquisition. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. The impairment guidance applicable to bank loans states that if it is probable or if repayment does not occur according to the terms of the original contract (i.e. payment timing and amounts), an impairment shall be considered to have occurred.

Mortgage Loans

7. Mortgage loans are in scope of SSAP No. 37—Mortgage Loans and reported on Schedule B: Mortgage Loans. The guidance in SSAP No. 37, paragraph 16 identifies that a mortgage loan shall be considered impaired when mortgage loan payments are not received in accordance with the contractual terms of the mortgage agreement. As such, a deferral or modification of mortgage loan payments (whether interest or principal) would ordinarily trigger an impaired classification and require impairment assessment under SSAP No. 37. The guidance in SSAP No. 37 utilizes a valuation allowance to recognize unrealized losses from impairment assessments and permits subsequent reversals of unrealized losses reflected in the valuation allowance based on subsequent assessments. If an impairment is deemed other than temporary, the unrealized loss is realized without the potential for subsequent recoveries.
SEC Registered Funds with Underlying Mortgage Loans

8. The scope of *SSAP No. 30—Common Stock* includes SEC registered open-end investment companies (mutual funds), closed-end funds and unit investment trusts, regardless of the types or mix of securities owned by the fund. Investments in scope of this statement include mortgage-backed mutual funds and other such investments. Items in scope of SSAP No. 30 are reported on Schedule D-2-2: Common Stock. These investments are reported at fair value, with changes in fair value recognized as unrealized gains or losses. The guidance in SSAP No. 30 requires recognition of an other than temporary impairment (OTTI) (realized loss) if a reporting entity decision has decided to sell the security at an amount below its carrying value or if the decline in fair value is determined to be other than temporary pursuant to *INT 06-07: Definition of Phrase “Other Than Temporary.”* As investments in scope of SSAP No. 30 are reported at fair value, subsequent recoveries (or losses) in fair value, after recognition of an OTTI, are recognized as unrealized gains or losses until sold or additional OTTI recognition.

Loan-Backed and Structured Securities with Underlying Mortgage Loans

9. The scope of *SSAP No. 43R—Loan-backed and Structured Securities* includes residential mortgage backed securities (RMBS), commercial mortgage backed securities (CMBS) and credit risk transfers (CRTs) issued through government sponsored enterprises (GSEs). (These are commonly referred as Structured Agency Credit Risk Securities (STACRs), which are issued by Freddie Mac, and Connecticut Avenue Securities (CAS), which are issued by Fannie Mae.) Other mortgage loan products that meet the structural requirements as a LBSS can also be captured in scope of SSAP No. 43R. Investments in scope of this statement securities are reported on Schedule D-1: Long-Term Bonds. Pursuant to the guidance in SSAP No. 43R, paragraphs 30-36, if a fair value of a LBSS is less than its amortized cost basis at the balance sheet date, an entity shall assess whether the impairment is other than temporary. Recognition of an OTTI is then contingent on the reporting entity intentions:

a. If the entity intends to sell the security, an OTTI shall be considered to have occurred. In these situations, the entity shall recognize a realized loss for the difference between the amortized cost basis and fair value. These realizes losses are not permitted to be reversed.

b. If the entity does not intend to sell the security, the entity shall assess whether it has the intent and ability to retain the investment in the security for a period of time sufficient to recover the amortized cost basis. If the entity does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, an OTTI shall be considered to have occurred. In these situations, the entity shall recognize a realized loss for the difference between the amortized cost basis and fair value. These realizes losses are not permitted to be reversed.

c. Regardless if the entity does not have the intent to sell or has the intent and ability to hold, if the entity does not expect to recover the entire amortized cost basis of the security, an OTTI shall be considered to have occurred. In these situations, the entity shall recognize a realized loss for the difference between the amortized cost basis and the present value of cash flows expected to be collected.

Other Invested Assets with Underlying Mortgage Loans

10. The scope of *SSAP No. 48—Joint Ventures, Partnerships and Limited Liabilities Companies* includes investments that may have underlying characteristics of mortgage loans. These items are reported on Schedule BA: Other Long-Term Invested Assets. These investments could include private equity mortgage loan funds as well mortgage or hybrid real estate investment trusts (REITs). The guidance in SSAP No. 48, paragraph 19 requires recognition of an OTTI if it is probable that the reporting entity will be unable to recover the carrying amount of the investment or sustain earnings to justify the carrying amount of the investment. The existing
guidance already indicates that a depressed fair value below the carrying amount or the existence of operating losses are not necessarily indicators of a loss that is other than temporary.

INT 20-04 Consensus

11. The Working Group reached a consensus for limited time exceptions to defer assessments of impairment for bank loans, mortgage loans and investments which predominantly hold underlying mortgage loans, which are impacted by forbearance or modifications in response to COVID-19. These exceptions are applicable for the March 31st and June 30th, 2020 (1st and 2nd quarter) financial statements and only in response to mortgage loan forbearance or modifications granted in response to COVID-19. As such, the exceptions provided in this interpretation are not applicable in the September 30, 2020 (3rd quarter) financial statements.

12. For modification programs designed to provide temporary relief for borrowers current as of December 31, 2019, the reporting entities may presume that borrowers are current on payments are not experiencing financial difficulties at the time of the modification for purposes of determining impairment status and thus no further impairment analysis is required for each loan modification in the program. The exceptions granted in this interpretation are detailed as follows:

a. **SSAP No. 26R—Bonds:** Provide a limited-time exception for assessing impairment under SSAP No. 26, paragraph 13, for bank loans with payments (either principal or interest) that have short-term deferrals or modifications in response to COVID-19. This interpretation shall not delay impairment assessments for reasons other than the short-term deferral or modification of interest or principal payments in response to COVID-19 and shall not delay recognition of realized losses if a reporting entity believes a bank loan is OTTI.

b. **SSAP No. 37—Mortgage Loans:** Provide a limited-time exception for assessing impairment under SSAP No. 37, paragraph 16, for mortgage loans with payments (either principal or interest) that have short-term deferrals or modifications in response to COVID-19. This interpretation shall not delay impairment assessments for reasons other than the short-term deferral or modification of interest or principal payments in response to COVID-19 and shall not delay recognition of realized losses if a reporting entity believes a mortgage loan is OTTI.

c. **SSAP No. 30R—Common Stock:** Provide a limited-time exception for assessing OTTI under SSAP No. 30, paragraph 10, and INT 06-07 due to fair value declines for SEC registered funds that have underlying mortgage loans that have been deferred or modified in response to COVID-19 unless the reporting entity intends to sell the security. If the entity has made a decision to sell the security, recognition of the OTTI shall continue to be required. As these investments are reported at fair value, declines in fair value would continue to be reported as unrealized losses.

d. **SSAP No. 43R—Loan-backed and Structured Securities:** Provide a limited-time exception for assessing OTTI under SSAP No. 43R, paragraphs 30-36, due to fair value declines in investments that have underlying mortgage loans deferred or modified in response to COVID-19 unless the reporting entity intends to sell the security. If the entity has made a decision to sell the security, then recognition of an OTTI shall continue to be required.

e. **SSAP No. 48—Joint Ventures, Partnerships and Limited Liabilities Companies:** Provide a limited-time exception for assessing OTTI under SSAP No. 48 due to fair value declines in investments that have underlying mortgage loans deferred or modified in response to COVID-19 unless the entity intends to sell the security. Additionally, an OTTI shall be assessed if factors other than the mortgage loan forbearance or modification have resulted with a decline that is
considered other than temporary, or the reporting entity does not believe it is probable they will collect the carrying amount of the investment.

13. Subsequent to modifications or restructurings that impact original contractual terms of items in scope of this interpretation, future assessments of impairment shall be based on the modified terms.

14. As detailed in paragraph 11, the exceptions granted in this interpretation are applicable for the March 31st and June 30th, 2020 (1st and 2nd quarter) financial statements and only in response to bank and mortgage loan forbearance or modifications granted in response to COVID-19. As the exceptions provided in this interpretation are not applicable in the September 30, 2020 (3rd quarter) financial statements, this interpretation will automatically expire as of September 29, 2020. This interpretation will be publicly posted on the Statutory Accounting Principles (E) Working Group’s website. This interpretation will be automatically nullified on September 29, 2020 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

INT 20-04 Status

15. The Statutory Accounting Principles (E) Working Group will subsequently review this interpretation to determine if an extension is needed to the effective date.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded March 26, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); Kathy Belfi (CT); Ryllynn Brown (DE); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Tom Dudek (NY); Jamie Walker (TX); David Smith (VA); and Amy Malm (WI).

1. Exposed Agenda Item 2020-12, INT 20-01, INT 20-02, INT 20-03 and INT 20-04

The Working Group conducted an e-vote to consider exposure of agenda item 2020-12: Reference Rate Reform, Interpretation (INT) 20-01: ASU 2020-04 - Reference Rate Reform, INT 20-02: Extension of Ninety-Day Rule for the Impact of COVID-19, INT 20-03: Troubled Debt Restructuring Due to COVID-19, and INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19 for a one-week public comment period ending April 2. A summary of the exposed interpretations are as follows:

1) Agenda Item 2020-12 and INT 20-01: Reference Rate Reform – This guidance proposes to adopt ASU 2020-04: Reference Rate Reform (Topic 848) Facilitation of the Effects of Reference Rate Reform on Financial Reporting, for statutory accounting. This guidance provides optional transition and expedient provisions to assist with the conversion from referencing the London Interbank Offered Rate (LIBOR) and other interbank offered rates (IBORs) and moving toward alternative reference rates that are more observable or transaction based. The guidance proposed to be adopted from ASU 2020-04 is that a qualifying modification as a result of reference rate reform should not be considered an event that requires contract remeasurement at the modification date or reassessment of a previous accounting determination.

2) INT 20-02: Extension of Ninety-Day Rule for the Impact of COVID-19 – This guidance proposes a limited-time exception to the 90-day rule for nonadmittance required in Statement of Statutory Accounting Principles (SSAP) No. 6—Uncollectible Premium Balance, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers and SSAP No. 65—Property and Casualty Contracts for high deductible policies.

3) INT 20-03: Troubled Debt Restructuring Due to COVID – This guidance proposes to clarify that a modification of mortgage loan terms in response to COVID-19 shall follow the provisions detailed in the March 22, “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus” in determining whether the modification shall be reported in accordance with SSAP No. 36—Troubled Debt Restructuring.

4) INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19 – This guidance proposes limited-time exceptions for impairment assessments due to situations caused by the forbearance or modification of mortgage loan payments related to COVID-19 for the following SSAPs: SSAP No. 30R—Unaffiliated Common Stocks, SSAP No. 37—Mortgage Loans, SSAP No. 43R—Loan-Backed and Structured Securities, and SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies.

Mr. Smith made a motion, seconded by Ms. Malm, to expose agenda item 2020-12, INT 20-01, INT 20-02, INT 20-03 and INT 20-04. The motion passed without opposition, with 13 members voting.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met via conference call March 18, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); Kathy Belfi and William Arfanis (CT); Rylednn Brown (DE); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Tom Dudek (NY); Joe DiMemmo and Kimberly Rankin (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Adopted its Jan. 8 and 2019 Fall National Meeting Minutes

Ms. Walker made a motion, seconded by Ms. Malm, to adopt the Working Group’s Jan. 8 (Attachment One-H1) and Dec. 7, 2019, (see NAIC Proceedings – Fall 2019, Accounting Practices and Procedures (E) Task Force, Attachment One) minutes. The motion passed unanimously.

2. Adopted Non-Contested Statutory Accounting Revisions During its Public Hearing

The Working Group held a public hearing to review comments (Attachment One-H2) on previously exposed items.

Mr. Hudson made a motion, seconded by Mr. Dudek, to adopt the statutory accounting revisions detailed below as non-contested statutory accounting revisions. The motion passed unanimously.

   a. Agenda Item 2018-26

Mr. Bruggeman directed the Working Group to agenda item 2018-26: SCA Loss Tracking – Accounting Guidance (Attachment One-H3). Fatima Sediqzad (NAIC) stated that this non-substantive agenda item adopts language that reported equity losses of a subsidiary, controlled and affiliated entity (SCA) would not go negative, thus stopping at zero; however, any guaranteed liabilities would be reported to the extent that there is a financial guarantee or commitment.

   b. Agenda Item 2018-38

Mr. Bruggeman directed the Working Group to agenda item 2018-38: Prepayment to Service and Claims Adjusting Providers (Attachment One-H4). Robin Marcotte (NAIC) stated that this non-substantive agenda item expands language emphasizing that loss and loss adjusting expense liabilities shall be established regardless of payments to third parties, except for capitated health claim payments. Furthermore, prepayments to third-party administrators (TPAs) that are not for claims or loss adjusting expenses are miscellaneous underwriting expenses.

   c. Agenda Item 2019-32

Mr. Bruggeman directed the Working Group to agenda item 2019-32: Look-Through with Multiple Holding Companies (Attachment One-H5). Ms. Sediqzad stated that this non-substantive agenda item emphasized existing guidance stating that a look-through is permitted through more than one downstream holding company if each entity complies with the look-through requirements of Statement of Statutory Accounting Principles (SSAP) No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

   d. Agenda Item 2019-35

Mr. Bruggeman directed the Working Group to agenda item 2019-35: Update Withdrawal Disclosures (Attachment One-H6). Ms. Marcotte stated that this non-substantive agenda item updates withdrawal disclosures that were previously developed by the Financial Stability (EX) Task Force. This agenda item made minor consistency and cross-reference edits in various SSAPs.
e. **Agenda Item 2019-43**

Mr. Bruggeman directed the Working Group to agenda item 2019-43: *ASU 2017-11, Earning Per Share, Distinguishing Liabilities from Equity, Derivatives & Hedging* (Attachment One-H7). Jim Pinegar (NAIC) stated that this non-substantive agenda item addressed the complexity of accounting for certain financial instruments that are not prevalent in the insurance industry. However, it provided the opportunity to address principle concepts regarding the accounting for instruments with characteristics of both liability and equity. This agenda item requires that issued, free-standing financial instruments with characteristics of both a liability and equity shall be reported as a liability, to the extent that they represent an unconditional obligation to the issuer.

f. **Agenda Item 2019-45**

Mr. Bruggeman directed the Working Group to agenda item 2019-45: *ASU 2013-11, Income Taxes – Presentation of an Unrecognized Tax Benefit* (Attachment One-H8). Mr. Pinegar stated that this non-substantive agenda item addressed the financial statement presentation of an unrecognized tax benefit. However, as an unrecognized tax benefit does not meet the more-likely-than-not recognition threshold, current statutory accounting guidance requires immediate expensing of the item. Mr. Pinegar stated that interested parties proposed one minor clarification change, and NAIC staff supported adoption with the edits proposed.

g. **Agenda Item 2019-48**

Mr. Bruggeman directed the Working Group to agenda item 2019-48: Disclosure Update for Reciprocal Jurisdiction Reinsurers (Attachment One-H9). Jake Stultz (NAIC) stated that this non-substantive agenda item adds reference of reciprocal jurisdictions as a result of the Executive (EX) Committee and Plenary adoption revisions to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786).

h. **Agenda Item 2019-46**

Mr. Bruggeman directed the Working Group to agenda item 2019-46: *ASU 2016-14, Presentation of Financial Statements for Not-for-Profit Entities* (Attachment One-H10). Mr. Pinegar stated that Accounting Standards Update (ASU) 2016-14, *Presentation of Financial Statements for Not-for-Profit Entities* detailed the financial statement presentation required for non-for-profit entities. He stated that requirements included the presentation of two classes of net assets. He stated that the non-substantive revisions to *Appendix D—Nonapplicable GAAP Pronouncements* are to reject ASU 2016-14.

3. **Adopted Revisions to Statutory Accounting with Minimal Discussion**

The Working Group held a public hearing to review comments (Attachment One-H2) on previously exposed items.

a. **Agenda Item 2019-08**

Mr. Bruggeman directed the Working Group to agenda item 2019-08: Reporting Deposit-Type Contracts. Mr. Pinegar stated that this non-substantive agenda item originated to gather information on deposit-type contracts that were reported in the annual statement Exhibit 5 – Aggregate Reserves for Life Contracts or Exhibit 6 – Aggregate Reserves for Accident and Health Contracts. He stated that the long-standing industry practice is to classify and report contracts in the appropriate schedule at policy inception and not move reporting schedules throughout the policy lifecycle. Accordingly, the exposed footnote for Exhibit 5 would capture contracts that no longer contain a mortality risk. Mr. Pinegar stated that the agenda item also sought feedback regarding the instructions for classifying deposit-type contracts in Exhibit 7 – Deposit-Type Contracts; however, if warranted, that may be addressed in a separate agenda item.

John Bauer (Prudential), representing interested parties, stated that they recommend adoption of this agenda item.

Ms. Belfi made a motion, seconded by Ms. Weaver, to adopt the recommendation to add a footnote for annual statement Exhibit 5, noting that no updates were required for statutory accounting (Attachment One-H11). The motion passed unanimously.
b. **Agenda Item 2019-40**

Mr. Bruggeman directed the Working Group to agenda item 2019-40: Reporting of Installment Fees and Expenses. Ms. Marcotte stated that exposed non-substantive edits address potential diversity in the application of the *SSAP No. 53—Property Casualty Contracts—Premiums* installment fee guidance. She stated that the recommendation in the agenda item was to clarify that the installment fee and service charges guidance should be applied narrowly to the specific situation described and not analogized to exclude other fees from premium. Furthermore, diversity in reporting was noted regarding installment fee expenses, even though the annual statement provides for reporting these items in underwriting expenses. This agenda requested input regarding the reporting of installment fee expenses. Mr. Marcotte stated that interested parties suggested a one-word edit, and NAIC staff were supportive of the suggested edit.

Ms. Marcotte stated that notifications of the exposure were sent to the Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk-Based Capital (E) Working Group. However, comments were not expected to be received until after the Summer National Meeting. She noted that, if warranted, comments can be addressed in a separate agenda item as they are received regarding installment fee expenses.

Richard Poniatowski (Travelers), representing interested parties, stated that they agreed with the language proposed for SSAP No. 53.

Mr. Hudson made a motion, seconded by Ms. Mears, to adopt the exposed agenda item with minor changes from interested parties, clarifying language in SSAP No. 53 stating that the existing installment fee revenue guidance should be narrowly applied (Attachment One-H12). The motion passed unanimously.

c. **Agenda Item 2019-33**

Mr. Bruggeman directed the Working Group to agenda item 2019-33: SSAP No. 25 – Disclosures. Julie Gann (NAIC) stated that this non-substantive agenda item was drafted to data-capture disclosures from *SSAP No. 25—Affiliates and Other Related Parties*. She noted that disclosures from SSAP No. 25 are currently completed in a narrative format. With the proposal to data-capture disclosures, the state insurance regulators can aggregate and query various related party relationships. She noted that interested parties proposed minor modifications, one of which was supported by NAIC staff. The Blanks (E) Working Group has a concurrent exposure to ensure reporting for year-end 2020.

Mr. Smith made a motion, seconded by Mr. Dudek, to adopt the exposed agenda item with minor changes from interested parties, detailing the data-capture of certain SSAP No. 25 disclosures, which are currently completed in narrative form (Attachment One-H13). The motion passed unanimously.

d. **Agenda Item 2019-39**

Mr. Bruggeman directed the Working Group to agenda item 2019-39: Acceptable Collateral for Derivatives. Mr. Pinegar stated that the intent of this agenda item was to facilitate a discussion to determine if a reporting entity should receive credit for initial margin pledged to them in central clearinghouse transactions. However, discussions with interested parties found that utilization of initial margin is not only a rare event, but additional compensating controls are in place to ensure variation margin compliance. Furthermore, non-cash collateral is often utilized for posting the initial margin and, as such, that collateral should remain on the books of the provider as they maintain the full rights of ownership. Mr. Pinegar stated that due to these facts, NAIC staff believe that the third-party derivative exposure is appropriately captured in existing reporting, and he recommended disposal of this agenda item.

Josh Bean (Transamerica), on behalf of interested parties, stated support for disposal of the agenda item, as they believe the derivative activity in central clearinghouse activities is appropriately captured in existing reporting framework.

Mr. Moser made a motion, seconded by Mr. Hudson, to dispose of this agenda item without statutory revision (Attachment One-H14). The motion passed unanimously.

4. **Reviewed Comments and Considered Exposure of Agenda Items with Minimal Discussion**

The Working Group held a public hearing to review comments (Attachment One-H2) on previously exposed items.
Mr. Smith made a motion, seconded by Mr. Hudson, to expose all items for comment with a distinction of the differing exposure periods for each item. The motion passed unanimously.

a. **Agenda Item 2019-04**

Mr. Bruggeman directed the Working Group to agenda item 2019-04: SSAP No. 32 – Investment Classification Project. Mr. Pinegar stated that the intent of the agenda item was to revise SSAP No. 32—Preferred Stock pursuant to the investment classification project. The revisions include definitions, measurement and impairment guidance. Mr. Pinegar stated that with this and prior exposures, comments were received regarding the proposed definitions (e.g., whether redemption is within control of the holder). He stated that while the original terminology proposed by NAIC staff reflects the common terminology used by industry and U.S. Generally Accepted Accounting Principles (GAAP), a potential reclassification of certain preferred stock could occur if adopted, which was not the intent of the project. He stated that NAIC staff agreed to the terminology and phraseology suggested by interested parties. The addition of a footnote was also added to cover certain joint venture or partnership entities in which issue instruments were identical to preferred stock but used differing legal naming conventions. He stated that NAIC staff support for the exposure of the issue paper and the revised SSAP No. 32R—Preferred Stock to reflect the proposed edits of all interested parties. This agenda item has a comment deadline of May 29.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

b. **Agenda Item 2019-38**

Mr. Bruggeman directed the Working Group to agenda item 2019-38: Financing Derivatives. Ms. Gann stated that this non-substantive agenda item addresses the reporting of financing derivatives, which represents situations where the premium due, as a result of acquiring or writing a derivative, is paid throughout the derivative term or at maturity. She stated that the agenda item proposes the elimination of the allowance of net reporting, with a requirement for gross reporting for derivatives purchased or sold. She stated that the proposed revisions to SSAP No. 86—Derivatives would require gross reporting of derivatives without the effect of financing premiums due or payable, and they would present the true financial asset and liability position associated with the use of derivatives. She noted that proposed concepts included in the agenda item suggest revisions to a Blanks proposal to capture additional information regarding any derivative financing components. She stated that the interested parties’ comments requested an effective date of Jan. 1, 2021, and other editorial changes. NAIC staff were supportive of the effective date and edits proposed, and they recommended exposure of the agenda item. Finally, with exposure, a referral would be sent to the Capital Adequacy (E) Task Force for consideration of these risk-based capital (RBC) changes.

Mr. Bruggeman stated that he appreciated staff and interested parties’ continual, collaborative effort on this agenda item to ensure that the appropriate reporting occurs without incurring any unintended consequences from this reporting change, and they confirmed that the exposure deadline for this item was May 29.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

c. **Agenda Item 2019-14**

Mr. Bruggeman directed the Working Group to agenda item 2019-14: Attribution of Goodwill. Ms. Gann stated that this non-substantive agenda item is a disclosure item for when a reporting entity purchases a holding company and said company owns multiple entities. The goodwill from the acquisition of the holding company shall be allocated to each entity at the time of purchase. She stated that comments received from interested parties on this item were combined with comments received for agenda item 2019-12: ASU 2014-17, Business Combinations – Pushdown Accounting regarding pushdown accounting. She stated that this agenda item does not necessarily pertain to pushdown accounting and, it is only intended to require disclosure of the goodwill attributed to the underlying holding companies in which pushdown accounting has not been applied. For clarification, an edit was proposed to ensure that pushdown is omitted from the disclosure requirements; however, she stated that once pushdown has been addressed the applicability of the attributed goodwill disclosure may be reassessed. This agenda item has a comment deadline of May 29.

D. Keith Bell (Travelers), representing interested parties, stated that they did not understand the intent nor the proposal, and they requested a conference with NAIC staff for further discussion. He stated that if an entity is sold, the associated goodwill should be removed. Ms. Gann stated that the intent of this agenda item was to assist NAIC staff and state insurance regulators with the identification of the amount of goodwill that should be removed upon the sale of an SCA, as that information is not currently available.
Mr. Bruggeman declared his understanding that U.S. GAAP allows instances where goodwill is associated with a business unit and perhaps not with a legal entity, and he encouraged the NAIC staff and interested parties’ continued collaboration on this agenda item.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

d. **Agenda Item 2019-20**

Mr. Bruggeman directed the Working Group to agenda item 2019-20: Rolling Short-Term Investments. Mr. Pinegar stated that this non-substantive agenda item was originally exposed to address certain investments that were structured as short-term investments, with those investments being rolled or renewed and remaining on a short-term schedule for multiple years. As the original agenda item captured both affiliated and unaffiliated investments, he stated that interested parties requested separating the discussion of both types of investments. NAIC staff agreed with the separation, as unaffiliated investments do occur in an arm’s length transaction, indicating that each party can independently review and elect not to renew an investment. With this independence, renewal or rolling of the investments and subsequent reporting as a short-term investment was likely appropriate. Additionally, certain affiliated transactions could, under certain circumstances, also operate independently as if both parties were unaffiliated. Mr. Pinegar stated that related operating units may have various review mechanisms to allow arm’s length review. He stated that this agenda item proposed additional guidance allowing certain affiliated or related party investments to be rolled or renewed if certain criteria are met. He stated that the criteria required the investment to be appropriately re-underwritten with adequate documentation, and each party must have the ability to independently review the terms and terminate the transaction prior to renewal. Additionally, a concurrent Blanks exposure includes a reporting code to identify short-term investments that remain on the short-term schedule for more than one year, and a general interrogatory has been proposed requiring certification that, if related party transactions have been renewed, appropriate re-underwriting has occurred. Mr. Pinegar stated that if adopted in current form, a referral will be sent to the Financial Analysis (E) Working Group and the Financial Analysis Solvency Tools (E) Working Group notifying them of the new reporting code, which captures renewed affiliated investments, and urging assistance to analysts and examiners on how to use the new data. This agenda item has a comment deadline of May 1.

Mr. Bruggeman confirmed that for efficiency in reporting, the code used to identify renewed short-term investment would apply to all investments and not solely affiliated investments. He stated that this code would allow state insurance regulators to identify such investments, at which time additional underwriting documentation could be requested.

Stephanie Rengstorf (Nationwide), on behalf of interested parties, appreciated NAIC staff’s collaboration on this agenda item, as liquidity management, through the efficient use of capital, is a critical function in terms of servicing policyholders. She stated that the proposed edits and disclosures were a welcome change, and she will provide feedback on subsequent exposure.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

e. **Agenda Item 2019-42**

Mr. Bruggeman directed the Working Group to agenda item 2019-42: Cash Equivalent – Cash & Liquidity Pools. Mr. Pinegar stated that this non-substantive agenda item arose as a result of the short-term rolling agenda item (Ref #2019-20), in which interested parties commented that cash pools were not appropriately scoped out of the proposed short-term restriction guidance. He stated that cash pools are techniques in which affiliates combine excess cash in order to earn additional interest, access additional short-term investment markets, and improve liquidity management. He stated that this agenda item originally proposed to allow cash pools that meet certain requirements to be reported as cash equivalents. He stated that interested parties provided responses that requested consideration on three items. First, interested parties requested that the reporting of cash pool assets be allowed on the schedule that most closely reflects the assets held by the pool (i.e., cash, cash equivalents, or short-term investments). Mr. Pinegar stated that NAIC staff originally proposed reporting as a cash equivalent for simplicity, but they were supportive of the request, noting that RBC and other analysis techniques combine these assets and that reporting on one schedule versus another should not cause any adverse effects. Second, NAIC staff were supportive of interested parties’ request to remove the U.S. GAAP audit of the liquidity pool, noting that the footnote disclosure, which details the assets held by investment type, would be subject to an independent audit under statutory accounting principles (SAP). Mr. Pinegar stated that NAIC staff did not concur with the third request of allowing for optionality in reporting asset valuations. He noted that current guidance requires that all short-term investments be accounted for in the same manner as similar long-term investments,
and NAIC staff believe assets should not be accounted for differently simply because they are in a liquidity pool. This agenda item has a comment deadline of May 1.

Diane Bellas (Allstate), representing interested parties, expressed appreciation to the Working Group for separating this agenda item, noting that cash and liquidity pools are an important function of many insurance entities, and support for the shortened exposure period.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

f. Agenda Item 2019-25

Mr. Bruggeman directed the Working Group to agenda item 2019-25: Working Capital Finance Investments. Ms. Marcotte noted that the materials contain the proposed substantive revisions, incorporating the industry proposed language for the six specific items directed by the Working Group at the 2019 Summer National Meeting to SSAP No. 105—Working Capital Finance Investments. She stated that NAIC staff recommended exposure of the SSAP and related Issue Paper No. 16x—Working Capital Finance Investment Updates. An effective date of June 30 was proposed for discussion, which, if preferred, would require comment from the Working Group by May 1.

Michael M. Monahan (American Council of Life Insurers—ACLI) stated that interested parties had no preference in the effective date; since all their requests were not granted, this will remain an un-investable asset class.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure with a proposed effective date of June 30.

g. Agenda Item 2019-36

Mr. Bruggeman directed the Working Group to agenda item 2019-36: Expand MGA and TPA Disclosures. Ms. Marcotte stated that this non-substantive agenda item was drafted pursuant to a request from two states that the existing annual statement disclosure regarding managing general agents (MGA) or TPAs be expanded to include additional information. She stated that state insurance regulators and policyholders should be able to fully understand the level and extent to which core services and binding authority are provided by MGAs or TPAs. Interested parties commented that a TPA should be consistently defined. Ms. Marcotte stated that the proposed modification is to add references to Registration and Regulation of Third-Party Administrators (TPAs) (GDL-1090). She stated that interested parties also commented on the proposed TPA claims reporting threshold, and she recommended using a premium threshold. The recommendation from the sponsors of the agenda is to use a claim count threshold. This agenda item has a comment deadline of May 1.

Mr. Bell, representing interested parties, stated that they appreciated the exposure; however, they would need to reassess any operational concerns with the proposed TPA reporting thresholds.

Albert Thomas Finnell (America’s Health Insurance Plans—AHIP) requested clarification regarding the shortened comment period. Ms. Marcotte stated that due to a concurrent Blanks exposure, a shortened comment period is required if the Working Group requests adoption for 2020.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

h. Agenda Item 2019-37

Mr. Bruggeman directed the Working Group to agenda item 2019-37: Surplus Notes – Enhanced Disclosures. Mr. Pinegar stated that this non-substantive agenda item was drafted from the Working Group’s request that additional disclosures be captured in SSAP No. 41R—Surplus Notes. He stated that the originally proposed disclosures materially reflected certain key details in the surplus note data call from 2019. These disclosures were intended to give state insurance regulators further insight into the issuances of surplus notes that do not contain cash flows typically associated with surplus notes. Mr. Pinegar stated that interested parties commented that the disclosures, as originally proposed, would not accurately reflect the disclosure of items sought by state insurance regulators and would disclose confidential pricing information. He stated that in conjunction with their comments, interested parties provided several suggested disclosure edits, of which NAIC staff note would achieve the same level of disclosure as requested by the Working Group. He stated that regarding the potential disclosure of confidential information, NAIC staff have proposed a modified disclosure element that disregards cashflows to the independent source of liquidity, thus maintaining pricing confidentiality. This agenda item has a comment deadline of May 1.
Mr. Bauer, representing interested parties, stated appreciation of NAIC staff’s efforts in integrating proposed interested party comments and how the proposed agenda item provides robust disclosure of surplus note activity.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

i. Agenda Item 2019-47

Mr. Bruggeman directed the Working Group to agenda item 2019-47: VM 21 Grading. Ms. Marcotte noted that the agenda item is addressing VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and grade-in requirements for reporting changes in valuation basis for years beginning Jan. 1. She stated that the revisions to the Valuation Manual allowed different optional phase-in requirements. She stated that the exposure includes non-substantive revisions to SSAP No. 51R—Life Contracts and SSAP No. 3—Accounting Changes and Corrections of Errors for reporting years beginning Jan. 1.

Ms. Marcotte stated that what was exposed would expand the disclosure for changes in valuation basis as a change in accounting principle under SSAP No. 3 to provide details regarding grade-in of changes in valuation basis. This includes the grade-in period applied, the remaining amount to be graded-in, the remaining time for the grade-in period, and any adjustments. The exposure also provided accounting for unrecognized graded-in reserve, which represents an unrecognized adjustment to surplus. The exposed revisions would have required the unrecognized grade-in amount due to a change in valuation basis, if resulting in an increase in reserves (decrease to surplus), to be reported as an allocation from unassigned funds to special surplus until the amount has been fully graded into unassigned funds.

Ms. Marcotte stated that the interested parties provided comments were opposed to requiring the segregation in special surplus of the unrecognized phase-in amounts. She noted that NAIC staff had some concern regarding the timing of re-exposure; however, discussion with ACLI representatives noted that the Valuation Manual allows the phase-in election to occur as late as Dec. 31. NAIC staff proposed revisions recommended for a short exposure by the Working Group, incorporating the major interested parties’ proposed edit of removing the reclassification to special surplus. Ms. Marcotte noted that “grade-in” was changed to “phase-in” that paragraph 39 of the illustration has two additional edits that change “grading” to “phase-in.” She stated that the revisions for exposure did not incorporate all the interested parties’ proposed revisions, language on retroactivity was not incorporated, and coordination on future Valuation Manual grade-in proposals will be required. She noted that the proposal will provide disclosure of the change in valuation basis from the VM-21 changes and add new disclosures regarding the phase-in process being applied. She noted that consistent with the prior exposure, notice of the exposure should also be sent to the Life Actuarial (A) Task Force as part of the Valuation Manual and Accounting Practices and Procedures Manual (AP&P Manual) coordination process. Mr. Monahan noted appreciation for a re-exposure and coordination with NAIC staff.

5. Considered Maintenance Agenda—Pending Listing—Exposures

Mr. Dudek made a motion, seconded by Ms. Weaver, to move agenda items 2020-01 through 2020-11 to the active listing and expose all items for comment with distinction of each item as either substantive or non-substantive and with corresponding referrals and comment periods as recommended by NAIC staff. The motion passed unanimously.

a. Agenda Item 2020-01

Mr. Bruggeman directed the Working Group to agenda item 2020-01: Update/Remove References to SVO Listings. Mr. Pinegar stated that this agenda item reflects a Valuation of Securities (E) Task Force notice regarding two pending revisions to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual). He stated that the Task Force is renaming the “U.S. Direct Obligations/Full Faith and Credit Exempt List” the “NAIC U.S. Government Money Market Fund List.” He noted that no revisions to the AP&P Manual would be required for this revision, as this list is not specifically identified. He stated that revisions would, however, likely be needed in the Blanks and RBC filings/instructions. He stated that the second revision was to discontinue the “NAIC Bond Fund List.” He noted that items that were on this list would be eligible for consideration in the “NAIC Fixed Income-Like SEC Registered Funds List.” The discontinuance will require an update in the AP&P Manual in SSAP No. 26R—Bonds and SSAP No. 30R—Unaffiliated Common Stock to eliminate references to the “NAIC Bond Fund List” and add reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R. This agenda item has a comment deadline of May 1.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.
b. **Agenda Item 2020-02**

Mr. Bruggeman directed the Working Group to agenda item 2020-02: Accounting for Bond Tender Offers. Mr. Pinegar stated that a bond tender offer is like a called bond, except a tender offer is contingent on acceptance of the offer by the holder. He stated that specific guidance for the reporting and allocation of investment income and/or capital gain/loss associated with callable bonds is noted in SSAP No. 26R; however, guidance is not reflected when a bond is retired early through a tender offer. He stated that the non-substantive revisions in this proposal clarify that the accounting and reporting of investment income and capital gain/loss due to the early liquidation, either through a call or a tender offer, shall be similarly applied. The existing guidance would include all dynamics in which an issuer provides a penalty/fee to the holder to retire the bond prior to maturity.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

c. **Agenda Item 2020-03**

Mr. Bruggeman directed the Working Group to agenda item 2020-03: Enhanced Goodwill Disclosures. Ms. Sediqzad stated that this agenda item was drafted to request additional goodwill information and clarify reporting on Schedule D, Part 6, Section 1 – Valuation of Shares of Subsidiary, Controlled and Affiliated Companies. She stated that with the adoption of agenda item 2017-18: Goodwill Limitations, the information reported regarding goodwill, as provided in annual statement Footnote 3 – Business Combinations and Goodwill, has improved. She said the agenda item proposes additional disclosures to enhance the reporting of an SCA’s book adjusted carrying value (BACV). She noted that as goodwill is a significant component of many SCA’s BACV, this agenda item will assist in facilitating the review and disclosure of each balance.

Ms. Sediqzad stated that during a review of SCA Sub 2 filings, it is noted that many companies do not calculate the amortization of goodwill correctly, which sometimes overstates the value of the SCA. She stated that many companies also do not provide additional information to verify beginning goodwill and purchase price; as such, NAIC staff rely on a review of Footnote 3 for these details. She stated that if the goodwill amount is not verifiable, it is not be allowed to be admitted as part of the SCA’s value.

Ms. Sediqzad stated that the goodwill limitation of 10% of the insurance reporting entity’s goodwill is a calculation that all reporting entities who have goodwill must perform. She noted that while the admitted result is in the annual statement, the details of the calculation are not easily identifiable, and this agenda item proposes the disclosure of the calculation components to ensure transparency in the admission of goodwill.

Ms. Sediqzad noted that feedback is requested in terms of the proposed edits to Schedule D – Part 6 – Sections 1 and 2. She stated that, as detailed in the proposal, two column headings and related Blanks instructions refer to “Intangible Assets”; however, NAIC staff believe the original intent of these disclosures was to capture goodwill. She noted that the Financial Accounting Standards Board (FASB) defines intangible assets as assets (not including financial assets) that lack physical substance and refer to assets other than goodwill. She stated that feedback is requested from state insurance regulators and interested parties regarding what has historically been included in this disclosure and if changing the definition to articulate goodwill is warranted. She noted that per a review by NAIC staff, it appears as though goodwill is the sole number currently being reported in these applicable columns. This agenda item has a comment deadline of May 29.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

d. **Agenda Item 2020-04**

Mr. Bruggeman directed the Working Group to agenda item 2020-04: Commissioner Discretion in the Valuation Manual. Ms. Marcotte stated that this agenda item has been drafted to maintain comparability by providing disclosures regarding the use of commissioner discretion pursuant to the Valuation Manual, which became operative on Jan. 1, 2017. She stated that after reviewing the instances that require commissioner approval in the Valuation Manual, the items involve making a voluntary choice between various acceptable methods, which is subject to commissioner approval. She stated that the identified instances in the Valuation Manual are consistent with a change in valuation basis. As these changes are voluntary and not required to change by the methodology, this agenda item recommends disclosing the use of commissioner discretion required for choosing between acceptable methods, consistent with a change in valuation basis.
Ms. Marcotte noted that the non-substantive revisions to SSAP No. 51R, SSAP No. 52—Deposit-Type Contracts, and SSAP No. 54R—Individual and Group Accident and Health Contracts are illustrated in the agenda item. She noted that the proposed guidance points to an existing change in valuation basis disclosures for voluntary decisions, which require commissioner approval and the ability to choose one allowable reserving methodology over another. She also stated that as part of the coordination process with the Valuation Manual, the Life Actuarial (A) Task Force should be notified of the exposure. This agenda item has a comment deadline of May 29.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

e. **Agenda Item 2020-05**

Mr. Bruggeman directed the Working Group to agenda item 2020-05: Repeal of the Affordable Care Act Section 9010 Assessment. Ms. Marcotte stated that the federal Affordable Care Act (ACA) Section 9010 assessment has had more than one deferral or moratorium, as addressed in INT 16-01: ACA Section 9010 Assessment 2017 Moratorium. She stated that in December 2019, the U.S. House of Representatives (House) and U.S. Senate (Senate) passed bills repealing Section 9010 assessments for calendar years beginning Jan. 1, 2021. She stated that this bill was subsequently signed into law. She noted that the assessment is required to be paid for calendar year 2020. She stated that the agenda item addresses the substantive impacts of the Section 9010 assessment repeal for calendar years beginning on Jan. 1, 2021, by recommending that SSAP No. 106—Affordable Care Act Section 9010 Assessment be superseded and INT 16-01 be nullified. She noted that both actions are proposed to be effective Jan. 1, 2021, and with these actions, both SSAP No. 106 and INT 16-01 would be moved to Appendix H - Superseded Statements of Statutory Accounting Principles and Nullified Interpretations for the 2021 publication of the AP&P Manual. She stated referrals to coordinate the related impacts with the Blanks (E) Working Group to ensure that the annual statement disclosures related to SSAP No. 106 currently reported in Note 22 are removed beginning in reporting years 2021 and to the Health Risk-Based Capital (E) Working Group to address the RBC implications related to the 2021 removal of the federal ACA adjustment sensitivity test, which uses data from the SSAP No. 106 disclosures. This agenda item has a comment deadline of May 29.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

f. **Agenda Item 2020-06EP**

Mr. Bruggeman directed the Working Group to agenda item 2020-06EP: Editorial and Maintenance Update. Ms. Marcotte stated that this item provides non-substantive editorial corrections in accordance with the maintenance process, deleting an unnecessary excerpt and updating various paragraphical references in SSAP No. 21R—Other Admitted Assets and SSAP No. 51R. This agenda item has a comment deadline of May 1.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

g. **Agenda Item 2020-07**

Mr. Bruggeman directed the Working Group to agenda item 2020-07: Change to the Summary Investment Schedule. Mr. Stultz stated that SSAP No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures requires disclosures as detailed in Appendix A-001: Investments of Reporting Entities (A-001). He stated that Section 3 of A-001 requires the Summary Investment Schedule in the statutory annual statements and the notes of the annual audited financial statements. This agenda item arose because NAIC staff support for the Blanks (E) Working Group were notified of a cross-check error where total mortgage loans reported on the Summary Investment Schedule do not tie to the amounts reported in Schedule B, Mortgages Part 1. Mr. Stultz noted that the non-substantive revisions will add the total valuation allowance to the Summary Investment Schedule to ensure that these schedules tie together. He stated that the agenda item is intended to be exposed concurrently with a Blanks (E) Working Group proposal. This agenda item has a comment deadline of May 1.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

h. **Agenda Item 2020-08**

Mr. Bruggeman directed the Working Group to agenda item 2020-08: ASU 2016-20, Technical Corrections & Improvements – Topic 606. Mr. Stultz stated that ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers was issued to clarify narrow aspects of the guidance issued in ASU 2014-09, Revenue from Contracts
with Customers. He stated that in 2018, the Working Group rejected the guidance in ASU 2014-09 and several other ASUs related to revenue recognition in SSAP No. 47—Uninsured Plans. He stated that the guidance in ASU 2016-20 provides updates and clarifications based on issues that were found during the initial U.S. GAAP implementation of ASU 2014-09 and Administrative Services Contract (ASC) Topic 606. He noted that the agenda item proposes to reject ASU 2016-20 in SSAP No. 47 as the revisions were consistent with how the prior ASUs related to Topic 606 have been treated. This agenda item has a comment deadline of May 1.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

i. Agenda Item 2020-09

Mr. Bruggeman directed the Working Group to agenda item 2020-09: ASU 2018-18, Collaborative Arrangements – Topic 808. Mr. Stultz stated that this ASU clarifies and aligns revenue recognition under the new Topic 606 for collaborative arrangements. He stated that a collaborative arrangement is defined as a contractual arrangement that involves a joint operating activity involving two or more parties that are active participants in the activity and are exposed to significant risks and rewards dependent on the commercial success of the activity. He noted that the intent of this guidance is to ensure that revenue recognized within a collaborative arrangement is consistent with revenue recognition in Topic 606. He noted that this agenda item proposes to reject ASU 2018-18, Collaborative Arrangements – Topic 808 in SSAP No. 47 as the revisions were consistent with how the prior ASUs related to Topic 606 have been treated. This agenda item has a comment deadline of May 1.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

j. Agenda Item 2020-10

Mr. Bruggeman directed the Working Group to agenda item 2020-10: ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topic 605 and Topic 606. Mr. Stultz stated that this ASU only affects U.S. Securities and Exchange Commission (SEC) paragraphs in Topic 220, Topic 605 and Topic 606. He stated that the revisions to Topic 220 update references from “income statement” to “statement of comprehensive income” and add a reference to revenue recognition in Topic 606. He noted that the revisions to Topic 605 remove guidance from and references to SEC Staff Accounting Bulletin 13, Revenue Recognition. He noted that the non-substantive revisions to Appendix D—Nonapplicable GAAP Pronouncements are to reject ASU 2017-14, Income Statement—Reporting Comprehensive Income (Topic 220), Revenue Recognition (Topic 605), and Revenue from Contracts with Customers (Topic 606), Amendments to SEC Paragraphs Pursuant to Staff Accounting Bulletin No. 116 and SEC Release No. 33-10403 as not applicable to statutory accounting. This agenda item has a comment deadline of May 1.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

k. Agenda Item 2020-11

Mr. Bruggeman directed the Working Group to agenda item 2020-11: ASU 2020-02, Amendments to SEC Paragraphs in Credit Losses and Lease. Mr. Stultz stated that this ASU only affects the SEC section in Topic 326, which clarifies reporting for SEC registrants and updates the effective date for these provisions and the updates to Topic 842, which updates the effective dates for the new lease guidance for SEC reporting companies.

He noted that the non-substantive revisions to Appendix D—Nonapplicable GAAP Pronouncements are to reject ASU 2020-02, Financial Instruments—Credit Losses (Topic 326) and Leases (Topic 842), Amendments to SEC Paragraphs Pursuant to SEC Staff Accounting Bulletin No. 119 and Update to SEC Section on Effective Date Related to Accounting Standards Update No. 2016-02, Leases (Topic 842) as not applicable to statutory accounting. This agenda item has a comment deadline of May 1.

In response to an inquiry from Mr. Bruggeman, there was no objection to exposure.

6. Considered Maintenance Agenda—Active Listing

a. Agenda Item 2019-21

Mr. Bruggeman directed the Working Group to agenda item 2019-21: SSAP No. 43R. Ms. Gann stated that as the result of a conference call that occurred on Jan. 8, the Working Group directed NAIC staff to work with interested parties in the creation of an issue paper which would review SSAP No. 43R—Loan-Backed and Structured Securities for a possible substantial
revision. She stated that many collaborative meetings with interested parties have produced the first draft of the issue paper; however, the draft was not a complete issue paper and only reflects the work product to-date, which is intended to continue the discussion process, not make final recommendations regarding accounting and reporting of various applicable SSAP No. 43R investments. She stated that the issue paper incorporates primary concepts used to determine if an investment is within scope of SSAP No. 43R and proposes various buckets or classifications of investments with similar characteristics. Upon agreement with the buckets, the next step would be to determine applicable accounting and reporting. She stated that while the comment period is June 26, input from interested parties through the comment period is requested as NAIC staff will continue work on this project throughout the comment period.

Mr. Bruggeman stated that the investment bucketing approach was to capture investments along a continuum of varying structures, assisting both state insurance regulators and interested parties throughout the discussion process.

Michael Reis (Northwestern Mutual), representing interested parties and the ACLI, stated that due to the magnitude of this project, the extended exposure period was appreciated. He stated that with the review of investments in scope of SSAP No. 43R, current investment portfolios would need to be analyzed for potential adverse accounting treatment or potential negative RBC implications. Under ideal circumstances, each affected company would independently review their applicable SSAP No. 43R investments; however, due to the current market and economic environment, an unprecedented amount of attention is being utilized elsewhere, which could cause issues if a substantial revision is effective in 2020. Mr. Reis stated that the issue paper may be capturing a broader set of securities known as collateralized fund obligations (CFOs); and in some instances, the bonds issued by CFOs are not dependent upon equity performance. He requested that state insurance regulators provide written comments on their concerns regarding such investment types so that they can be responded to directly as opposed through an issue paper.

Ms. Gann stated that operational procedures for substantially revised items typically require the exposure of the issue paper and the proposed substantively revised SAP. This exposure is only a partial issue paper; and while any effective date would be at the Working Group’s discretion, it would be unlikely that substantial revisions to SSAP No. 43R would occur in 2020. Additionally, a regulator-only call is anticipated to discuss equity types of investments that are categorized and reported as bonds.

Mr. Bruggeman concurred with Mr. Gann’s statement, adding that the review of these products is occurring because these are relatively new investment structures. Additionally, other known instances where certain assets were placed into a trust and repackaged as bonds may be occurring under SSAP No. 43R.

Mr. Dudek made a motion, seconded by Mr. Hudson, to expose the agenda item and direct continual collaborative effort with interested parties throughout the exposure period. The motion passed unanimously.

7. Deferred Discussion for a Subsequent Call or Meeting

Due to time constraints, the Working Group did not discuss the following agenda items. Discussion will occur later at a venue to be determined.

   e. Agenda Item 2019-49: Retroactive Reinsurance Exception.

8. Discussed Other Matters

a. Reference Rate Reform - LIBOR

Mr. Pinegar stated that the FASB issued an ASU regarding reference rate reform, and a subsequent agenda item is forthcoming, which is anticipated for interim exposure.

Due to time constraints, the Working Group did not discuss the following items; however, information was provided in conjunction with the meeting material:
a. Ref #2016-20: Credit Losses
b. Risk Corridors – Supreme Court
c. Working Group Referrals from the Valuation of Securities (E) Task Force
d. Process Update for SCA Filing Reviews
e. Review of U.S. GAAP Exposures
f. Health Test Update Notice

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

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Statutory Accounting Principles (E) Working Group
Conference Call
January 8, 2020

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted a conference call on Jan. 8, 2020. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears, Vice Chair (IA); Richard Ford (AL); Kim Hudson (CA); William Arfanis (CT); Danielle Hopp (DE); Eric Moser and Kevin Fry (IL); Stewart Guerin (LA); Judy A. Weaver (MI); Doug Bartlett (NH); Joe DiMemmo (PA); Doug Stolte (VA); Jamie Walker (TX); and Elena Vetrina and Randy Milquet (WI).

1. **Adopted Editorial Revisions from Agenda Item 2019-44EP**

Mr. Bruggeman directed the Working Group to agenda item 2019-44EP: Editorial Updates. Robin Marcotte (NAIC) stated that during the 2019 Fall National Meeting, the Working Group exposed editorial revisions to SSAP No. 62—Property and Casualty Reinsurance and throughout the *NAIC Accounting Practices and Procedures Manual* (Manual) to update references to the Annual Statement Instructions. Ms. Marcotte stated that the editorial revisions were exposed with a shortened comment period to allow for the edits to be reflected in the “As of March 2020” Manual. She stated that no comments were received.

Mr. Hudson made a motion, seconded by Ms. Walker, to adopt the exposed editorial revisions (Attachment One-H1a). The motion passed unanimously.

2. **Reviewed Comments on Agenda Item 2019-21: SSAP No. 43R – Equity Instruments**

The Working Group held a public hearing to review comments (Attachment One-H1b) on Agenda Item 2019-21.

Mr. Bruggeman directed the Working Group to agenda item 2019-21: SSAP No. 43R – Equity Instruments. Julie Gann (NAIC) stated that during the 2019 Summer National Meeting, the Working Group exposed revisions to SSAP No. 43R—Loan-Backed and Structured Securities to exclude collateralized fund obligations (CFOs), and similar structures that reflect underlying equity interests, from the scope of the Statement, as well as prevent existing equity assets from being repackaged as securitizations and reported as long-term bonds. Ms. Gann stated that comments were received from interested parties as well as Global Atlantic. After review of the comments, NAIC staff is recommending that the Working Group direct NAIC staff to undertake a substantive project to review and consider revisions to SSAP No. 43R. In making this recommendation, Ms. Gann stated that there have been regulator concerns with the current application of SSAP No. 43R. These concerns have included structures that mask affiliated transactions, structures that have utilized the “trust” component in SSAP No. 43R to classify investments that primarily determine repayment based on market returns that have been reflected as “debt instruments,” and situations in which insurer-owned assets may be repackaged (self-securitized) to obtain different accounting and reporting treatment.

Ms. Gann stated that NAIC staff proposes to proceed with an issue paper to address SSAP No. 43R holistically and clarify the securities intended to be in scope of the statement. Ms. Gann stated that the recommendation included potential initial concepts to be considered in the issue paper, but highlighted that all aspects would be discussed throughout the issue paper process. Additionally, Ms. Gann stated that a key aspect of the recommendation is for NAIC staff to work directly with key members of industry throughout the drafting of the issue paper and preparing an initial draft for exposure at the Spring National Meeting.

Ms. Gann summarized the initial concepts to be considered in the issue paper as follows:

- Division of guidance between items considered “asset-backed securities” as defined under the Code of Federal Regulations (CFR) and items that do not meet this definition. Ms. Gann stated that initial guidance is anticipated to retain historical SSAP No. 43R accounting and reporting guidance for items that meet the CFR definition. An assessment of whether different accounting and reporting treatment, including potential use of lower of amortized cost or fair value or the elimination of filing exempt (FE), will occur for investments that do not meet the ABS definition.

- Removal from SSAP No. 43R, investments in the form of a debt instrument where the investment provides that the amount of principal or interest to be earned or returned to the holder is calculated solely with reference to an external market indicator.

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• Inclusion of guidance, investment reporting provisions and disclosures to clearly identify and assess insurer sponsored securitizations. Disclosures are anticipated to capture the conditions from SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities and how an insurer concluded that the conditions were met to attain “sale” accounting treatment.

• Separate review and reference for equipment trust certificates, credit tenant loans and lease-backed securities. This review will coordinate work with the SVO staff on provisions reflected in the Purposes and Procedures Manual of the NAIC Investment Analysis Office and discussions occurring the Valuation of Securities (E) Task Force.

Mr. Bruggeman stated that the proposed issue paper approach is a logical step to properly review SSAP No. 43R using principle concepts. Ms. Mears stated support for the approach, agreeing with the use of principle concepts within SSAP No. 43R.

Mike Reis (Northwestern Mutual), stated that a small group of industry representatives worked together to develop the interested parties’ comment letter. He stated that this group is interested in the actual concerns that regulators are trying to address. He stated that they want to be supportive and assist NAIC staff, as well as regulators in addressing concerns, but they would like more detail and direct regulator comments on what those concerns are so they can be as helpful as possible. Mr. Reis stated that the proposed issue paper is intended to address concerns, but the review of these investments is also in response to the Working Group’s ongoing Investment Classification Project. He stated that if the Working Group proceeds with the direction to holistically review and possibly revise SSAP No. 43R, industry would like to make the following comments or requests:

1. Industry does not believe the concerns on CFOs were fully or clearly articulated in the recent exposure and the potential solution went beyond addressing the potential abuses noted. As a result, some CFO securities were indicted without specific regulator concerns being attributed to them, causing the applicable market to freeze and become very inactive. He stated that companies hold these securities and industry believes there are perfectly accepted CFO debt-type securities. Industry believes that if regulators understood these securities, they would agree that they are in the best interest of holders. Such as, industry requests that CFOs be addressed concurrently with the project in order to unfreeze the CFO market.

2. Industry identified that the proposal seems to indict any security that does not meet the CFR ABS definition, as the agenda proposes to possibly consider use of lower or amortized cost or fair value and removal of eligibility for a filing exempt (FE) status for NAIC designations. Although he stated that the recommendation includes qualifiers that these could be the possible treatment, it is requested that the direction just be to consider the appropriate accounting and reporting for securities that do not meet the CFR ABS definition.

3. The American Council of Life Insurers—ACLI, North American Securities Valuation Association—NASVA, and the Private Placement Investors Association—PPIA are all willing to work with NAIC staff, but the emphasis should be on getting the guidance right and not getting the guidance done quickly. Although industry would prefer for the project to be done timely, it needs to be done correctly. He stated that an exposure for the Spring National Meeting may be aggressive if it is to properly identify the population of securities that do not meet the CFR ABS definition. He stated that interested parties request NAIC staff work with the SVO as part of this project. He stated that the SVO has also been working on CFOs, principal-protected notes (PPNs) and combo notes and the NAIC staff for the Working Group could leverage off those discussions.

Mr. Hudson noted that the reference to possible exposure at the Spring National Meeting is simply a marker to work towards, but the focus would be getting the project done correctly. Mr. Bruggeman agreed with these comments noting that NAIC staff is aiming for a Spring exposure and will be working with industry in the interim to develop the document.

Mr. Bruggeman responded to the comments from Mr. Reis, initially stating that the exposure reference to “CFO” investments was not necessarily intended to solely identify CFO’s, but was intended to capture investments that include components of both debt and equity. He stated that these structures seemingly takes an investment that would be on the bond schedule and an investment that would be on the Other Invested Asset Schedule (Schedule BA) and with combining, the entire investment is reported as a bond on the bond schedule. He stated that the reference for “equity interest” was intended to be a generic reference that went beyond CFOs to encompass these combined structures. Mr. Bruggeman stated that regulators understand that industry is predominantly trying to do the right thing, and the regulators understand that there is a drive for yield in this low-interest rate environment, but industry needs to be sensitive that regulators have noted concerning investments and cannot disclose company
specifics. Mr. Reis stated that his company has investments in debt from closed-end funds and CFOs and it is difficult to address questions on whether additional securities can be acquired since the future accounting and reporting is uncertain.

Mr. Bruggeman stated that the proposal from NAIC staff is attempting to use overarching principles and use of the CFR ABS definition is a good starting point as it provides an overall principle basis to begin discussions. He stated that the assessment for non-ABS securities will be whether the securities are truly debt, or debt tranches, with NRSRO rated principal and interest, maturity dates, scheduled payments, additional structural protections, diversification, ratings triggers and/or other protections that safeguard the debt instrument. Mr. Bruggeman stated that even if insurers acquire investments that are allowed in accordance with the state investment code, the insurer should be cognizant of the impact the investment will have on the balance sheet and overall statutory financial statements.

Mr. Hudson stated that it would be productive for industry and the NAIC SVO to work with NAIC staff for the Working Group on this project. Charles Theriault (NAIC) stated agreement with the overall proposal from Ms. Gann and noted that they have seen concerning investments in both SSAP No. 43R and SSAP No. 26R—Bonds. He stated that they agree with the use of the SVO to review these transactions, noting that they have seen some structures that are debt instruments that have the noted protections and others that do not appear to be an actual debt instrument. He stated that the SVO is willing to assist the NAIC staff throughout the process. Steve Broadie (American Property Casualty Insurance Association—APCI) stated that the property casualty industry has the same investments as the life companies and would like to be included in the industry group working with NAIC staff.

Brian Keating (Guardian Life), representing the interested parties’ comment letter drafting group, stated that about half of their securities reported on Schedule D-1 as “Other Loan-Backed and Structured Securities” would meet the ABS definition. He stated there are definitely large categories of securities that do not meet the ABS definition that are perfectly fine debt investments that should be retained within SSAP No. 43R, and they believe the regulators will agree with these assessments. Mr. Bruggeman stated that NAIC staff has done a good job in taking into account the comment letter in determining the initial focus of the issue paper discussion.

Mr. Reis asked whether the proposed direction would be clarified to not specify that the possible options for non-ABS securities could include lower of amortized cost or fair value or elimination of filing exempt reporting provisions. Ms. Gann stated that the direction proposed is to review the non-ABS for accounting and reporting treatment. Mr. Bruggeman stated that the agenda item reference to lower of amortized cost or fair value and/or elimination of FE are possible options, and potentially the worst-case options, and do not reflect the only possibilities that could result from the review of the securities. Mr. Bruggeman stated that if the guidance was to be restated, it would be to indicate that the review could result with any treatment permitted in accordance with Manual, pursuant to the statutory accounting principles and consistency concepts. Mr. Hudson agreed that the review could result with a range of varying accounting and reporting treatments.

Mr. Bruggeman stated that since the Working Group is simply providing direction a formal vote is not needed, but in response to his inquiry, no Working Group members objected to providing direction to NAIC staff as recommended for development of an issue paper to review and revise SSAP No. 43R. He stated agreement with following the general approach of the Working Group and focusing on a detailed issue paper in determining the proper statutory treatment rather than aiming to resolve the issue quickly. Ms. Gann clarified that the intent of NAIC Staff is to have consistent forward progress on the issue, so although it will be the goal to have a document prepared for the Spring National Meeting, it is not anticipated that the issue will be presented for resolution. Rather, it is anticipated that staff will present aspects for discussion, along with comments and questions that will assist NAIC staff in developing the appropriate statutory accounting guidance.

3. Discussed Other Matters

Mr. Bruggeman reminded that the comment deadline for items currently exposed is Jan. 31. He also stated that the Valuation of Securities (E) Task Force had provided four referrals to the Working Group on Jan. 7. Mr. Bruggeman advised that NAIC staff is currently reviewing the referrals. He directed NAIC staff to post the referrals on the Working Group’s website so they could be reviewed during the interim.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

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Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual*, such as editorial corrections, reference changes and formatting.

<table>
<thead>
<tr>
<th>SSAP/Appendix</th>
<th>Description/Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSAP No. 62R</td>
<td>Update references in Exhibit A – Implementation Questions and Answers, question 31, which provides a retroactive reinsurance illustration. This revision does not revise the illustrated journal entries it just revises the referenced “item numbers” to the appropriate SSAP No. 62R, paragraph 34 references.</td>
</tr>
<tr>
<td>SSAP No. 62R</td>
<td>Update reference in SSAP No. 62R, paragraph 85 to match the current format of property casualty annual statement Schedule F - Reinsurance.</td>
</tr>
</tbody>
</table>
| Various SSAPs | Revise all references to the annual statement instructions for consistency and combine the life and fraternal references.  
  - Generic references: annual statement instructions  
  - Specific Names:  
    - Property/Casualty Annual Statement Instructions  
    - Life, Accident and Health/Fraternal Annual Statement Instructions  
    - Title Annual Statement Instructions  
    - Health Annual Statement Instructions  
  Note: Only the changes to combine the Fraternal and Life references will be tracked as edits to the AP&P Manual. Since the other changes are just consistency changes to existing title references, those changes will not be tracked in the AP&P Manual. |

**(Since there are several instances, they are not individually shown in this Form A.)**

**Recommendation:**
NAIC staff recommends that the Statutory Accounting Principles (E) Working Group move this agenda item to the active listing, categorized as nonsubstantive, and expose editorial revisions, as illustrated below.

**Status:**
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to *SSAP No. 62R—Property and Casualty Reinsurance* and various other SSAPs, as illustrated herein.

On January 8, 2020, the Statutory Accounting Principles (E) Working Group adopted the exposed editorial revisions to *SSAP No. 62R—Property and Casualty Reinsurance*, and various other SSAPs, as illustrated herein, as final.

1. Update references in Exhibit A – Implementation Questions and Answers, question 31, which provides a retroactive reinsurance illustration. The revisions do not revise the illustrated journal entries. The revisions are to the update the referenced “item numbers” to the appropriate related SSAP No. 62R, paragraph 34 references. For example, journal entry #1 includes a references retroactive reinsurance reserves with an explanatory note of “see
item #3” becomes “see paragraph 34.c.” which discusses the accounting for retroactive reinsurance reserves. The item numbers are being updated to the related subparagraph of paragraph 34; “see item #4” becomes “see paragraph 34.d.” NAIC staff has verified that the referenced paragraph 34 subparagraphs are relevant to the journal entry explanatory note and illustrated SSAP No. 62R, paragraph 34 for ease of review below the changes.

SSAP No. 62R Property and Casualty Reinsurance - Tracked revisions

EXHIBIT A – IMPLEMENTATION QUESTIONS AND ANSWERS

31. Q: What accounting entries would a ceding entity make to report a retroactive reinsurance contract?

A: Accounting Entries for a Ceding Entity to Report a Retroactive Reinsurance Contract:

<table>
<thead>
<tr>
<th>Entry 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retroactive Reinsurance Reserves</td>
<td></td>
</tr>
<tr>
<td>Ceded or Assumed (B/S)</td>
<td>10,000</td>
</tr>
<tr>
<td>Retroactive Reinsurance Gain (I/S)</td>
<td>2,000</td>
</tr>
<tr>
<td>Cash</td>
<td>8,000</td>
</tr>
</tbody>
</table>

To record initial portfolio transfer see items #3 paragraph 34.c. and #8 paragraph 34.h. The ceding entity must establish the segregated surplus per item #4 paragraph 34.d.

<table>
<thead>
<tr>
<th>Entry 1A</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retro. Reins. Gain</td>
<td>2,000</td>
</tr>
<tr>
<td>Profit/Loss Account</td>
<td>2,000</td>
</tr>
</tbody>
</table>

To close gain from retroactive transaction.

<table>
<thead>
<tr>
<th>Entry 1B</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit/Loss Account</td>
<td>2,000</td>
</tr>
<tr>
<td>Special Surplus from Retro. Reins.</td>
<td>2,000</td>
</tr>
</tbody>
</table>

To close profit from retroactive reinsurance to special surplus.

<table>
<thead>
<tr>
<th>Entry 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>2,000</td>
</tr>
<tr>
<td>Retroactive Reinsurance Reserves</td>
<td>2,000</td>
</tr>
<tr>
<td>Ceded or Assumed (B/S)</td>
<td></td>
</tr>
</tbody>
</table>

To record recovery of paid losses from the reinsurer. Outstanding ceded reserves after this recovery equals $8,000, and special surplus from retroactive reinsurance account equals $2,000; therefore, segregated surplus account is not changed per item #10 paragraph 34.j.

<table>
<thead>
<tr>
<th>Entry 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retroactive Reinsurance Reserves</td>
<td></td>
</tr>
<tr>
<td>Ceded or Assumed (B/S)</td>
<td>3,000</td>
</tr>
<tr>
<td>Retroactive Reinsurance Gain (I/S)</td>
<td>3,000</td>
</tr>
</tbody>
</table>

To record subsequent revision of the initial reserves ceded per item #10 paragraph 34.j. The segregated surplus account is increased to $5,000 as a result of this upward development.
Entry 3A
Retro. Reinsurance Gain 3,000
Profit/Loss Account 3,000

To close profit from retroactive reinsurance.

Entry 3B
Profit/Loss (I/S) 3,000
Special Surplus from Retro. Reins. 3,000

To close profit and loss account to special surplus. (Retroactive reinsurance reserves ceded or assumed account balance equals $11,000. Special Surplus from retroactive reinsurance balance equals $5,000.)

Entry 4
Cash 4,000
Retroactive Reinsurance Reserves Ceded or Assumed (B/S) 4,000

To record recovery of paid losses from the reinsurer. Outstanding ceded reserves after this recovery equals $7,000, therefore segregated surplus account is not changed per item #10 paragraph 34.j.

Entry 5
Cash 3,000
Retroactive Reinsurance Reserves Ceded or Assumed (B/S) 3,000

To record recovery of paid losses from reinsurer. Outstanding ceded reserves after recovery equals $4,000, therefore the following entry is needed per items #6 paragraph 34.f. and #10 paragraph 34.j.

Entry 5A
Special Surplus—Retro. Reins. 1,000
Unassigned Funds 1,000

Retroactive Reinsurance reserves ceded or assumed after this entry equals $4,000.

Entry 6
Retroactive Reinsurance Loss (I/S) 1,000
Retroactive Reinsurance Reserves Ceded or Assumed (B/S) 1,000

To record subsequent revision of the initial reserves ceded per item #10 paragraph 34.j. The segregated surplus account is decreased as a result of this downward development to $3,000. The following entry is needed per items #6 paragraph 34.f. and #10 paragraph 34.j.

Entry 6A
Profit/Loss Account 1,000
Retro. Reins. Loss 1,000

To close loss to profit and loss account.

Entry 6B
Special Surplus from Retro. Reins. 1,000
Profit/Loss Account 1,000
To close profit and loss account to special surplus. (Remaining balance of retroactive reinsurance reserve ceded or assumed account equals $3,000.) (Special surplus from retro. reins. account balance equals $3,000.)

**Entry 7**

Cash 2,500  
Retroactive Reinsurance Gain (l/S) 500  
Retroactive Reinsurance Reserves Ceded or Assumed (B/S) 3,000

**Entry 7A**

Profit and Loss Account 500  
Retro. Reins. Gain 500

To close other income to profit and loss account.

**Entry 7B**

Special Surplus from Retro. Reins. 500  
Profit/Loss Account 500

To close profit and loss account to special surplus. (Remaining balance of special surplus from retro. reins. account equals $2,500.) (Remaining balance of retroactive reinsurance reserve ceded or assumed account -0-.)

**Entry 7C**

Special Surplus from Retro. Reins. 2,500  
Unassigned Funds 2,500

To close remaining special surplus account to unassigned surplus.

For ease of review, the referenced SSAP No. 62R, paragraphs 33 and 34 are illustrated below (No revisions are proposed to these paragraphs):

**Accounting for Retroactive Reinsurance Agreements**

33. Certain reinsurance agreements which transfer both components of insurance risk cover liabilities which occurred prior to the effective date of the agreement. Due to potential abuses involving the creation of surplus to policyholders and the distortion of underwriting results, special accounting treatment for these agreements is warranted.

34. All retroactive reinsurance agreements entered into, renewed or amended on or after January 1, 1994 (including subsequent development of such transactions) shall be accounted for and reported in the following manner:

   a. The ceding entity shall record, without recognition of the retroactive reinsurance, loss and loss expense reserves on a gross basis on the balance sheet and in all schedules and exhibits;

   b. The assuming entity shall exclude the retroactive reinsurance from loss and loss expense reserves and from all schedules and exhibits;

   c. The ceding entity and the assuming entity shall report by write-in item on the balance sheet, the total amount of all retroactive reinsurance, identified as retroactive reinsurance reserve...
ceded or assumed, recorded as a contra-liability by the ceding entity and as a liability by the assuming entity;

d. The ceding entity shall, by write-in item on the balance sheet, restrict surplus resulting from any retroactive reinsurance as a special surplus fund, designated as special surplus from retroactive reinsurance account;

e. The surplus gain from any retroactive reinsurance shall not be classified as unassigned funds (surplus) until the actual retroactive reinsurance recovered exceeds the consideration paid;

f. The special surplus from retroactive reinsurance account for each respective retroactive reinsurance agreement shall be reduced at the time the ceding entity begins to recover funds from the assuming entity in amounts exceeding the consideration paid by the ceding entity under such agreement, or adjusted as provided in paragraph 34.j.;

g. For each agreement, the reduction in the special surplus from retroactive reinsurance account shall be limited to the lesser of (i) the actual amount recovered in excess of consideration paid or (ii) the initial surplus gain resulting from the respective retroactive reinsurance agreement. Any remaining balance in the special surplus from retroactive reinsurance account derived from any such agreement shall be returned to unassigned funds (surplus) upon elimination of all policy obligations subject to the retroactive reinsurance agreement;

h. The ceding entity shall report the initial gain arising from a retroactive reinsurance transaction (i.e., the difference between the consideration paid to the reinsurer and the total reserves ceded to the reinsurer) as a write-in item on the statement of income, to be identified as Retroactive Reinsurance Gain and included under Other Income;

i. The assuming entity shall report the initial loss arising from a retroactive reinsurance transaction, as defined in the preceding paragraph 34.g., as a write-in item on the statement of income, to be identified as Retroactive Reinsurance Loss and included under Other Income;

j. Any subsequent increase or reduction in the total reserves ceded under a retroactive reinsurance agreement shall be reported in the manner described in the preceding paragraphs 34.h. and 34.i., in order to recognize the gain or loss arising from such increase or reduction in reserves ceded. The Special Surplus from Retroactive Reinsurance Account write-in entry on the balance sheet shall be adjusted, upward or downward, to reflect such increase or reduction in reserves ceded. The Special Surplus from Retroactive Reinsurance Account write-in entry shall be equal to or less than the total ceded reserves under all retroactive reinsurance agreements in-force as of the date of the financial statement. Special surplus arising from a retroactive reinsurance transaction shall be considered to be earned surplus (i.e., transferred to unassigned funds (surplus)) only when cash recoveries from the assuming entity exceed the consideration paid by the ceding entity as respects such retroactive reinsurance transaction; and

k. The consideration paid for a retroactive reinsurance agreement shall be reported as a decrease in ledger assets by the ceding entity and as an increase in ledger assets by the assuming entity.

(For an illustration of ceding entity accounting entries see question 31 in Exhibit A.)
2. Update reference in SSAP No. 62R, paragraph 85 to match the current format of property casualty annual statement Schedule F - Reinsurance.

Provision for Reinsurance

85. The NAIC Property/Casualty Annual Statement Instructions for Property and Casualty Companies for Schedule F, Part 3 - Ceded Reinsurance, references the Provision-provision for Overdue Reinsurance, which provides for a minimum reserve for uncollectible reinsurance with an additional reserve required if an entity’s experience indicates that a higher amount should be provided. The minimum reserve for Reinsurance is recorded as a liability and the change between years is recorded as a gain or loss directly to unassigned funds (surplus). Any reserve over the minimum amount shall be recorded on the statement of income by reversing the accounts previously utilized to establish the reinsurance recoverable.
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Accounting Policy  
Corporate Finance  
The Travelers Companies, Inc.  
860-277-0537; FAX 860-954-3708  
Email: d.keith.bell@travelers.com

Rose Albrizio, CPA  
Vice President  
Accounting Practices  
AXA Equitable.  
201-743-7221  
Email: rosemarie.albrizio@axa-equitable.com

October 11, 2019

Mr. Dale Bruggeman, Chairman  
Statutory Accounting Principles Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

RE: Exposure Draft Ref #2019-21: SSAP No. 43R – Equity Instruments Released for Comment During NAIC National Meeting with Comments due October 11

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on Exposure Draft Ref #2019-21: SSAP No. 43R – Equity Instruments released for comment by the Statutory Accounting Principles (E) Working Group (the “Working Group”), during the NAIC Summer National Meeting in New York. We are responding to this exposure in a letter separate from our responses to the other exposures, per request of NAIC Staff. We offer the following comments.

Ref #2019-21: SSAP No. 43R – Equity Instruments

NAIC Staff Description of Issue:
This agenda item has been drafted to consider clarifications to the scope of SSAP No. 43R—Loan-backed and Structured Securities, particularly with regards to collateralized fund obligations (CFOs) and similar structures that reflect underlying equity interests but are issued in the form of bonds / debt instruments.

Overview: A collateralized fund obligation (CFO) is a form of securitization involving private equity fund or hedge fund assets, similar to collateralized debt obligations (CDOs). A CDO uses loans as the collateral backing the security, whereas a CFO is backed by interests in funds, often private equity or hedge funds. (A CFO can also be backed by other equity interests, such as a limited liability partnership.) Although the CFO appears to have a “debt instrument” cash flow and may receive a credit rating from an NRSRO, the backing of the issued security is based on the equity performance of the underlying funds or equity interest. From a Bloomberg article from Oct. 2018, it was noted that CFOs have been noted as allowing an opportunity for “regulatory capital relief.” This article cited a statement that entities “can exchange their equity interests into CFOs, maintain the same level of exposure, without having to hold as much capital against the...
investments because regulators treat CFOs as bonds, not the private equity-linked investments that they are.”

NAIC staff was contacted by a rating provider with a request for information on how CFOs are considered for statutory accounting. The rating provider noted that this information would assist them in determining their methodology for reviewing CFOs under their credit policy and providing credit ratings. As part of that discussion, the rating provider provided the following information regarding their knowledge of CFOs:

- CFOs were first issued prior to the financial crisis in the early 2000’s.
- The early CFOs were packages of hedge funds assets, not private equity funds.
- CFOs did not perform well in the financial crisis and the development / issuance was halted.
- CFOs have now returned to the market, with the majority of holders identified as insurance companies.
- Although CFOs have returned, it was noted they have not seen many issuances.
- CFOs have been formed through repackaging of existing owned assets. (For example, if an insurance company held private equity on Schedule BA, they can package these assets in a CFO and report on Schedule D under SSAP No. 43R.) The rating agency noted that they do not formally receive information on the source of the CFO assets, but they receive source information informally through company inquiries.
- CFOs can be acquired individually (not through the repackaging of existing assets).
- CFOs can include both debt and equity components. Per the rating agency, in the situations seen, the insurance company either keeps the entire structure (both debt and equity pieces), or they sell the debt component and retain the equity component. They identified that in the situations they have seen, insurance companies have always retained the equity portion.

As identified in SSAP No. 26R—Bonds, loan-backed and structured securities (LBSS), although they may meet the definition of a bond, are excluded from SSAP No. 26R and follow the accounting and reporting guidance within SSAP No. 43R. The accounting and reporting of LBSS is similar to the reporting of bonds, with the measurement method (amortized cost or the lower of amortized cost or fair value) determined in accordance with the credit risk of the security (NAIC designation). Securities in scope of SSAP No. 43R are reported on Schedule D-1 as long-term bonds consistent with securities captured in scope of SSAP No. 26R.

Pursuant to the NAIC Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) NAIC designations are used to determine the category of credit risk and are security specific based on the position of a specific security in the issuer’s capital structure.

**NAIC Staff Recommendation from the 8/3/2019 SAPWG Meeting Agenda**

Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 43R – Loan-backed and Structured Securities to clarify that CFOs (or similarly structured instruments), and other structures with underlying equity exposures, are excluded from the scope of SSAP No. 43R. Additionally, the revisions prevent existing assets from
being repackaged as “securitizations” for reporting in scope of SSAP No. 43R. Key elements noted in the revisions include:

- The intent for SSAP No. 43R securities to have “bond-like cash flows.”
- Exclusion of equity instruments, investments with underlying assets that include equity instruments, or structures representing an equity interest (e.g., joint venture, LLCs, partnerships).
- Exclusion of assets that were previously reported as standalone assets by the reporting entity to change the investment schedule / reporting value / RBC charge.
- Clarification that lease-backed securities and equipment trust certificates are in the scope when eligible per the P&P Manual of the NAIC Investment Analysis Office.

**Interested Party Comments**

The proposed changes are categorized as non-substantive and the impetus behind the exposure seems to be concerns surrounding collateralized fund obligations (CFOs); but more specifically 1) repackaging of private equity held on Schedule BA (whereby the CFO vehicle issues structured securities through tranches) so the tranches can qualify for reporting on Schedule D, Part 1 and 2) repackaging of private equity held on Schedule BA with only the residual equity interest retained by the insurance company and 3) insurers investing in various tranches of a securitization or other debt securities where the underlying investments in the structure are equity. While we are supportive of eliminating perceived potential abuses, we believe the proposed changes go well beyond the perceived abuses and possibly affect billions of dollars of other insurer invested assets which we believe are appropriately accounted for under existing NAIC SSAPs and RBC rules. Further, the proposed changes do not address how some of these investments, currently clearly allowed for under SSAP No. 43R, would be reported are eliminated from scope of SSAP No. 43R.

The proposed changes to paragraph 2 of SSAP No. 43R provides an illustration of a CFO where:

“insurers gain exposure to a collection of funds (or equity interests) with the established interest and principal based on the issuers’ expected performance of the underlying funds”

When considering the proposed change noted above, we evaluated a hypothetical investment in the form of a debt instrument, where the instrument provides that the amount of principal or interest to be returned to the holder is to be calculated solely with reference to the movement of the S & P 500, up or down. We agree that such an instrument is in essence an equity and should be excluded from the scope of SSAP No. 43R; and we further agree that the existence of a rating letter for the instrument should have no bearing on the proper classification of the instrument. However, it is not clear to interested parties, whether the current proposal is limited to investments resembling this hypothetical. The key statement that appears to be redefining the scope of SSAP No. 43R seeks to exclude:

“…investments with underlying assets that include equity instruments … in which the cash flow payments (return of principal or interest) are partially or fully contingent on the equity performance of an underlying asset”.

This reference is hard to interpret and could be read to include a wide array of debt investments that have been issued in the capital markets for decades. At times, some of the commentary seems to suggest that if
the issuer of a debt instrument owns assets “that include equity instruments”, then the debt itself should be viewed as equity. This appears to be saying that, if a commercial mortgage loan is “backed by” equity in real estate investments (i.e., amount invested in the real estate property), and dependent in a general sense on the “performance” of such real estate investment, the investment in the commercial mortgage loan could be deemed a real estate equity investment. We do not believe anyone would advance such an extreme proposition, but some of the commentary accompanying this proposal comes close to stating a parallel proposition.

Lastly, the exposure also addresses equipment trust certificates (ETCs) and leased back securities (LBSs), with no background information or rationale to support those specific proposed changes. Given the preceding, the potential scope, the sophisticated nature of investments within SSAP No. 43R, and its interaction with the P&P Manual, we believe the proposed changes are substantial.

We therefore recommend that, for the CFO component, these issues be documented, in detail, in a separate issue paper that addresses the rationale for all investments covered by the proposed changes, the rationale for removing them from the scope of SSAP No. 43R, and the alternate reporting if they are ultimately removed from scope. We believe this is would be an appropriate first step prior to developing a proposed amendment to SSAP No. 43R. This will facilitate full transparency, to both industry and regulators, on the nature of these investments, the magnitude for which it will impact insurers, and the full rationale for each investment type impacted.

The remainder of our letter addresses some of our more specific concerns surrounding those asset classes or types of transactions we believe would be impacted. It is in two parts; 1) Proposed Changes Related to ETCs and LBSs and 2) Proposed Changes Related to “CFO-Type Transactions” and Other Debt Securities.

Proposed Changes Related to Equipment Trust Certificates and Leased Back Securities

As mentioned previously, no background information is provided in the exposure supporting why these proposed changes are being made other than a bullet in the Staff Recommendation as follows:

- Clarification that lease-backed securities and equipment trust certificates are in scope when eligible per the P&P Manual of the NAIC Investment Analysis Office.

We did a search of the 2019 reconfigured P&P Manual and found no reference to equipment trust certificates. Prior to this reconfiguration, certain interested parties, including ACLI, PPIA and NASVA, raised concerns about the deletion of the definitions of “Bond” and “Obligation” from the P&P Manual. Specifically, these definitions enumerated a number of securities, including equipment trust certificates, that were then referenced in the filing exemption rule of the P&P Manual. Interested parties were concerned that deletion of these definitions would potentially call into question the filing exempt nature of such securities and were assured by the NAIC Securities Valuation Office (SVO) and certain members of the Valuation of Securities Task Force (VOSTF) that this was not the intent.

Insurers have widely invested in equipment trust certificates (and related securities known as enhanced equipment trust certificates) for decades. These securities are specifically mentioned in SSAP No. 43R and have historically been recognized as Schedule D, filing exempt-eligible securities by both the SVO and by VOSTF and were specifically listed in the supplementary flow charts presented to and approved
by VOSTF for filing exemption, when the new rules for private ratings letter filing requirements were adopted.

These securities enjoy both the benefit of a claim to a corporation via a mortgage or lease agreement with a special purpose vehicle (“SPV”), and the benefit of a security interest in SPV’s owned equipment collateral (such as railroad equipment, locomotives, or aircraft). As such, they have lower credit risk than traditional unsecured corporate debt issued by the same corporations under SSAP No. 26R. The proposed changes would make it unclear whether equipment trust certificates would remain filing exempt or would continue to be viewed as an acceptable asset class.

Similarly, we believe the only reference to leased-backed securities in the P&P Manual relates to conforming credit tenant loans (CTLs). There are other classes of similarly structured leased-back securities, in addition to CTLs, that we believe are appropriately included within the scope of SSAP No. 43R as it references leased-backed securities in much broader context than just CTLs. Specifically, paragraph 2 of SSAP No. 43R states that loan-backed and structured securities include but are not limited to “pass-through securities, lease-backed securities, and equipment trust certificates.” Insurers invest in many different types of securitizations that are backed by lease payments on a variety of different types of underlying assets. These securities have historically proven to be safe, well secured investments with fixed income cash flows, which enhance insurers’ investment portfolios. Any changes to the types of lease-backed securitizations that are currently allowed under SSAP No. 43R could be very impactful to industry, since under the current guidance, securitizations whose cash flows are based on lease payments are currently reported as SSAP No. 43R securities.

ACLI, PPIA and NASVA representatives have had recent (post-exposure) discussions with Charles Therriault of the SVO regarding this component. We understand the SVO would like to define the term Equipment Trust Certificate within the P&P Manual and is willing to work with industry to do so. Similarly, we understand similar work is anticipated for certain types of leaseback securities.

As such, we believe this concept within the proposal, should be deferred until the SVO completes any such work (under the direction of the VOSTF) mentioned above. We are concerned about the potential confusion and unintended consequences that could result from maintaining the proposed changes related to this topic.

**Proposed Changes Related to “CFO-Type Transactions” and other Debt Securities**

As noted above, we understand concerns with certain CFO transactions and we are supportive of helping eliminate perceived potential abuses; however, we believe the proposed changes go well beyond the perceived potential abuses and possibly affect billions of dollars of other insurer assets which we believe are appropriately accounted for under the NAIC SSAPs and RBC rules. We address what we perceive to have unintended consequences in two broad groups:

1) Debt Securities Supported by Equity Interests, and
2) Insurer Sponsored Securitizations.

**Debt Securities Supported by Equity Interests**

The proposed changes related to debt securities issued by CFOs are indistinct, but the exposure indicates that the debt would no longer be expected to be captured by SSAP No. 43R. Interested parties would like...
to better understand the proposed accounting and capital treatment of these debt securities going forward. This could have implications for existing investments, but also for future issuances.

If the concept of debt being backed by equity interests is the core of the issue, we note that debt of this type is quite common in the capital markets and universally viewed as having bond-like characteristics. Other examples of debt issued by CFO-like structures (or equity-reliant) include debt issued by Holding Companies (e.g. Utilities, Berkshire Hathaway), Business Development Corporations, Closed-end Funds, Master Limited Partnerships and Real Estate Investment Trusts.

Interested parties would like the opportunity to have an open dialogue about the nature of debt issued by CFO and CFO-like structures, with the intent of creating a framework for distinguishing between instruments that have bond-like cash flows and those that do not.

**Background:**

Securities issued by CFOs represent a diversified opportunity set of investments with varying degrees of risk. The securities issued can be Senior Secured Debt, Unsecured Debt, Subordinated Debt, Preferred Stock and Common Stock. As it pertains to the debt securities issued by CFOs, the expected loss rate is not uniform, but when structured properly, the expected performance is bond-like in nature. Fundamentally, the debt holder is a creditor to the CFO structure and has a priority claim over the equity first loss tranche and any other subordinated tranches that provides appropriate subordination to support the debt’s credit ratings. In addition, the structural protections in these securities work towards preserving the contractual bond-like cashflows and risk profiles during periods of elevated volatility.

The diversified pool of assets and cashflows supporting CFO securities is similar to the assets and cash flows supporting many common asset-backed transactions. In addition, CFO securities include many of the structural features and protections often found in asset-backed securities, such as payment priority and cash trap events, excess collateral and collateral coverage covenants.

Interested parties respectfully present the following potential framework for debt issued by CFOs to demonstrate how the likelihood of debt repayment can be underwritten for such securities.

**Primary Risks:**

When analyzing CFO debt securities, there are two primary attributes to focus on:

1) The portfolio risk or volatility and nature of the underlying assets. Industry participants and Rating Agencies have developed frameworks to assess portfolio risk based on the fund type, expected price volatility, price integrity, liquidity risk, income attributes and correlation. Rating Agencies also perform stress tests and simulations to quantify portfolio performance in a variety of expected market conditions when determining the appropriate subordination and liquidity features necessary to support the credit ratings.

2) The amount of debt issued by the CFO, or inversely, the amount of subordination supporting the debt.

To obtain an investment grade rating on debt issued by a CFO, a CFO must balance the level of volatility of the underlying assets with the amount of leverage debt issued by the CFO. The assigned rating on the debt and expected loss rate should be comparable to other similarly rated debt securities in the market (i.e. debt not issued by CFOs).
Secondary Risks:

CFOs also possess operational, counterparty, and audit related risks that need to be considered, but these are unlikely to be the main driver of an assigned rating. These risks are not dissimilar from the operational and counterparty risks associated with a corporate credit or an asset-backed transaction and certainly do not disqualify CFOs from being treated as debt instruments.

Structural Protections:

Most CFO debt securities benefit from substantial structural protections, including reserve requirements, that work to minimize credit migration risk and maintain certainty of bond-like cashflows during periods of heightened volatility or uncertainty. They fundamentally ensure that equity holders of the CFO assume most of the performance risk instead of the debt holders. They also generally work to ensure that the servicing and repayment of the debt securities is not contingent upon appreciation of the underlying assets.

To support an investment grade rating on the debt issued by a CFO, the size of the equity tranche is typically set at a level so that it can absorb the expected gross losses in the underlying assets along with a margin for uncertainty. The equity tranche sizing also differs based on the variance of the expected losses, form of income generation and desired rating on the issued debt security.

See below for a sample of structural protections that support bond-like treatment for securities issued by CFOs:

Loan-to-value limitations or overcollateralization requirements: Restricts the amount of leverage that can be placed on the CFO. May also force rapid amortization with cashflows from assets prioritized to the debt tranches or to the reserve accounts before the equity investors have access to cash generated by the CFO.

Diversification or performance requirements: General requirements that work towards minimizing the volatility of the underlying assets. These may also act in conjunction with the loan to value limitations or overcollateralization requirements so that as the underlying portfolio becomes more volatile, the level of leverage allowed is reduced. These protections may also include requirements limiting concentration in any single asset or class of assets and requirements relating to overall portfolio diversity.

Debt service coverage ratio requirements: Ensures that CFO debt servicing needs can be met with current cashflows from the portfolio of investments. This works to maintain predictability and periodicity of the coupon payments on the CFO issued debt.

“First in/first out” structures: May require senior tranches to fund first, but then restrict any return of capital to the subordinated tranches until the senior tranche has received its contractual interest and principal payments.

Funded reserve accounts: Accounts are typically set up to prefund interest, capital calls or principal repayments. The size of the accounts can also vary based on the performance of the underlying portfolio or leverage on the vehicle.

Keep well provisions: Sponsors of CFOs may be contractually required to contribute additional assets or equity to cure a breach if covenants within the CFO level are violated.
Rating based triggers: A change in the credit rating could require any of the above structural protections to be triggered or have the thresholds increased to mitigate the increase in risk.

Not only do interested parties support developed underwriting frameworks used to assess risks associated with repayment of CFO debt, interested parties also have concerns about the possibility of scope creep into non-CFO assets, should the SAPWG proposal be adopted as drafted. The following are examples of debt securities held by insurers. The first example (Debt issued by Private Equity CFOs) falls into the scope of the proposed SAPWG recommendation. The remaining examples are not within scope of the recommended changes, yet they share some similar characteristics to Debt Issued by Private Equity CFOs. Interested parties believe that each of these debt classes can be structured in a way, such that the underlying equity investments provide, with high likelihood, cash flows sufficient to cover scheduled debt service payments. The key is to appropriately design the structural protections provided within these securities, assessing whether such protections are sufficient to offset the possibility of declining valuations or cashflows of the underlying equity investments, so that the debt obligations can still be fulfilled.

Debt Issued by Private Equity CFOs (PE CFOs): Invest in private equity funds and may also invest in debt securities. The PE CFOs that have recently been issued include seasoned pools of underlying private equity funds that are well diversified by type and vintage, and as a result, generate relatively consistent cash flows to pay principal and interest. In general, capabilities of the asset manager and counterparty exposure are strong. Debt securities issued by PE CFOs pre-crisis and post-crisis have been rated between B and AAA by an NRSRO, with senior tranches rated between A and AAA and typically sized at between 21% and 56% of the value of the underlying asset portfolio. The features of PE CFO debt are fundamentally different from those of private equity interests themselves; they typically bear interest at a fixed rate, come with no commitment to fund additional capital calls, have significant overcollateralization and benefit from the diversified pool of underlying investments at various investment and liquidity stages. In certain situations, sponsors are also required to provide incremental support. Debt securities are structured to apply cash flow to pay interest and repay principal on the debt as cash flow is realized with a liquidity facility or reserve to cover capital calls and interest shortfalls due to timing mismatches. Cash flows from underlying investments have been adequate to meet interest and principal obligations in both pre-crisis and post-crisis PE CFOs that have been broadly distributed. All rated notes issued by pre-crisis PE CFOs have paid off in full according to their terms. One post-crisis PE CFO has completely paid off rated notes and another has paid off the most senior debt tranche.\(^1\)

Debt Issued by Closed-end Funds: Listed 1940 Act vehicles that invest in equity or debt securities. These funds are required from a regulatory perspective to maintain Asset to Debt ratios of 300% and Asset to [Debt+Preferred Stock] ratios of 200% (typical debt covenants in these funds are slightly higher). These vehicles have been cycle-tested through several volatile periods with modest credit migration and no credit losses (for both Debt and Preferred Stock issuance by Closed-end Funds). For example, multiple closed-end fund debt transactions, collateralized by publicly traded energy-related Master Limited Partnership (“MLPs”) units, were issued in the private placement market over the last decade. When oil prices fell from more than $100/barrel to below $40 in less than one year, the structures proved robust. As energy MLP prices fell, and the funds approached their required minimum overcollateralization thresholds, Closed-end Fund managers sold MLP units in the open market and used the proceeds to repay debt and

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\(^1\) Information relative to the structure and performance of PE CFOs and their underlying investments obtained from Fitch Ratings Report, PE CFOs: Securitizing Private Equity Fund Interests, issued 10 October 2019.
preferred securities. All of these structures made the mandatory debt and preferred stock repayments at par plus accrued interest, or higher, and all honored remaining debt service payments. Debt securities issued by Closed-end Funds are typically rated AA to AAA by CRPs.

**Debt issued by Business Development Corporations (BDC’s):** Corporations with preferential tax status established to invest in the debt and equity of predominately US companies (public and private). Covenants can vary significantly, but most do have a core Asset Coverage ratio. While some BDC’s did experience distress during the global financial crisis, private placement debt issued by BDCs came with structural protections to enable noteholders to recover all principal invested, plus accrued interest, and in some cases, full make whole payments. Debt ratings are typically BB to BBB+.

**Debt Issued by Corporate Holding Companies: **Insurance companies have significant investments in debt issued by holding companies (HOLDCOs). The HOLDCOs typically have no hard assets and only own the equity in operating subsidiaries (OPCOs). Oftentimes, the OPCOs do not guarantee the HOLDCO debt and many OPCOs have direct or indirect restrictions on the amount of cashflows they can dividend up to the HOLDCO (e.g. Utilities). The debt issued by these HOLDCOs is only supported by the equity interests they hold and ratings vary significantly based the issuer’s inherent financial and business risk.

*See below for a summary of hypothetical capital structures and ratings for various CFO or equity-reliant transactions:*

![Diagram of capital structures and ratings]

**Summary:**
At the start of evaluating any CFO debt security, the relevant questions should be:

- Does the fact that the underlying risk is held in a CFO structure change the expected performance of the debt and equity securities issued by that structure?
- Is the proportion of risk borne by the first loss tranche or subordinated capital enough such that the debt security will exhibit debt like attributes?
- Are the loss expectations comparable to other rated debt securities in the capital markets?
• Do the structural protections ensure the transfer of risk to the equity tranche and stability of expected debt cashflows are preserved in a variety of market conditions?

Rating agencies have developed frameworks for evaluating CFOs and CFO-like structures. They have concluded that if the CFO has the right balance of underlying portfolio volatility and leverage, along with appropriate structural protections, they are bond-like in nature and can be rated investment grade. This is also the view of interested parties. We look forward to having further dialogue to ensure this asset class remains an opportunity for investment.

Insurer Sponsored Securitizations

Interested parties’ interpretation of the proposed changes (i.e., the phrase in the exposure that states “Exclusion of assets that were previously reported as standalone assets by the reporting entity to change the investment schedule / reporting value / RBC charge”) would be that they would likely deter insurers from securitizing already owned assets (insurer sponsored securitizations), where some interest was retained after securitization, and such a transaction would be deemed inappropriate pursuant to the exposure document. The below expands on these concepts and describes why we believe insurer sponsored securitizations of owned assets should not be discouraged and have been executed over time for valid business purposes.

Insurers have used insurer sponsored securitizations throughout the years for many important business reasons highlighted below. Interested parties believe, as long as the SSAPs are applied appropriately, insurers should be able to derecognize already owned assets from their balance sheets, and if the insurer sponsor purchases various tranches from the securitization vehicle, they should be afforded the ability to recognize, account for, and report the tranches the same as if they were purchased from an unrelated third party. Insurer sponsored securitizations, where either the insurer sponsor purchases various tranches from the securitization, or its affiliates purchase the various tranches, have been used for some of the following legitimate reasons throughout the years. Interested parties strongly believe they should continue to be afforded the ability to securitize in this way because:

• It provides insurers an important ability to change the risk profile, economics, and cash flows in its insurance and non-insurance companies
  o Improves risk transparency of underlying investments through debt ratings and purchase by independent third parties, when applicable
• It prevents the need for the insurer to sell assets to unrelated third parties in an inefficient private market
• Enhances liquidity in that the beneficial interests issued by the securitization are rated by NRSROs and may be sold externally to raise cash and provide the insurer sponsor the ability to invest in other investment types for their investment portfolio (i.e., diversification)
• Provides the insurer sponsor the ability to earn management fees from unrelated third-party purchases of the various tranches of the securitization
• Affords insurers the ability to manage asset allocation and duration of its asset portfolios for an optimal asset liability management match

SSAP No. 103R, Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, provides insurers the ability to securitize owned assets. The owned assets may be derecognized from an insurer’s

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balance sheet only when the three “sale” conditions in paragraph 8 are met. The conditions in paragraph 8 are consistent with the conditions applied on a U.S. GAAP basis when determining if “sale” accounting may be applied. An insurer would evaluate the three conditions in paragraph 8 very carefully, based on their own set of facts and circumstances, to ensure the conditions are met and “sale” treatment is achieved. The newly issued tranches by the securitization vehicle may be purchased by the insurer sponsor, purchased by affiliates of the insurer sponsor, sold to unrelated third parties, or any combination of the above. If affiliates of the insurer or the insurer itself purchase various tranches issued by the securitization, SSAP No. 25, Affiliates and Other Related Parties, would be applied to ensure there is permanence to the transaction, any gains from the transaction would not result in an inflation of surplus, and the transaction is arm’s-length.

Interested parties believe that the guidance in SSAP No. 103R and No. SSAP 25, if applied appropriately, should result in a valid business transaction where the currently owned assets would be derecognized from the insurer sponsor balance sheet because the insurer sponsor would no longer possess all of the risks associated with the assets. Based on the guidance in paragraph 8, that means the assets would have been isolated from the insurer sponsor beyond the reach of creditors (condition a); if removed for purposes of a securitization, the third party holder of its beneficial interests must have the right to pledge or exchange its beneficial interests and no condition would both constrain the beneficial interest holder from taking advantage of its right to pledge or exchange the beneficial interest and provide more than a trivial benefit to the transferor (insurer sponsor) (condition b); and the transferor does not maintain effective control over the transferred assets (condition c).

Insurers generally evaluate the three conditions in paragraph 8 as follows. Again, these evaluations are consistent with those performed for U.S. GAAP purposes:

- In order to meet conditions a and b, insurers assess various facts and circumstances in their own individual transactions to ensure the conditions are met. Although not individually determinative, insurers rely on a “true-sale/non-consolidation” opinion from external legal counsel. The “true-sale/non-consolidation” opinion is a lengthy and robust evaluation performed by external counsel, based on the facts and circumstances in the transaction, to provide an opinion, in their best judgment, that the transferred assets would be isolated in bankruptcy proceedings of the transferor. It is important to note that external counsel does not issue a “true-sale/non-consolidation” opinion unless a significant enough percentage of the tranches issued by the securitization vehicle are sold to either unrelated third parties of the insurer sponsor or to affiliates outside the ownership stack of the insurer sponsor (e.g., not a parent or subsidiary of the insurer sponsor). Additionally, the insurer would consider factors such as the non-recourse nature of the transaction to the sponsor and the separateness of the SVP that is formed. The SPV that is formed is a distinct separate partnership (or LLC) and all partnership formalities are followed with respect to their organization and operation; the assets of the SPVs are not commingled with the assets of any member of the sponsor; proper books and records of the SPVs are maintained at all times; all transactions between the SPVs and the sponsor will be fair and reasonable and reflect arm’s-length terms; the general partner for each SPV has at least one independent director experienced in securitizations.

- To ensure condition c is met, the insurer would assess facts and circumstances, such as what party controls decisions associated with the transferred assets, including future decisions to sell the assets after transfer, to ensure that the insurer sponsor does not directly or indirectly control the decisions associated with the transferred assets. It is important to note that condition c is assessed
at the insurance company legal entity level (i.e., the insurer sponsor itself does not retain control of the assets).

To illustrate the application of the conditions in SSAP No. 103R, interested parties offer the following examples of facts and circumstances that do NOT meet the conditions of SSAP No. 103R, where already owned assets should not be derecognized from the insurer sponsor balance sheet. The SSAP No. 103R analysis is summarized below and is not indicative of the extensive analysis performed by insurers to ensure SSAP No. 103R “sale” conditions are met. Although the example is for a private equity securitization, the same SSAP No. 103R and SSAP No. 25 analysis is performed for any securitization of owned assets (e.g., CLOs):

All examples (examples 1-4) below have the following in common:

- Insurer sponsor transfers private equity funds reported on its Schedule BA into a special purpose vehicle (SPV)
- The SPV securitizes the private equity funds and various debt tranches are issued; the remaining equity in the SPV is considered residual equity (i.e., LLC/LP equity interest)

Example 1:

- Investors in securitization: The insurer sponsor purchases substantially all or all of the tranches issued by the SPV and substantially all or all of the residual equity
- SSAP No. 103R assessment:
  - Insurer sponsor retains all or substantially all of the risks associated with the private equity funds
  - A “true-sale/non-consolidation” opinion would not be received from external legal counsel because not a significant enough amount of the tranches was purchased by either unrelated third parties or affiliates outside the sponsor’s ownership stack
  - This transaction does NOT meet the conditions in paragraph 8 (neither condition a nor b are met) SSAP No. 103R to attain “sale” accounting; the private equity funds should not be derecognized from the insurer sponsor balance sheet

Example 2:

- Investors in securitization: The insurer sponsor sells a significant amount of the tranches to unrelated third parties or affiliates outside the ownership stack
- Unique provision of the securitization: The insurer sponsor can call the securitization beneficial interests at any time at a pre-determined price that was set at below market price
- SSAP No. 103R assessment:
  - The transaction does not meet condition b of SSAP No. 103R because the insurer sponsor has the ability to both constrain the beneficial interest holder from taking advantage of its right to pledge or exchange the beneficial interest and provides more than a trivial benefit to the transferor (paragraph 53 of SSAP No. 103R)
  - This transaction does NOT meet the conditions in paragraph 8, SSAP No. 103R to attain “sale” accounting; the private equity funds should not be derecognized from the insurer sponsor balance sheet
To further illustrate the conditions of SSAP No. 103R, interested parties offer the following examples of facts and circumstances that DO meet the conditions of SSAP No. 103R, where owned assets should be derecognized from the insurer sponsor balance sheet:

Example 3:

- Investors in securitization: The insurer sponsor sells a significant amount of the tranches to unrelated third parties or affiliates outside the ownership stack; insurer sponsor purchases either all of the residual equity of the securitization or all of the residual equity and some allocation of other tranches in the securitization
- SSAP No. 103R assessment:
  - The transaction meets the conditions a and b of SSAP No. 103R because the insurer sponsor would receive a “true-sale/non-consolidation” opinion from outside legal counsel as a significant enough portion of the tranches was sold to unrelated third parties or affiliates outside the ownership stack
  - The transaction meets condition c of SSAP No. 103R because the insurer sponsor does not maintain effective control of the transferred assets or the beneficial interests issued by the securitization (e.g., no sponsor call provision)
  - This transaction DOES meet the conditions in paragraph 8, SSAP No. 103R to attain “sale” accounting; the private equity funds should be derecognized from the insurer sponsor balance sheet
  - The transaction also meets the requirements in SSAP No. 25, including permanence of the transaction

Example 4:

- Investors in securitization: The insurer sponsor sells almost 100% of the tranches to unrelated third parties or affiliates outside the ownership stack; insurer sponsor retains less than 10% of the residual equity. This example is included in the letter because for securitizations of CLOs, for example, the sponsor must retain a certain percentage of the residual due to U.S. Risk Retention rules.
- SSAP No. 103R assessment:
  - The transaction meets the conditions a and b of SSAP No. 103R because the insurer sponsor would receive a “true-sale/non-consolidation” opinion from outside legal counsel as a significant enough amount of the securitization was sold to unrelated third parties or affiliates outside the ownership stack
  - The transaction meets condition c of SSAP No. 103R because the insurer sponsor does not maintain effective control of the transferred assets or the beneficial interests issued by the securitization (e.g., no sponsor call provision)
  - This transaction DOES meet the conditions in paragraph 8, SSAP No. 103R to attain “sale” accounting; the private equity funds should be derecognized from the insurer sponsor balance sheet
  - The transaction also meets the requirements in SSAP No. 25, including permanence of the transaction
Assuming a transaction meets the conditions in SSAP No. 103R and SSAP No. 25 is applied appropriately, assets the insurer sponsor purchases from the securitization should be treated as if the insurer sponsor purchased the tranches from an unrelated third party. This is aligned with the U.S. GAAP treatment of such transactions. The section of our letter related to debt securities supported by equity interests provides interested parties thoughts as to why the beneficial interests issued in an insurer sponsored CFO should be reported as SSAP No. 43R investments.

Consistent with SSAP No. 48 (or SSAP No. 97 if relevant) the residual LP/LLC equity from a private equity securitization would be reported on Schedule BA and equity method of accounting would be applied, because the investor owns LP/LLC equity interest. For other securitizations, such as CLOs, a residual security (i.e., residual tranche) is usually issued, which meets the definition of an SSAP No. 43R security, is reported on Schedule D as debt, debt accounting is applied, and the investment would receive a low NAIC designation. Schedule D debt treatment is consistent with U.S. GAAP as the residual tranche is considered to have fixed income-like cash flows, because the securitization involves financial assets with contractual cash flows.

Interested parties believe proposal 2019-21 is concerned about the perceived abuse associated with the application of SSAP No. 103R and SSAP No. 25 to insurer sponsored securitizations. Interested parties recommend disclosures be expanded to require disclosure of the conditions in SSAP No. 103R paragraph 8 and how an insurer sponsor concluded that the conditions were met to attain “sale” accounting upon securitization.

**Summary Conclusion**

While we believe the proposed exposure is attempting to address some valid regulatory concerns, we do have significant concerns about the broad-brush approach to the proposed changes and the likely unintended consequences:

- The exposure does not propose alternative reporting for investments that would no longer be allowed under the exposure.
- As it relates to both Equipment Trust Certificates and Lease Backed Securities, the exposure has little, if any, analytical support for the proposed changes and has insufficient clarity surrounding the types of securities that we believe would impact billions of dollars of industry assets. This is a substantial change and more work needs to be done before changes, if any, are incorporated into SSAP No. 43R.
- As it relates to “CFOs”, this is a very complicated area and the exposure goes well beyond the perceived regulatory concerns stated. The proposed changes would also potentially impact billions of dollars of industry assets as well as significantly reduce the ability of insurance companies to securitize owned assets for valid business purposes. A thoughtful and well-articulated issue paper is needed to facilitate full transparency, to both industry and regulators, on the magnitude for which the changes will impact insurers as well as the full rationale for each investment type impacted, prior to any changes being incorporated into SSAP No. 43R.

We stand ready to assist NAIC staff, and regulators, to provide clarifying answers to any questions on the content of this letter as well as to provide additional education on the various types of transactions that we
believe are inappropriately captured by the scope of this exposure. We appreciate the opportunity to provide comment and engage in future dialogue.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell                     Rose Albrizio
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Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the Statutory Accounting Principles (E) Working Group (the “Working Group”), during the NAIC Fall National Meeting in Austin. We offer the following comments:

**Ref #2018-26: SCA Loss Tracking – Accounting Guidance**

The Working Group exposed revisions, with modifications suggested by interested parties to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* to expand guidance regarding financial guarantees and the use of the equity method for when losses exceed the equity value of an SCA investment. With the revisions, the equity value of an SCA would not go negative, and guaranteed liabilities would be reported to the extent that there is a financial guarantee or commitment. The “Illustration of the Application of INT 00-24” will also be inserted into *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities*.

Interested parties have no comment on this item.

**Ref #2018-38: Prepayments to Service and Claims Adjusting Providers**

NAIC Staff recommended that the Working Group expose revisions incorporating the majority of interested parties’ comments to *SSAP No. 55 (rather than the changes reflected in the draft for the Summer 2019 exposure)*. Interested parties’ comments primarily delete the exposed guidance and move the same or similar concepts into the broad product guidance for property and casualty, life and health or health in SSAP No. 55. These revisions are to reinstate annual statement references by entity type and to adjust scoping language and make the SSAP No. 29 prepaid guidance consistent. (Staff proposed variations in wording are shaded to differentiate from the interested parties proposed wording that accomplishes a similar intent.)
The exposed revisions to *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* incorporate interested parties’ previous recommendations to separate the guidance by product type and emphasize guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments). The revisions emphasize existing guidance that claims related liabilities are not recognized as paid until the losses are paid to claimants or claims are adjusted.

Interested parties have no comment on this item.

**Ref #2019-04: SSAP No. 32 – Investment Classification Project**

The Working Group exposed a revised *Issue Paper No. IX—Preferred Stock* and a substantively-revised draft *SSAP No. 32—Preferred Stock* as part of the Investment Classification Project.

Interested parties substantially agree with the objectives of the proposal and appreciate Staff’s inclusion of revisions for previously communicated comments. We have the following additional comments related to the issue paper:

**Scope**

Interested parties note that the scope retains, albeit edited, the guidance that preferred stock of subsidiary, controlled and affiliated entities is included and therefore accounted for under the guidance for preferred stock regardless of their SCA character. We acknowledge the current exposure added the requirement to file investments in response to our request. The existing wording in SSAP No. 32 and the exposed language for SSAP No. 32 is below with interested parties suggested clarifying sentence and additional wording (underlined).

Existing language in SSAP No. 32:

**SCOPE OF STATEMENT**

1. This statement establishes statutory accounting principles for preferred stock.

2. Investments in preferred stock of subsidiaries, controlled or affiliated entities, including preferred stock interests of certified capital companies (CAPCO) per INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO) are included within the scope of this statement.

Exposed language in SSAP No. 32 and interested parties suggested additional sentence (underlined):

**SCOPE OF STATEMENT**

1. This statement establishes statutory accounting principles for preferred stock.

2. Investments in preferred stock of entities captured in SSAP No. 97—*Investments in Subsidiaries, Controlled or Affiliated Entities* or SSAP No. 48—*Joint Ventures, Partnerships and Limited...*
Liability Companies, as well as preferred stock interests of certified capital companies per INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO) are included within the scope of this statement. The requirement to file investments in preferred stock of certain subsidiaries, controlled or affiliated entities with the NAIC pursuant to SSAP No. 97 does not affect the application of the accounting, valuation or admissibility under this statement.

Definitions

We are opposed to the proposed edits to the definitions of redeemable and perpetual preferred stock for the following reasons:

a. The change would create a divergence from GAAP that does not exist under the current definitions. Both the definition and accounting for redeemable securities under the current definition aligns with the GAAP definition and accounting for debt securities. Preferred stock accounted for as debt securities under GAAP are those where ability for the holder to collect repayment is assured by the contract terms. We have not identified any benefit to diverging from this view for statutory reporting. The NAIC guidance is different from the GAAP ASC 480 guidance for issuers in multiple ways:

- Preferred stock redeemable at the option of the holder for GAAP is classified as equity (mezzanine equity for SEC filers) but under statutory reporting currently (and proposed) is classified as debt-like in valuation. This conflicts with GAAP ASC 480 guidance for issuers and so it is more straightforward to use the GAAP ASC guidance for holders.
- Alignment of statutory accounting with the ASC 320 guidance for holders results in more equity-like classification in the valuation of preferred stock which is generally more conservative than debt-like classification in valuation.
- Preferred stock redeemable for other reasons outside of issuer’s control is equity (mezzanine equity for SEC filers) for GAAP but equity-like in valuation under current statutory reporting and debt-like in valuation under the proposed statutory reporting.

b. The definition that the NAIC staff has proposed to align to is used in GAAP only for compliance with SEC Regulation S-X, Rule 5-02, which is relevant only to the issuer of preferred stock and does not apply to nonpublic companies. Further, the definitions under Rule 5-02 were designed to include preferred stock with redemption features outside of the control of the issuer in order to provide investors information regarding potential future cash obligations. This is not a relevant consideration for the holder of preferred stock, which is why GAAP does not consider this from the holder’s perspective. From the holder’s perspective, the only relevant consideration is whether the holder is able to redeem its investment, either through a fixed and determinable date, or through a redemption option that the holder can control.

c. Evaluation of whether there are any features that are outside the control of the issuer is a very complex and cumbersome analysis, even on an infrequent basis as is the case under GAAP (as it only applies to issuers). This is because there are a vast number of potential features that could be outside the control of the issuer (i.e., change in control, lapse in SEC registration, failure to pay dividend, etc.). Insurance companies frequently invest in preferred
stock and often purchase many such securities each reporting period. Evaluating every preferred stock investment at this level of detail would be operationally burdensome and would provide no additional benefit as the investor is often economically indifferent to many of these low-probability redemption features that are outside of the control of both the issuer and investor.

As a result, we propose the following edits to the proposed definitions:

a. Redeemable preferred stock, which is preferred stock subject to mandatory redemption requirements or whose redemption is outside the control at the option of the issuer. Redeemable preferred stock is any stock which 1) the issuer undertakes to redeem at a fixed or determinable price on the fixed or determinable date or dates, whether by operation of a sinking fund or otherwise; or 2) is redeemable at the option of the holders; or 3) has conditions for redemption which are not solely within the control of the issuer, such as stock which must be redeemed out of future earnings. Preferred stock which meet one or more of these three criteria would be classified as redeemable preferred stock regardless of other attributes such as voting rights or dividend rights;

b. Perpetual preferred stock, which is preferred stocks which are not redeemable or for which redemption is not at the option of the holder are redeemable solely at the option of the issuer (non-redeemable preferred stock). Perpetual preferred stock is any preferred stock which does not meet the criteria to be classified as redeemable preferred stock pursuant to paragraph 3.a.

Balance Sheet Amount

The issue paper discusses carrying perpetual preferred at fair value capped by any stated call price. However, it did not provide guidance on timing for application of the cap. Because the call may not be effective for a period of time, and to ensure that purchases of perpetual preferred stock could still be carried at values greater than par (assuming market values remain above par), we recommend the following revisions to paragraph 10.a.ii, 10.b.ii and the correspondingly to paragraph 11 (underlined):

Paragraphs 10.a.ii and 10.b.ii:

i. Perpetual preferred stocks shall be valued at fair value, not to exceed *any currently effective call price*.

Paragraph 11:

11. An other-than-temporary (INT 06-07) impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of the preferred stock in effect at the date of acquisition. An assessment of other-than-temporary impairment shall occur whenever mandatory redemption rights or sinking fund requirements do not occur. A decline in fair value which is other-than-temporary includes situations where the reporting entity has made a decision to sell the
preferred stock prior to its maturity at an amount below its carrying value (i.e., amortized cost). If it is determined that a decline in the fair value of a redeemable preferred stock is other-than-temporary, an impairment loss shall be recognized as a realized loss equal to the entire difference between the redeemable preferred stock’s carrying value and its fair value, not to exceed any currently effective call price, at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR, realized losses shall be accounted for in accordance with SSAP No. 7.

Income

The issue paper clarifies the guidance on dividends on preferred stock. Specifically, paragraph 14 states:

“14. Dividends on preferred stock shall be recorded as investment income for qualifying preferred stock on the ex-dividend date with a corresponding receivable to be extinguished upon dividend settlement.”

Interested parties request clarification on the use of the term “qualifying” preferred stock as the term is not defined within the issue paper or within the new glossary of terms. If the inclusion of the word “qualifying” was unintentional, interested parties recommend deleting the word from paragraph 14 to avoid confusion.

Ref #2019-08: Update Reporting Deposit-Type Contracts

The Working Group exposed this agenda item to: 1) request feedback on the inclusion of a footnote excerpt for Exhibit 5 to disclose cases when a mortality risk is no longer present or a significant factor – i.e., due to a policyholder electing a payout benefit, 2) request feedback on circumstances where a morbidity risk is no longer present or a significant factor for Exhibit 6 items and whether a similar footnote disclosure would be appropriate, and 3) requested industry and regulator input for instruction clarifications regarding the classifications of deposit-type contracts captured in Exhibit 7. With this exposure, there are no proposed edits for statutory accounting. The Working Group directed NAIC staff to notify the Financial Stability (Ex) Task Force of this exposure.

Interested parties support the proposed Exhibit 5 footnote which, among other things, would provide clarification on contracts where a mortality risk is no longer present or a significant factor.

With respect to the implementation of additional disclosures for Exhibit 6, interested parties believe that the current product disaggregation in Exhibit 6 is sufficient to analyze the risks present in the subject contracts, and would suggest no changes.

Interested parties have no additional clarifications for Exhibit 7 instructions – we believe the current instructions are sufficiently clear for deposit type contracts.
Ref #2019-12: ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force

The Working Group adopted, as final, a clarification edit to SSAP No. 68—Business Combinations and Goodwill to clarify that all goodwill from an insurance entity’s acquisition of SCAs, regardless of whether pushdown accounting is applied, is subject to the existing 10% admittance limitation. (With adoption of this edit, paragraph 9 was split into two separate paragraphs with the additional wording shown below.) The remainder of this agenda item was re-exposed to allow additional time for specific examples of pushdown accounting to be provided by interested parties, as well as consider comments received on pushdown.

9. Positive goodwill recorded under the statutory purchase method of accounting shall be admitted subject to the following limitation: Positive goodwill from all sources, including life, accident and health, and deposit-type assumption reinsurance and goodwill resulting from the acquisition of an SCA by the insurance reporting entity that is reported on the SCA’s financial statements (resulting from the application of pushdown accounting), is limited in the aggregate to 10% of the acquiring entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Additionally, all positive goodwill shall be nonadmitted when the underlying investment in the SCA or partnership, joint venture and limited liability company is nonadmitted. When negative goodwill exists, it shall be recorded as a contra-asset.

Interested parties is working on developing examples to illustrate the various ways in which goodwill can be generated and suggested approaches to how the statutory limitations could be applied. As a result of these efforts, we request an extension for this and the following item.

Ref #2019-14: Attribution of Goodwill

The Working Group re-exposed this agenda item to clarify that the “assignment” of goodwill is a disclosure element. The Working Group directed NAIC staff to prepare revisions to the Sub 1 Acquisition Overview template to capture this information for new SCA acquisitions.

Please see the comments on the preceding item.

Ref #2019-20: Rolling Short-Term Investments

The Working Group exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, as shown in the “Proposed Revisions for Fall 2019 Discussion” to incorporate additional principle concepts in classifying investments as cash equivalents or short-term investments to prevent the “rolling” of certain investments. Fall revisions to the prior Summer National
Meeting exposure incorporate guidance to exclude qualifying cash pools from the short-term rolling provisions.

With the Fall exposure, comments were requested from regulators and industry representatives on whether other investments should be included / excluded from the short-term rolling provisions. In particular, comments are requested on whether short-term lending (both collateral loans and affiliated loans) should be permitted to be continuously rolled/renewed as short-term, whether non-affiliated SSAP No. 26R investments should be subject to the short-term rolling restrictions, and whether an assessment of “re-underwriting” could be used as support to allow the rolling of short-term investments.

Interested parties appreciate the staff’s exclusion of qualifying cash pools from the provisions of the short-term rolling re-exposure. There remain two types of short-term lending arrangements within the scope of the re-exposure that should be addressed separately. We respectfully request that the Working Group give consideration to the broader implications discussed below prior to moving forward with this proposal. Specifically, it might be advantageous to split the exposure into two work streams – one for affiliated investments and another for unaffiliated investments.

**Non-affiliate Short-Term Lending**

In the case of non-affiliated loans (i.e., Schedule BA Other Invested Assets), in order to provide appropriate flexibility to both the lender and the borrower, a loan facility may be structured as a short-term obligation. Such short-term obligations permit an insurer to more efficiently deploy its capital and streamline its underwriting process. Specifically, short term, non-affiliated loans: (a) provide the insurer with the ability to review and consider credit and collateral on a regular basis, (b) allow the insurer to reevaluate each investment at maturity and make new investments based on current market conditions if desired, and (c) allow the insurer to consider a renewal with an existing base of knowledge about the borrower and collateral, making the underwriting process more streamlined and allowing for better informed credit decisions. As with any investment, diligent underwriting of the borrower and the collateral, and structuring of the investment with appropriate safeguards is critical and should not deviate from standards used for longer-term investments. These facilities fill a market need for borrowers that require short-term or warehouse-type financings on assets prior to reaching the window for securitization and provide the insurer with attractive risk-adjusted returns relative to other short-term investments.

In this context, interested parties propose that all non-affiliated short-term obligations, obligations in scope of either SSAP No. 26 or SSAP No. 43R, where the counterparty is not an affiliate or related party of the reporting entity, including collateral loans, which meet certain objective criteria should be defined, reported, and monitored in the existing Schedule DA as a non-affiliated short-term investment. In order for a non-affiliated transaction to qualify as short term for reporting purposes, such investment must include the following features:

1) The loan includes a maturity date less than one year from closing at which the borrower has an unconditional repayment obligation and on which the lender has a reasonable expectation that the investment can be terminated and repaid if so desired by the insurer; and
2) Any subsequent renewal is only completed in the sole discretion of BOTH the borrower and the lender.

Given that the transaction is between unaffiliated counterparties, interested parties believe the terms of these transactions, including the interest rate and advance rate, are on arms’ length terms.

Finally, with no obligation at any time to renew a transaction, the reporting entity is required to re-evaluate and re-underwrite the transaction at maturity. If any of the relevant underwriting criteria have changed, the insurer can require repayment or can request adjustments to the terms and conditions to conform to market conditions. If, but only if, both the borrower and lender agree to renew the transaction on the same or adjusted terms, the transaction may be renewed. This process, however, requires an independent credit decision and results in a new transaction.

Interested parties acknowledges the NAIC staff’s concern about the ability of auditors and regulators to discern between renewals that have been re-underwritten and those that have not; however, without an appreciation for the nuanced economic differences of these transactions, interested parties have concerns about unintended consequences of the re-exposure. Consider a transaction in which an entity purchases a GNMA with less than a one-year maturity, which was classified as a short-term investment or cash equivalent and matures/is settled as expected. Shortly after, that entity decides to purchase another GNMA with less than a one-year maturity. As proposed, the guidance precludes short-term investment or cash equivalent reporting for reacquired investments (or substantially similar investments) when purchased within one year from the initial investment. Without further clarification regarding substantially similar investments, or alternative objective criteria like those proposed above, we anticipate that diversity in practice could result. Additionally, regarding the example described, operationally burdensome tracking requirements would be required for entities to ensure appropriate reporting.

Therefore, we believe that unaffiliated SSAP No. 26 investments should be excluded from the scope of this exposure for the reasons discussed above. The scope of this exposure should also continue to exclude other unaffiliated SSAP No. 26 investments such as treasury bills, commercial paper, certificates of deposits and other similar short-term investments since such investments are used for short-term liquidity and do not have long-term investment risk.

**Affiliate Short-Term Lending**

Interested parties believe that the same principles discussed above and in our previous letter apply to affiliated short-term investments to merit continued classification as short term in nature, even when a subsequent short-term investment is re-underwritten to the same borrower within a year. We believe there is already sufficient regulatory oversight on the fundamental objectives, usage and risks of material affiliated transactions to validate the alignment of these vehicles with the fundamental characteristics implied by the statutory short-term investment classification. In this case, prudently managed, governed and executed liquidity optimization across an insurance holding company system can be observed with the current regulatory oversight mechanisms. While re-underwriting may be warranted based on liquidity needs, the risk profile continues to be commensurate with that of short-term investments.
NAIC Guidance should not supersede regulatory oversight. The domiciliary commissioners already have authority to disapprove of material affiliated transactions as deemed necessary. The NAIC Model Holding Company Act (the “Act”), which has been broadly incorporated into state laws, requires filing and domiciliary commissioner approval of affiliated transactions over certain materiality thresholds. As the Act was promulgated by the NAIC, interested parties believe that through use of the Act, commissioners put in place filing and approval requirements they deemed satisfactory to address their regulatory needs. Through these filings, state regulators have oversight over both the risk elements considered and the methodology utilized by companies in underwriting each material extension of credit within the holding company system. It would run counter to state authority to implement requirements resulting in NAIC guidance that would effectively supersede the authority of domiciliary commissioners or cast doubt, even implicitly, upon states’ ability to appropriately regulate the domiciled insurers with which they are intimately familiar. Principally, the Act allows regulators to verify the appropriateness of the short-term classification of material affiliated investments, providing oversight to ensure consistency in classification between affiliated and unaffiliated short-term investments.

Prudent and appropriately governed liquidity management within a holding company structure enhances insurance company solvency. Appropriately managed, governed and regulator-approved affiliate lending programs create opportunities for liquidity optimization across a holding company system, essentially sharing objectives similar to that of affiliated liquidity pools. This management is necessary due to diversification of product offerings as timing of cash receipts and disbursements will vary across such products and different entities within a holding company system. The ability to prudently draw upon excess liquidity surplus within one entity at a time when another entity has a short-term need for liquidity serves as an immediate buffer against uneconomic alternatives such as forced asset sales or relatively costly external short-term financing. If adopted as written, the exposed guidance could result in entities foregoing this powerful in-house liquidity tool, which enables companies within a holding company system to more effectively manage inherent cash flow timing mismatches, and instead resort to alternatives that would result in an unnecessary drain on capital available to support policyholder obligations.

SSAP 43R—Loan-backed and Structured Securities

Investments in the scope of SSAP 43R, Loan-backed and Structured Securities, have payments that are driven by underlying collateral with modifications that are driven by the performance of the underlying assets and typically overseen by a collateral manager or otherwise laid out in deal documents. In many cases, these instruments also have clean-up call provisions that would remove the investment from the market while the remaining underlying collateral may be repackaged into a re-securitization. The concept of rolling a short-term investment that would be in the scope of SSAP 43R is often-times outside the control of investors in these instruments and possibly part of the normal life cycle of a small portion of the underlying collateral. Because of these characteristics, the interested parties propose that any non-affiliated investment that would qualify within SSAP 43R—Loan-backed and Structured Securities be exempt from the proposed new concepts like what is proposed for non-affiliated investment that would qualify within SSAP 26R—Bonds. Further consideration of affiliated investments that fall within SSAP 43R is recommended, given the underlying assets drive these investments and the other considerations for affiliate short-term lending outlined previously in this response.
Interested parties respectfully requests that the Working Group give consideration to these broader implications prior to moving forward with this proposal. If the Working Group has lingering concerns or appetite for additional elaboration as to the character and traditional efficacy of existing regulatory oversight mechanisms, interested parties would request that staff work with industry to draft materials for future dialogue and examination of this topic.

**Ref #2019-24: Levelized and Persistency Commission**

The Working Group exposed revisions to *SSAP No. 71—Policy Acquisition Costs and Commissions*, to include additional NAIC staff modifications regarding persistency commission and levelized commission arrangements to address certain comments received and to allow for further discussion. With this exposure, the Working Group directed a notification of the exposure to be sent to the Life Actuarial (A) Task Force.

Interested parties appreciate staff’s availability to discuss the proposed revisions. Based on that discussion and the discussion at the Fall Meeting, interested parties propose suggested edits that we believe achieve the goal of a nonsubstantive change and clarify the original intent of SSAP 71. (Note: the *NAIC Accounting Practices and Procedures Manual-Life* which was in force prior to the effective date of current SAP includes the same wording as current SSAP No. 71). The suggested edits add a clear definition of a funding agreement. This will clarify the distinction between funding agreements and persistency-based commissions, without unintentionally changing the existing accounting. We welcome the opportunity to discuss the suggested edits further with the Working Group.


The Working Group exposed substantive revisions to *SSAP No. 105—Working Capital Finance Investments* (SSAP No. 105) to incorporate industry revisions to program requirements, as previously directed by the Working Group during the Summer National Meeting. The Working Group directed NAIC staff to prepare an issue paper.

In 2016, the American Council of Life Insurers (ACLI) advised the NAIC that the implementation of SSAP No. 105 was not successful and that adoption had been low. ACLI began a dialogue with staff and regulators about both the shortcomings of the 2013 adopted rules and outlined required changes to make the rules suitable. As part of that process, ACLI marked up both the SSAP and NAIC SVO Purposes and Procedures Manual (P&P Manual) with the suggested changes which have subsequently been characterized as "10 required items", which staff have in turn opined on, and noted that four of the items are not supported by staff. Absent all 10 required items, WCFI adoption will remain low. Staff have noted an immaterial number of programs have been filed with only a subset of those approved, resulting in limited investments made. The existing Exposure provided to staff and regulators by ACLI and was utilized by staff to produce the current proposal, without addressing the proposed language by ACLI on the four required items not supported by staff.

Objections to the four required changes are:

1) evaluating non-rated subsidiaries of obligors (even though the existing SSAP already provides guidance to do).
2) expanding covered investment credit quality to include NAIC 3 and 4 investments, 
3) requiring domiciliary regulator authorization for investment, and 
4) requiring reporting on Schedule BA even though the asset class qualifies for look through RBC treatment.

In the ACLI draft provided to the NAIC, ACLI proposed an evaluation mechanism that is suitable for NAIC implementation on un-rated subsidiaries. With regard to NAIC objection on lower rated investments, such position is inexplicable as statutory RBC requirements reflect investment quality decisions in capital calculations limiting Industry investments to compliant assets. Domiciliary regulator prior approval for investment is a transfer of transaction review from staff to state insurance departments when, if regulators are concerned about the asset class, they can uniformly limit investment as a whole. Finally, Schedule BA reporting is both cumbersome and expensive for industry further exacerbating adoption without useful purpose. Regulators can track any specific asset class or investment by requiring the use of a specific investment code on the appropriate accounting schedule, which in the case of WCFI is Schedule DA).

Interested parties note that private placements, as opposed to public investments, are typically available only to large industry participants and that the economic impact of a $10,000 industry filing fee per issue per filing entity has an operating impact on a $1,000,000 investment in WCFI, which for the avoidance of doubt would be sizable for most industry investors, of 1% of the investment income in year 1 of that investment. Current investment yields for NAIC 1 and 2 investments in WCFI offer gross returns of 2 – 2.5%. Such a high cost to a small industry investor, coupled with the fact that dealers would unlikely choose to document such investments bilaterally with small industry investors, limits access to the assets to large industry investors. In summary, interested parties request that regulators re-consider ACLI markup with the additional four requirements as originally submitted by ACLI and ultimately, after appropriate exposure and review, to direct staff to implement these changes.

Ref #2019-32: Look-Through with Multiple Holding Companies

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, to clarify that a more-than-one holding company structure is permitted as a look-through if each of the holding companies within the structure complies with the requirements in SSAP No. 97.

Interested parties have no comment on this item.

Ref #2019-33: SSAP No. 25 – Disclosures

The Working Group moved this agenda item to the active listing and exposed the proposed data-capture templates. This exposure does not propose revisions to SSAP No. 25.

Interested parties believe that clarifications to paragraph 20 of SSAP No. 25 are necessary. We believe that the aggregation of similar transactions may result in immaterial transactions becoming material, meeting the threshold of 1/2 of 1% of the total admitted assets of the reporting entity. Therefore, we propose the edits highlighted below to ensure that aggregation occurs subsequent to the application of the criteria in paragraph 20.b. for materially identified transactions.
Proposed Edits to the exposure

Disclosures

20. The financial statements shall include disclosures of all material related-party transactions. In some cases, aggregation of similar transactions, that on a stand-alone basis are not material, may be appropriate. Sometimes, the effect of the relationship between the parties may be so pervasive that disclosure of the relationship alone will be sufficient. If necessary to the understanding of the relationship, the name of the related party should be disclosed. Transactions shall not be purported to be arm’s-length transactions unless there is demonstrable evidence to support such statement. The disclosures shall include:

a. **The nature of the relationships involved:**
b. **A description of the transactions for each of the periods for which financial statements are presented, and such other information considered necessary to obtain an understanding of the effects of the transactions on the financial statements.** Exclude reinsurance transactions, any non-insurance transactions which involve less than ½ of 1% of the total admitted assets of the reporting entity, and cost allocation transactions. The following information shall be provided if applicable:

Ref #2019-34: Related Parties, Disclaimers of Affiliation and Variable Interest Entities

The Working Group Staff exposed revisions to SSAP No. 25—Affiliates and Other Related Parties. Key elements for discussion in the exposure draft are to:

- Clarify the identification of related parties and ensure that any related party identified under U.S. generally accepted accounting principles (GAAP) or Securities Exchange Commission (SEC) reporting requirements would be considered a related party under statutory accounting principles (SAP).

- Clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation.

- Clarify the impact of a disclaimer of control or disclaimer of affiliate under SAP. As detailed, such disclaimers impact holding company group allocation and reporting as an SCA under SSAP No. 97, but do not eliminate the classification as a “related party” and the disclosure of material transactions as required under SSAP No. 25.

- Incorporate a new disclosure of known non-arm’s-length transactions with any entity not identified as a related party.

- Propose rejection of several U.S. GAAP standards addressing variable interest entities.

Interested parties understand and agree with the need for transparency in disclosures of related party transactions. However, we have significant concerns with the proposal as it is not very clear based on
the proposed changes to SSAP No. 25 what it is that will be required going forward based on the expansion of the definition of a related party. We include some of our observations below.

Interested parties would like clarity around the new proposed wording that states that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation. One of our concerns in this area relates to limited partnership/joint ventures/limited liability company (LPs/JVs/LLCs) investments where the insurer owns more than 10% of the equity of the investee but has no affiliation to the investee’s general partner/asset manager. SSAP No. 97 currently includes a possible scope exception in paragraph 6 for these types of investments so that they are not considered affiliated or controlled investees of the insurer. It is not clear from the proposal what the expected impact is from now having to consider all investments in unaffiliated LPs/JVs/LLCs where the insurer owns more than 10% of the equity but has no other affiliation, as related parties. If the intent is just to have insurers disclose material transactions with these entities other than the equity investment held in each entity, we believe that this needs to be more clearly stated in the proposal so that there is no misrepresentation of what needs to be disclosed or whether these investments need to be reported in a different section of Schedule BA (i.e., affiliated vs. non-affiliated).

Another, but similar concern relates to certain entities consolidated under U.S. GAAP based on the Variable Interest Entity (VIEs) guidance. For some of these consolidated VIEs, the insurer has no control or affiliation with the VIE other than its debt investment in the entity. The insurer is simply a passive investor in the structure. However, under the VIE rules, the insurer must consolidate the entity as the insurer may be able to make decisions for the VIE if there is ever an event of default of the assets at some point in the future. These rights are given to certain classes of bonds issued by the securitization as a protection to the investors, but do not give the investors any type of power or control over the VIE at inception or on a day-to-day basis. It is important to note that consolidation rules under FASB Codification Topic 810 are very complex with some insurers concluding consolidation is required under a set of facts and circumstances and others concluding consolidation is not required under the same set of facts and circumstances. In the example just shared, some insurers have concluded consolidation is required because when no day-to-day decisions are being made for the VIE, decisions upon the occurrence of a certain event which may be unlikely to occur, rise to the point where they are the decisions that have the most significant impact on the economic results of the VIE. We believe that even though insurers have to consolidate these entities, there is no true related party affiliation. The proposal requires that any entity identified as a related party under U.S. GAAP will also be considered a related party for statutory reporting. Since these entities are consolidated for GAAP, the presumption would be that they are a related party of the insurer. If these entities will be considered related parties on a statutory basis going forward, the exposure needs to clarify that the inclusion of these types of entities only impacts related party disclosures for any material transactions held with these entities other than the debt investment held by the insurer in the VIE and that the debt instrument is still reported on Schedule D as unaffiliated.

Interested parties also have concerns with SSAP No. 25 including references to U.S. GAAP and SEC reporting for mutual insurers that do not prepare U.S. GAAP financial statements and do not file with the SEC. Therefore, interested parties recommend that the specific guidance from the GAAP and SEC be stated in SSAP No. 25 (rather than incorporated by reference) so that any future changes in GAAP and SEC guidance are subject to NAIC review prior to being applicable. Also, it is important to note that even when an entity is considered a related party under U.S. GAAP, disclosure of that relationship is
only required when there are material transactions with that party. U.S. GAAP allows reporting entities to evaluate the significance of a relationship and determine when disclosure of that relationship is material/significant enough for disclosure to a user of the financial statements. As a result, we suggest this be clarified in the exposure as well so that it is clear that the reference to related parties under GAAP and SEC rules is only relevant if the insurer has material transactions with such parties outside of the insurer’s investment in the entity.

Ref #2019-35: Update Withdrawal Disclosures

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts, and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, as illustrated in the staff recommendation, to:

- Add a consistency revision to SSAP No. 51R to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosures;
- Correct an identified inconsistency in one of the new disclosures that was added regarding products that will move from the reporting line of having surrender charges at 5% or more to the reporting line of surrender charges at less than 5%. A clarification is being recommended to ensure consistency in annual statement reporting; and
- Add a cross-reference from SSAP No. 56 to the existing disclosures by withdrawal characteristics in SSAP No. 51R and SSAP No. 61R as the disclosure include separate account products.

Interested parties have no comment on this item.

Ref #2019-36: Expand MGA and TPA Disclosures

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 51R—Life Contracts, paragraph 50, SSAP No. 53—Property Casualty Contracts—Premiums, paragraph 19, SSAP No. 54R—Individual and Group Accident and Health Contracts, paragraph 33 and SSAP No. 59—Credit Life and Accident and Health Insurance Contracts, paragraph 19, as illustrated in the staff recommendation above, to expand the MGA/TPA note as follows:

- Aggregate direct written premium and total premium written by MGA/TPA;
- Aggregate dollar amount of claims process / total claims processed by MGA/TPA; and
- Information on related party / affiliate status and if the MGA/TPA is independently audited and / or bonded.

Interested parties note that the proposal does not define a TPA. It just states that TPAs “that write direct policies or provide claims adjusting or other services”. That is overly broad and could include a variety of entities that provide services. The NAIC model (NAIC Third Party Administrator Act, or NAIC model) guidelines define TPAs as it relates to life/health and workers compensation. Also, the NAIC model definition has a long list of activities that are excluded from the definition, such as self-insured employers administering its own workers’ compensation, insurers administering coverage, producers
engaged in selling insurance, attorneys handling claims, MGAs, etc. We recommend that the proposed disclosure reference the NAIC model so that there is consistency in the definition used in applying the guidance.

Additionally, it is unclear how the reporting threshold should be applied. The reporting applies to TPAs if “the claims adjusting services are greater than 5% of annual average claims volume”. Is that threshold based on the amount of claim dollars paid or the number of claims handled? Is that measured across all lines of business for the company? Would claims paid within insureds’ deductibles/SIRs be included? Depending on how this is defined, it could be quite burdensome for insurers to monitor. We recommend that the threshold be based on written premium, consistent with how other thresholds have been applied.

**Ref #2019-37: Surplus Notes – Enhanced Disclosures**

During the 2018 Spring National Meeting, the Working Group exposed revisions to *SSAP No. 41R – Surplus Notes* (“SSAP No. 41R”) to indicate that surplus notes, where the proceeds from the issuance of the surplus note were used to purchase an asset directly or indirectly from the holder of the surplus note, are not subordinate and do not qualify for reporting as surplus and should be classified as debt. Furthermore, the exposure draft stated that these assets were not considered available for policyholder claims and should be non-admitted. The exposure was the result of a referral from a Subgroup of the Reinsurance Task Force that was more narrowly focused on whether specific securities could be considered Primary Securities.

At the 2019 Summer National Meeting, the Working Group agreed to have an industry data call, due by December 31, 2019, to determine what financing structures existed that utilized the types of surplus notes described above.

At the 2019 Fall National Meeting, the Working Group exposed additional disclosures that should be captured in *SSAP No. 41R*. The Working Group does intend, later in 2020, to continue discussions on how to treat surplus notes where an associated asset is received by the surplus note issuer. This discussion will occur after a review and analysis of the data call.

**General Comments**

Interested parties understand regulators’ concerns that the details of certain transactions involving surplus notes may not be transparent to regulators who were not involved in the initial approval or ongoing review of such transactions. However, these transactions and the related pricing represent confidential information that we believe is inappropriate for public disclosure and may be misleading if presented in the proposed format.

Our concerns with the proposed disclosures are outlined in detail below, followed by our suggested revisions.

*The proposed disclosures may not provide the desired transparency or consistency*
Throughout the discussion on any potential revisions to SSAP No. 41R over the past twenty-two months, interested parties have agreed that robust disclosures should be added to SSAP No. 41R to fully reflect situations where a reporting entity receiving proceeds from the issuance of surplus notes used those proceeds to purchase an asset directly or indirectly from the holder of the surplus note. However, we also believe that these disclosures should be included in the financial statements of a ceding company, which would provide a much greater level of transparency and consistency in disclosure. We believe that in most situations where a surplus note issuer uses proceeds from the issuance to purchase an asset directly or indirectly from the holder of the surplus note, the surplus note issuer is an affiliated captive reinsurer. As some captive financial statements are not provided to the NAIC, we believe disclosure in the financial statements of the ceding company would provide a much greater level of transparency and consistency in disclosure for these transactions. Our proposed revisions include suggested language for this disclosure requirement.

The proposed disclosure goes beyond the stated regulatory concern and requires additional information that may be incorrectly interpreted.

We believe that the proposed disclosure departs from the original regulatory concern expressed in the public meetings of the Working Group, namely that a reporting entity should not be permitted to circumvent regulatory authority as it relates to the preservation of capital at a regulated entity by contractually linking the cash outflows associated with a surplus note to cash inflows from another financial instrument held by the surplus note issuer. However, rather than identify such transactions, the proposed disclosure would require detailed information about surplus note interest regardless of whether cash flows are contractually linked. We are concerned that the operational burden of compiling this information for all surplus notes with netting provisions exceeds the benefit to regulators of providing information on the few transactions of concern.

Interested parties note that the scope of the proposed disclosure is substantially identical to that of the recent surplus note data call issued by the NAIC. The stated intent of this data call was to obtain information on surplus note transactions without regard to whether offsetting of cash flows was due to: a) contractual linkage or b) administrative offset provisions. While we agree that this scope was appropriate to assess the universe of affected transactions, we do not believe it is the appropriate scope for an Annual Statement disclosure and could be misleading in certain cases as outlined below.

The proposed disclosure includes confidential information that is not appropriate for public filings.

The proposal would require the disclosure of surplus note interest paid, net of any payments made by the surplus note holder. As a practical matter, for many captive structures, this amount often corresponds to the fees paid to the financing provider(s) to provide liquidity in the event of adverse experience or other conditions with respect to the subject policies, as defined in the applicable agreement.

The pricing and terms of the subject transactions were heavily vetted, negotiated, and submitted to state regulators for approval with the reasonable understanding that this information was subject to robust confidentiality protections. We do not object to this information being made available to regulators in the context of a confidential data call or regulator communication. However, we are concerned with its
inclusion in public filings. The primary focus should be on whether the surplus note issuer is statutorily solvent rather than its surplus note pricing terms.

The net presentation of interest paid could be misleading for some transactions

We also believe that the change to the current disclosure to replace surplus note interest paid with interest paid net of amounts offset is problematic. We believe this disclosure could be misleading for many of the transactions in the scope of the disclosure, given that the full amount of surplus note interest paid was/would be due regardless of whether a portion is offset pursuant to an administrative netting arrangement.

Proposed Revisions

Interested parties recommend revisions to the proposed disclosures which would provide regulators who are not involved in the approval and ongoing review of a surplus note transaction with information to assess the nature of the transaction and to determine whether more detailed review is needed. Specifically, our revisions would require disclosure of whether cash flows are offset but would differentiate between administrative offsetting and the contractual “linkage” that is of concern to regulators. These revisions would also remove information that we believe is confidential in nature and would not be appropriate for public disclosure. Finally, we have proposed several additions to the required disclosures, which we believe would provide useful information about transactions involving surplus notes.

Our suggested revisions to the disclosures are included in Exhibit A and summarized below. For ease of review, revisions proposed by NAIC staff have been accepted, and interested parties’ comments are presented as tracked changes.

Summary of Proposed Revisions

- Expand the disclosure requirement to the financial statements of the ceding company as well as the surplus note issuer.
- Retain the current disclosure of total interest paid (gross of any administrative or other netting)
- Replace quantitative disclosure of “interest remitted” and “cost of liquidity” with three Y/N disclosure columns which correspond to the criteria used in the data call scoping:
  1. Do surplus note / associated asset terms negate or reduce cash flow exchanges, and/or are amounts payable under surplus notes and amounts receivable under other agreements contractually linked? (For example, the asset provides interest payments only when the surplus note provides interest payments.)
  2. Are any amounts due under surplus notes and associated assets netted or offset (partially or in full) thus eliminating or reducing the exchange of cash or assets that would normally occur throughout the duration, or at maturity, of the agreement. (This may be referred to as administrative offsetting.)?
3. Were the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note?
   
   - Replace confidential information about 3rd party liquidity (e.g. maximum liquidity amount and cost of liquidity source) with a description of terms under which liquidity would be provided should a triggering event occur.
   - Add requirement for narrative disclosure of any related guarantees or support agreements.

Ref #2019-38: Financing Derivatives

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 86—Derivatives, to clarify the reporting of derivatives with financing premiums. The reporting revisions propose allowing the present value of the derivative premium receivable (and payable) for financed derivatives to be factored into the counterparty risk assessment for life RBC. (If supported, RBC changes would be subsequently referred to the Capital Adequacy (E) Task Force for consideration.) Comments are also requested as to whether derivatives and related financing provisions that would generally not meet the SSAP No. 64—Offsetting and Netting of Assets and Liabilities right to offset criteria and if explicit guidance allowing offset should be considered.

Interested parties request the exposure be given an effective date of at least January 1, 2021. The exposure represents a significant change to how certain companies account for derivatives and must be implemented in our investment systems prior to adoption. Interested parties do not believe the assets and liabilities under this exposure meet the right to offset criteria in SSAP No. 64—Offsetting and Netting of Assets and Liabilities, because they originate within the same contract. Additionally, we believe the netting guidance outlined in paragraph 19c would be difficult to implement and recommend it be removed.

Ref #2019-39: Acceptable Collateral - Counterparty Exposure for Derivative Instruments

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 86—Derivatives, to clarify that the fair value of collateral received or held, for derivative disclosure purposes, shall be reported net of collateral paid/pledged, in the event a counterparty has the legal right to offset against, as defined in SSAP No. 64—Offsetting and Netting of Assets and Liabilities. Minor updates to the applicable annual statement instructions were also proposed to be concurrently exposed.

Interested parties fully support the appropriate depiction within the statutory financial statements and schedules of the availability of insurance company assets to fulfill policyholder obligations, including consideration of a reporting entity’s access to and control over the assets and any contingencies pertaining to the attendant rights & benefits of ownership. We appreciate the opportunity to dialogue further on this matter and ensure the regulatory objective is achieved regarding both financial statement presentation and the risk-based assessment of capital.

The ability to make efficient use of derivative instruments as part of hedging transactions, income generation transactions and replication (synthetic asset) transactions, in accordance with SSAP No. 86 – Derivatives (“SSAP No. 86”), is a crucial component of insurers’ ability to effectively manage risk and prudently maintain yields in support of our ability to deliver on promises to our policy and contract holders.
holders. With broader federal regulation now driving a migration for many of the interest rate and credit derivatives insurers use to these ends towards the central clearinghouse or “cleared” space, the significance of appropriately depicting the specific economic substance and attendant risks associated with each of the various forms of collateral posted to central clearinghouses has never been greater.

Given this backdrop, our concerns with exposure 2019-39 are as follows:

1) The language in the proposal does not provide clear, consistent definition of scope or objective(s);
2) The exchange of initial margin on cleared trades represents a contingency distinct from that associated with the exchange of variation margin; and
3) The existing statutory accounting, reporting and risk-based capital models already appropriately depict the economic substance and inherent risk associated with the exchange of initial margin, and the proposed changes would result in inappropriate duplication of risk-based capital charges.

In terms of intended scope, the narrative commentary and proposed updates to existing guidance make it unclear as to whether the proposal aims to refine accounting & reporting guidance for:

- initial margin, variation margin, or both;
- bilateral (over-the-counter, “OTC”) trades, trades executed with central clearinghouses, or both;
- exchanges of cash collateral, non-cash collateral (e.g. securities) or both.

The summary introduction to the proposal appears to target a perceived issue with the Schedule DB-D, Section 1 reporting of initial margin exchanged with central clearinghouses. The narrative commentary provided does not identify specific concerns pertaining to the reporting of collateral associated with bilateral OTC trades or variation margin. However, the attendant proposed edits to SSAP No. 86 and the Blank Instructions for Schedule DB-D, Section 1 encompass collateral exchanges with both bilateral OTC counterparties and central clearinghouses…inherently scoping in both OTC and cleared trades as well as all forms of collateral (variation margin, initial margin and traditional margin on legacy bilateral OTC trades). In addition, the proposal makes no clear distinction between proposed updates regarding exchanges of cash collateral vs exchanges of non-cash collateral, often using the terms collectively and interchangeably, whereas the guidance within the AP&P Manual makes clear distinctions regarding their respective accounting and reporting - as they have distinct implications for users of statutory financial statements. The guidance for cash collateral exchanges under SSAP No. 103R – Transfers and Servicing of Financial Assets and Extinguishments of Liabilities (“SSAP 103R”) paragraphs 19 & 20 is distinct from that of non-cash collateral exchanges, which is also further detailed in INT 01-31 – Assets Pledged as Collateral (“INT 01-31”). Anecdotally, though the SSAP No. 86 Appendix C guidance for the initial carrying value on futures paraphrased in the 2019-39 exposure commentary applies to exchange traded derivatives (which do not appear to be within the scope of this current exposure), it maintains conceptual symmetry with the distinct cash collateral guidance from SSAP No. 103R; classifying only cash postings of initial margin as a form of basis deposit necessitating distinct accounting and financial statement presentation. Additional clarification regarding both the perceived issue(s) and the objective(s) underlying the proposed updates is requested in order to ensure industry can assist in fully and appropriately addressing each underlying concern in light of the applicable regulatory objective(s).
The exchange of initial margin with central clearinghouses is clearly distinct in function from the exchange of variation margin. As referenced in the proposal, initial margin is a minimum amount of equity that must be provided to a clearinghouse to initiate a position. It effectively represents the deposit of chips required to play at the table (“table stakes”), and is required from both respective parties entering into the derivative transaction as protection for the clearinghouse against the potential that either respective party will not make good on its respective commitments (i.e., initial and continuing participation in the transaction and the associated exchanges of variation margin driven by the derivative price movements until expiry or novation) – leaving the clearinghouse exposed, as intermediary, to the remaining party. Once such a trade expires or is novated, assuming the respective party has made good on all its variation margin payments during the course of the trade being open, the asset(s) posted to the clearinghouse as initial margin is returned to that exiting party. In the instance that a party exiting the derivative transaction has not stayed current with its respective variation margin obligations, the clearinghouse will return the remaining value of the initial margin after settling up the unpaid variation margin obligations. As such, the contingencies associated with maintenance of exclusive control over the rights and benefits of asset ownership for an entity posting initial margin are primarily a function of the entity’s continuing involvement in the trade with the clearinghouse, which is distinct from the derivative price movement contingencies directly associated with variation margin.

Reporting entities often utilize non-cash collateral (e.g., US Treasuries) for posting as initial margin to clearinghouses, as the required initial margin value can be comparatively high (driven by risk adjusted trailing price volatility of the underlying derivative and overcollateralization conventions) but the reporting entity maintains the full rights & benefits of ownership over an already held yield generating asset – in many instances preferable to locking up a chunk of otherwise investible cash. The ability to maintain full control over the rights and benefits of ownership on this yield generating non-cash collateral posted (e.g., avoiding forced sales of the non-cash collateral to satisfy unfulfilled variation margin obligations) also incentivizes a reporting entity to remain current on variation margin obligations while the trade remains open.

Existing statutory accounting guidance (e.g., the previously referenced SSAP No. 103R and INT 01-31) already provides for appropriate classification, measurement and presentation of collateral posted as initial margin. In the much more likely instance that non-cash collateral has been posted to a clearinghouse as initial margin, the pledging insurer continues to record the pledged collateral as an admitted asset until they have committed a contract default that has not been cured. In the unlikely instance that the non-cash collateral has to be liquidated in order to satisfy unmet variation margin payment obligations associated with a trade being exited, any associated realized loss would be recognized and the reclassification of the remaining initial margin value due back from the clearing house will be recorded – likely as either cash or a receivable - in accordance with applicable statutory guidance. The Blanks instructions require that any such non-cash or cash collateral posted as initial margin be marked as such on the attendant investment schedule, identified at the specific asset level on Schedule DB-D Section 2 (complete with an identifier indicating that the posting represents initial margin) and summarized within Note 5 (Restricted Assets). As such, the availability of the assets to fulfill policyholder obligations, as well as identification at the specific asset level of the unique and specific contingencies associated with initial margin posting are already presented appropriately for the consideration of financial statement users. Altering the presentation of initial margin postings on the summary Schedule DB-D Section 1 would not augment a financial statement user’s understanding of the reporting entity’s solvency or financial condition, as the “net realizable margin” associated with the open derivative contracts is already appropriately presented – initial margin posted is not directly or
typically subject to the derivate price movement contingencies inherent in arriving at an appropriate “Exposure Net of Collateral” total on Schedule DB-D Section 1.

Equally as important, incorporation of initial margin posted into the “Exposure Net of Collateral” total on Schedule DB-D Section 1 would lead to inappropriate and misleading downstream consequences for a reporting entity’s Risk Based Capital calculation. Any collateral (whether non-cash or cash) posted as initial margin is already captured in the Life RBC formula on LR017 (Off Balance Sheet and Other Items), where all collateral postings are pulled directly from Schedule DB-D Section 2 and assessed RBC charges associated with the specific contingency of pledging of the assets to an external counterparty. Thus, netting initial margin postings into the “Exposure Net of Collateral” total on Schedule DB-D Section 1 would make the total derivative exposure (net of collateral) that flows through to LR012 in the Life RBC formula too high – inappropriately double counting the RBC charges associated with the posting of initial margin to a clearinghouse. In addition, the understatement of net realizable collateral (Fair Value of Acceptable Collateral) on Schedule DB-D Section 1 would also, in many instances, mechanically carry through to overstate the “Off Balance Sheet Exposure” reported on the same schedule – which would result in even further overstatement of RBC charges as this “Off Balance Sheet Exposure” flows through the Life RBC formula to be assessed charges on LR017. Doubling, and possibly tripling the RBC charges associated with the posting of initial margin to a central clearinghouse is not an appropriate depiction of true risk for such margin.

Given the ambiguities in the exposure language, the appropriate depiction of economic substance and inherent risk associated with exchanging initial margin within the existing statutory accounting, reporting and RBC frameworks, and the importance of maintaining insurers’ ability to utilize cleared derivatives to effectively manage risk and prudently support yields, we respectfully request that the Working Group withdraw the current proposal and direct NAIC Staff to collaborate with industry to specify and appropriately address any remaining concerns. We stand ready to work through any lingering misgivings the Working Group may have with regard to financial statement presentation but request that such endeavors be empirically grounded in specific observed instances of incomplete or inappropriate reporting.

Ref #2019–40: Reporting of Installment Fees and Expenses

The Working Group proposed revisions to SSAP No. 53 – Property and Casualty Contracts (SSAP No. 53) to clarify that the installment fee reporting guidance should be narrowly applied. Comments are also requested on whether guidance should be developed to allow expenses associated with installment fees to be reported as a contra revenue in “aggregate write-ins for miscellaneous income” and whether diversity should be permitted in reporting installment fee expenses. Additionally, the Casualty Actuarial (C) Task Force and Property and Casualty Risk Based (E) Working Group will be notified of this exposure.

With regard to the proposed change to emphasize that current guidance in SSAP No. 53 should be interpreted narrowly, interested parties recommend the following revision to the last sentence of the proposed wording in the footnote to SSAP No. 53 paragraph 6:
Clarification: Reporting of installment fees as other income should not be construed as having any bearing on whether such charges are subject to premium taxation, which remains an issue of state law and regulation.

Although interested parties did not survey companies, we believe the assertion by NAIC staff that expenses associated with installment fees are often immaterial is reasonable. We also believe that current reporting of the related installment fee expenses in other underwriting expenses is appropriate. For practical purposes, we do not see the benefit of isolating the expense related to processing the relatively small fee component of a premium billing for separate expense reporting purposes. We believe the reporting of expenses should be consistent and would not support the reporting of the related expenses as an “aggregate write-ins for miscellaneous income” or as a contra revenue to “finance and service charges not included in premiums.”

Ref #2019-41: Eliminating Financial Modeling Process

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 43R—Loan-backed and Structured Securities, to eliminate the multi-step financial modeling designation guidance in determining final NAIC designations for residential mortgage-backed securities (RMBS) / commercial mortgage-backed securities (CMBS) securities. Exposure was contingent upon the Valuation of Securities (E) Task Force’s concurrent exposure, which occurred on December 8, 2019. The Working Group noted that final action on this would not be taken until the Valuation of Securities (E) Task Force takes action on their related item.

Interested parties have no comment on this item at this time.

Ref #2019-42: Inclusion of Cash / Liquidity Pools - Cash Equivalents as defined in SSAP No. 2R

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments to specify that cash pooling structures that meet specified criteria qualify as cash equivalents.

Interested parties appreciate that a separate Form A (Ref #2019-42) was written related to Cash/Liquidity Pools (“pools”) to clarify the accounting associated with them. We agree with the addition of a paragraph, similar to paragraph 8, to SSAP No. 2R to provide guidance related to pools; however, given that the characteristics of pools differ by company, we propose some modifications to paragraph 8 in order to address those varied characteristics.

Interested parties’ comments related to the proposed paragraph 8 are as follows:

1) Regarding the proposal to look through the ownership structure to report the assets held as cash equivalents, we agree that look through is appropriate. Some pools, as approved by regulators, consist of assets that meet the Statutory definition of cash equivalents and thus the interest held in the pools are reported as cash equivalents on Schedule E2. However, other pools, also approved by regulators, include assets that meet the definition of short-term investments in SSAP No. 2 and thus the interest held in the pools are reported as short-term investments on Schedule DA. Some pools may include both short-term investments and cash equivalents.
Given the varied characteristic discussed above, we recommend paragraph 8 be modified to state that, if the requirements of paragraph 8 are met, the reporting entity may look through the ownership structure and report the assets as either cash equivalents or short-term assets based on the predominant characteristic of the underlying assets. This would allow companies the flexibility to report their investments in the pools in the Statutory statement schedule that is more reflective of the type of underlying investments in their pool and prevent the need for companies to reclassify/change their existing reporting to Schedule E2 from DA if they currently report the pools in DA due to the underlying assets.

2) Regarding paragraph 8d (i.e., the requirement to produce annual U.S. GAAP audited report of the pools including schedules showing each affiliate’s prorata share of the investments), insurance companies already receive an independent audit under Statutory Accounting Principles (“SAP”), which would include the insurance company’s investment in a pool. Requiring cash pools to be separately audited under U.S. GAAP would come at a cost, in time and resources, to insurers with pools. In addition, some insurers have pools which are not in the form of legal entities.

An alternative to the U.S. GAAP audit requirement of paragraph 8d is to require a footnote disclosure at the reporting date for each insurer that participates in a pool, which identifies that the insurer is invested in a cash pool, provides the reporting entity’s share of the pool, and the insurers dollar share of cash equivalents and short-term investments in the pool. This disclosure would be subject to audit on an SAP basis of accounting. IPs believe the audit of the disclosure along with the audit of the insurance company would be adequate to meet the objectives of ensuring that the pool allocation process is accurate. Other alternatives include targeted financial examination procedures for pools, which could include procedures to confirm the balance of the pool and verify the individual legal entities’ balances for participating in the pool.

3) We note that the addition of the proposed pool language in SSAP No. 2 does not specifically address the reporting and accounting for the interests held in the pool. We recommend, if the pool is managed on a fair value basis (i.e., interest in the pool are bought and sold at fair value), that the book/adjusted carrying value for the interest held in the pool would be reported at fair value with changes in fair value reported in unrealized gains and losses. If the pool is not managed on a fair value basis, the interest held in the pool would be reported at amortized cost. It is important to note that pools managed on a fair value basis may use amortized cost as the best estimate of fair value, depending on the characteristics of the underlying assets.

Finally, in the issue paper, NAIC staff questioned whether changes to SSAP No. 48, Joint Ventures, Partnerships and Limited Liability Companies are needed, since many pools are held in a Limited Liability Company (“LLC”). Interested parties do not believe such changes are needed to SSAP No. 48; however, it would be helpful to users of the SSAPs to add a footnote to paragraph 8 of proposed SSAP No. 2R stating that pools may be held in LLCs, for example, and if so, SSAP No. 2 is to be applied and not SSAP No. 48.
Ref #2019-43: **ASU 2017-11 - Financial Instruments with Down Round Features**

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 86—Derivatives to reject ASU 2017-11, *Earning Per Share, Distinguishing Liabilities from Equity, Derivatives & Hedging* and incorporate guidance into SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets and SSAP No. 72—Surplus and Quasi-Reorganizations for when certain freestanding instruments shall be recognized as liabilities and not equity.

Interested parties have no comment on this item.

Ref #2019-45: **ASU 2013-11, Presentation of an Unrecognized Tax Benefit**

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 101—*Income Taxes* to reject ASU 2013-11, *Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists* for statutory accounting.

Interested parties support adoption of this item but note that the following statement should be removed from the document as it is incorrect (see IFRC 23, *Uncertainty over Income Tax Treatments*):

**Convergence with International Financial Reporting Standards (IFRS):**

IFRS does not include specific guidance on the presentation of unrecognized tax benefits.

Ref #2019-46: **ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities**

The Working Group moved this agenda item to the active listing and exposed revisions to *Appendix D—Nonapplicable GAAP Pronouncements* to reject ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities* as not applicable to statutory accounting.

Interested parties have no comment on this item.

Ref #2019-47: **Grade in of Variable Annuity Reserves**

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 51R—*Life Contracts* and SSAP No. 3—*Accounting Changes and Corrections of Errors*. The revisions add reference, disclosures and accounting for Section 21 of the *Valuation Manual*, Requirements for Principle-Based Reserves for Variable Annuities, and grade-in requirements for reporting changes in the valuation basis for years beginning January 1, 2020.

This exposure consists of several parts, some of which we agree with and others we find both confusing and unnecessary. We agree that documentation of the choices made among the options for phase-in in VM-21 and the impact of those choices is important. The exposed edits focus on the adoption of the new reserve requirements for variable annuities (revised VM-21 and AG-43). Information on those choices and impacts will be provided to regulators through the PBR Actuarial Memorandum required by VM-31. This includes highlighting the elements of any Phase-in in the executive summary of the PBR.
Actuarial Memorandum. Given the current requirements of SSAP3 and SSAP51, documentation in the notes to the Annual Statement is also appropriate.

In Recommendation #2, the proposal would require the amounts from the Phase-in to be designated as “special surplus”. We disagree with this recommendation for the following reasons:

- This is a new requirement whose need has not been established. Disclosure of the amounts will provide information necessary for users of the financial statements to understand the basis of the reported financials.
- SSAP72 defines Special Surplus as amounts designated for specific contingencies. Recommendation #2 would be a change to the definition and purpose of special surplus that is inappropriate and would create an undesirable precedent.

Finally, the proposed language is unnecessary, and possibly confusing. VM-21 defines the minimum reserve requirement. Within that requirement, the company has the option to compute the reserves using the Phase-in provision of Section 2.B. Whichever option is elected, VM-21 defines the reserve. SSAP51 defines the amount of the “Change in Basis” as the difference between the amount under the prior VM-21 and the amount required by the current VM-21 as of 1/1/2020. If the Phase-in has been elected, that difference will generally be zero. The change in basis amount as defined in SSAP51 paragraph 39 is not being graded in – it is what it is following the VM-21 reserve requirements as stated. As such, SSAP51 does not need to make provision for a grade in. We propose the attached language as being clearer in defining the amounts to be disclosed, to use language consistent with VM-21, and to recognize the role of VM-21 to define the reserve requirement.

Ref #2019-48: Disclosure Update for Reciprocal Jurisdiction Reinsurers

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 62R—Property and Casualty Reinsurance, to incorporate disclosure updates for reinsurers from Reciprocal Jurisdictions.

Interested parties have no comment on this item.

Ref #2019-49: Retroactive Reinsurance Exception

The Working Group moved this agenda item to the active listing with a request for comments on the preferred approaches to reporting and the advantages and disadvantages to each approach being used, including impacts on the Schedule P (and related loss analysis) and risk-based capital. Industry and state insurance regulator volunteers are requested to assist with developing guidance to clarify both the accounting and reporting for retroactive contracts which are accounted for prospectively. The Working Group directed NAIC staff to notify the Casualty Actuarial and Statistical (C) Task Force of the request for comments.

With regard to retroactive portfolio transfer deals within the same group that qualify for prospective treatment, interested parties identified the following issues related to reporting transactions in Schedule P.
Main Issues

- Should there be a requirement to have offsetting entries for the ceding and assuming entity within the group, such that the group Schedule P is not impacted (and industry Schedule P is not impacted)? (If so, then the ceding entity can’t record ceded amounts for prior AYs while the assuming company records assumed amounts all in the current CY/AY.)

- Should retroactive changes in previous premium amounts be allowed? (If no, and there is a desire to have both entities record the ceded/assumed in the affected older AYs, then the reinsurance premium would need to be treated as a paid loss – positive paid for the ceding entity and negative paid for the assuming entity.)

- Should the reporting prevent “cliffs” in the historic development reported in Schedule P. (If the cede transaction is reported as a premium and spreading to prior CYs, effectively changing prior values retroactively, then the prior incurred loss amounts in Schedule P, Part 2 would need to be adjusted to avoid a “cliff”.) Note that cliffs in Schedule P, Part 2 can have a material RBC impact with regard to the company experience adjustment.

Two Alternative Approaches

Interested parties identified two alternative approaches to recording intercompany, retroactive reinsurance:

- Record the reinsurance premium as a paid loss (positive paid for the cedant, negative for the assuming company), spreading the “premium” to the same AYs as the ceded losses. This avoids cliffs and avoids restating past CY Earned Premium, although it produces unusual results for the assuming company’s Schedule P.

- Record the reinsurance premium as premium, restating prior CY Earned Premium. Spread losses to the impacted AYs. This would create cliffs in Schedule P unless prior AYs are restated for the impact by AY of the reinsurance contract at inception.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell            Rose Albrizio
Disclosures

18. The notes to the financial statements of a reporting entity that issues surplus notes shall disclose the following as long as the surplus notes are outstanding:

a. Date issued;
b. Description and fair value of the assets received;
c. Holder of the note or if public, the names of the underwriter and trustee, with identification on whether the holder of the surplus note is a related party per SSAP No. 25;
d. Original issue amount of note;
e. Carrying value of note;
f. The rate at which interest accrues;
g. Maturity dates or repayment schedules, if stated;
h. Unapproved interest and/or principal;
i. Life-to-date and current year approved interest and/or principal recognized;

j. Disclosure of whether the surplus note was issued as “paid” part of a transaction with identification any of the amount of approved following attributes:

i. Do surplus note / associated asset terms negate or reduce cash flow exchanges, and/or are amounts payable under surplus notes and amounts receivable under other agreements contractually linked (For example, the asset provides interest and/or principal remitted payments only when the surplus note provides interest payments)?

ii. Are any amounts due under surplus notes and associated assets netted or offset (partially or in full) thus eliminating or reducing the exchange of cash or assets that would normally occur throughout the duration, or at maturity, of the agreement. (This may be referred to as administrative offsetting)?

iii. Were the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note (actual transfer of cash / assets) and the amount of approved interest and/or principal not remitted to the holder of the surplus note (no transfer of cash / assets)? If so, was the asset issuer a related party per SSAP 25?

k. Information regarding a 3rd party liquidity source including name, identification if a related party, cost of the liquidity guarantee, and maximum amount available should a triggering event occur.

l. Principal amount and fair value of assets received upon Surplus Note issuance, if applicable;

m. Subordination terms;

k. Liquidation preference to the reporting entity’s common and preferred shareholders;

n. The repayment conditions and restrictions;

o. Information about any guarantees, support agreements, or related party transactions associated with the surplus note issuance, and whether payments have been made under such agreements.

1 Interest and principal reported pursuant to 18.i include amounts offset by amounts receivable under other agreements, unless the reporting entity has a legal right of offset. Such offsetting arrangements shall be disclosed pursuant to paragraph 18.j.i through 18.j.iii
19. If a reporting entity has ceded business to a surplus note issuer that is not remitting actual cash or assets to a related party as part of a reinsurance transaction in which the surplus note meets any of the criteria in 18. j above, the ceding entity shall provide a description of the transaction, including whether the criteria in 18. j. above were met with respect to the surplus note issuance, as long as the reinsurance agreement remains in force. The ceding entity should provide a description of the risks reinsured, the related party reinsurer, any guarantees or support agreements and the amount of notes outstanding.

20. If the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note for approved interest or principal (as reported under paragraph 18.h), because the reporting entity is offsetting the amount owed under the surplus note with an amount receivable from a reported asset, the following information shall be disclosed regarding the offsetting asset received:

a. Identification of asset, including the investment schedule where the asset is reported and reported NAIC designation.

b. Book/ adjusted carrying value of asset and interest income recognized in as of the current year.

c. Amount of principle return and interest income from the asset not received by the reporting entity as the amounts were offset with approved amounts owed by the reporting entity’s issued surplus note date.

d. A description of terms under which liquidity would be provided should a triggering event occur.

20.21. In addition to the above, a reporting entity shall identify all affiliates that hold any portion of a surplus debenture or similar obligation (including an offering registered under the Securities Act of 1933 or distributed pursuant to rule 144A under the Securities Act of 1933), and any holder of 10% or more of the outstanding amount of any surplus note registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933.

Proposed Blanks Disclosures:

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<th>Date Issued</th>
<th>Interest Rate</th>
<th>Original Issue Amount of Note</th>
<th>Is Surplus Note Holder a Related Party? (Y/N)</th>
<th>Surplus Note Issuer Liquidated</th>
<th>Carrying Value of Note Prior Year</th>
<th>Carrying Value of Note Current Year</th>
<th>Unapproved Interest And / Or Principal Recognized Interest Paid Current Year</th>
<th>Approved Interest Recognized Interest Paid Current Year</th>
<th>Life-To-Date Total Interest Remitted (Actual Transfer of Cash/Assets) Remitted Paid</th>
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| Current Year Approved Interest Not Remitted Since Issuance (No Transfer of Cash/Assets) | *Were Surplus Note proceeds used to purchase an asset directly from the holder of the surplus note? (Y/N) |
| Current Year Approved Principal Not Remitted Since Issuance (No Transfer of Cash/Assets) | *Is Asset Issuer a Related Party? (Y/N) |
| Current Year Approved Interest Not Remitted Since Issuance | *Was Surplus Note proceeds subject to administrative offsetting provisions? (Y/N) |
| Current Year Approved Interest Not Remitted Since Issuance | Type of Assets Received Upon Issuance Is Non-Remitted Interest or Principal Offset with Amounts Owed from Surplus Note Holder? (Y/N) |
| Current Year Approved Interest Not Remitted Since Issuance | Does Remitted Interest or Principal Payments Result with Acquisition of a Source of Liquidity Through the Surplus Note Holder? (Y/N) |
| Current Year Approved Principal Not Remitted Since Issuance | Principal Amount of Assets Received Upon Issuance Is Surplus Note Holder a Related Party? (Y/N) |

| Book/Adjusted Carry Value of Assets Issued by Surplus Note Holder | Name of 3rd Party Liquidity Source Acquired | Is Liquidity Source a Related Party to the Surplus Note Issuer? |
| Total Cost of Liquidity Source Reported as Surplus Note Interest Since Acquisition | Total Cost of Liquidity Source Reported as Surplus Note Interest | Current Year Total Cost of Liquidity Source |
| Total Cost of Liquidity Source Since Acquisition | Maximum Amount Surplus Note Issuer Can Receive from Liquidity Source |

* Include amounts offset with amounts owed from the holder of the surplus note.

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SSAP No. 51R:

Change In Valuation Basis

36. A change in valuation basis for reserves determined under paragraphs 18-21, except for reserves defined under Actuarial Guideline XLIII—CARVM: For Variable Annuities (AG 43), as detailed in Appendix C of this Manual, shall be defined as a change in the interest rate, mortality assumption, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors (SSAP No. 3).

37. Changes in reserves developed under paragraph 22 or AG 43 shall be reviewed to determine whether the change represents a change in valuation basis and if it meets the definition of a change in accounting as defined in SSAP No. 3.

   a. Changes in principle-based reserving assumptions are often the result of updating assumptions and other factors required by the existing reserving methodology. Reserve changes resulting from the application of principle-based reserving methodology including, but not limited to, updating assumptions based on reporting entity, industry or other experience, and having the reported reserve transition between net premium reserve, deterministic reserve or stochastic reserve, as required under existing guidance, shall not be considered a change in valuation basis. These types of changes also include, but are not limited to, periodic updates in Valuation Manual tables, such as industry valuation basic tables, asset spread tables and default cost tables.

   b. A change in valuation basis for principle-based reserves shall include cases where the required reserve methodology has changed, or the insurer makes a voluntary decision to choose one allowable reserving method over another. These types of changes include, but are not limited to, new standardized mortality tables such as Commissioners Standard Ordinary tables and regulatory changes in methodology.

38. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus (under changes to surplus in the change in valuation basis annual statement line) rather than as a part of the reserve change recognized in the summary of operations.

39. The impact of a change in valuation basis on surplus is based on the difference between the reported reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless this statement or the Valuation Manual in section VM-21 Requirements for Principle Based Reserves for Variable Annuities (VM-21) prescribes a new method and a specific transition that allows for grading. If the grading permitted by this statement or Valuation Manual section VM-21 represents an increase in the reserve liabilities, the unrecognized change in valuation basis reserve increase shall initially be reflected as an allocation from unassigned funds to special surplus until fully recognized in reserving and unassigned funds. The reclassification from unassigned funds to special surplus does not reduce total surplus, but highlights the ungraded in amount for transparency as it represents an unrecognized adjustment (decrease) to total surplus. The allocation to special surplus is
reversed to unassigned funds as the grading of the increase in reserving is recognized as a decrease to total surplus. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies in force for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies in force for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements as of 1/1.[JB1] The changes remain subject to the disclosures prescribed in SSAP No. 3. Effective January 1, 2020, if the phase-in provision of the Valuation Manual section VM-21 (on variable annuities) is elected or this statement prescribes or permits a grading in period or provides the option of multiple grading periods, reporting entities shall also include in the change in accounting disclosures required by SSAP No. 3, disclosure of the following:

a. ______ the grade phase-in period being applied, and the remaining time period of the grade phase-in

b. ______ any adjustments to the grade phase-in period.

c. ______ The phase-in amount as defined in VM-21 of change in valuation basis grade in, which has been recognized in unassigned funds and

d. ______ the remaining amount to be graded phase-in amount (reflected in special surplus if the ungraded in amount represents an increase in reserving).

40. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies in force for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. While the Valuation Manual is effective prospectively for policies written on or after the operative date, subsequent changes may be applied retroactively to all business issued since that operative date however, as the CARVM methodology was already principles based, some changes to the CARVM methodology in section VM-21 (on variable annuities) and to the related AG 43, which may result in retroactive application to the reserving for existing contracts. Therefore, upon the initial prospective adoption of principle-based reserving, the change in valuation basis reflected as an adjustment to surplus will be zero. After initial adoption of the Valuation Manual, changes in valuation basis will need to be evaluated to determine the amount of any surplus adjustments.
Disclosures

Disclosure of material changes in accounting and correction of errors shall include:

a. A brief description of the change, encompassing a general disclosure of the reason and justification for change or correction;

b. The impact of the change or correction on net income, surplus, total assets, and total liabilities for the two years presented in the financial statements (i.e., the balance sheet and statement of income and operations); and

c. The effect on net income of the current period for a change in estimate that affects several future periods, such as a change in the service lives of depreciable assets or actuarial assumptions affecting pension costs. Disclosure of the effect on those income statement amounts is not necessary for estimates made each period in the ordinary course of accounting for items such as uncollectible accounts; however, disclosure is recommended if the effect of a change in the estimate is material;

d. Changes in accounting that are changes in reserve valuation basis as described in SSAP No. 51R—Life Contracts which have elected grade phase-in or other optional application features defined in the Valuation Manual, shall also include in the change in accounting disclosures information regarding the application of any grade phase-in as provided for in SSAP No. 51R, and

e. When subsequent financial statements are issued containing comparative restated results as a result of the filing of an amended financial statement, the reporting entity shall disclose that the prior period has been restated and the nature and amount of such restatement.

SSAP No. 3—Accounting Changes and Corrections of Errors

Disclosures

Disclosure of material changes in accounting and correction of errors shall include:

a. A brief description of the change, encompassing a general disclosure of the reason and justification for change or correction;

b. The impact of the change or correction on net income, surplus, total assets, and total liabilities for the two years presented in the financial statements (i.e., the balance sheet and statement of income and operations); and

c. The effect on net income of the current period for a change in estimate that affects several future periods, such as a change in the service lives of depreciable assets or actuarial assumptions affecting pension costs. Disclosure of the effect on those income statement amounts is not necessary for estimates made each period in the ordinary course of accounting for items such as uncollectible accounts; however, disclosure is recommended if the effect of a change in the estimate is material;

d. Changes in accounting that are changes in reserve valuation basis as described in SSAP No. 51R—Life Contracts which have elected grade phase-in or other optional application features defined in the Valuation Manual, shall also include in the change in accounting disclosures information regarding the application of any grade phase-in as provided for in SSAP No. 51R, and

e. When subsequent financial statements are issued containing comparative restated results as a result of the filing of an amended financial statement, the reporting entity shall disclose that the prior period has been restated and the nature and amount of such restatement.
February 18, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment During the NAIC Winter National Meeting with Comments due January 31 Regarding Goodwill

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts regarding the recognition of goodwill for statutory accounting that was released for comment by the Statutory Accounting Principles (E) Working Group (the “Working Group”), during the NAIC Fall National Meeting in Austin.

Interested parties note that in October 2018, the FASB decided to add to its technical agenda a broad project to revisit the subsequent accounting for goodwill. In 2019, the FASB issued an Invitation to Comment, *Identifiable Intangible Assets and Subsequent Accounting for Goodwill*, and held public roundtable meetings to discuss the topics included in the Invitation to Comment. The FASB is still in the initial deliberations phase of this project. Given the broad scope of the FASB project and the potential for changes to the current GAAP goodwill accounting model, interested parties recommend that any changes to statutory accounting that impact the accounting for goodwill be limited in their nature in recognition that the Working Group will need to consider the applicability of the changes to GAAP accounting for goodwill once the FASB completes the project.

We offer the following comments to the exposure drafts released for comment by the Working Group:

**Ref #2019-12: ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force**

The Working Group adopted, as final, a clarification edit to *SSAP No. 68—Business Combinations and Goodwill* to clarify that all goodwill from an insurance entity’s acquisition of SCAs, regardless of whether pushdown accounting is applied, is subject to the existing 10% admittance limitation. (With adoption of this edit, paragraph 9 was split into two separate paragraphs.) The remainder of this agenda item was re-exposed to allow additional time for specific examples of pushdown accounting to be...
provided by interested parties, as well as consider comments received on pushdown accounting.

Interested parties recommend that paragraph 5 of SSAP No. 68 be revised further as marked below to clarify the appropriate valuation that should be used for an acquired entity:

5. A business combination accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with paragraphs 8.b.ii., 8.b.iii. or, 8.b.iv. of SSAP No. 97 shall determine the amount of positive goodwill or negative goodwill created by the combination using the reporting entity's share of the GAAP net book value of the acquired entity, adjusted to a statutory basis of accounting in accordance with paragraph 9 of SSAP No. 97 in the case of acquired entities valued in accordance paragraphs 8.b.ii. or 8.b.iv. of SSAP No. 97. The GAAP net book value of the acquired entity used in this determination shall reflect the acquisition-date fair values of identifiable assets acquired and liabilities assumed, and goodwill, as recognized in the post pushdown GAAP financial statements of the acquired entity, if applicable. Business combinations accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with, paragraph 8.b.i. of SSAP No. 97 shall determine the amount of positive or negative goodwill created by the business combination using the insurer's share of the statutory book value of the acquired entity.

**Pushdown Accounting**

Interested parties note that the GAAP guidance in ASU 2014-17, which was adopted by the SEC in Staff Accounting Bulletin (SAB) 115, provides clear guidance that an acquired entity has the option to apply pushdown accounting in its separate financial statements upon the occurrence of an event in which an acquirer obtains control of the acquired entity. Under applicable GAAP guidance, control generally results when one entity obtains, either directly or indirectly, more than 50 percent of the outstanding voting shares of another entity. This differs from the definition of control under statutory guidance which uses a threshold of 10 percent or more of voting control. As such, under GAAP, there would not be a scenario where an entity would be controlled by multiple owners with 10% or more ownership of outstanding shares.

Whether a company chooses to apply pushdown accounting depends on the facts and circumstances of a particular transaction. In certain situations, pushdown is preferable to eliminate the basis difference between an acquirer and the acquired entity. In other situations, a company may prefer pushdown accounting to better reflect the actual values of the acquired assets and assumed liabilities based on the purchase price of the entity.

When the SEC required pushdown for SEC registrants, there was limited guidance for non-registrants under GAAP which resulted in some non-registrants also applying the SEC pushdown guidance. We believe retaining the optionality for statutory reporting allows for consistency and comparability across both SEC registrants and non-registrants and provides operational efficiency.

The option of not allowing subsequent elections for pushdown accounting is not practicable for SEC registrants that previously elected to use pushdown accounting. In order for such companies to discontinue use of pushdown accounting, a preferability letter would be required for a change in accounting policy to discontinue the use of pushdown accounting. Given that an election to discontinue
use of pushdown accounting is not likely preferable, the insurer would be in the position of having to continue using pushdown accounting in order to receive a clean audit opinion on the GAAP financial statements of the SCA. Additionally, while ASC 805, *Business Combinations*, allows the election to be made for each change in control event, acquirers that report consolidated results may as a practical matter choose pushdown accounting at the subsidiary level to avoid separately tracking assets, and liabilities at two different values in two different ledgers.

As noted in the examples below, and in accordance with the guidance adopted during the December 7, 2019 Working Group meeting, interested parties understand the guidance clarified that all goodwill from an insurance entity’s acquisition of SCAs, regardless of whether pushdown accounting is applied, is subject to the existing 10% admittance limitation. Interested parties have summarized the interpretation of this clarification for an insurance entity’s acquisition of an 8.b.i (example 1), 8.b.ii (example 2a and 2b), 8.b.iii (example 3a and 3b) or 8.b.vi (example 2a and 2b) entity as follows:

<table>
<thead>
<tr>
<th>Example</th>
<th>Type of acquired SCA</th>
<th>Is Pushdown elected?</th>
<th>Where does Goodwill resides?</th>
<th>Admissibility of goodwill limited to 10% of</th>
<th>Is Goodwill required to be amortized?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8.b.i</td>
<td>Not permitted per SSAP No. 68 para 6</td>
<td>Insurance entity (Statutory goodwill)</td>
<td>Insurance Entity's Surplus per SSAP No. 68 para 7</td>
<td>Yes per SSAP No. 68 para 8</td>
</tr>
<tr>
<td>2a</td>
<td>8.b.ii or 8.b.iv</td>
<td>No</td>
<td>Insurance entity (Statutory goodwill)</td>
<td>Insurance Entity's Surplus per SSAP No. 68 para 7</td>
<td>Yes per SSAP No. 68 para 8</td>
</tr>
<tr>
<td>2b</td>
<td>8.b.ii or 8.b.iv</td>
<td>Yes</td>
<td>SCA (GAAP goodwill)</td>
<td>SCA's GAAP equity per SSAP No. 97 para 9.d</td>
<td>Yes per SSAP No. 97 para 9.c.iii</td>
</tr>
<tr>
<td>3a</td>
<td>8.b.iii</td>
<td>No</td>
<td>Insurance entity (Statutory goodwill)</td>
<td>Insurance Entity's Surplus per SSAP No. 68 para 7</td>
<td>Yes per SSAP No. 68 para 8</td>
</tr>
<tr>
<td>3b</td>
<td>8.b.iii</td>
<td>Yes</td>
<td>SCA (GAAP goodwill)</td>
<td>Insurance Entity's Surplus per SSAP No. 68 para 7</td>
<td>No *</td>
</tr>
</tbody>
</table>

* See further discussion below related to amortization

After evaluating the accounting for goodwill from the various entities described in paragraph 8.b, we concluded that the NAIC should continue to allow insurers to elect pushdown accounting for acquisitions of non-insurance entities (Option 2) for the following reasons:

1. Statutory goodwill, created when the insurer is the acquirer, is subject to an existing 10% admittance limitation as clarified in the changes adopted by the Working Group during the Fall National Meeting and demonstrated above; therefore, the resulting goodwill from pushdown accounting is subject to the statutory thresholds.

2. Pushdown accounting is consistent with GAAP, prior to ASU 2014-17, for SEC registrants and non-registrants that used pushdown accounting. As noted above, it is not practical to discontinue use of pushdown accounting as an insurer would need to continue the use of pushdown
accounting in order to obtain a clean audit opinion on the GAAP financial statements of the SCA.

3. It is important to maintain consistency with current GAAP. Under ASU 2014-17, pushdown accounting may be elected in a later reporting period, after the initial acquisition date. We understand that there may be concerns with electing pushdown at a later reporting period after goodwill was originally determined and reported at initial acquisition date. However, rather than disallowing a later election to apply pushdown accounting, which creates a variance to GAAP, we suggest this could be addressed through changes to SSAP No. 97 to ensure that goodwill is not subsequently increased for statutory reporting, in the event pushdown accounting is elected after the initial acquisition date.

4. The recommendations above would allow the continued use of audited GAAP equity as the statutory carrying value for all non-insurance entities for insurers that previously elected pushdown accounting (both SEC registrants and non-registrants). Additionally, the ability to elect pushdown accounting for future acquisitions retains GAAP equity as the statutory valuation basis for SCAs and avoids restrictions that can impact insurers’ ability to obtain an unqualified opinion on the stand-alone financial statements of SCAs.

If a restriction were placed on the use of pushdown accounting at a future date, those entities that have previously elected pushdown will be forced to separately track assets, and liabilities at two different values in two different ledgers as well as address the issue of making a change in accounting policy that may not have preferability.

As a separate point, we suggest changing the heading for Option 2 from “Permission to use pushdown for all non-insurance entities” to “Use of pushdown for all non-insurance entities”, as the term “permission” implies that use of pushdown accounting is a permitted practice under the statutory accounting framework.

**Amortization**

Interested parties reiterate the concern that the revisions from the adopted language (new SSAP No. 68 paragraph 10) would inadvertently require amortization of pushdown goodwill. While staff has noted that amortization may be the proper approach, interested parties believes as it relates to paragraph 8.b.iii entities acquired by an insurance entity where pushdown is applied, there has been diversity in practice.

Interested parties concur with the NAIC’s staff’s position described in the December 2019 Public Hearing Agenda materials:

“(As detailed in the earlier discussion, the minor edit being discussed only focuses on nonadmittance for insurer entity acquired SCAs that have been pushdown. The edit would not mandate amortization for those pushdown situations. The discussion on whether amortization should be required for those situations is proposed to occur after the next exposure.)”
Ref #2019-14: Attribution of Goodwill

The Working Group re-exposed this agenda item to clarify that the “assignment” of goodwill is a disclosure element. The Working Group directed NAIC staff to prepare revisions to the Sub 1 Acquisition Overview template to capture this information for new SCA acquisitions.

Recommended Action:

NAIC staff identifies that the comments received on the proposed disclosure enhancement under this agenda item are limited, but generally request additional time before adoption. NAIC staff believes the disclosure information requested under this agenda item will be necessary regardless of the decision involving pushdown accounting. As a reminder, the proposed disclosure only details the amount of goodwill recognized from the acquisition of a downstream holding company and the assignment of the goodwill to the entities owned by the holding company. This information is necessary in determining the amount of goodwill that would need to be nonadmitted, or derecognized, if an underlying company in the downstream holding company was nonadmitted or sold.

Interested parties note that the December 2019 Public Hearing Agenda materials state:

“It is important to highlight that the clarification edit proposed for adoption consideration is specific to insurance entity acquisitions of SCAs. As such, if an acquisition occurred downstream from the insurance company (by a non-insurance holding company), and the holding company applied pushdown accounting, so that the goodwill was reported at the holding company’s acquired SCA, the proposed edit would not require that push down goodwill to be brought up to the insurance entity’s level and included in the 10% limit.”

Requiring attribution would be onerous and misleading to the users of the financial statements, particularly if the disclosure included detailing GAAP goodwill that is not subject to the 10% limit. Interested parties do not believe it is necessary to “attribute” goodwill to downstream SCAs of downstream holding companies. We believe that any concerns about the carrying value of the downstream holding company being overstated because it did not push down GAAP goodwill to a downstream SCA that was subsequently sold is mitigated by the fact that GAAP already requires the attribution and derecognition of goodwill associated with the business or SCA that is sold. To layer in a statutory attribution of goodwill is not necessary, overly complex, and may distort the accounting impact of a sale of a downstream SCA.

Therefore, we recommend that the disclosure of GAAP goodwill attributed to downstream SCAs of downstream holding companies focus on actual GAAP goodwill that was pushed down to the

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1 ASC 350-20-40, Intangibles – Goodwill and Other - Goodwill – Derecognition, paragraphs 1 and 2:

40-1: When a reporting unit is to be disposed of in its entirety, goodwill of that reporting unit shall be included in the carrying amount of the reporting unit in determining the gain or loss on disposal.

40-2: When a portion of a reporting unit that constitutes a business (see Section 805-10-55) or nonprofit activity is to be disposed of, goodwill associated with that business or nonprofit activity shall be included in the carrying amount of the business or nonprofit activity in determining the gain or loss on disposal.
downstream SCAs and any statutory goodwill that occurred when the insurer is the acquirer, subject to the existing 10% admittance limitation as illustrated and discussed in the examples above.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell     Rose Albrizio
January 31, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners

Re: Ref #2019-20, Rolling Short-Term Investments

Dear Mr. Bruggeman:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to comment on the Statutory Accounting Principles (E) Working Group’s exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities relating to rolling short-term investments. APCIA is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

APCIA writes to highlight our support for the recommendations on this proposal provided in the comment letter of the “Interested Parties” coalition. APCIA and our members regularly participate in the Interested Parties’ discussions and drafting process.

SSAP No. 2R generally requires debt obligations with a maturity date of less than one year to be reported on Schedule DA. However, the proposed revisions to SSAP No. 2R would specify that any investment reported as a short-term obligation which was renewed or extended past its original maturity date would need to be reported as a long-term obligation, and a reporting entity would not be permitted to acquire the same or a substantially similar security within a 1-year time frame unless such security is reported as a long-term obligation. APCIA believes appropriate safeguards already exist, or could be put in place, to address the concerns underlying this proposal.

We support the recommendations of the Interested Parties in the context of both unaffiliated and affiliated short-term loans.

Unaffiliated short-term loans provide important flexibility and efficiencies for insurers. So long as the lender has a reasonable expectation that the investment can terminate and be repaid on the maturity date, and both the borrower and lender have the ability to reevaluate and renew the loan at maturity, we believe unaffiliated short-term loans are properly reported on Schedule DA as a short-term risk asset. As such, APCIA supports the objective criteria proposed by the Interested Parties for determining when an unaffiliated loan qualifies as short term:

1) The loan includes a maturity date less than one year from closing at which the borrower has an unconditional repayment obligation and on which the lender has a reasonable expectation that the investment can be terminated and repaid if so desired by the insurer; and
2) Any subsequent renewal is only completed in the sole discretion of both the borrower and the lender.

In the context of short-term loans between affiliates, the Model Holding Company Act already requires regulatory filing and approval of loans exceeding a materiality threshold. Further, as the Interested Parties’ letter also points out, loans between affiliates are an important mechanism for meeting short-term liquidity needs for an entity within a broader group. Given the importance of insurers being able to utilize loans from affiliates to meet short-term needs and the regulatory oversight of these transactions that already exists, APCIA agrees with Interested Parties that short-term loans between affiliates should continue to be classified as short term.
Thank you for considering our comments. If you have any questions or would like to discuss this further, please contact Steve Broadie at steve.broadie@apci.org or 847.553.3606.

Sincerely,

Stephen W. Broadie
Vice President, Financial & Counsel
Dale Bruggeman  
Chair of Statutory Accounting Principles (E) Working Group

We have reviewed the proposed changes to SSAP No. 71 – Policy Acquisition Costs and Commissions as outlined in Ref. #2019-24 as revised on December 7, 2019.

The most effective way to appreciate the unintended consequences of the proposal is to start with a basic understanding of a typical distribution structure. Reporting entities execute distribution agreements, including compensation structure, with distribution partners (IMO, BGA, TPM, MGA, BD, for example). These distribution partners recruit, contract, train, supervise, and compensate smaller organizations (agencies, selling groups, brokerages, etc.) and individual producers (agents, brokers, etc.).

SSAP No. 71 proscribes statutory accounting treatment for reporting entity compensation agreements entered for the sale, distribution, and servicing of policies. The revisions proposed in Exposure Draft 2019-24 (as revised December 7, 2019) focus on two areas: (1) levelized commissions or “trail” payments paid directly to distribution partners or individual producers by a reporting entity and (2) levelized commissions or other installment payments paid to “third parties” by the reporting entity solely in exchange for the third party making non-levelized payments to the distribution partners or individual producers in place of the reporting entity (sometimes called “funding agreements”).

The proposed Exposure Draft relating to the first are in Paragraph 2 and call for “…commission shall be accrued based on experience to date for the policy period that the commission relates.” This specifically relates to the required timing or obligating event of a reporting entity’s liability for the cost of a commission payment specifically linked to persistency or policy renewal upon the anniversary of a policy issue date or some other future date or event.

The proposed Exposure Draft revisions relating to the second are (a) in paragraph 4, “...regardless of how the payment to the third party is characterized.”, (b) in paragraph 5, “…paid by a third party to the agents...by the reporting entity.”, and (c) in a footnote to paragraph 5, “The guidance in this paragraph notes that levelized commissions which use a third party to pay agents that are linked to traditional elements require establishment of a liability for the amounts that have been paid to the agents and any interest accumulated to date.”

The proposed revisions have different implications for different constituencies. We have endeavored to capture the essence of the concern from each party below. The proposed revisions have substantive
implications for each of the noted constituencies, contrary to the non-substantive assertion in the revised exposure draft 2019-24. As a direct result of the inequity of the proposed changes upon various constituencies and the potential for substantial financial and economic harm incurred by the adoption of these changes to a variety of constituencies, we strongly recommend and request that the proposal not go forward.

Reporting Entity/Carrier perspective:

1. Levelized commission programs are economic equivalents to “normal (non-level) commissions.” Levelized commission programs are preferable as they create a virtuous cycle linking the interests of consumers, agents, distribution partners and carriers to maintain ongoing servicing relationships, improving consumer support and policy persistency. Distribution relationships are multi-faceted, including agent recruitment and oversight, sales, sales support, underwriting support, premium collection, policy delivery and agent payment. Characterizing distribution partners as a ‘third party’ under the proposed footnote to paragraph 5 of SSAP No. 71 discounts the complexity of these relationships and the value of these vital roles dramatically altering carrier dynamics with distribution partners.

2. Reporting entities or carriers will be unduly penalized for economic transactions negotiated under existing accounting principles as a direct result of this proposal. The value of those transactions is retroactively altered by the introduction of a modified accounting principle which neither party initially anticipated, negotiated or priced.

3. Higher required capital and lower returns resulting from an arbitrary modification to an existing accounting practice will drive product design reviews and likely product redesigns modifying or eliminating levelized commission options or reducing value to the consumer through higher premiums and/or lower benefits.

4. The proposal to require reserves for future persistency based levelized commissions creates a disconnect with GAAP accounting where there is no reserve requirement. Moreover, the proposal creates new uncertainty around which other, long standing accounting treatment will be changed next.

Distributor/Agent perspective

1. The trail compensation approach incentivizes all parties to maintain a long-term relationship based upon ongoing agent support of consumer needs. Reducing or removing recurring compensation in the form of persistency based levelized commissions, shifts distributor economic motivation to new product sales, further degrading product level returns for the carrier. Reducing benefit levels or increasing premiums for the same benefit levels will lower the value proposition for effected products very likely reducing sales and consumer protection delivered by the products.
Consumer perspective:

1. The fallout from the changes will diminish value of insurance products through higher premiums and/or lower benefits enacted by carriers seeking to make up lost economic value and from lower service levels provided by brokers or agents as their incentives shift from ongoing consumer service relating to in-force policies to selling new policies (whether to the individual policyholder or other prospective clients).
January 30, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street
Kansas City, MO 64106

Re: SSAP No. 71—Policy Acquisition Costs and Commissions

Dear Mr. Bruggeman:

Thank you for the opportunity to provide comments on Proposal 2019-24 from the Statutory Accounting Principles Working Group regarding Policy Acquisition Costs and Commissions. The Working Group voted to re-expose revisions to SSAP 71 – Policy Acquisition Costs and Commissions - for comment at the NAIC Fall Meeting on December 7, 2019, continued to categorize the revisions as non-substantive, and further clarified levelized commission guidance and direction regarding certain commission obligations. I offer comments on behalf of our client, DRB Insurance Solutions, LLC, a licensed insurance producer (“DRB”).

SSAP No. 71 provides that levelized commissions occur in situations in which a third party, such as a funding agent, pays agents non-levelized commissions and the reporting entity pays the third party by levelized payments. The Working Group notes that it is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third-party would ultimately be repaid to the third-party from the reporting entity. SSAP No. 71 identifies such arrangements as “funding agreements” between the reporting entity and the third-party. SSAP No. 71 further provides that the use of a commission arrangement where commission payments are not linked to traditional elements (such as premium payments and policy persistency) requires the establishment of a liability for the full amount of the unpaid principal and accrued interest which is payable to a third-party related to levelized commissions.

While revisions were made to several paragraphs and footnote 1 in the initial proposal at the Working Group’s meeting in December, the current exposure language remains overly broad to address the issue identified and intended to be clarified by the Working Group. Regulators have identified levelized commissions as funding arrangements to bypass recognition of acquisition costs by insurers and believe recognizing the full acquisition expense at the time of policy issuance is appropriate accounting treatment pursuant to SSAP No. 5R and the Statement of Concepts focusing on Recognition. Notably, the Working Group intended to restrict intercompany and affiliated transfers of trailing commission structures as pure
accounting transactions solely for the purpose of deferring expense recognition of commission obligations, which is a laudable goal.

However, the language exposed to classify trailing commission transactions as funding arrangements is so broad, it encompasses practically every broker contract with an insurer that allows for any alternative payment arrangement between the broker and the issuing agent. DRB Insurance Solutions is an independent third-party master producer which uses various contracts between DRBIS and its sub-agents for commission payment, including trailing, heaped, partially heaped and trailing commissions, etc. The agreements between DRBIS and reporting entities are arms-length transactions, include the transfer of lapse risk, mortality risk and the commission expense obligation. The proposal requiring all insurers to accrue the full commission expense under these circumstances is illogical when the insurer no longer has the legal obligation to pay the expense and therefore, no longer has legally incurred the expense.

While regulators have opined that affiliated transactions shrouded as commission arrangements appear to circumvent accrual of commission expense at policy issuance, the goal to affect those transactions may continue to be addressed while narrowing the language to clarify that non-affiliated third-party contracts are not included. Accordingly, DRBIS offers the following amendment to the exposure draft to narrow the applicability to those affiliated transactions. Suggested language for Paragraph 4 and the footnote to Paragraph 5 is shown as shaded text as follows:

4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party under the control of the reporting entity, its parent, and/or any subsidiary or affiliate of the reporting entity or its parent. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity. (Note: levelized repayments made by the reporting entity extend the repayment period but might not be a straight-line repayment.) These transactions are, in fact, funding agreements between a reporting entity and the third party, regardless of how the payment to the third party is characterized. The continuance of the stream of payments specified in the levelized commission contract is a mechanism to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent's license with the reporting entity is not maintained with respect to the payment stream.

5. The use of an arrangement such as a levelized commission arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency, but rather are linked to the repayment of an advance amount paid by a third party under the control of the reporting entity, its parent, and/or any subsidiary or affiliate of the reporting entity or its parent to the agents requires the establishment of a liability by the reporting entity for the full amount of the unpaid principal and accrued interest which is payable to a third party under the control of the reporting entity, its parent, and/or any subsidiary or affiliate of the reporting entity or its parent related to levelized commissions.

New Footnote – The guidance in this paragraph notes that levelized commissions which use a third party to pay agents does not imply that levelized commissions that are linked to traditional elements do not require establishment of a liability for the amounts that have been paid to the agents and any interest accumulated to date. Rather, such levelized commission obligations should be accrued for as set forth in paragraph 3.
The proposed language requires recognition of commission expense in situations where affiliated companies trade lapse and mortality risk amongst and between affiliated reporting entities using a commonly owned master producer while excepting unaffiliated third-party transactions from similar treatment. In these unaffiliated contractual arrangements, where risk and liability is transferred, the reporting entity may not even be aware of the payment schedule between the master producer and its sub-agents and certainly should not be required to accrue the full amount of the commission expense at policy issuance when the insurer is no longer legally required to pay that expense.

**Non-Substantive Change**

Finally, DRBIS would like to restate its opposition to consideration of the exposure draft as a non-substantive change. As previously stated, levelized commission programs began over thirty years ago, before the 1998 publication of Statutory Issue Paper No. 71 and the January 1, 2001 codification of Statutory Accounting Principles. The primary objectives of a levelized commission structure include aligning the interests of the customer, the agent, and the company and improved persistency from providing ongoing customer service. There is a duty to act in the best interests of the policyholder, as well as a compensation incentive, to make sure policies are well serviced so they stay in-force.

The proposed revisions to SSAP No. 71 are designated as non-substantive and deemed to be a clarification of intent of the codified statutory guidance. However, levelized commission programs were implemented more than a decade before the codification in 2001. Therefore, this is a material change to historical accounting practices and not a clarification of original intent. Even after codification, levelized commission programs continued for years and were not identified as applying statutory accounting incorrectly.

In conclusion, the current exposure draft of SSAP 71 is clearly not “non-substantive” and would have substantial unintended consequences without the amendments proposed above. Additionally, the expansive effect of this policy decision should be subject to open deliberation and public comment as the Working Group considers adoption. Thank you for the opportunity to comment.

Very truly yours

GREENBERG TRAURIG, P.A.

Julie Mix McPeak

Julie Mix McPeak
January 14, 2020

Mr. Dale Bruggeman, Chair
NAIC Statutory Accounting Principles (E) Working Group
1100 Walnut Street, Suite #1500
Kansas City, MO 64106-2197

RE: REPORTING OF INSTALLMENT FEES AND EXPENSES – REQUESTS FOR COMMENTS

Dear Mr. Dale Bruggeman,

At the December 2019 meeting, the NAIC exposed and requested comments on the “Reporting of Installment Fees and Expenses” in the financial statements. This guidance allows for installment fees that meet specified criteria to be excluded from premium income, if it is an avoidance amount by the policyholder and the policy would not be cancelled for nonpayment of the installment fees. The guidance is consistent with the footnote in SSAP No.53 (“Property Casualty Contracts – Premiums”) and in line with our current industrywide reporting of this item in the financial statements.

With respect to the reporting of the corresponding “Installment fees related Expenses”, we believe that these associated Expenses should be reported as part of the Other Underwriting Expenses Incurred (“OUE”) on Line 4 of the Statement of Income and as an ancillary to the normal underwriting activities primarily due to immateriality. Such a presentation will allow insurers to report and reconcile the gross Installment fees amount to the corresponding balance reflected in Schedule T, Column 8 as well as in the Write-ins amount on the Statutory Page 14, along with premium tax payments. Currently, there is inconsistency in reporting in the industry, with some companies reflecting these associated Expenses as part of the Other Underwriting Expenses Incurred on Line 4 of the Statement of Income while others reflect such Expenses as part of the Aggregate write-ins for miscellaneous income on Line 14 of the Statement of Income.

However, as we believe others have also pointed out, this guidance specifically addresses fees charged on Installment premiums, but there are other equally nonrefundable “Other fees” charged by many companies, as part of the billing and collection process, but that are not specifically mentioned in this guidance. That is to say, there are “Other Fees” charged by insurers as part of the collection process, all of which, like Installment fees, are not only non-refundable, but are also avoidance amount by the policyholder and would not be cancelled for non-payment of the installment fees, similar to Installment fees.

These nonrefundable “Other fees”, include, but are not limited to:

1. Late fees - fees and expenses charged on flexible/installment plans that are received after a specified cut-off period e.g. 30 days
2. Non-sufficient funds (“NSF”) fees - fees and expenses collected on returned payments due to non-sufficient funds

3. Reinstatement fees - fees and expenses received on policies that expired and are subsequently reinstated, among others etc.

Currently, there is divergence in reporting in this area of this relatively immaterial amounts for nonstandard and standard writers and therefore need for clarification for consistency in reporting going in.

The reporting issue here then is, where and how to report all of these “Other fees”, excluding Installment fees. Should all these “Other fees” be reported as part of:

a) Other underwriting expense incurred on Line 4 of the Statement of Income
b) Finance and service charges on Line 13 of the Statement of income, akin to installment fees
c) Aggregate write-ins for miscellaneous income on Line 14 of the Statement of income

Typically, most companies report these nonrefundable “Other fees” as “Other income” on Line 14 of the Statement of Income

Consistent with current practice, we also believe all these “Other fees”, net of applicable expenses, if any, should be reported as part of the Aggregate-write-ins for miscellaneous income on Line 14 of the Statement of Income. However, if for some reason this first preference is determined to be untenable, then we believe the next viable alternative could be the “Other underwriting expenses incurred” on Line 4 of the Statement of Income, under the assumption that all these other fees are ancillary to the normal underwriting activities, but defer ultimately decision to the NAIC staff for review and consideration.

We appreciate the opportunity to comment on this and related issues. Thank you.

Sincerely,

Joseph Hammond, CPA, FLMI
Director of P&C Accounting
Farmers Insurance Group
(818) 876-7924

"Internal Use Only"

cc: Robin Marcotte File
February 27, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners

Via email

Dear Mr. Bruggeman:

I am writing on behalf of the American Academy of Actuaries1 Committee on Property and Liability Financial Reporting (COPLFR). We are following up on previous correspondence regarding Schedule P Instructions for Retroactive Reinsurance between Affiliates and Non-Affiliates.

COPLFR appreciates that the Statutory Accounting Principles Working Group (SAPWG) is looking into certain inconsistencies that were identified in our May 21, 2019, letter to you. In July, Julie Lederer, acting in her capacity as a member of the Casualty Actuarial and Statistical (C) Task Force, posed several questions about specific details in our initial comment letter. Her comments and COPLFR’s replies are presented here.

**Julie Lederer’s Comment**

1. I’m not sure what Allianz/Allianz Re agreement the letter is referring to. The letter suggests that this agreement was enacted in 2015 and that the accounting changed between year-ends 2015 and 2016, but Allianz Re’s 2018 MD&A (which is said to be included as an attachment to COPLFR’s letter but is not) suggests that the agreements between Allianz and Allianz Re weren’t enacted until 2016. Allianz Re did assume retroactive business from a different entity, Fireman’s Fund, in 2015:

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
There’s hardly any workers comp data in Allianz’s 2015 Schedule P. There’s a lot of WC data at year-end 2016, which appears to be due to the addition of Firemen’s Fund to the pooling agreement.

When I compare Allianz Re’s 2015 and 2016 Schedule Ps, I don’t see major changes. There is significant assumed premium reported in CY 2015 in both statements, and both statements show assumed reserves only for AYs 2012 and prior. I think this is related to Allianz Re’s transaction with FFIC (as mentioned in the MD&A above), not with Allianz.

COPLFR’s Response

The May 21, 2019, COPLFR letter is referring to the July 1, 2015, reinsurance agreement between FFIC and Allianz Reinsurance America (“Allianz Re”), where Allianz Re agreed to reinsure certain workers’ compensation (WC) and construction defect liabilities. The 2015 Schedule P, Part 1 of Allianz Re (page 4 of the May 21 letter PDF) shows $1.1 billion of 2015 accident year direct and assumed WC earned premium, presumably this Loss Portfolio Transfer. The 2016 Schedule P of Allianz Global Risk US Ins Co. (“Allianz or FFIC”) (page 7 of the May 21 letter PDF) shows $1.1 billion of 2015 accident year WC ceded earned premium, about equal to the assumptions of the Allianz Re premium discussed in the prior sentence. Allianz Global Risk US is synonymous with FFIC, as we understand it.

In our May 21, 2019, letter, we did state that “Initially, as of December 31, 2015, Allianz included all of the ceded losses in accident year (‘AY’) 2015.” We did only include the 2016 Allianz Schedule P; it would have been clearer to include the 2015 Allianz Schedule P as well, which we have attached as page 15 of the May 21 letter PDF (Attachment A). We agree with the comment in a. above that the additional data is due to the addition of Fireman’s Fund in the pooling agreement. Similarly, for b., we only show Allianz Re’s 2015 Schedule P.; we should additionally obtain Allianz Re’s 2016 Schedule P. We would not expect much change from the 2015 to 2016 Schedule P. Finally, our comments were not intended to suggest that the agreement between Allianz and Allianz Re was not enacted until 2016. We did, however, want to point out that as of Dec. 31, 2015, Allianz included all of the ceded losses in AY 2015, and in the following year, as of Dec. 31, 2016, Allianz recorded the ceded losses across the subject AYs 2012 and prior, as shown in Schedule P, Part 2 of Allianz (see page 8 of the PDF).

Julie Lederer’s Comment

2. I believe some of the attachments noted in the letter are missing:

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a. The letter includes Allianz Re’s 2015 Schedule P and Allianz’s 2016 Schedule P, but the text of the letter suggests that Allianz’s 2015 and 2016 Schedule Ps are included.
   i. Regardless, it’s pretty hard to compare Allianz’s 2015 and 2016 Schedule Ps anyway, since Fireman’s Fund was added to the intercompany pool in 2016 and the historical AYs in Allianz’s 2016 Schedule P were adjusted accordingly.
   ii. When I compare Allianz Re’s 2015 and 2016 Schedule Ps, I don’t see major changes. The assumed premium is reported in CY 2015 in both statements, and both statements show assumed reserves only for AYs 2012 and prior.

b. Attachment A1SAO (Allianz Re’s 2018 SAO) is missing. I looked up the SAO myself and found this passage, which is rather vague, doesn’t name the counterparties, and doesn’t discuss the accounting for the agreements:

   "The Company entered into several significant reinsurance arrangements during calendar years 2015 – 2018, some of which serve to mitigate the risk factors discussed above.
   1. Effective January 1, 2015, the Company entered into a reinsurance agreement whereby the Company assumed and agreed to reinsure certain A&E reserves. Effective July 1, 2015, the Company further assumed and agreed to reinsure certain WC and CD reserves.
   2. Effective January 1, 2016, the Company entered into a reinsurance agreement by which the Company ceded 50% of the Company’s carried A&E, WC, and CD liabilities acquired in 2015.
   Additionally, effective January 1, 2016, the Company entered into reinsurance agreements whereby the Company assumed and agreed to reinsure certain Professional Healthcare liabilities and certain A&E, GL/Excess and WC liabilities. Effective July 1, 2016, the Company entered into another reinsurance agreement by which the Company assumed and agreed to reinsure certain GL/Excess exposure."

c. Attachment A2MDA (Allianz Re’s 2018 MD&A) is missing. I looked this up myself and included a relevant passage above in item #1.

COPLFR’s Response

The attachments were in the Academy’s submission to the CASTF and were in the CASTF materials for a call in June, but apparently were omitted by NAIC staff in materials provided for subsequent calls and referrals.

We too consider the excerpt you provided to be vague. To help clarify the issue, we are attaching MD&As from 2015 and 2016 that include Fireman’s Fund Insurance Company in their scope (attachments B and C). One of the difficulties in tracking this issue is the series of actions taken by Allianz since 2015.

Julie Lederer’s Comment

3. GEICO’s Note 21, included as an attachment, is useful, but it’s not clear what we should take away from GEICO’s 2014 Schedule P alone. It might have been useful to attach the 2013 Schedule P as well. By comparing the 2013 and 2014 Schedule Ps, it’s clear that GEICO made significant cessions in 2014 and that these were spread among older AYs.
COPLFR’s Response

Our takeaway from GEICO’s 2014 Schedule P alone is that Schedule P, Part 2 (page 13 of the PDF) shows $3.3 billion of decreased development. This is a distortion as we understand it and is supported by the 2013 and 2014 comparison noted above. That distortion would carry over to the RBC filings of the respective entities (based on our understanding of the RBC formula and related instructions). Industry Schedule P data can also be distorted based on what is and is not included in industry totals based on the data scrubbing performed.

We believe that this additional information clarifies our original comments and will help SAPWG to move forward with its own analysis. If you have additional questions, contact Marc Rosenberg, the Academy’s senior casualty policy analyst, at 202-785-7865 or rosenberg@actuary.org.

Sincerely,

Kathy Odomirok, MAAA, FCAS
Chairperson, COPLFR
American Academy of Actuaries

3 attachments

w:\national meetings\2020\summer\tf\app\sap\minutes\03_18_2020 attachments (h)\att one-h2i_sapwg lpt follow up 20200227.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SCA Loss Tracking – Accounting Guidance

Check (applicable entity):

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Description of Issue:
This agenda item has been drafted to clarify the accounting guidance for SCA losses that result in zero or negative equity in an SCA. Agenda item 2018-09 - SCA Loss Tracking clarified the reporting guidance for SCA losses that result in zero, or negative, equity in an SCA. When reviewing that agenda item, it was identified that there could be uncertainty on the existing provisions that require a negative SCA reporting amount (rather than a zero reporting value). The intent of this agenda item is to clarify the instances that require a negative SCA value and ensure the accounting guidance in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities for these instances is clear.

Existing Authoritative Literature:

SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets

Guarantees

16. A guarantee contract is a contract that contingently requires the guarantor to make payments (either in cash, financial instruments, other assets, shares of its stock, or provision of services) to the guaranteed party based on changes in the underlying that is related to an asset, a liability, or an equity security of the guaranteed party. Commercial letters of credit and loan commitments, by definition, are not considered guarantee contracts. Also excluded from the definition are indemnifications or guarantees of an entity’s own performance, subordination arrangements or a noncontingent forward contract. This definition could include contingent forward contracts if the characteristics of this paragraph are met.

19. With the exception of the provision for guarantees made to/or on behalf of a wholly-owned subsidiaries in paragraph 18.f. and “unlimited” guarantees in 18.g., this guidance does not exclude guarantees issued as intercompany transactions or between related parties from the initial liability recognition requirement. Thus, unless the guarantee is provided on behalf of a wholly-owned subsidiary or considered “unlimited,” guarantees issued between the following parties are subject to the initial recognition and disclosure requirements:

a. Guarantee issued either between parents and their subsidiaries or between corporations under common control;

b. A parent’s guarantee of its subsidiary’s debt to a third party; and

c. A subsidiary’s guarantee of the debt owed to a third party by either its parent or another subsidiary of that parent.
20. At the inception of a guarantee, the guarantor shall recognize in its statement of financial position a liability for that guarantee. Except as indicated in paragraph 22, the objective of the initial measurement of the liability is the fair value\(^1\) of the guarantee at its inception.

21. The issuance of a guarantee obligates the guarantor (the issuer) in two respects: (a) the guarantor undertakes an obligation to stand ready to perform over the term of the guarantee in the event that the specified triggering events or conditions occur (the noncontingent aspect) and (b) the guarantor undertakes a contingent obligation to make future payments if those triggering events or conditions occur (the contingent aspect). Because the issuance of a guarantee imposes a noncontingent obligation to stand ready to perform in the event that the specified triggering event occurs, the provisions of paragraph 8 should not be interpreted as prohibiting the guarantor from initially recognizing a liability for that guarantee even though it is not probable that payments will be required under that guarantee.

22. In the event that, at the inception of the guarantee, the guarantor is required to recognize a liability under paragraph 8 for the related contingent loss, the liability to be initially recognized for that guarantee shall be the greater of (a) the amount the satisfies the fair value objective as discussed in paragraph 20 or (b) the contingent liability amount required to be recognized at inception of the guarantee by paragraph 8. For many guarantors, it would be unusual for the contingent liability under (b) to exceed the amount that satisfies the fair value objective at the inception of the guarantee.

**SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities**

13. On at least a quarterly basis, the procedures set forth below shall be followed by a reporting entity in applying an equity method of accounting (as described in paragraphs 8.b.i. through 8.b.iv.), as applicable, to investments in SCA entities:

   e. For entities subject to 8.b.i., 8.b.iii. and 8.b.iv. a reporting entity's share of losses of an investee may equal or exceed the carrying amount of an investment accounted for by an equity method plus advances made by the investor. The reporting entity shall discontinue applying an equity method when the investment (including advances) is reduced to zero\(^2\) and shall not provide for additional losses unless the reporting entity has guaranteed obligations of the investee or is otherwise committed to provide further financial support for the investee (guaranteed obligations meeting the definition of liabilities in **SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets** shall be recorded as liabilities). If the investee subsequently reports net income, the reporting entity shall resume applying an equity method only after its share of that net income equals the share of net losses not recognized during the period that an equity method was suspended;

**Disclosures**

34. All SCA investments within the scope of this statement (except paragraph 8.b.i. entities) shall include disclosure of the SCA balance sheet value (admitted and nonadmitted) as well as information received from the NAIC in response to the SCA filing (e.g., date and type of filing, NAIC valuation amount, whether resubmission of filing is required). This disclosure shall include an aggregate total of all SCAs (except paragraph 8.b.i. entities) with detail of the aggregate gross value under this statement with the admitted and nonadmitted amounts reflected on

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\(^1\) As practical expedients, when a guarantee is issued in a standalone arm’s-length transaction, the liability recognized at the inception of the guarantee should be the premium received or receivable by the guarantor. When a guarantee is issued as part of a transaction with multiple elements, the liability recognized at the inception of the guarantee should be an estimate of the guarantee’s fair value. In that circumstance, guarantors should consider what premium would be required by the guarantor to issue the same guarantee in a standalone arm’s-length transaction.

\(^2\) Refer to the additional guidance related to discontinuance of an equity method in paragraphs 15-17 and INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses.
the balance sheet. (As noted in paragraph 4, joint ventures, partnerships and limited liability companies are accounted for under the guidance in SSAP No. 48. As such, those entities are not subject to this disclosure.)

a. For all periods presented, a reporting entity whose shares of losses in an SCA exceeds its investment in the SCA shall disclose its share of losses. (This is required regardless of a guarantee or commitment of future financial support to the SCA.) This disclosure shall include the following:

i. The reporting entity’s accumulated share of the SCA losses not recognized during the period that the equity method was suspended;

ii. The reporting entity’s share of the SCA’s equity, including negative equity;

iii. Whether a guaranteed obligation or commitment for financial support exists; and

iv. The SCA’s reported value.

This disclosure shall apply beginning in the period the SCA’s equity initially falls below zero and shall continue to be disclosed as long as the SCA investment is in a deficit position. Additionally, the reporting entity shall detail in a narrative disclosure whether losses in the SCA have impacted other investments as required by INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses.

SCA Loss Tracking FN1

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NOTE: FN1 - This disclosure is only required for SCAs in which the reporting entity’s share of losses exceed the investment in an SCA, (the SCA investment is in a negative equity position). This disclosure shall apply beginning in the period the investment in the SCA equity initially falls below zero and shall continue to be disclosed as long as the SCA investment is in a negative equity position. The disclosure is required whenever an investment in an SCA entity is in a negative equity position, and in the first year subsequent to the negative equity position in which a positive equity position has been attained.
FN2 - For Column 6, as detailed in SSAP No. 97, (unless the entity is subject to statutory adjustments under paragraph 9), once the reporting entity’s share of losses equals or exceeds the investment in the SCA, the SCA shall be reported at zero, with discontinuation of the equity method, unless there is a guaranteed obligation or a commitment for future financial support. If there is a guaranteed obligation or a commitment for future financial support, the guarantee requirement shall be recognized pursuant to SSAP No. 5R, and the reporting entity shall report the investment in the SCA reflecting their share of losses as a contra-asset. *(Disclosure of the guarantee or commitment would be captured in Note 14 and is not duplicated in this disclosure.)*

**SSAP No. 97, Exhibit C – Implementation Questions and Answers**

7. **Q - Is it possible for an SCA investment valued using an equity method to be reported as a negative value?**

7.1 **A - Yes, the equity method noninsurance SCA could have a negative equity. SSAP No. 97 paragraph 8.b.ii. relating to noninsurance SCA entities requires some assets to be reported as a negative value (nonadmitted) in paragraph 9. For example an 8.b.ii. SCA subsidiary that is only holding furniture, which is nonadmitted, would be reflected with negative equity to the extent the value of the nonadmitted asset(s) exceed(s) reported equity. It should be noted that although SSAP No. 97, paragraph 13.e. discusses some situations in which the equity method should be discontinued, this does not apply to SCA entities, which meet the requirements of paragraph 8.b.ii. In addition, SSAP No. 97, paragraph 13.e. lists some situations where the equity method would result in a valuation that is less than zero; examples are if reporting entity has guaranteed obligations of the investee or is otherwise committed to provide further financial support for the investee, in these cases, the valuation of the investment in subsidiary could be a negative value.**

8. **Q - Paragraph 13.e. of SSAP No. 97, lists some situations where the equity method should be discontinued. If the equity method is discontinued, does the reporting entity cease tracking equity losses?**

8.1 **A - No, the reporting entity does not cease tracking losses related to the investment in the SCA if an equity method is discontinued. If the equity method is discontinued, follow the guidance in paragraphs 15-17 and INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses (INT 00-24).**

8.2 **INT 00-24 lists situations that might require the reporting entity to write down other investments in the SCA subsidiary, such as loans, because of continuing losses in the SCA investment. Paragraphs 15-17 provides guidance to assist in determining whether prior losses are being funded if the reporting entity purchases additional stock, etc. after suspending the equity method. Paragraphs 15-17 in INT 00-24 note that even if the equity method is not being applied, the investment should be tracked to determine if additional losses have to be applied to other items and to determine if the investment in the SCA has a future recovery.**

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):**
The Statutory Accounting Principles (E) Working Group previously adopted agenda item 2018-09 – SCA Loss Tracking, which incorporated an additional disclosure to track an SCA’s losses.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:**
None

**Convergence with International Financial Reporting Standards (IFRS): N/A**

**Staff Recommendation:**
Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 97—*Investments in Subsidiary, Controlled and Affiliated Entities*, as detailed
below, to clarify the existing reporting requirements for an SCA in a loss position. Staff would also request comments from regulators and interested parties regarding additional situations that require negative reporting.

**Proposed Revisions:**

**SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities**

13. On at least a quarterly basis, the procedures set forth below shall be followed by a reporting entity in applying an equity method of accounting (as described in paragraphs 8.b.i. through 8.b.iv.), as applicable, to investments in SCA entities:

   e. For entities subject to 8.b.i., 8.b.ii., 8.b.iii. and 8.b.iv. a reporting entity’s share of losses of an investee may equal or exceed the carrying amount of an investment accounted for by an equity method plus advances made by the investor. The reporting entity shall discontinue applying an equity method when the investment (including advances) is reduced to zero\(^3\) and shall not provide for additional losses unless the situations in paragraph 13.e.i. or paragraph 13.e.ii. exist. Reporting entity has guaranteed obligations of the investee or is otherwise committed to provide further financial support for the investee (guaranteed obligations meeting the definition of liabilities in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R) shall be recorded as liabilities). If the investee subsequently reports net income, the reporting entity shall resume applying an equity method only after its share of that net income equals the share of net losses not recognized during the period that an equity method was suspended. In situations in which negative equity is reported (paragraph 13.e.i. and paragraph 13.e.ii.), the book adjusted carrying value for the investment in the SCA shall reflect the reporting entity’s negative equity value (reflecting the reporting entity’s share of the SCA losses). (This would be reported as a contra-asset.)

   i. In all instances in which the limited statutory adjustments required by paragraph 9 results in a negative equity valuation of the investment. (This would apply to 8.b.ii and 8.b.iv entities.)

   ii. When the reporting entity has guaranteed obligations or committed further financial support to an SCA. Recognition of the negative equity in the SCA is in addition to the guarantee liability required under SSAP No. 5R. (This applies to all SCA entities.)

Staff Review Completed by:
Fatima Sediqzad - NAIC Staff
July 2018

**Status:**
On August 4, 2018, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as shown above, to clarify the existing reporting requirements for when the reporting entity has a negative equity valuation in an SCA investment.

On November 15, 2018, the Statutory Accounting Principles (E) Working Group re-exposed this agenda item and directed NAIC staff to work with interested parties and research applicable U.S. GAAP guidance to consider

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\(^3\) Refer to the additional guidance related to discontinuance of an equity method in paragraphs 15-17 and INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses.
revisions to existing guidance that requires negative subsidiary, controlled and affiliated (SCA) entity reporting when there is a guarantee or commitment to provide financial support.

On April 6, 2019, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as detailed below, to revise the existing reporting requirements for when a reporting entity has a negative value in an SCA investment when the reporting entity has provided a financial commitment or guarantee. The illustration from the existing INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses has also been moved to SSAP No. 97, in its entirety, as a new exhibit. This INT provides examples of how losses in an SCA shall be applied to other investments once the SCA equity investment has been halted at zero.

**Spring 2019 National Meeting Exposure:**

**SSAP No. 97—Subsidiary, Controlled and Affiliated Entities:**

13. On at least a quarterly basis, the procedures set forth below shall be followed by a reporting entity in applying an equity method of accounting (as described in paragraphs 8.b.i. through 8.b.iv.), as applicable, to investments in SCA entities:

   e. For entities subject to 8.b.i., 8.b.ii., 8.b.iii. and 8.b.iv. a reporting entity’s share of losses of an investee may equal or exceed the carrying amount of an investment accounted for by an equity method plus advances made by the investor. The reporting entity shall discontinue applying an equity method when the investment (including advances) is reduced to zero\(^4\) and shall not provide for additional losses, while still continuing to track the amount of unreported equity method losses, until any future equity method income can be reported. If the reporting entity has guaranteed obligations of the investee or is otherwise committed to provide further financial support for the investee, such as (guaranteed obligations meeting the definition of liabilities in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R), they shall be recorded as liabilities). If the entire loss is recognized under SSAP No. 5R, it does not also need to be recognized under SSAP No. 97. However, if there is a guarantee or commitment, and the entire loss is not recognized under SSAP No. 5R, the reporting entity shall not stop at zero, and shall recognize a negative value of the SCA. If the investee subsequently reports net income, the reporting entity shall resume applying an equity method only after its share of that net income equals the share of net losses not recognized during the period that an equity method was suspended;

Footnote 2: Refer to the additional guidance related to discontinuance of an equity method in paragraphs 15-17 and INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses. As detailed in INT 00-24, a reporting entity’s share of losses in an SCA shall be applied to other investments held in the SCA once the SCA (common stock) investment has been reduced to zero.
EXHIBIT F – ILLUSTRATION OF THE APPLICATION OF INT 00-24

XYZ Investment in ABC Company

1. ABC Company is a life insurance company, formed January 2, 20X1 to sell health insurance in the state of New York. On January 2, 20X1, XYZ Insurance Company invested $500,000 in ABC, and purchased 100,000 shares of common stock at par, and 40,000 shares of preferred stock at par. ABC Preferred stock is non-voting, 5% cumulative.

2. XYZ determined it has obtained a controlling interest in ABC as XYZ owns 50% of the voting interests of ABC. XYZ accounted for its investment in ABC Insurance Company under the statutory equity method of accounting. The following table is selected information from the financial statements of ABC Insurance Company.

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<th>12/31/20X9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Surplus:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common stock, $1 par, 200,000 shares issued and outstanding</td>
<td>$200,000</td>
<td>$200,000</td>
<td>$200,000</td>
<td>$200,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Preferred stock, $10 par, 100,000 shares issued and outstanding</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Surplus Notes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unassigned Funds (Surplus)</td>
<td>($1,980,000)</td>
<td>($1,830,000)</td>
<td>($1,280,000)</td>
<td>($430,000)</td>
<td>$820,000</td>
</tr>
<tr>
<td>Total Capital and Surplus</td>
<td>($280,000)</td>
<td>$370,000</td>
<td>$920,000</td>
<td>$1,770,000</td>
<td>$3,020,000</td>
</tr>
</tbody>
</table>

3. At 1/2/20X1, XYZ recorded the following entry to record its investment in ABC:

Investment in ABC Common stock | $ 100,000 |
Investment in ABC Preferred stock | $ 400,000 |
Cash | $ 500,000 |

To record initial investment in ABC Insurance Company.
4. During the year ended 12/31/20X1, ABC had statutory net income before dividends of $200,000. At 12/31/20X1, ABC declared and paid a 5% preferred dividend, and a common stock dividend of $.10 per share. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Cash</th>
<th>Dividend Income</th>
<th>$ 20,000</th>
<th>$ 20,000</th>
</tr>
</thead>
</table>

To record preferred dividend income from ABC Insurance Company for 20X1.

<table>
<thead>
<tr>
<th>Investment in ABC Common stock</th>
<th>Unrealized Gain/Loss</th>
<th>$ 75,000</th>
<th>$ 75,000</th>
</tr>
</thead>
</table>

To record 20X1 unrealized gain on investment in ABC Common. (($200,000 - $50,000) * 50%)

<table>
<thead>
<tr>
<th>Cash</th>
<th>Unrealized Gain/Loss</th>
<th>Dividend Income</th>
<th>Investment in ABC Common stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 10,000</td>
<td>$ 10,000</td>
<td>$ 10,000</td>
<td>$ 10,000</td>
</tr>
</tbody>
</table>

To record 20X1 dividend on ABC Common. (100,000 shares * $.10)

5. During the year ended 12/31/20X2, ABC issued an 8% surplus note of $500,000. XYZ purchased 100% of the surplus note. During that same year, ABC incurred a statutory net loss before dividends of $250,000. At 12/31/20X2, ABC declared and paid a 5% preferred dividend, and a common stock dividend of $.05 per share. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Investment in ABC Surplus Notes</th>
<th>Cash</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 500,000</td>
<td>$ 500,000</td>
</tr>
</tbody>
</table>

To record investment in ABC Insurance Company surplus notes.

<table>
<thead>
<tr>
<th>Cash</th>
<th>Dividend Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 20,000</td>
<td>$ 20,000</td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X2.

<table>
<thead>
<tr>
<th>Unrealized Gain/Loss</th>
<th>Investment in ABC Common stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 150,000</td>
<td>$ 150,000</td>
</tr>
</tbody>
</table>

To record 20X2 unrealized loss on investment in ABC Common. (($-250,000 - $50,000) * 50%)

<table>
<thead>
<tr>
<th>Cash</th>
<th>Unrealized Gain/Loss</th>
<th>Dividend Income</th>
<th>Investment in ABC Common stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 5,000</td>
<td>$ 5,000</td>
<td>$ 5,000</td>
<td>$ 5,000</td>
</tr>
</tbody>
</table>

To record 20X2 dividend on ABC Common. (100,000 shares * $.05)

6. During the year ended 12/31/20X3, ABC Insurance Company incurred a statutory net loss before dividends of $400,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:
Dividends Receivable $ 20,000
  Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X3.

Unrealized Gain/Loss $ 182,000
  Investment in ABC Preferred stock $ 172,000
  Investment in ABC Common stock $ 10,000

To record 20X3 unrealized loss on investment in ABC Common and Preferred.

Total net loss and preferred stock dividend ($450,000).
  Common stock component reduces the Investment in ABC Common stock component to $0. (20,000 * 50%)
    Total net loss and preferred dividend (-$400,000 - $50,000) $450,000
    Less amount used to reduce common stock investment to $0 20,000
    Amount remaining to be allocated to investment in preferred 430,000
    XYZ ownership % of preferred 40%
      i. XYZ reduction in investment in preferred $172,000

7. During the year ended 12/31/20X4, ABC Insurance Company incurred a statutory net loss before dividends of $750,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

Dividends Receivable $ 20,000
  Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X4.

Unrealized Gain/Loss $ 458,000
  Investment in ABC Preferred stock $ 228,000
  Investment in ABC Surplus note $ 230,000

To record 20X4 unrealized loss on investment in ABC Preferred and Surplus Notes.

Total net loss and preferred stock dividend ($800,000).
  Common stock component reduces the Investment in ABC Preferred stock component to $0. (570,000 * 40%)
  Preferred stock component calculated as:
    Total net loss and preferred dividend (-$750,000 - $50,000) $800,000
    Less amount used to reduce preferred stock investment to $0 570,000
    Amount remaining to be allocated to investment in surplus note 230,000
    XYZ ownership % of surplus note 100%
      iii. XYZ reduction in investment in ABC Surplus Notes $230,000

8. During the year ended 12/31/20X5, ABC Insurance Company incurred a statutory net loss before dividends of $500,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:
Dividends Receivable $ 20,000
Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X5.

Unrealized Gain/Loss $ 270,000
Investment in ABC Surplus note $ 270,000

To record 20X5 unrealized loss on investment in ABC Surplus Notes.

Total ABC net loss and preferred stock dividend (-$500,000 - $50,000), Surplus Note component calculated as:

Total net loss and preferred dividend (-$500,000 - $50,000) $550,000
XYZ ownership % of ABC Surplus Note 100%
Amount of unrealized loss recognized in 20X5 $270,000
iv. Amount of unrealized loss suspended $280,000

9. Since XYZ has not guaranteed any liabilities of ABC, the reduction they would recognize is limited to their remaining investment in ABC Surplus Notes. Therefore, they would only recognize a 20X5 unrealized loss on their investment in ABC of $270,000.

10. During the year ended 12/31/20X6, ABC Insurance Company realigned their marketing efforts and modified the products they were selling. ABC also issued an additional 8% surplus note of $500,000. This surplus note was purchased by an unaffiliated third party. During the year ended 12/31/X6, ABC Insurance Company had statutory net income before dividends of $200,000. ABC Insurance Company did not declare any dividends on common stock, but declared and paid current and dividends in arrears on preferred. XYZ recorded the following entries:

Cash $ 80,000
Dividends Receivable $ 60,000
Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X6, and receipt of preferred dividends receivable for 20X3, 20X4 and 20X5.

11. XYZ did not record any change in their investment in ABC Surplus Notes, ABC Preferred or ABC Common, since ABCs’ net income after preferred dividends did not exceed the losses accumulated during the period that XYZ suspended recording unrealized losses.

12. The following amounts were tracked:

Total ABC net income and preferred stock dividend ($200,000 - $50,000), Surplus Note component calculated as:

Total net income and preferred dividend ($200,000 - $50,000) $150,000
XYZ ownership % of ABC Surplus Note 50%
Amount of unrealized loss suspended in 20X5 $ 75,000
Remaining amount of unrealized loss suspended $280,000 $205,000
13. During the year ended 12/31/20X7, ABC Insurance Company had statutory net income before dividends of $600,000. At 12/31/20X7, ABC declared and paid a 5% preferred dividend. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

- **Cash**  
  Dividend Income  
  $20,000

  To record preferred dividend income from ABC Insurance Company for 20X7.

- **Investment in ABC Surplus Notes**  
  Unrealized Gain/Loss  
  $70,000

  To record 20X7 unrealized gain on investment in ABC Surplus Notes.

**Total ABC net income and preferred stock dividend ($600,000 - $50,000):**

- **Surplus Note component calculated as:**

  - Total net income and preferred dividend ($600,000 - $50,000)  
    $550,000
  - XYZ ownership % of ABC Surplus Note  
    50%  
    $275,000
  - Remaining amount of unrealized loss suspended in 20X5  
    $205,000
  - 20X7 amount of unrealized gain on investment in ABC Surplus Note  
    $70,000

14. During the year ended 12/31/20X8, ABC Insurance Company had statutory net income before dividends of $900,000. At 12/31/20X8, ABC declared and paid a 5% preferred dividend. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

- **Cash**  
  Dividend Income  
  $20,000

  To record preferred dividend income from ABC Insurance Company for 20X8.

**Total ABC net income and preferred stock dividend ($900,000 - $50,000):**

- **Surplus Note component calculated as:**

  - Total net income and preferred dividend ($900,000 - $50,000)  
    $850,000
  - XYZ ownership % of ABC Surplus Note  
    50%  
    $425,000
  - 20X8 amount of unrealized gain on investment in ABC Surplus Note  
    $425,000

15. During the year ended 12/31/20X9, ABC Insurance Company had statutory net income, before interest on surplus notes and dividends, of $1,400,000. The Commissioner approved one year’s interest payment on the surplus notes. At 12/31/20X9, ABC declared and paid a 5% preferred dividend, and a $.10 dividend per share on Common stock. XYZ recorded the following entries:

- **Cash**  
  Dividend Income  
  $20,000

  To record preferred dividend income from ABC Insurance Company for 20X9.
Cash  $ 40,000
Interest Income $ 40,000

To record surplus notes interest income from ABC Insurance Company for 20X9. ($500,000 * 8%)

Investment in ABC Surplus Notes $ 5,000
Investment in ABC Preferred Stock $ 400,000
Investment in ABC Common Stock $ 130,000

Unrealized Gain/Loss $ 535,000
To record 20X9 unrealized gain on investment in ABC Common, Preferred and Surplus Notes.
Components computed as follows:

Total Net Income net of preferred stock dividend and interest on surplus notes $ 1,270,000
($1,400,000 - $50,000 - $80,000)
Less amount needed to restore investment in surplus notes ($ 10,000)
Amount available for preferred stock and common stock investment restoration $ 1,260,000
Amount needed to restore preferred stock component ($1,000,000)
Amount available to restore common stock component $ 260,000

Surplus Notes component ($10,000 * 50%) $ 5,000
Preferred Stock component ($1,000,000 * 40%) $ 400,000
vii. Common stock component ($260,000 * 50%) $ 130,000

Cash $ 10,000
Unrealized Gain/Loss $ 10,000
Dividend Income $ 10,000
Investment in ABC Common stock $ 10,000

To record 20X9 dividend on ABC Common. (100,000 shares * $.10)

On August 3, 2019, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as illustrated below, to require a financial commitment or guarantee for a subsidiary, controlled, or affiliated entity to be recognized as a non-contingent guarantee liability. These proposed revisions differ from the prior exposure as they would capture the entire financial guaranty or commitment for an SCA within scope of SSAP No. 5R and report a zero value for SCAs with a negative equity value.

**SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets**

8. An estimated loss from a loss contingency or the impairment of an asset shall be recorded by a charge to operations if both of the following conditions are met:

a. Information available prior to issuance of the statutory financial statements indicates that it is probable that an asset has been impaired or a liability has been incurred at the date of the statutory financial statements. It is implicit in this condition that it is probable that one or more future events will occur confirming the fact of the loss or incurrence of a liability; and

b. The amount of loss can be reasonably estimated.

18. The following types of guarantees are exempted from the initial liability recognition in paragraphs 20-25, but are subject to the disclosure requirements in paragraphs 29-32. For the guarantees addressed in paragraphs 18f and 18g, recognition of a contingent guarantee may be required subsequent to initial recognition in accordance with paragraph 24a:
a. Guarantee that is accounted for as a derivative instrument, other than credit derivatives within SSAP No. 86;

b. Guarantee for which the underlying is related to the performance of nonfinancial assets that are owned by the guaranteed party, including product warranties;

c. Guarantee issued in a business combination that represents contingent consideration;

d. Guarantee in which the guarantor’s obligation would be reported as an equity item;

e. Guarantee by an original lessee that has become secondarily liable under a new lease that relieved the original lessee from being the primary obligor;

f. Guarantees (as defined in paragraph 16) made to/or on behalf of directly or indirectly wholly-owned insurance or non-insurance subsidiaries; and

g. Intercompany and related party guarantees that are considered “unlimited” (e.g., typically in response to a rating agency’s requirement to provide a commitment to support).

19. With the exception of the provision for guarantees made to/or on behalf of a wholly-owned subsidiaries in paragraph 18.f. and “unlimited” guarantees in 18.g., this guidance does not exclude guarantees issued as intercompany transactions or between related parties from the initial liability recognition requirement. Thus, unless the guarantee is provided on behalf of a wholly-owned subsidiary or considered “unlimited,” guarantees issued between the following parties are subject to the initial recognition and disclosure requirements:

d. Guarantee issued either between parents and their subsidiaries or between corporations under common control;

e. A parent’s guarantee of its subsidiary’s debt to a third party; and

f. A subsidiary’s guarantee of the debt owed to a third party by either its parent or another subsidiary of that parent.

20. At the inception of a guarantee, the guarantor shall recognize in its statement of financial position a liability for that guarantee. Except as indicated in paragraph 22, the objective of the initial measurement of the liability is the fair value of the guarantee at its inception.

Footnote: As practical expediency, when a guarantee is issued in a standalone arm’s-length transaction, the liability recognized at the inception of the guarantee should be the premium received or receivable by the guarantor. When a guarantee is issued as part of a transaction with multiple elements, the liability recognized at the inception of the guarantee should be an estimate of the guarantee’s fair value. In that circumstance, guarantors should consider what premium would be required by the guarantor to issue the same guarantee in a standalone arm’s-length transaction.

21. The issuance of a guarantee obligates the guarantor (the issuer) in two respects: (a) the guarantor undertakes an obligation to stand ready to perform over the term of the guarantee in the event that the

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5 The exclusion for wholly-owned subsidiaries includes guarantees from a parent to, or on behalf of, a direct wholly-owned insurance or non-insurance subsidiary as well as guarantees made from a parent to, or on behalf of, an indirect wholly-owned insurance or non-insurance subsidiary. The “wholly-owned” exclusion in paragraph 18.f. does not include guarantees issued from one subsidiary to another subsidiary, regardless if both subsidiaries are wholly-owned (directly or indirectly) by a parent company.
specified triggering events or conditions occur (the noncontingent aspect) and (b) the guarantor undertakes a contingent obligation to make future payments if those triggering events or conditions occur (the contingent aspect). Because the issuance of a guarantee imposes a noncontingent obligation to stand ready to perform in the event that the specified triggering event occurs, the provisions of paragraph 8 should not be interpreted as prohibiting the guarantor from initially recognizing a liability for that guarantee even though it is not probable that payments will be required under that guarantee.

22. In the event that, at the inception of the guarantee, the guarantor is required to recognize a liability under paragraph 8 for the related contingent loss, the liability to be initially recognized for that guarantee shall be the greater of (a) the amount the satisfies the fair value objective as discussed in paragraph 20 or (b) the contingent liability amount required to be recognized at inception of the guarantee by paragraph 8. For many guarantors, it would be unusual for the contingent liability under (b) to exceed the amount that satisfies the fair value objective at the inception of the guarantee.

23. The offsetting entry pursuant to the liability recognition at the inception of the guarantee depends on the circumstances in which the guarantee was issued. Examples include:

   a. If the guarantee was issued in a standalone transaction for a premium, the offsetting entry would the consideration received.

   b. If the guarantee was issued in conjunction with the sale of assets, a product, or a business, the overall proceeds would be allocated between the consideration being remitted to the guarantor for issuing the guarantee and the proceeds from that sale. That allocation would affect the calculation of the gain or loss on the sale transaction.

   c. If a residual value guarantee were provided by a lessee-guarantor when entering into an operating lease, the offsetting entry would be reflected as prepaid rent, which would be nonadmitted under SSAP No. 29.

   d. If a guarantee were issued to an unrelated or related party for no consideration on a standalone basis, the offsetting entry would be to expense.

24. Except for the measurement and recognition of continued guarantee obligations after the settlement of a contingent guarantee liability described in paragraph 25, and the provisions for SCAs detailed in paragraph 24a, this standard does not describe in detail how the guarantor’s liability for its obligations under the guarantee would be measured subsequent to initial recognition. The liability that the guarantor initially recognized in accordance with paragraph 20 would typically be reduced (as a credit to income) as the guarantor is released from risk under the guarantee. Depending on the nature of the guarantee, the guarantor’s release from risk has typically been recognized over the term of the guarantee (a) only upon either expiration or settlement of the guarantee, (b) by a systematic and rational amortization method, or (c) as the fair value of the guarantee changes (for example, guarantees accounted for as derivatives). The reduction of liability does not encompass the recognition and subsequent adjustment of the contingent liability recognized under paragraph 8 related to the contingent loss for the guarantee. If the guarantor is required to subsequently recognize a contingent liability for the guarantee, the guarantor shall eliminate any remaining noncontingent liability for that guarantee and recognize a contingent liability in accordance with paragraph 8.

   a. In situations in which a reporting entity has provided a financial guarantee or commitment to support a subsidiary, controlled or affiliated entity (SCA), and the reporting entity’s share of losses in the SCA exceed the equity method carrying amount of the SCA (resulting in a negative equity value in the SCA), the reporting entity shall adjust the initially recognized guarantee obligation to reflect the greater of the then-current fair value of the guarantee or the negative equity position. (For guarantees captured in paragraphs 18f and 18g, this guidance requires recognition of a contingent guaranty when negative equity exists in an SCA.) The recognized guarantee liability shall not exceed the maximum amount of the
financial guarantee or commitment provided by the reporting entity. The guidance in paragraphs 24 and 25 shall be followed for recognizing a contingent liability and subsequent re-recognition of a noncontingent liability as applicable.

25. After recognition and settlement of a contingent guarantee liability in accordance with paragraph 8, a guarantor shall assess whether remaining potential obligations exist under the guarantee agreement. If the guarantor still has potential obligations under the guarantee contract, the guarantor shall recognize the remaining noncontingent guarantee that represents the current fair value of the potential obligation remaining under the guarantee agreement. This noncontingent guarantee liability shall be released in accordance with paragraph 24.

**SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities**

13. On at least a quarterly basis, the procedures set forth below shall be followed by a reporting entity in applying an equity method of accounting (as described in paragraphs 8.b.i. through 8.b.iv.), as applicable, to investments in SCA entities:

e. For entities subject to 8.b.i., 8.b.ii., 8.b.iii. and 8.b.iv. a reporting entity’s share of losses of an investee may equal or exceed the carrying amount of an investment accounted for by an equity method plus advances made by the investor. The reporting entity shall discontinue applying an equity method when the investment (including advances) is reduced to zero and shall not provide for additional losses, while still continuing to track the amount of unreported equity method losses, until any future equity method income can be reported. If the reporting entity has guaranteed obligations of the investee or is otherwise committed to provide further financial support for the investee, the provisions of such as (guaranteed obligations meeting the definition of liabilities in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets) shall be followed (SSAP No. 5R). In such cases, the reporting entity shall resume applying an equity method only after its share of that net income equals the share of net losses not recognized during the period that an equity method was suspended;

Footnote 2: Although the SCA is reported at zero in the investment schedule, a guarantee liability (either contingent or noncontingent) may be required to be reported under SSAP No. 5R. Additionally, refer to the additional guidance related to discontinuance of an equity method in paragraphs 15-17 and INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses. As detailed in INT 00-24, a reporting entity’s share of losses in an SCA shall be applied to other investments held in the SCA once the SCA (common stock) investment has been reduced to zero.

35. All SCA investments within the scope of this statement (except paragraph 8.b.i. entities) shall include disclosure of the SCA balance sheet value (admitted and nonadmitted) as well as information received from the NAIC in response to the SCA filing (e.g., date and type of filing, NAIC valuation amount, whether resubmission of filing is required). This disclosure shall include an aggregate total of all SCAs (except paragraph 8.b.i. entities) with detail of the aggregate gross value under this statement with the admitted and nonadmitted amounts reflected on the balance sheet. (As noted in paragraph 4, joint ventures, partnerships and limited liability companies are accounted for under the guidance in SSAP No. 48. As such, those entities are not subject to the disclosures in this statement, unless specifically directed by SSAP No. 48.)
a. For all periods presented, a reporting entity whose shares of losses in an SCA exceeds its investment in the SCA shall disclose its share of losses. (This is required regardless of a guarantee or commitment of future financial support to the SCA.) This disclosure shall include the following:

i. The reporting entity’s accumulated share of the SCA losses not recognized during the period that the equity method was suspended;

ii. The reporting entity’s share of the SCA’s equity, including negative equity;

iii. Whether a guaranteed obligation or commitment for financial support exists; and

iv. The SCA’s reported value.

2019 Fall National Meeting Exposure

SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets - (Industry edits are shaded.)

8. An estimated loss from a loss contingency or the impairment of an asset shall be recorded by a charge to operations if both of the following conditions are met:

a. Information available prior to issuance of the statutory financial statements indicates that it is probable that an asset has been impaired or a liability has been incurred at the date of the statutory financial statements. It is implicit in this condition that it is probable that one or more future events will occur confirming the fact of the loss or incurrence of a liability; and

b. The amount of loss can be reasonably estimated.

18. The following types of guarantees are exempted from the initial liability recognition in paragraphs 20-25, but are subject to the disclosure requirements in paragraphs 29-32. For the guarantees addressed in paragraphs 18f and 18g, recognition of a contingent guarantee may be required subsequent to initial recognition in accordance with paragraph 24a:

a. Guarantee that is accounted for as a derivative instrument, other than credit derivatives within SSAP No. 86;

b. Guarantee for which the underlying is related to the performance of nonfinancial assets that are owned by the guaranteed party, including product warranties;

c. Guarantee issued in a business combination that represents contingent consideration;

d. Guarantee in which the guarantor’s obligation would be reported as an equity item;

e. Guarantee by an original lessee that has become secondarily liable under a new lease that relieved the original lessee from being the primary obligator;

f. Guarantees (as defined in paragraph 16) made to/or on behalf of directly or indirectly wholly-owned insurance or non-insurance subsidiaries; and

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8 The exclusion for wholly-owned subsidiaries includes guarantees from a parent to, or on behalf of, a direct wholly-owned insurance or non-insurance subsidiary as well as guarantees made from a parent to, or on behalf of, an indirect wholly-owned insurance or non-insurance
g. Intercompany and related party guarantees that are considered “unlimited” (e.g., typically in response to a rating agency’s requirement to provide a commitment to support).

The exemptions for items f and g above do not apply in situations in which a reporting entity has provided a financial guarantee or commitment to support a subsidiary, controlled or affiliated entity (SCA), and the SCA’s equity is negative (see paragraph 24).

19. With the exception of the provision for guarantees made to/or on behalf of a wholly-owned subsidiaries in paragraph 18.f and “unlimited” guarantees in 18.g., this guidance does not exclude guarantees issued as intercompany transactions or between related parties from the initial liability recognition requirement. Thus, unless the guarantee is provided on behalf of a wholly-owned subsidiary or considered “unlimited,” guarantees issued between the following parties are subject to the initial recognition and disclosure requirements:

   a. Guarantee issued either between parents and their subsidiaries or between corporations under common control;

   b. A parent’s guarantee of its subsidiary’s debt to a third party; and

   c. A subsidiary’s guarantee of the debt owed to a third party by either its parent or another subsidiary of that parent.

20. At the inception of a guarantee, the guarantor shall recognize in its statement of financial position a liability for that guarantee. Except as indicated in paragraph 22, the objective of the initial measurement of the liability is the fair value of the guarantee at its inception. Footnote: As practical expedients, when a guarantee is issued in a standalone arm’s-length transaction, the liability recognized at the inception of the guarantee should be the premium received or receivable by the guarantor. When a guarantee is issued as part of a transaction with multiple elements, the liability recognized at the inception of the guarantee should be an estimate of the guarantee’s fair value. In that circumstance, guarantors should consider what premium would be required by the guarantor to issue the same guarantee in a standalone arm’s-length transaction.

21. The issuance of a guarantee obligates the guarantor (the issuer) in two respects: (a) the guarantor undertakes an obligation to stand ready to perform over the term of the guarantee in the event that the specified triggering events or conditions occur (the noncontingent aspect) and (b) the guarantor undertakes a contingent obligation to make future payments if those triggering events or conditions occur (the contingent aspect). Because the issuance of a guarantee imposes a noncontingent obligation to stand ready to perform in the event that the specified triggering event occurs, the provisions of paragraph 8 should not be interpreted as prohibiting the guarantor from initially recognizing a liability for that guarantee even though it is not probable that payments will be required under that guarantee.

22. In the event that, at the inception of the guarantee, the guarantor is required to recognize a liability under paragraph 8 for the related contingent loss, the liability to be initially recognized for that guarantee shall be the greater of (a) the amount the satisfies the fair value objective as discussed in paragraph 20 or (b) the contingent liability amount required to be recognized at subsidiary. The “wholly-owned” exclusion in paragraph 18.f. does not include guarantees issued from one subsidiary to another subsidiary, regardless if both subsidiaries are wholly-owned (directly or indirectly) by a parent company.
inception of the guarantee by paragraph 8. For many guarantors, it would be unusual for the contingent liability under (b) to exceed the amount that satisfies the fair value objective at the inception of the guarantee.

23. The offsetting entry pursuant to the liability recognition at the inception of the guarantee depends on the circumstances in which the guarantee was issued. Examples include:

a. If the guarantee was issued in a standalone transaction for a premium, the offsetting entry would the consideration received.

b. If the guarantee was issued in conjunction with the sale of assets, a product, or a business, the overall proceeds would be allocated between the consideration being remitted to the guarantor for issuing the guarantee and the proceeds from that sale. That allocation would affect the calculation of the gain or loss on the sale transaction.

c. If a residual value guarantee were provided by a lessee-guarantor when entering into an operating lease, the offsetting entry would be reflected as prepaid rent, which would be nonadmitted under SSAP No. 29.

d. If a guarantee were issued to an unrelated or related party for no consideration on a standalone basis, the offsetting entry would be to expense.

24. Except for the measurement and recognition of continued guarantee obligations after the settlement of a contingent guarantee liability described in paragraph 25, and the provisions for SCAs detailed in paragraph 24a, this standard does not describe in detail how the guarantor’s liability for its obligations under the guarantee would be measured subsequent to initial recognition. The liability that the guarantor initially recognized in accordance with paragraph 20 would typically be reduced (as a credit to income) as the guarantor is released from risk under the guarantee. Depending on the nature of the guarantee, the guarantor’s release from risk has typically been recognized over the term of the guarantee (a) only upon either expiration or settlement of the guarantee, (b) by a systematic and rational amortization method, or (c) as the fair value of the guarantee changes (for example, guarantees accounted for as derivatives). The reduction of liability does not encompass the recognition and subsequent adjustment of the contingent liability recognized under paragraph 8 related to the contingent loss for the guarantee. If the guarantor is required to subsequently recognize a contingent liability for the guarantee, the guarantor shall eliminate any remaining noncontingent liability for that guarantee and recognize a contingent liability in accordance with paragraph 8.

25. In situations in which a reporting entity has provided a financial guarantee or commitment to support a subsidiary, controlled or affiliated entity (SCA), and the reporting entity’s share of losses in the SCA exceed the equity method carrying amount of the SCA (resulting in a negative equity value in the SCA), the reporting entity shall adjust the initially recognized guarantee obligation to reflect the greater impact of (i) the then-current fair value liability for of the guarantee or (ii) the negative equity position, limited to the maximum amount of the financial guarantee or commitment provided by the reporting entity. (ForThis guidance requires the recognition of a guarantee liability for guarantees captured in paragraphs 18f and 18q, when negative equity exists in an SCA, this guidance requires recognition of a contingent guaranty.) The recognized guarantee liability shall not exceed the maximum amount of the financial guarantee or commitment provided by the reporting entity. The guidance in paragraphs 24 and 2520 through 26 shall be followed for the recognition of recognizing a contingent liability and subsequent re-recognition of a noncontingent liability, as applicable.

25.26 After recognition and settlement of a contingent guarantee liability in accordance with paragraph 8, a guarantor shall assess whether remaining potential obligations exist under the
guarantee agreement. If the guarantor still has potential obligations under the guarantee contract, the guarantor shall recognize the remaining noncontingent guarantee that represents the current fair value of the potential obligation remaining under the guarantee agreement. This noncontingent guarantee liability shall be released in accordance with paragraph 24.

SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities – No industry edits to this section

12. On at least a quarterly basis, the procedures set forth below shall be followed by a reporting entity in applying an equity method of accounting (as described in paragraphs 8.b.i. through 8.b.iv.), as applicable, to investments in SCA entities:

   e. For entities subject to 8.b.i., 8.b.ii., 8.b.iii. and 8.b.iv. a reporting entity’s share of losses of an investee may equal or exceed the carrying amount of an investment accounted for by an equity method plus advances made by the investor. The reporting entity shall discontinue applying an equity method when the investment (including advances) is reduced to zero and shall not provide for additional losses, while still continuing to track the amount of unreported equity method losses, until any future equity method income can be reported. If the reporting entity has guaranteed obligations of the investee or is otherwise committed to provide further financial support for the investee, the provisions of such as (guaranteed obligations meeting the definition of liabilities in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets shall be followed. (SSAP No. 5R), they shall be recorded as liabilities). If the entire equity method loss (subject to the financial guarantee / commitment) shall be recognized under SSAP No. 5R, it does not also need to be recognized under SSAP No. 97. If the investee subsequently reports net income, the reporting entity shall resume applying an equity method only after its share of that net income equals the share of net losses not recognized during the period that an equity method was suspended;

Footnote 2: Although the SCA is reported at zero in the investment schedule, a guarantee liability (either contingent or noncontingent) may be required to be reported under SSAP No. 5R. Additionally, Refer to the additional guidance related to discontinuance of an equity method in paragraphs 15-17 and INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses. As detailed in INT 00-24, a reporting entity’s share of losses in an SCA shall be applied to other investments held in the SCA once the SCA (common stock) investment has been reduced to zero.

35. All SCA investments within the scope of this statement (except paragraph 8.b.i. entities) shall include disclosure of the SCA balance sheet value (admitted and nonadmitted) as well as information received from the NAIC in response to the SCA filing (e.g., date and type of filing, NAIC valuation amount, whether resubmission of filing is required). This disclosure shall include an aggregate total of all SCAs (except paragraph 8.b.i. entities) with detail of the aggregate gross value under this statement with the admitted and nonadmitted amounts reflected on the balance sheet. (As noted in paragraph 4, joint ventures, partnerships and limited liability companies are accounted for under the guidance in SSAP No. 48. As such, those entities are not subject to the disclosures in this statement, unless specifically directed by SSAP No. 48.)

   a. For all periods presented, a reporting entity whose shares of losses in an SCA exceeds its investment in the SCA shall disclose its share of losses. (This is required regardless of a
guarantee or commitment of future financial support to the SCA.) This disclosure shall include the following:

i. The reporting entity’s accumulated share of the SCA losses not recognized during the period that the equity method was suspended;

ii. The reporting entity’s share of the SCA’s equity, including negative equity;

iii. Whether a guaranteed obligation or commitment for financial support exists; and

iv. The SCA’s reported value. The amount of the recognized guarantee under SSAP No. 5R.

Proposed New Exhibit F – This is not new guidance, it pulls in prior guidance from INT 00-24

EXHIBIT F – ILLUSTRATION OF THE APPLICATION OF INT 00-24

**XYZ Investment in ABC Company**

1. ABC Company is a life insurance company, formed January 2, 20X1 to sell health insurance in the state of New York. On January 2, 20X1, XYZ Insurance Company invested $500,000 in ABC, and purchased 100,000 shares of common stock at par, and 40,000 shares of preferred stock at par. ABC Preferred stock is non-voting, 5% cumulative.

2. XYZ determined it has obtained a controlling interest in ABC as XYZ owns 50% of the voting interests of ABC. XYZ accounted for its investment in ABC Insurance Company under the statutory equity method of accounting. The following table is selected information from the financial statements of ABC Insurance Company.

<table>
<thead>
<tr>
<th>Capital and Surplus:</th>
<th>20X1 – 20X4</th>
<th>20X5 – 20X9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common stock, $1 par, 200,000 shares issued and outstanding</td>
<td>1/2/20X1 $200,000 12/31/20X1 $200,000 12/31/20X2 $200,000 12/31/20X3 $200,000 12/31/20X4 $200,000</td>
<td>12/31/20X5 $200,000 12/31/20X6 $200,000 12/31/20X7 $200,000 12/31/20X8 $200,000 12/31/20X9 $200,000</td>
</tr>
<tr>
<td>Preferred stock, $10 par, 100,000 shares issued and outstanding</td>
<td>$1,000,000 $1,000,000 $1,000,000 $1,000,000 $1,000,000</td>
<td>$1,000,000 $1,000,000 $1,000,000 $1,000,000 $1,000,000</td>
</tr>
<tr>
<td>Surplus Notes</td>
<td>$500,000 $500,000 $500,000</td>
<td>$1,980,000 ($1,980,000) ($1,980,000) ($1,980,000) ($1,980,000)</td>
</tr>
<tr>
<td>Unassigned Funds (Surplus)</td>
<td>$130,000 ($180,000) ($630,000) ($1,430,000) ($1,430,000)</td>
<td>($1,830,000) ($1,280,000) ($430,000) $820,000</td>
</tr>
<tr>
<td>Total Capital and Surplus</td>
<td>$1,230,000 $1,520,000 $1,070,000 $270,000</td>
<td>$1,800,000 $2,160,000 $1,770,000 $3,020,000</td>
</tr>
</tbody>
</table>
3. At 1/2/20X1, XYZ recorded the following entry to record its investment in ABC:

<table>
<thead>
<tr>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in ABC Common stock</td>
<td>$100,000</td>
</tr>
<tr>
<td>Investment in ABC Preferred stock</td>
<td>$400,000</td>
</tr>
<tr>
<td>Cash</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

To record initial investment in ABC Insurance Company.

4. During the year ended 12/31/20X1, ABC had statutory net income before dividends of $200,000. At 12/31/20X1, ABC declared and paid a 5% preferred dividend, and a common stock dividend of $.10 per share. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$20,000</td>
</tr>
<tr>
<td>Dividend Income</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X1.

<table>
<thead>
<tr>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in ABC Common stock</td>
<td>$75,000</td>
</tr>
<tr>
<td>Unrealized Gain/Loss</td>
<td>$75,000</td>
</tr>
</tbody>
</table>

To record 20X1 unrealized gain on investment in ABC Common. (($200,000 - $50,000) * 50%)

<table>
<thead>
<tr>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$10,000</td>
</tr>
<tr>
<td>Dividend Income</td>
<td>$10,000</td>
</tr>
<tr>
<td>Investment in ABC Common stock</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

To record 20X1 dividend on ABC Common. (100,000 shares * $.10)

5. During the year ended 12/31/20X2, ABC issued an 8% surplus note of $500,000. XYZ purchased 100% of the surplus note. During that same year, ABC incurred a statutory net loss before dividends of $250,000. At 12/31/20X2, ABC declared and paid a 5% preferred dividend, and a common stock dividend of $.05 per share. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in ABC Surplus Notes</td>
<td>$500,000</td>
</tr>
<tr>
<td>Cash</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

To record investment in ABC Insurance Company surplus notes.

<table>
<thead>
<tr>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$20,000</td>
</tr>
<tr>
<td>Dividend Income</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X2.

<table>
<thead>
<tr>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrealized Gain/Loss</td>
<td>$150,000</td>
</tr>
<tr>
<td>Investment in ABC Common stock</td>
<td>$150,000</td>
</tr>
</tbody>
</table>

To record 20X2 unrealized loss on investment in ABC Common. (($-250,000 - $50,000) * 50%)

<table>
<thead>
<tr>
<th>Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$5,000</td>
</tr>
<tr>
<td>Unrealized Gain/Loss</td>
<td>$5,000</td>
</tr>
<tr>
<td>Dividend Income</td>
<td>$5,000</td>
</tr>
<tr>
<td>Investment in ABC Common stock</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
To record 20X2 dividend on ABC Common. (100,000 shares * $.05)

6. During the year ended 12/31/20X3, ABC Insurance Company incurred a statutory net loss before dividends of $400,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Dividends Receivable</th>
<th>$ 20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dividend Income</td>
<td>$ 20,000</td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X3.

<table>
<thead>
<tr>
<th>Unrealized Gain/Loss</th>
<th>$ 182,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in ABC Preferred stock</td>
<td>$ 172,000</td>
</tr>
<tr>
<td>Investment in ABC Common stock</td>
<td>$ 10,000</td>
</tr>
</tbody>
</table>

To record 20X3 unrealized loss on investment in ABC Common and Preferred.

Total net loss and preferred stock dividend ($450,000).
Common stock component reduces the Investment in ABC Common stock component to $0. (20,000 * 50%)

| Total net loss and preferred dividend (-$400,000 - $50,000) | $450,000 |
| Less amount used to reduce common stock investment to $0 | $20,000 |
| Amount remaining to be allocated to investment in preferred | $430,000 |
| XYZ ownership % of preferred | 40% |
| XYZ reduction in investment in preferred | $172,000 |

7. During the year ended 12/31/20X4, ABC Insurance Company incurred a statutory net loss before dividends of $750,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Dividends Receivable</th>
<th>$ 20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dividend Income</td>
<td>$ 20,000</td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X4.

<table>
<thead>
<tr>
<th>Unrealized Gain/Loss</th>
<th>$ 458,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment in ABC Preferred stock</td>
<td>$ 228,000</td>
</tr>
<tr>
<td>Investment in ABC Surplus note</td>
<td>$ 230,000</td>
</tr>
</tbody>
</table>

To record 20X4 unrealized loss on investment in ABC Preferred and Surplus Notes.

Total net loss and preferred stock dividend ($800,000).
Common stock component reduces the Investment in ABC Preferred stock component to $0. (570,000 * 40%)
Preferred stock component calculated as:

| Total net loss and preferred dividend (-$750,000 - $50,000) | $800,000 |
| Less amount used to reduce preferred stock investment to $0 | $570,000 |
| Amount remaining to be allocated to investment in surplus note | $230,000 |
| XYZ ownership % of surplus note | 100% |
| XYZ reduction in investment in ABC Surplus Notes | $230,000 |

8. During the year ended 12/31/20X5, ABC Insurance Company incurred a statutory net loss before dividends of $500,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:
Dividends Receivable $ 20,000
Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X5.

Unrealized Gain/Loss $ 270,000
Investment in ABC Surplus note $ 270,000

To record 20X5 unrealized loss on investment in ABC Surplus Notes.

Total ABC net loss and preferred stock dividend (-$500,000 - $50,000).
Surplus Note component calculated as:
Total net loss and preferred dividend (-$500,000 - $50,000) $550,000
XYZ ownership % of ABC Surplus Note 100%
Amount of unrealized loss recognized in 20X5 $270,000
Amount of unrealized loss suspended $280,000

9. Since XYZ has not guaranteed any liabilities of ABC, the reduction they would recognize is limited to their remaining investment in ABC Surplus Notes. Therefore, they would only recognize a 20X5 unrealized loss on their investment in ABC of $270,000.

10. During the year ended 12/31/20X6, ABC Insurance Company realigned their marketing efforts and modified the products they were selling. ABC also issued an additional 8% surplus note of $500,000. This surplus note was purchased by an unaffiliated third party. During the year ended 12/31/X6, ABC Insurance Company had statutory net income before dividends of $200,000. ABC Insurance Company did not declare any dividends on common stock but declared and paid current and dividends in arrears on preferred. XYZ recorded the following entries:

Cash $ 80,000
  Dividends Receivable $ 60,000
  Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X6, and receipt of preferred dividends receivable for 20X3, 20X4 and 20X5.

11. XYZ did not record any change in their investment in ABC Surplus Notes. ABC Preferred or ABC Common, since ABCs’ net income after preferred dividends did not exceed the losses accumulated during the period that XYZ suspended recording unrealized losses.

12. The following amounts were tracked:

Total ABC net income and preferred stock dividend ($200,000 - $50,000).
Surplus Note component calculated as:
Total net income and preferred dividend ($200,000 - $50,000) $150,000
XYZ ownership % of ABC Surplus Note 50%
Amount of unrealized loss suspended in 20X5 $75,000
Remaining amount of unrealized loss suspended $280,000
$205,000

13. During the year ended 12/31/20X7, ABC Insurance Company had statutory net income before dividends of $600,000. At 12/31/20X7, ABC declared and paid a 5% preferred dividend. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

Cash $ 20,000
Dividend Income $ 20,000
To record preferred dividend income from ABC Insurance Company for 20X7.

<table>
<thead>
<tr>
<th>Investment in ABC Surplus Notes</th>
<th>$ 70,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrealized Gain/Loss</td>
<td>$ 70,000</td>
</tr>
</tbody>
</table>

To record 20X7 unrealized gain on investment in ABC Surplus Notes.

Total ABC net income and preferred stock dividend ($600,000 - $50,000).

<table>
<thead>
<tr>
<th>Surplus Note component calculated as:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total net income and preferred dividend ($600,000 - $50,000)</td>
<td>$550,000</td>
</tr>
<tr>
<td>XYZ ownership % of ABC Surplus Note</td>
<td>50%</td>
</tr>
<tr>
<td>Remaining amount of unrealized loss suspended in 20X5</td>
<td>$205,000</td>
</tr>
<tr>
<td>20X7 amount of unrealized gain on investment in ABC Surplus Note</td>
<td>$ 70,000</td>
</tr>
</tbody>
</table>

14. During the year ended 12/31/20X8, ABC Insurance Company had statutory net income before dividends of $900,000. At 12/31/20X8, ABC declared and paid a 5% preferred dividend. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Cash</th>
<th>$ 20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dividend Income</td>
<td></td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X8.

Total ABC net income and preferred stock dividend ($900,000 - $50,000).

<table>
<thead>
<tr>
<th>Surplus Note component calculated as:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total net income and preferred dividend ($900,000 - $50,000)</td>
<td>$850,000</td>
</tr>
<tr>
<td>XYZ ownership % of ABC Surplus Note</td>
<td>50%</td>
</tr>
<tr>
<td>20X8 amount of unrealized gain on investment in ABC Surplus Note</td>
<td>$425,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investment in ABC Surplus Notes</th>
<th>$ 425,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrealized Gain/Loss</td>
<td>$ 425,000</td>
</tr>
</tbody>
</table>

To record 20X8 unrealized gain on investment in ABC Surplus Notes.

15. During the year ended 12/31/20X9, ABC Insurance Company had statutory net income, before interest on surplus notes and dividends, of $1,400,000. The Commissioner approved one year's interest payment on the surplus notes. At 12/31/20X9, ABC declared and paid a 5% preferred dividend, and a $.10 dividend per share on Common stock. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Cash</th>
<th>$ 20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dividend Income</td>
<td></td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X9.

<table>
<thead>
<tr>
<th>Cash</th>
<th>$ 40,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest Income</td>
<td></td>
</tr>
</tbody>
</table>

To record surplus notes interest income from ABC Insurance Company for 20X9. ($500,000 * 8%)
Investment in ABC Surplus Notes $ 5,000
Investment in ABC Preferred Stock $ 400,000
Investment in ABC Common Stock $ 130,000
Unrealized Gain/Loss $ 535,000

To record 20X9 unrealized gain on investment in ABC Common, Preferred and Surplus Notes. Components computed as follows:

Total Net Income net of preferred stock dividend and interest on surplus notes $ 1,270,000
($1,400,000 - $50,000 - $80,000)
Less amount needed to restore investment in surplus notes ($ 10,000)
Amount available for preferred stock and common stock investment restoration $ 1,260,000
Amount needed to restore preferred stock component ($1,000,000)
Amount available to restore common stock component $ 260,000

Surplus Notes component ($10,000 * 50%) $ 5,000
Preferred Stock component ($1,000,000 * 40%) $ 400,000
Common stock component ($260,000 * 50%) $ 130,000

Cash $ 10,000
Unrealized Gain/Loss $ 10,000
Dividend Income $ 10,000
Investment in ABC Common stock $ 10,000

To record 20X9 dividend on ABC Common. (100,000 shares * $.10)

On December 7, 2019, the Statutory Accounting Principles (E) Working Group exposed revisions, with modifications suggested by interested parties, as illustrated above, to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets to expand guidance regarding financial guarantees and the use of the equity method for when losses exceed the equity value of an SCA investment. With the revisions, the equity value of an SCA would not go negative, and guaranteed liabilities would be reported to the extent that there is a financial guarantee or commitment. The “Illustration of the Application of INT 00-24” will also be inserted into SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as illustrated below, so that equity losses of an SCA would not go negative (thus stopping at zero), however the guaranteed liabilities would be reported to the extent there is a financial guarantee or commitment.

**Adopted Revisions:**

**SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets - (Industry edits from the previous exposure are shaded.)**

18. The following types of guarantees are exempted from the initial liability recognition in paragraphs 20-25, but are subject to the disclosure requirements in paragraphs 29-32.

   a. Guarantee that is accounted for as a derivative instrument, other than credit derivatives within SSAP No. 86;

   b. Guarantee for which the underlying is related to the performance of nonfinancial assets that are owned by the guaranteed party, including product warranties;
c. Guarantee issued in a business combination that represents contingent consideration;

d. Guarantee in which the guarantor’s obligation would be reported as an equity item;

e. Guarantee by an original lessee that has become secondarily liable under a new lease that relieved the original lessee from being the primary obligator;

f. Guarantees (as defined in paragraph 16) made to/or on behalf of directly or indirectly wholly-owned insurance or non-insurance subsidiaries\(^{11}\); and

g. Intercompany and related party guarantees that are considered “unlimited” (e.g., typically in response to a rating agency’s requirement to provide a commitment to support).

The exemptions for items f and g above do not apply in situations in which a reporting entity has provided a financial guarantee or commitment to support a subsidiary, controlled or affiliated entity (SCA), and the SCA’s equity is negative (see paragraph 24).

24. Except for the measurement and recognition of continued guarantee obligations after the settlement of a contingent guarantee liability described in paragraph 25, and the provisions for SCAs detailed in paragraph 24a, this standard does not describe in detail how the guarantor’s liability for its obligations under the guarantee would be measured subsequent to initial recognition. The liability that the guarantor initially recognized in accordance with paragraph 20 would typically be reduced (as a credit to income) as the guarantor is released from risk under the guarantee. Depending on the nature of the guarantee, the guarantor’s release from risk has typically been recognized over the term of the guarantee (a) only upon either expiration or settlement of the guarantee, (b) by a systematic and rational amortization method, or (c) as the fair value of the guarantee changes (for example, guarantees accounted for as derivatives). The reduction of liability does not encompass the recognition and subsequent adjustment of the contingent liability recognized under paragraph 8 related to the contingent loss for the guarantee. If the guarantor is required to subsequently recognize a contingent liability for the guarantee, the guarantor shall eliminate any remaining noncontingent liability for that guarantee and recognize a contingent liability in accordance with paragraph 8.

25. In situations in which a reporting entity has provided a financial guarantee or commitment to support a subsidiary, controlled or affiliated entity (SCA), and the reporting entity’s share of losses in the SCA exceed the equity method carrying amount of the SCA (resulting in a negative equity value in the SCA), the reporting entity shall recognize the greater impact of (i) the then-current fair value liability for of the guarantee or (ii) the negative equity position, limited to the maximum amount of the financial guarantee or commitment provided by the reporting entity. (This guidance requires the recognition of a guarantee liability for guarantees captured in paragraphs 18f and 18g, when negative equity exists in an SCA. The guidance in paragraphs 20 through 26 shall be followed for the recognition of: a contingent liability and a noncontingent liability, as applicable.

SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities

4314. On at least a quarterly basis, the procedures set forth below shall be followed by a reporting entity in applying an equity method of accounting (as described in paragraphs 8.b.i. through 8.b.iv.), as applicable, to investments in SCA entities:

e. For entities subject to 8.b.i., 8.b.ii., 8.b.iii. and 8.b.iv. a reporting entity’s share of losses of an investee may equal or exceed the carrying amount of an investment accounted for by an equity method plus advances made by the investor. The reporting entity shall discontinue applying an

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\(^{11}\) The exclusion for wholly owned subsidiaries includes guarantees from a parent to, or on behalf of, a direct wholly owned insurance or non-insurance subsidiary as well as guarantees made from a parent to, or on behalf of, an indirect wholly owned insurance or non-insurance subsidiary. The “wholly-owned” exclusion in paragraph 18.f. does not include guarantees issued from one subsidiary to another subsidiary, regardless if both subsidiaries are wholly owned (directly or indirectly) by a parent company.
equity method when the investment (including advances) is reduced to zero and shall not provide for additional losses, while still continuing to track the amount of unreported equity method losses, until any future equity method income can be reported. If the reporting entity has guaranteed obligations of the investee or is otherwise committed to provide further financial support for the investee, the provisions of such as (guaranteed obligations meeting the definition of liabilities in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets) shall be followed (SSAP No. 5R), they shall be recorded as liabilities. If as the entire equity method loss (subject to the financial guarantee / commitment) shall be recognized under SSAP No. 5R, it does not also need to be recognized under SSAP No. 97. If the investee subsequently reports net income, the reporting entity shall resume applying an equity method only after its share of that net income equals the share of net losses not recognized during the period that an equity method was suspended;

Footnote 2: Although the SCA is reported at zero in the investment schedule, a guarantee liability (either contingent or noncontingent) may be required to be reported under SSAP No. 5R. Additionally, refer to the additional guidance related to discontinuance of an equity method in paragraphs 15-17 and INT 00-24: EITF 98-13: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses. As detailed in INT 00-24, a reporting entity’s share of losses in an SCA shall be applied to other investments held in the SCA once the SCA (common stock) investment has been reduced to zero.

35. All SCA investments within the scope of this statement (except paragraph 8.b.i. entities) shall include disclosure of the SCA balance sheet value (admitted and nonadmitted) as well as information received from the NAIC in response to the SCA filing (e.g., date and type of filing, NAIC valuation amount, whether resubmission of filing is required). This disclosure shall include an aggregate total of all SCAs (except paragraph 8.b.i. entities) with detail of the aggregate gross value under this statement with the admitted and nonadmitted amounts reflected on the balance sheet. (As noted in paragraph 4, joint ventures, partnerships and limited liability companies are accounted for under the guidance in SSAP No. 48. As such, those entities are not subject to the disclosures in this statement, unless specifically directed by SSAP No. 48.)

a. For all periods presented, a reporting entity whose shares of losses in an SCA exceeds its investment in the SCA shall disclose its share of losses. (This is required regardless of a guarantee or commitment of future financial support to the SCA.) This disclosure shall include the following:

i. The reporting entity’s accumulated share of the SCA losses not recognized during the period that the equity method was suspended;

ii. The reporting entity’s share of the SCA’s equity, including negative equity;

iii. Whether a guaranteed obligation or commitment for financial support exists; and

iv. The SCA’s reported value. The amount of the recognized guarantee under SSAP No. 5R.

EXHIBIT F – ILLUSTRATION OF THE APPLICATION OF INT 00-24

XYZ Investment in ABC Company

1. ABC Company is a life insurance company, formed January 2, 20X1 to sell health insurance in the state of New York. On January 2, 20X1, XYZ Insurance Company invested $500,000 in ABC, and purchased 100,000 shares of common stock at par, and 40,000 shares of preferred stock at par. ABC Preferred stock is non-voting, 5% cumulative.

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2. XYZ determined it has obtained a controlling interest in ABC as XYZ owns 50% of the voting interests of ABC. XYZ accounted for its investment in ABC Insurance Company under the statutory equity method of accounting. The following table is selected information from the financial statements of ABC Insurance Company.

### 20X1 – 20X4

<table>
<thead>
<tr>
<th></th>
<th>1/2/20X1</th>
<th>12/31/20X1</th>
<th>12/31/20X2</th>
<th>12/31/20X3</th>
<th>12/31/20X4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital and Surplus:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common stock, $1 par, 200,000 shares issued and outstanding</td>
<td>$ 200,000</td>
<td>$ 200,000</td>
<td>$ 200,000</td>
<td>$ 200,000</td>
<td>$ 200,000</td>
</tr>
<tr>
<td>Preferred stock, $10 par, 100,000 shares issued and outstanding</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td><strong>Surplus Notes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$ 500,000</td>
<td>$ 500,000</td>
<td>$ 500,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unassigned Funds</strong> (Surplus)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$ 130,000</td>
<td>($180,000)</td>
<td>($630,000)</td>
<td>($1,430,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Capital and Surplus</strong></td>
<td>$1,200,000</td>
<td>$1,330,000</td>
<td>$1,520,000</td>
<td>$1,070,000</td>
<td>$270,000</td>
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### 20X5 – 20X9

<table>
<thead>
<tr>
<th></th>
<th>12/31/20X5</th>
<th>12/31/20X6</th>
<th>12/31/20X7</th>
<th>12/31/20X8</th>
<th>12/31/20X9</th>
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</thead>
<tbody>
<tr>
<td><strong>Capital and Surplus:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common stock, $1 par, 200,000 shares issued and outstanding</td>
<td>$ 200,000</td>
<td>$ 200,000</td>
<td>$ 200,000</td>
<td>$ 200,000</td>
<td>$ 200,000</td>
</tr>
<tr>
<td>Preferred stock, $10 par, 100,000 shares issued and outstanding</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td><strong>Surplus Notes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$ 500,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td><strong>Unassigned Funds</strong> (Surplus)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>($1,980,000)</td>
<td>($1,830,000)</td>
<td>($1,280,000)</td>
<td>($430,000)</td>
<td>$820,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total Capital and Surplus</strong></td>
<td>($280,000)</td>
<td>$ 370,000</td>
<td>$ 920,000</td>
<td>$1,770,000</td>
<td>$3,020,000</td>
</tr>
</tbody>
</table>

3. At 1/2/20X1, XYZ recorded the following entry to record its investment in ABC:

Investment in ABC Common stock | $ 100,000 |
Investment in ABC Preferred stock | $ 400,000 |
Cash | $ 500,000 |

To record initial investment in ABC Insurance Company.

4. During the year ended 12/31/20X1, ABC had statutory net income before dividends of $200,000. At 12/31/20X1, ABC declared and paid a 5% preferred dividend, and a common stock dividend of $.10 per share. XYZ recorded the following entries:

Cash | $ 20,000 |
Dividend Income | $ 20,000 |

To record preferred dividend income from ABC Insurance Company for 20X1.

Investment in ABC Common stock | $ 75,000 |
Unrealized Gain/Loss | $ 75,000 |

To record 20X1 unrealized gain on investment in ABC Common. (($200,000 - $50,000) * 50%)
To record 20X1 dividend on ABC Common. (100,000 shares * $.10)

5. During the year ended 12/31/20X2, ABC issued an 8% surplus note of $500,000. XYZ purchased 100% of the surplus note. During that same year, ABC incurred a statutory net loss before dividends of $250,000. At 12/31/20X2, ABC declared and paid a 5% preferred dividend, and a common stock dividend of $.05 per share. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

Investment in ABC Surplus Notes $ 500,000
Cash $ 500,000

To record investment in ABC Insurance Company surplus notes.

Cash $ 20,000
Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X2.

Unrealized Gain/Loss $ 150,000
Investment in ABC Common stock $ 150,000

To record 20X2 unrealized loss on investment in ABC Common. ((-$250,000 - $50,000) * 50%)

Cash $ 5,000
Unrealized Gain/Loss $ 5,000
Dividend Income $ 5,000
Investment in ABC Common stock $ 5,000

To record 20X2 dividend on ABC Common. (100,000 shares * $.05)

6. During the year ended 12/31/20X3, ABC Insurance Company incurred a statutory net loss before dividends of $400,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

Dividends Receivable $ 20,000
Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X3.

Unrealized Gain/Loss $ 182,000
Investment in ABC Preferred stock $ 172,000
Investment in ABC Common stock $ 10,000

To record 20X3 unrealized loss on investment in ABC Common and Preferred.

Total net loss and preferred stock dividend ($450,000).
Common stock component reduces the Investment in ABC Common stock component to $0. (20,000 * 50%)
Total net loss and preferred dividend (-$400,000 - $50,000) $450,000
Less amount used to reduce common stock investment to $0 $20,000
Amount remaining to be allocated to investment in preferred $430,000
7. During the year ended 12/31/20X4, ABC Insurance Company incurred a statutory net loss before dividends of $750,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

**Dividends Receivable**
- $20,000

**Dividend Income**
- $20,000

To record preferred dividend income from ABC Insurance Company for 20X4.

**Unrealized Gain/Loss**
- $458,000

- **Investment in ABC Preferred stock**
  - $228,000

- **Investment in ABC Surplus note**
  - $230,000

To record 20X4 unrealized loss on investment in ABC Preferred and Surplus Notes.

**Total net loss and preferred stock dividend ($800,000),**
Common stock component reduces the Investment in ABC Preferred stock component to $0. (570,000 * 40%)

**Preferred stock component calculated as:**
- **Total net loss and preferred dividend (-$750,000 - $50,000)**
  - $800,000
- **Less amount used to reduce preferred stock investment to $0**
  - $570,000
- **Amount remaining to be allocated to investment in surplus note**
  - $230,000
- **XYZ ownership % of surplus note**
  - 100%
- **XYZ reduction in investment in ABC Surplus Notes**
  - $230,000

8. During the year ended 12/31/20X5, ABC Insurance Company incurred a statutory net loss before dividends of $500,000. ABC Insurance Company did not declare any dividends, and no interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

**Dividends Receivable**
- $20,000

**Dividend Income**
- $20,000

To record preferred dividend income from ABC Insurance Company for 20X5.

**Unrealized Gain/Loss**
- $270,000

**Investment in ABC Surplus note**
- $270,000

To record 20X5 unrealized loss on investment in ABC Surplus Notes.

**Total ABC net loss and preferred stock dividend (-$500,000 - $50,000),**
**Surplus Note component calculated as:**
- **Total net loss and preferred dividend (-$500,000 - $50,000)**
  - $550,000
- **XYZ ownership % of ABC Surplus Note**
  - 100%
  - $550,000
- **Amount of unrealized loss recognized in 20X5**
  - $270,000
- **Amount of unrealized loss suspended**
  - $280,000

9. Since XYZ has not guaranteed any liabilities of ABC, the reduction they would recognize is limited to their remaining investment in ABC Surplus Notes. Therefore, they would only recognize a 20X5 unrealized loss on their investment in ABC of $270,000.
10. During the year ended 12/31/20X6, ABC Insurance Company realigned their marketing efforts and modified the products they were selling. ABC also issued an additional 8% surplus note of $500,000. This surplus note was purchased by an unaffiliated third party. During the year ended 12/31/X6, ABC Insurance Company had statutory net income before dividends of $200,000. ABC Insurance Company did not declare any dividends on common stock but declared and paid current and dividends in arrears on preferred. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Cash</th>
<th>Dividends Receivable</th>
<th>Dividend Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 80,000</td>
<td>$ 60,000</td>
<td>$ 20,000</td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X6, and receipt of preferred dividends receivable for 20X3, 20X4 and 20X5.

11. XYZ did not record any change in their investment in ABC Surplus Notes, ABC Preferred or ABC Common, since ABCs’ net income after preferred dividends did not exceed the losses accumulated during the period that XYZ suspended recording unrealized losses.

13. The following amounts were tracked:

- Total ABC net income and preferred stock dividend ($200,000 - $50,000).
- Surplus Note component calculated as:
  - Total net income and preferred dividend ($200,000 - $50,000) $150,000
  - XYZ ownership % of ABC Surplus Note 50%
  - Amount of unrealized loss suspended in 20X5 $75,000
  - Remaining amount of unrealized loss suspended $280,000
  - $205,000

13. During the year ended 12/31/20X7, ABC Insurance Company had statutory net income before dividends of $600,000. At 12/31/20X7, ABC declared and paid a 5% preferred dividend. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:

<table>
<thead>
<tr>
<th>Cash</th>
<th>Dividend Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 20,000</td>
<td>$ 20,000</td>
</tr>
</tbody>
</table>

To record preferred dividend income from ABC Insurance Company for 20X7.

- Investment in ABC Surplus Notes $70,000
- Unrealized Gain/Loss $70,000

To record 20X7 unrealized gain on investment in ABC Surplus Notes.

- Total ABC net income and preferred stock dividend ($600,000 - $50,000).
- Surplus Note component calculated as:
  - Total net income and preferred dividend ($600,000 - $50,000) $550,000
  - XYZ ownership % of ABC Surplus Note 50% $275,000
  - Remaining amount of unrealized loss suspended in 20X5 $205,000
  - 20X7 amount of unrealized gain on investment in ABC Surplus Note $70,000

14. During the year ended 12/31/20X8, ABC Insurance Company had statutory net income before dividends of $900,000. At 12/31/20X8, ABC declared and paid a 5% preferred dividend. No interest or principal repayments of the surplus note were approved. XYZ recorded the following entries:
Cash $ 20,000

Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X8.

Total ABC net income and preferred stock dividend ($900,000 - $50,000).

Surplus Note component calculated as:

Total net income and preferred dividend ($900,000 - $50,000) $850,000
XYZ ownership % of ABC Surplus Note 50%

20X8 amount of unrealized gain on investment in ABC Surplus Note $425,000

Investment in ABC Surplus Notes $ 425,000

Unrealized Gain/Loss $ 425,000

To record 20X8 unrealized gain on investment in ABC Surplus Notes.

15. During the year ended 12/31/20X9, ABC Insurance Company had statutory net income, before interest on surplus notes and dividends, of $1,400,000. The Commissioner approved one year’s interest payment on the surplus notes. At 12/31/20X9, ABC declared and paid a 5% preferred dividend, and a $.10 dividend per share on Common stock. XYZ recorded the following entries:

Cash $ 20,000

Dividend Income $ 20,000

To record preferred dividend income from ABC Insurance Company for 20X9.

Cash $ 40,000

Interest Income $ 40,000

To record surplus notes interest income from ABC Insurance Company for 20X9. ($500,000 * 8%)

Investment in ABC Surplus Notes $ 5,000
Investment in ABC Preferred Stock $ 400,000
Investment in ABC Common Stock $ 130,000

Unrealized Gain/Loss $ 535,000

To record 20X9 unrealized gain on investment in ABC Common, Preferred and Surplus Notes.

Components computed as follows:

Total Net Income net of preferred stock dividend and interest on surplus notes $ 1,270,000
($1,400,000 - $50,000 - $80,000)

Less amount needed to restore investment in surplus notes ($ 10,000)

Amount available for preferred stock and common stock investment restoration $ 1,260,000

Amount needed to restore preferred stock component ($1,000,000)

Amount available to restore common stock component $ 260,000

Surplus Notes component ($10,000 * 50%) $ 5,000
Preferred Stock component ($1,000,000 * 40%) $ 400,000

Common stock component ($260,000 * 50%) $ 130,000

Cash $ 10,000
Unrealized Gain/Loss $ 10,000

Dividend Income $ 10,000
Investment in ABC Common stock $ 10,000

To record 20X9 dividend on ABC Common. (100,000 shares * $.10)
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Prepayments to Service and Claims Adjusting Providers

Check (applicable entity):

<table>
<thead>
<tr>
<th>Modification of existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Issue or SSAP Interpretation</td>
<td></td>
<td></td>
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</tbody>
</table>

Description of Issue:

This agenda item seeks to address a regulator inquiry regarding prepayments to providers of claims and adjusting services in which the service provider is prepaid by the insurer. While the initial inquiry for this agenda item was a prepaid roadside assistance provider, the accounting issues are relevant to other providers of claims and adjusting services as well.

The prepayments can take a variety of forms and the provider can take on a variety of duties, but in the example provided, the roadside assistance provider was being prepaid a flat fee for a minimum number of vehicles/policies regardless of claims incurred or sales. The provider additionally received a flat fee per vehicle if actual sales exceed the negotiated minimum number of vehicles. The provider, who is not an insurer, was contracted to provide roadside assistance and administer and settle claims using only the prepaid amounts. So, to use a health care analogy, the provider accepts a “capitated” payment to administer and settle claims.

Roadside assistance is a common feature or rider to many automobile insurance policies that has been available for several years. Roadside assistance provides towing and other services such as jumpstarting car batteries, unlocking doors and gas refills for the insured. Discussions with industry representatives indicate that in most cases, roadside assistance providers may have rates that are negotiated, but providers are not typically prepaid. Rather, when the insured calls for assistance negotiated rate providers are dispatched and subsequently paid at negotiated rates as the claims for assistance are incurred. This agenda item is focused on prepayments to providers.

To provide a fictional numeric example, the minimum annual payment to the provider was for 50,000 vehicles at $10 per vehicle, with additional payments per vehicle required if sales exceed the initial fees. The provider in this example, was also responsible for administering claims and dispatching service in exchange for the “capitated” fee. Therefore, the roadside assistance provider would not bill the insurer further when claims are incurred.

The guidance in SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, paragraphs 4 and 5 (excerpted in the Authoritative Literature section) are relevant to the timing of claims recognition and payment of loss adjustment expenses. The guidance provides that claims are recognized when incurred. The existing guidance indicates that paying a third party in advance to adjust claims in the future does not decrease the claims adjustment liability. The claim adjustment liability is only reduced when the claim has been adjusted, not when it is prepaid. In accordance with SSAP No. 64—Offsetting and Netting of Assets and Liabilities, prepayments to a third party do not meet the right of offset requirements.

The statutory accounting and reporting questions at issue are how the direct writer accounts for and reports the prepaid claims and adjusting expenses initially and subsequently. The existing guidance notes that claim adjusting expenses are not reduced for payments to third parties. The guidance in SSAP No. 55 indicates liabilities shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the
exception that the liability is established net of capitated payments to managed care providers. The prepaid expenses under consideration may include a prepayment for claims administration and or a prepayment for the claims.

In reviewing the annual statement instructions for the Underwriting and Expense Exhibit, Part 3, and the related instructions for property and casualty expenses, the initial prepayment to the provider seems be consistent with miscellaneous underwriting expense.

For policies that purchase the coverage and incurred a claim, it seems appropriate to reclassify a proportionate percentage of the initial prepayment to claims incurred and loss adjustment expenses as losses are incurred and adjusted. However, it would be inappropriate to allocate claims expense and claims adjusting expenses to policies that did not purchase the coverage and inappropriate to allocate the costs of the provider to claims or claims adjusting expenses prior to incurring the claims. Therefore, in the event of prepayment to a third-party provider, some of the costs may remain in miscellaneous adjusting expense.

Existing Authoritative Literature:

- SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, paragraphs 4 and 5 includes the following:

SUMMARY CONCLUSION

4. Claims, losses, and loss/claim adjustment expenses shall be recognized as expenses when a covered or insured event occurs. In most instances, the covered or insured event is the occurrence of an incident which gives rise to a claim or the incurring of costs. For claims-made type policies, the covered or insured event is the reporting to the entity of the incident that gives rise to a claim. Claim payments and related expense payments are made subsequent to the occurrence of a covered or insured event, and in order to recognize the expense of a covered or insured event that has occurred, it is necessary to establish a liability. Liabilities shall be established for any unpaid claims and unpaid losses (loss reserves), unpaid loss/claim adjustment expenses (loss/claim adjustment expense reserves) and incurred costs, with a corresponding charge to income. Claims related extra contractual obligations losses and bad-faith losses shall be included in losses. See individual business types for the accounting treatment for adjustment expenses related to extra contractual obligations and bad-faith lawsuits.

5. The liability for unpaid LAE shall be established regardless of any payments made to third-party administrators, management companies or other entities except for capitated payments under managed care contracts. The liability for claims adjustment expenses on non-capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments made to third-party administrators, etc. The liability for claims adjustment expenses on capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the exception that the liability is established net of capitated payments to providers.

General

10. The liability for claim reserves and claim liabilities, unpaid losses, and loss/claim adjustment expenses shall be based upon the estimated ultimate cost of settling the claims (including the effects of inflation and other societal and economic factors), using past experience adjusted for current trends, and any other factors that would modify past experience. These liabilities shall not be discounted unless authorized for specific types of claims by specific SSAPs, including SSAP No. 54R and SSAP No. 65—Property and Casualty Contracts.
The guidance in SSAP No. 55, paragraph 5 was incorporated from INT 02-21: Accounting for Prepaid Loss Adjustment Expenses and Claim Adjustment Expenses, which was nullified when the guidance was moved to SSAP No. 55.

- **SSAP No. 64—Offsetting and Netting of Assets and Liabilities** provides the following:
  
  2. Assets and liabilities shall be offset and reported net only when a valid right of setoff exists except as provided for in paragraphs 3 and 4. A right of setoff is a reporting entity's legal right, by contract or otherwise, to discharge all or a portion of the debt owed to another party by applying an amount that the other party owes to the reporting entity against the debt[INT 09-08]. A valid right of setoff exists only when all the following conditions are met:
    
    a. Each of the two parties owes the other determinable amounts. An amount shall be considered determinable for purposes of this provision when it is reliably estimable by both parties to the agreement;
    
    b. The reporting party has the right to set off the amount owed with the amount owed by the other party;
    
    c. The reporting party intends to setoff; and
    
    d. The right of setoff is enforceable at law.

- **Property and Casualty Annual Statement Instructions Underwriting and Investment Exhibit Part 3 – Expenses** provides the following:

  A company that pays any affiliated entity (including a managing general agent) for the management, administration, or service of all or part of its business or operations shall allocate these costs to the appropriate expense classification items (salaries, rent, postage, etc.) as if these costs had been borne directly by the company. Management, administration, or similar fees should not be reported as a one-line expense. The company may estimate these expense allocations based on a formula or other reasonable basis.

  A company that pays any non-affiliated entity (including a managing general agent) for the management, administration, or service of all or part of its business or operations shall allocate these costs to the appropriate expense classification item as follows:

  a. Payments for claims handling or adjustment services are allocated to Loss Adjustment Expenses (Column 1) in the Underwriting and Investment Exhibit, Part 3. If the total of such expenses incurred equals or exceeds 10% of the total incurred Loss Adjustment Expenses (Line 25, Column 1), the company shall allocate these costs to the appropriate expense classification items as if these costs had been borne directly by the company. If such expenses are less than 10% of the total, they may be reported on Line 1 of Column 1.

  b. Payments for services other than claims handling or adjustment services are allocated to the appropriate expense classification items as if these costs had been borne directly by the company, if the total of such fees paid equals or exceeds 10% of the total incurred Other Underwriting Expenses (Line 25, Column 2). If the total is less than 10%, the payments may be reported on Line 2 if the fees are calculated as a percentage of premiums, or on Line 3 if the fees are not calculated as a percentage of premiums.

  The total management and service fees incurred attributable to affiliates and non-affiliates is reported in the footnote to the Underwriting and Investment Exhibit, Part 3 of the annual statement, and the
method(s) used for allocation shall be disclosed in the Notes to the Financial Statements. The company shall use the same allocation method(s) on a consistent basis. Refer to SSAP No. 70—Allocation of Expenses for accounting guidance.

Exclude from investment expenses brokerage and other related fees, to the extent they are included in the actual cost of a bond upon acquisition. Refer to SSAP No. 26R—Bonds for accounting guidance.

Include all other internal costs or costs paid to an affiliated company related to origination, purchase or commitment to purchase bonds.

For the purpose of establishing uniformity in classifications of expenses in reporting entities’ statements and reports filed with the Insurance Departments, the company shall observe the instructions contained in the Appendix of these instructions for the Uniform Classification of Expenses.

Activity to Details of Write-ins Aggregated at Line 24 for Miscellaneous Expenses

List separately each category of miscellaneous expenses for which there is no pre-printed line on Underwriting and Investment Exhibit, Part 3.

- **Property and Casualty Annual Statement Instructions Underwriting Appendix Instructions for Uniform Classifications of Expenses of Property and Casualty Insurers** provides the following:

  1.1 **Direct**

  Include: The Following Expenses When in Connection with the Investigation and Adjustment of Policy Claims:

  **Independent Adjusters**: Fees and expenses of independent adjusters or settling agents

  **Legal**: Fees and expenses of lawyers for legal services in the defense, trial, or appeal of suits, or for other legal services

  **Bonds**: Premium costs of bonds

  **Appeal Costs and Expenses**: Appeal bond premiums, charges for printing records, charges for printing briefs, court fees and incidental to appeals

  **General Court Costs and Fees**: Entry fees and other court costs, and other fees not includible in Losses (Note: Interest and costs assessed as part of or subsequent to judgment are includible in Losses.)

  **Medical Testimony**: Fees and expenses of medical witnesses of attendance or testimony at trials or hearings ("Medical" includes physicians, surgeons, chiropractors, chiropodists, dentists, osteopaths, veterinarians, and hospital representatives.)

  **Expert Witnesses**: Fees and expenses of expert witnesses for attendance or testimony at trials or hearings

  **Lay Witnesses**: Fees and expenses of lay witnesses for attendance or testimony at trials or hearings

  **Services of Process**: Constables, sheriffs, and other fees and expenses for service of process, including subpoenas

  **Transcripts of Testimony**: Stenographers’ fees and fees for transcripts of testimony
**Medical Examinations:** Fees for medical examinations, fees for performing autopsies, fees for impartial examination, x-rays, etc., for the purpose of trial and determining questions of liability (This does not include fees for medical examinations, x-rays, etc., made to determine necessary treatment, or made solely to determine the extent or continuation of disability, or first aid charges, as such fees and charges are includible in Losses.)

**Miscellaneous:** Costs of appraisals, expert examinations, surveys, plans, estimates, photographs, maps, weather reports, detective reports, audits, credit or character reports, watchmen (Charges for hospital records and records of other kinds, notary fees, certified copies of certificates and legal documents, charges for Claim Adjustment Services by underwriting syndicates, pools, and associations)

Exclude: Compensation to employees (see Salaries)

Expenses of salaried employees (see Travel and Travel Items)

Items includible in Allowances to Managers and Agents

Payments to State Industrial Commissions (see Taxes, Licenses, and Fees)

Payments to claim adjusting organizations except where the expense is billed specifically to individual companies (see Boards, Bureaus, and Associations)

Cost of services of medical examiners for underwriting purposes (see Surveys and Underwriting Reports)

Salvage and subrogation recovery expense, rewards, lost and found advertising, expenses for disposal of salvage (Such expenses shall be deducted from salvage.)

Any expenses which by these instructions are includible elsewhere

Separation of Claim Adjustment Services:

The Statistical Plans filed by certain rating bureaus contain definitions of “Allocated Loss Adjustment Expenses” which exclude for rating purposes certain types of claim adjustment services as defined herein. For the lines of business thus affected, companies that are members of such rating bureaus shall maintain records necessary to the reporting of Claim Adjustment Services—Direct, as follows:

a. As defined in Statistical Plans

b. Other than as defined in Statistical Plans

**Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** June 2017 updates to the AICPA Revenue Recognition Guide noted in Issue #9- 1: Considerations for applying the scope exception in FASB ASC 606-10-15-2 and 606-10-15-4 to Contracts within the Scope of ASC 944 contains some discussion on roadside assistance that is tangential but does not address the prepayments under discussion. The updates were issued in response to questions regarding Accounting Standards Update (ASU) 2016-20: Technical Corrections and Improvements to Topic 606, Revenue from Contracts from Customers.

At issue was whether to bifurcate insurance contracts within the scope of Topic 944, Financial Services—Insurance that contain noninsurance elements and account for them within the scope of Topic 606, Revenue from Contracts from Customers. Roadside assistance provided with an automobile insurance policy was listed as an
example of activities performed by an insurance entity, included in contracts within the scope of FASB Topic 944, that Financial Reporting Executive Committee (FinREC) believes generally should be considered fulfillment activities (that either mitigate risks to the insurer or contain costs related to services to fulfill the insurer’s obligation) that are not within the scope of FASB Topic 606, but should be considered part of the insurance contract within the scope of FASB Topic 944. Roadside assistance was noted as mitigating the risk of a further accident or damage to the insured automobile.

**Convergence with International Financial Reporting Standards (IFRS):** During the development of *IFRS 17, Insurance Contracts*, the International Accounting Standards Board (IASB) had discussions regarding classification for the revenue which are not on point to roadside assistance prepayments. Similar to the AICPA issue noted above, the issue was whether roadside assistance sold as part of an insurance policy should be included within the scope of insurance contracts or whether it should be accounted for separately as fee for service. The IFRS 17 issued in May 2017 notes that some fixed-fee service contracts meet the definition of an insurance contract (for example, automobile roadside assistance) and IFRS 17 provides an option to use *IFRS 15, Revenue from Contracts with Customers* to account for as fee for service.

**Staff Review Completed by:**
Robin Marcotte, NAIC Staff - September 2018

**Staff Recommendation:**

NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 55 to provide guidance as follows:

1. The initial prepayment for providers of claims adjusting expense and claim payment is recognized as a miscellaneous underwriting expense.

2. Subsequently, for direct policies that purchased the related insurance coverage which used the claims or adjusting services incur losses which are paid, a proportionate percentage of the initial provider prepayment amounts are reclassified from miscellaneous underwriting expense to claims adjustment expense and or claims expense, as applicable.

3. To the extent that additional amounts are prepaid for direct policies that did not purchase services, the prepaid expenses shall remain in miscellaneous underwriting expenses.

Note that NAIC staff envisions that additional annual statement instruction clarifications may be indicated after the Working Group finalizes guidance.

Proposed revisions to SSAP No. 55 recommended for November 2018 exposure:

4. Claims, losses, and loss/claim adjustment expenses shall be recognized as expenses when a covered or insured event occurs. In most instances, the covered or insured event is the occurrence of an incident which gives rise to a claim or the incurring of costs. For claims-made type policies, the covered or insured event is the reporting to the entity of the incident that gives rise to a claim. Claim payments and related expense payments are made subsequent to the occurrence of a covered or insured event, and in order to recognize the expense of a covered or insured event that has occurred, it is necessary to establish a liability. Liabilities shall be established for any unpaid claims and unpaid losses (loss reserves), unpaid loss/claim adjustment expenses (loss/claim adjustment expense reserves) and incurred costs, with a corresponding charge to income.
a. Prepays to third party administrators, management companies or other entities for unpaid losses/claims, except for capitated payments for manage care contracts, shall not reduce losses/claims and shall be initially reported as miscellaneous underwriting expenses. When incurred losses/claims are paid, claims prepays to third party administrators, management companies or other entities (except for capitated payments for manage care contracts) are reclassified proportionately based on the losses/claims cost from miscellaneous underwriting expenses to loss/claim expenses paid. Flat fee minimum prepays to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as miscellaneous underwriting expenses and not reclassified to loss/claim adjusting expenses.

b. Claims related extra contractual obligations losses and bad-faith losses shall be included in losses. See individual business types for the accounting treatment for adjustment expenses related to extra contractual obligations and bad-faith lawsuits.

5. The liability for unpaid LAE shall be established regardless of any payments made to third-party administrators, management companies or other entities except for capitated payments under managed care contracts. The liability for claims adjustment expenses on non-capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments made to third-party administrators, etc. The liability for claims adjustment expenses on capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the exception that the liability is established net of capitated payments to providers.

a. Prepays to third party administrators, management companies or other entities, except for capitated payments for manage care contracts, for unpaid losses/ claims adjusting expenses shall be initially reported as miscellaneous underwriting expenses.

b. When incurred losses/claims adjusting expenses are paid, prepays to third party administrators, management companies or other entities (except for capitated payments for manage care contracts) are reclassified proportionately based on the adjusting expenses from miscellaneous underwriting expenses to paid loss /claim adjusting expenses. Flat fee minimum prepays to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as miscellaneous underwriting expenses and not reclassified to loss/claim adjusting expenses.

Status:
On November 15, 2018, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, as shown above, to provide guidance clarifying that prepays to providers of claims and adjusting services shall be recognized as miscellaneous underwriting expenses, with guidance for reclassification as claims adjustment expense or claims expense, as applicable, as claims are paid. During the November 2018 Working Group discussion, it was highlighted that the proposed treatment is different than recognizing a nonadmitted prepaid asset, as the amounts are not expected to be material. Comments were requested on this difference and if the amounts are expected to be material.

Spring 2019 National Meeting discussion:

NAIC staff recommends re-exposure of modified proposed language which was developed with interested parties input as illustrated below and in the agenda item. The interested parties responded to the request for comments and noted a preference to “nonadmit a prepaid asset” for prepaid loss and LAE, which is consistent
with existing guidance, instead of the to the previously exposed “expense and reclassify as amounts are paid” approach. NAIC staff has proposed a modification to the interested parties’ proposed language to exclude the reference to SSAP No. 84—Health Care and Government Insured Plan Receivables which is not currently referenced in SSAP No. 55. In addition, NAIC staff has recommended guidance regarding flat fee bundled payments which indicates nonadmission of prepaid amounts and allocation to expense categories as benefits or services are rendered.

On April 6, 2019, the Statutory Accounting Principles (E) Working Group exposed modified language, developed with interested parties’ input as described above, which requires nonadmittance for prepaid loss and LAE. This guidance is consistent with existing statutory accounting principles and was revised from the previously exposed “expense and reclassify as amounts are paid” approach. In addition, guidance was exposed regarding flat fee bundled payments which indicates nonadmission of prepaid amounts and allocation to expense categories as benefits or services are rendered. The exposed language is illustrated below.

2019 Spring National Meeting exposure:

SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses:

4. Claims, losses, and loss/claim adjustment expenses shall be recognized as expenses when a covered or insured event occurs. In most instances, the covered or insured event is the occurrence of an incident which gives rise to a claim or the incurring of costs. For claims-made type policies, the covered or insured event is the reporting to the entity of the incident that gives rise to a claim. Claim payments and related expense payments are made subsequent to the occurrence of a covered or insured event, and in order to recognize the expense of a covered or insured event that has occurred, it is necessary to establish a liability. Liabilities shall be established for any unpaid claims and unpaid losses (loss reserves), unpaid loss/claim adjustment expenses (loss/claim adjustment expense reserves) and incurred costs, with a corresponding charge to income.

   a. All prepayments (i.e., variable, fixed or bundled amounts) to third party administrators, management companies or other entities for unpaid claims, losses and losses/claims adjustment expenses, except for capitated payments for managed care contracts, shall not reduce losses/claims and shall be initially reported as a prepaid asset and nonadmitted in accordance with SSAP No. 29—Prepaid Expenses. When the benefit has been provided to the policyholder or claimant, the claims prepayments to third party administrators, management companies or other entities (except for capitated payments for managed care contracts), are reclassified proportionately from the prepaid nonadmitted asset to claims, losses or loss/claim expenses paid based on the amount of losses/claims cost incurred to provide the benefit.

   b. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as miscellaneous underwriting expenses.

   c. Claims related extra contractual obligations losses and bad-faith losses shall be included in losses. See individual business types for the accounting treatment for adjustment expenses related

5. The liability for unpaid LAE shall be established regardless of any payments made to third-party administrators, management companies or other entities except for capitated payments under managed care contracts. The liability for claims adjustment expenses on non-capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments made to third-party administrators, etc. The liability for claims adjustment expenses on
capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the exception that the liability is established net of capitated payments to providers.

a. When the prepaid benefit as described in paragraph 4 has been provided to the policyholder or the claimant, the associated prepayments to third party administrators, management companies or other entities (except for capitated payments for managed care contracts) are reclassified proportionately from the prepaid nonadmitted asset to paid loss/claim adjusting expenses based on the amount of losses/claims cost incurred to provide the benefit. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as miscellaneous underwriting expenses.

On August 3, 2019, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 55, as illustrated below, that emphasize existing guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments). The liabilities are not recognized as paid until the losses are paid to claimants or claims are adjusted. Prepayments to third party administrators, which are not for claims or loss adjusting expense, are “miscellaneous underwriting expenses.” The revisions also add a reference to SSAP No. 84—Health Care and Government Insured Plan Receivables regarding prepayments to providers.

2019 Summer National Meeting exposure:

SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses:

4. Claims, losses, and loss/claim adjustment expenses shall be recognized as expenses when a covered or insured event occurs. In most instances, the covered or insured event is the occurrence of an incident which gives rise to a claim or the incurring of costs. For claims-made type policies, the covered or insured event is the reporting to the entity of the incident that gives rise to a claim. Claim payments and related expense payments are made subsequent to the occurrence of a covered or insured event, and in order to recognize the expense of a covered or insured event that has occurred, it is necessary to establish a liability. Liabilities shall be established for any unpaid claims and unpaid losses (loss reserves), unpaid loss/claim adjustment expenses (loss/claim adjustment expense reserves) and incurred costs, with a corresponding charge to income.

a. The liability for unpaid losses and claims shall be established regardless of any payments made to third-party administrators, management companies or other entities except for capitated payments under managed care contracts. The liability for claims on non-capitated payments under managed care contracts shall be established in an amount necessary to pay the losses/claims irrespective of payments made to third-party administrators, etc. The liability for claims on capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the exception that the liability is established net of capitated payments to providers. As loss or claims payments occur, from the third-party administrators, management companies or other entities, to the policyholder or claimant (except for capitated payments for managed care contracts) paid claims, losses or paid loss/paid claim adjusting liabilities are reduced. Note that guidance regarding the admissibility of loans and advances to providers which apply to health insurance and managed care contracts are addressed in SSAP No. 84—Health Care and Government Insured Plan Receivables.

b. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are
reported as 1) Aggregate write ins for miscellaneous expenses - Property and Casualty (Underwriting and Investment Exhibit Part 3); 2) Aggregate write ins for expenses - Life/Health (Exhibit 2 – General expenses) or 3) aggregate write ins for expenses (General Administrative Expenses)- health (Underwriting and Investment Exhibit Part 3)

c. Claims related extra contractual obligations losses and bad-faith losses shall be included in losses. See individual business types for the accounting treatment for adjustment expenses related

5. The liability for unpaid LAE shall be established regardless of any payments made to third-party administrators, management companies or other entities except for capitated payments under managed care contracts. The liability for claims adjustment expenses on non-capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments made to third-party administrators, etc. The liability for claims adjustment expenses on capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the exception that the liability is established net of capitated payments to providers.

a. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as 1) Aggregate write ins for miscellaneous expenses - Property and Casualty (Underwriting and Investment Exhibit Part 3); 2) Aggregate write ins for expenses - Life/Health (Exhibit 2 – General expenses) or 3) aggregate write ins for expenses (General Administrative Expenses) - health (Underwriting and Investment Exhibit Part 3).

For Fall 2019 National Meeting Discussion:

NAIC Staff recommends that the Working Group expose revisions incorporating the majority of interested parties’ comments as reflected below as tracked changes to SSAP No. 55 (rather than as reflected as changes to the Summer 2019 exposure). Interested parties’ comments primarily delete the exposed guidance and move the same or similar concepts into the broad product guidance for property and casualty, life and health or health in SSAP No. 55. These revisions are to reinstate annual statement references by entity type and to adjust scoping language and make the SSAP No. 29 prepaid guidance consistent. Note that shading reflects staff proposed variations in wording from the interested parties proposed wording that accomplishes a similar intent.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, as illustrated below, that incorporate interested parties’ recommendations to separate the guidance by product type and emphasize guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments). The revisions emphasize existing guidance that claims that related liabilities are not recognized as paid until the losses are paid to claimants or claims are adjusted. Note that shading reflects staff proposed variations in wording from the interested parties’ proposed wording that accomplishes a similar intent.

2019 Fall Exposure:

Unpaid Claims, Losses and Loss Adjustment Expenses SSAP No. 55

SUMMARY CONCLUSION

4. Claims, losses, and loss/claim adjustment expenses shall be recognized as expenses when a covered or insured event occurs. In most instances, the covered or insured event is the occurrence of an incident which gives rise to a claim or the incurring of costs. For claims-made type policies, the covered or insured event is the reporting to the entity of the incident that gives rise to a
claim. Until claim payments and related expense payments are made subsequent to the occurrence of a covered or insured event, and in order to recognize the expense of a covered or insured event that has occurred, it is necessary to establish a liability. Liabilities shall be established for any unpaid claims and unpaid losses (loss reserves), unpaid loss/claim adjustment expenses (loss/claim adjustment expense reserves) and incurred costs, with a corresponding charge to income. Claims related extra contractual obligations losses and bad-faith losses shall be included in losses. See individual business types for the accounting treatment for adjustment expenses related to extra contractual obligations and bad-faith lawsuits.

5. The liability for unpaid LAE shall be established regardless of any payments made to third-party administrators, management companies or other entities except for capitated payments under managed care contracts for which ... The liability for claims adjustment expenses on non-capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments made to third-party administrators, etc. The liability for claims adjustment expenses on capitated payments under managed care contracts shall be established in an amount necessary to adjust all unpaid claims irrespective of payments to third parties with the exception that the liability is established net of capitated payments to providers.

Property/Casualty

6. The following are types of future costs relating to property and casualty contracts, as defined in SSAP No. 50, which shall be considered in determining the liabilities for unpaid losses and loss adjustment expenses:

   a. Reported Losses: Expected payments for losses relating to insured events that have occurred and have been reported to, but not paid by, the reporting entity as of the statement date;

   b. Incurred But Not Reported Losses (IBNR): Expected payments for losses relating to insured events that have occurred but have not been reported to the reporting entity as of the statement date. As a practical matter, IBNR may include losses that have been reported to the reporting entity but have not yet been entered to the claims system or bulk provisions. Bulk provisions are reserves included with other IBNR reserves to reflect deficiencies in known case reserves;

   c. Loss Adjustment Expenses: Expected payments for costs to be incurred in connection with the adjustment and recording of losses defined in paragraphs 6.a. and 6.b. Examples of expenses incurred in these activities are estimating the amounts of losses, disbursing loss payments, maintaining records, general clerical, secretarial, office maintenance, occupancy costs, utilities, computer maintenance, supervisory and executive duties, supplies, and postage. Loss adjustment expenses can be classified into two broad categories: Defense and Cost Containment (DCC) and Adjusting and Other (AO):

      i. DCC include defense

         (a) Surveillance expenses;

         (b) Fixed amounts for medical cost containment expenses;

         (c) Litigation management expenses;
(d) Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by accident year;

(c) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;

(f) Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and

(g) The cost of engaging experts;

ii. AO are those expenses other than DCC as defined in (i) above assigned to the expense group "Loss Adjustment Expense." AO include, but are not limited to, the following items:

(a) Fees and expenses of adjusters and settling agents;

(b) Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by calendar year;

(c) Attorney fees incurred in the determination of coverage, including litigation between the reporting entity and the policyholder;

Legal defense costs incurred under the definition of covered damages or losses as the only insured peril would be accounted for as losses, while legal defense costs incurred under a duty to defend would be accounted for as Defense and Cost Containment (DCC). For policies where legal costs are the only insured peril, the insurer would record the legal costs that reimburse the policyholder as loss and, to the extent the insurer participated in the defense, would record its legal costs as DCC. This is not intended to change the classifications of legal expenses for existing long tailed lines of liability coverage, such as medical malpractice and workers' compensation insurance.

(d) Fees and salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in the capacity of an adjuster; and

(c) Adjustment expenses arising from claims related lawsuits such as extra contractual obligations and bad faith lawsuits.

d. The contractual terms for arrangements (i.e., variable, fixed or bundled amounts) to third party administrators, management companies, or other entities for unpaid claims, losses and losses/claims adjustment expenses, shall be evaluated to determine if the arrangement meets the criteria to be reported as a prepaid asset and nonadmitted in accordance with SSAP No. 29—Prepaid Expenses. These payments shall not be offset against any amounts required to be reported in accordance with paragraphs 4 or 5 within this guidance. Only when loss/claim and related adjusting expense payments which are made by the third-party administrators, management companies or other entities, to the policyholder or claimant, shall the insurer’s liability (loss/claim or loss/claim adjustment expense reserves) be reduced.
c. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as aggregate write-in for miscellaneous underwriting benefits in the Underwriting and Investment exhibit Part 3.

Life, Accident and Health

7. The following future costs relating to life and accident and health indemnity contracts, as defined in SSAP No. 50, shall be considered in determining the liability for unpaid claims and claim adjustment expenses:

a. Accident and Health Claim Reserves: Reserves for claims that involve a continuing loss. This reserve is a measure of the future benefits or amounts not yet due as of the statement date which are expected to arise under claims which have been incurred as of the statement date. This shall include the amount of claim payments that are not yet due such as those amounts commonly referred to as disabled life reserves for accident and health claims. The methodology used to establish claim reserves is discussed in SSAP No. 54R.

b. Claim Liabilities for Life/Accident and Health Contracts:
   
i. Due and Unpaid Claims: Claims for which payments are due as of the statement date;
   
ii. Resisted Claims in Course of Settlement: Liability for claims that are in dispute and are unresolved on the statement date. The liability either may be the full amount of the submitted claim or a percentage of the claim based on the reporting entity’s past experience with similar resisted claims;
   
iii. Other Claims in the Course of Settlement: Liability for claims that have been reported but the reporting entity has not received all of the required information or processing has not otherwise been completed as of the statement date;
   
iv. Incurred But Not Reported Claims: Liability for which a covered event has occurred (such as death, accident, or illness) but has not been reported to the reporting entity as of the statement date.

c. Claim Adjustment Expenses for Accident and Health Reporting Entities are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in paragraphs 7.a. and 7.b. Certain claim adjustment expenses reduce the number or cost of health services thereby resulting in lower premiums or lower premium increases. These claim adjustment expenses shall be classified as cost containment expenses.

d. Claim Adjustment Expenses for Life Reporting Entities: Costs expected to be incurred (including legal and investigation) in connection with the adjustment and recording of life claims defined in paragraph 7.b. This would include adjustment expenses arising from claims-related lawsuits such as extra contractual obligations and bad-faith lawsuits.

e. In cases where insurers advance funds to third-party administrators, management companies or other entities prior to the occurrence of the claim who then, on behalf of
the insurer, adjudicate the claim and make payments to insureds or other claimants, the guidance in paragraph 9 applies.

Managed Care

8. The following costs relating to managed care contracts as defined in SSAP No. 50 shall be considered in determining the claims unpaid and claims adjustment expenses:

a. Claims unpaid for Managed Care Reporting Entities:
   i. Unpaid amounts for costs incurred in providing care to a subscriber, member or policyholder including inpatient claims, physician claims, referral claims, other medical claims, resisted claims in the course of settlement and other claims in the course of settlement;

   ii. Incurred But Not Reported Claims: Liability for which a covered event has occurred (such as an accident, illness or other service) but has not been reported to the reporting entity as of the statement date;

   iii. Additional unpaid medical costs resulting from failed contractors under capitation contracts and provision for losses incurred by contractors deemed to be related parties for which it is probable that the reporting entity will be required to provide funding;

b. Claim Adjustment Expenses for Managed Care Reporting Entities are those costs expected to be incurred in connection with the adjustment and recording of managed care claims defined in paragraph 8.a. Certain claim adjustment expenses reduce the number or cost of health services thereby resulting in lower premiums or lower premium increases. These claim adjustment expenses shall be classified as cost containment expenses.

c. Liabilities for percentage withholds (“withholds”) from payments made to contracted providers;

d. Liabilities for accrued medical incentives under contractual arrangements with providers and other risk-sharing arrangements whereby the health entity agrees to share savings with contracted providers.

e. In cases where insurers advance funds to third-party administrators, management companies or other entities prior to the occurrence of the claim who then, on behalf of the insurer, adjudicate the claim and make payments to insureds or other claimants, the guidance in paragraph 9 applies.

Managed Care and Accident and Health

*Drafting Note: New guidance is issued within par. 9, which is underlined. Existing par 9 is renumbered to par. 10, and all other pars within existing guidance (i.e., pars. 10 – 23, will be renumbered to 11 – 24, respectively.*

9. In some instances, insurers advance funds to third-party administrators, management companies or other entities prior to the occurrence of the claim who then, on behalf of the insurer, adjudicate the claim and make payments to insureds or other claimants. In such cases the following guidance applies:

a. For capitated payments under managed care contracts, the liability for claims and claim adjusting expenses shall be established in an amount necessary to adjudicate and pay all
unpaid claims irrespective of payments to third-party administrators, management companies or other entities, and is reported net of capitated payments to providers.

b. For non-capitated advance payments, the liability for unpaid losses/claims and related adjustment expenses shall be established regardless of any payments made to third-party administrators, management companies or other entities, and such payments shall be reported by the insurer as prepayments. All prepayments (i.e., variable, fixed or bundled amounts) to third party administrators, management companies, or other entities for unpaid claims, losses and losses/claims adjustment expenses, shall be initially reported as a prepaid asset and nonadmitted in accordance with SSAP No. 29—Prepaid Expenses. These payments shall not be offset against any amounts required to be reported in accordance with paragraphs 4 or 5 within this guidance. Only when loss/claim and related adjusting expense payments which are made by the third-party administrators, management companies or other entities, to the policyholder or claimant, shall the insurer’s liability (loss/claim or loss/claim adjustment expense reserves) be reduced.

c. Prepayments to third party administrators or management companies or other entities that do not relate to services or adjusting for the underlying direct policy benefits are reported as (1) Aggregate write ins for expenses - Life/Health (Exhibit 2 – General expenses) or (2) Aggregate write ins for expenses (General Administrative Expenses) - Health (Underwriting and Investment Exhibit Part 3).

Note that this guidance in paragraph 9 does not alter existing guidance regarding the admissibility of loans and advances to providers which apply to health insurance and managed care contracts which is addressed in SSAP No. 84—Health Care and Government Insured Plan Receivables.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, as illustrated above under “2019 Fall Exposures,” that emphasize guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments). The revisions also emphasize existing guidance that claims and related liabilities are not recognized as paid until the losses are paid to claimants or claims are adjusted.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Look-Through with Multiple Holding Companies

Check (applicable entity):

<table>
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<th>Modification of Existing SSAP</th>
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<th>Health</th>
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<td>New Issue or SSAP Interpretation</td>
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Description of Issue:
This agenda item was drafted in response to Working Group direction from the 2019 Summer National Meeting. A clarification question arose while discussing agenda item 2019-13, Clarification of a Look-Through Approach. The Working Group verbalized the conclusion that a look-through is permitted through more than one downstream company so as long as each look-through entity complies with SSAP No. 97—Investment in Subsidiary, Controlled and Affiliated Entities. In response to interested party request for formal clarification, the Working Group directed a separate agenda item to provide this guidance in SSAP No. 97. This agenda item formally documents this guidance within statutory accounting.

Existing Authoritative Literature:

SSAP No. 97:

27. The process of admitting audited investments in entities owned by an unaudited downstream noninsurance holding company SCA entity will be known as a “look through.” In order to admit the investments in audited SCAs or the audited non SCA SSAP No. 48 entities owned by an unaudited downstream noninsurance holding company, a reporting entity may apply the look through approach, provided all of the following conditions are met:

a. Downstream holding company is an 8.b.iii entity.

b. The downstream holding company does not own any other assets which are material to the downstream holding company other than the audited SCA entities and/or audited non SCA SSAP No. 48 entities, and

c. The downstream noninsurance holding company is not subject to liabilities, commitments, contingencies, guarantees or obligations which are material to the downstream noninsurance holding company.

If an investment in a downstream noninsurance holding company meets the requirements set forth above, the reporting entity can admit the individual audited SCA entities and/or audited non SCA SSAP No. 48 entities; however, unaudited immaterial assets of the downstream noninsurance holding company are to be carried at the lesser of the paragraph 8 valuation or nonadmitted (e.g. some equity method investments are required to be carried at a negative value due to either statutory adjustments or to parental obligations to keep funding the subsidiary).

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Agenda item 2019-13, Clarification of a Look-Through Approach was disposed at the Summer 2019 National Meeting. As part of the disposal action, the Statutory Accounting Principles (E) Working Group directed NAIC staff to draft a new
agenda item clarifying that a more-than-one holding company structure is permitted if each of the holding companies complies with SSAP No. 97.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS):
Not applicable.

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, to clarify that a more-than-one holding company structure is permitted as a look-through if each of the holding companies within the structure complies with the requirements in SSAP No. 97.

Proposed Revisions:

27. The process of admitting audited investments in entities owned by an unaudited downstream noninsurance holding company SCA entity will be known as a “look through.” In order to admit the investments in audited SCAs or the audited non SCA SSAP No. 48 entities owned by an unaudited downstream noninsurance holding company, a reporting entity may apply the look through approach, provided all of the following conditions are met:

a. The downstream noninsurance holding company is an 8.b.iii entity, and

b. The downstream noninsurance holding company does not own any other assets which are material to the downstream holding company other than the audited SCA entities and/or audited non SCA SSAP No. 48 entities, and

c. The downstream noninsurance holding company is not subject to liabilities, commitments, contingencies, guarantees or obligations which are material to the downstream noninsurance holding company.

If an investment in a downstream noninsurance holding company meets the requirements set forth above, the reporting entity can admit the individual audited SCA entities and/or audited non SCA SSAP No. 48 entities; however, unaudited immaterial assets of the downstream noninsurance holding company are to be carried at the lesser of the paragraph 8 valuation or nonadmitted (e.g. some equity method investments are required to be carried at a negative value due to either statutory adjustments or to parental obligations to keep funding the subsidiary). If a holding company structure has more than one downstream noninsurance holding company, each downstream non-insurance holding company may be looked through, provided each downstream non-insurance holding company meets all of the conditions in paragraph 27.

Staff Review Completed by:
Fatima Sediqzad - NAIC Staff - September 2019

Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as illustrated above, to clarify that a more-than-one holding company structure is permitted as a look-through if each of the holding companies within the structure complies with the requirements in SSAP No. 97.
On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as illustrated above, to clarify that a more-than-one holding company structure is permitted as a look-through if each of the holding companies within the structure complies with the look-through requirements in SSAP No. 97.

W:\National Meetings\2020\Summer\TF\App\SAP\Minutes\03_18_2020 Attachments (H)\Att One-H5_19-32 - Look-Through with Multiple Holding Companies.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Update Withdrawal Disclosures

Check (applicable entity):

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<th>Modification of existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
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<tr>
<td>New Issue or SSAP Interpretation</td>
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Description of Issue:
In November 2018, the Working Group updated the life, health and separate account liquidity disclosures to provide more granularity of the withdrawal characteristics by product type. These updates were developed by the Financial Stability (Ex) Task Force and were adopted in agenda item 2018-28: Updates to Liquidity Disclosures. Agenda item 2018-28 updated the liquidity disclosures in SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts, and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance with an effective date of year-end 2019.

This agenda item proposes minor clarifying edits to the disclosures identified subsequent to the adoption of the related 2019 annual statement blanks proposal. These items include:

- Addition of separate account guaranteed products in one of the illustrations to remedy its omission. As quoted in the authoritative literature section below, SSAP No. 51R, SSAP No. 52 and SSAP No. 61R currently reference both guaranteed and nonguaranteed separate account products. This adds a consistency revision to SSAP No. 51R to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosures.

- Correct an identified inconsistency in one of the new disclosures that was added regarding products that will move from the reporting line of having surrender charges at 5% or more to the reporting line of surrender charges at less than 5%. A clarification is being recommended to ensure consistency in annual statement reporting.

- Add a cross-reference from SSAP No. 56—Separate Accounts to the existing disclosures by withdrawal characteristics in SSAP No. 51R and SSAP No. 61R as the disclosures include separate account products.

Existing Authoritative Literature:
The below includes excerpts of text that was updated in agenda item 2018-28.

SSAP No. 51R—Life Contracts (Bolding added for emphasis):

45. For the disclosures noted below, disclose the amount of annuity actuarial reserves and deposit liabilities by withdrawal characteristics for the categories of general account, separate account with guarantees, separate account nonguaranteed as well as the total and percentage of the total, include a separate section for individual Annuities, Group Annuities, and Deposit-Type Contracts (with no life contingencies). Supplementary contracts with life contingencies are reported in the appropriate Annuities section (Individual or Group).

NOTE: Subparagraphs a-f omitted for brevity.
46. Disclose the amounts of account value, cash value and reserve for the breakouts of life insurance by withdrawal characteristics, separately for General Account products and **Separate Account Nonguaranteed** products, as follows:

   a. Subject to discretionary withdrawal, surrender values, or policy loans:
      
      i. Term Policies with Cash Value
      
      ii. Universal Life
      
      iii. Universal Life with Secondary Guarantees
      
      iv. Indexed Universal Life
      
      v. Indexed Universal Life with Secondary Guarantees
      
      vi. Indexed Life
      
      vii. Other Permanent Cash Value Life Insurance
      
      viii. Variable Life
      
      ix. Variable Universal Life
      
      x. Miscellaneous Reserves

   b. Not subject to discretionary withdrawal or no cash value:
      
      i. Term Policies without Cash Value
      
      ii. Accidental Death Benefits
      
      iii. Disability – Active Lives
      
      iv. Disability – Disabled Lives
      
      v. Miscellaneous Reserves

   c. Total gross (Direct + Assumed)

   d. Reinsurance ceded

   e. Total net (Net: Total gross (paragraph 46.c.) less Reinsurance ceded (paragraph 46.d.))

The difference between the account value and the cash value is the surrender charge, if any. After the surrender period is over, there is no difference. Some contract types have no account value such as traditional whole life, term, etc. So, if there is no account value, leave it blank. UL typically has an account value and a cash surrender value. Just as account values are not reduced for policy loans taken and outstanding, the cash value amount reported in this disclosure should not be reduced for policy loans taken and outstanding. This will ensure the difference between account value and cash value is the actual surrender charge.

47. Reconcile total life insurance reserves amount disclosed to the appropriate sections of the Aggregate Reserves for Life Policies and Contracts Exhibit (Exhibit 5) of the Life, Accident and Health Annual Statement and the corresponding lines in the Separate Accounts Statement. The reconciliation is
SSAP No. 52—Deposit-Type Contracts (Bolding added for emphasis):

19. For the disclosures noted below, disclose the amount of annuity actuarial reserves and deposit liabilities by withdrawal characteristics for the categories of general account, separate account with guarantees, separate account nonguaranteed as well as the total and percentage of the total, include a separate section for Individual Annuities, Group Annuities, and Deposit-Type Contracts (with no life contingencies). Supplementary contracts with life contingencies are reported in the appropriate Annuities section (Individual or Group).

NOTE: Subparagraphs omitted for brevity.

SSAP No. 61R (Bolding added for emphasis):

69. For the disclosures noted below, disclose the amount of annuity actuarial reserves and deposit liabilities by withdrawal characteristics for the categories of general account, separate account with guarantees, separate account nonguaranteed as well as the total and percentage of the total, include a separate section for Individual Annuities, Group Annuities, and Deposit-Type Contracts (with no life contingencies). Supplementary contracts with life contingencies are reported in the appropriate Annuities section (Individual or Group).

NOTE: Subparagraphs omitted for brevity.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): This agenda item proposes consistency edits related to the disclosures developed by the Financial Stability (Ex) Task Force, which were adopted in November 2018 in agenda item 2018-28: Updates to Liquidity Disclosures.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: The Blanks (E) Working Group addressed this issue for 2019 reporting in an editorial change in June 2019 and is proposing separate tables for the guaranteed and nonguaranteed separate account products for 2020 reporting in agenda item 2019-21BWG.

Convergence with International Financial Reporting Standards (IFRS): Not applicable

Staff Recommendation:

NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 51R, SSAP No. 56 and SSAP No. 61R as described and illustrated below:

1. Add a consistency revision to SSAP No. 51R, to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosures.

2. Correct an identified inconsistency in one of the new disclosures that was added regarding products that will move from the reporting line of having surrender charges at 5% or more to the reporting line of surrender charges at less than 5%. A clarification is being recommended to ensure consistency in annual statement reporting.
3. Add a cross reference from *SSAP No. 56—Separate Accounts* to the existing disclosures by withdrawal characteristics in SSAP No. 51R and SSAP No. 61R as the disclosures include separate account products.

**Proposed Revisions:**

**SSAP No. 51R—Life Contracts**

45. For the disclosures noted below, disclose the amount of annuity actuarial reserves and deposit liabilities by withdrawal characteristics for the categories of general account, separate account with guarantees, separate account nonguaranteed as well as the total and percentage of the total, include a separate section for individual Annuities, Group Annuities, and Deposit-Type Contracts (with no life contingencies). Supplementary contracts with life contingencies are reported in the appropriate Annuities section (Individual or Group).

a. Subject to discretionary withdrawal:

i. With market value adjustment, where withdrawal of funds is payable at all times, or prior to specified maturity dates where such dates are more than one year after the statement date and;

   (a) In a lump sum with adjustments to reflect general changes in interest rates, or asset values since receipt of funds by the insurer;

   (b) In installments over five years or more, with or without a reduction in the interest rate during the installment period;

ii. At book value less current surrender charge, where the withdrawal of funds is payable at all times, or at any time within one year from the statement date in a lump sum subject to a current fixed surrender charge of 5% or more and it does not contain a meaningful bail out rate as described in paragraph 45.a.v.(d);

iii. At fair value, where the withdrawal of funds is payable at current fair value of the assets supporting the liabilities, the assets are stated at current fair value, and the liabilities are stated at the current fair value or per unit value of the assets supporting the liabilities. These liabilities are for contracts where the customer bears the entire investment risk;

iv. Total with adjustment or at fair value;

v. At book value without adjustment (minimal or no charge or adjustment), where the withdrawal of funds is either payable at all times, or at any time (including a withdrawal on a scheduled payment date) within one year from the statement date and:

   (a) In a lump sum without adjustment;

   (b) In installments over less than five years, with or without a reduction in interest rate during the installment period;

   (c) In a lump sum subject to a fixed surrender charge of less than 5%;

   (d) In a lump sum subject to surrender charge, but such charge is waived if the credited rate falls below a specified “bail out” rate and the “bail out” rate is more than the maximum statutory valuation rate for life insurance policies for more than 20 years for new issues;
b. Not subject to discretionary withdrawal;

c. Total gross;

d. Reinsurance ceded;

e. Total net.

f. Amount with current surrender charge of 5% or more included in the current year in paragraph 45.a.ii. that will have less than a 5% surrender charge (and thus be reported with the amounts at book value with minimal or no charge or adjustment noted in paragraph 45.a.v.) for the first time within the year subsequent to the balance sheet year. (Note that percentage of total is not required for this item.)

46. Disclose the amounts of account value, cash value and reserve for the breakouts of life insurance by withdrawal characteristics, separately for General Account products, Separate Account Guaranteed products and Separate Account Nonguaranteed products, as follows:

a. Subject to discretionary withdrawal, surrender values, or policy loans:

i. Term Policies with Cash Value

ii. Universal Life

iii. Universal Life with Secondary Guarantees

iv. Indexed Universal Life

v. Indexed Universal Life with Secondary Guarantees

vi. Indexed Life

vii. Other Permanent Cash Value Life Insurance

viii. Variable Life

ix. Variable Universal Life

x. Miscellaneous Reserves

b. Not subject to discretionary withdrawal or no cash value:

i. Term Policies without Cash Value

ii. Accidental Death Benefits

iii. Disability – Active Lives

iv. Disability – Disabled Lives

v. Miscellaneous Reserves

c. Total gross (Direct + Assumed)

d. Reinsurance ceded
e. Total net (Net: Total gross (paragraph 46.c.) less Reinsurance ceded (paragraph 46.d.))

The difference between the account value and the cash value is the surrender charge, if any. After the surrender period is over, there is no difference. Some contract types have no account value such as traditional whole life, term, etc. So, if there is no account value, leave it blank. UL typically has an account value and a cash surrender value. Just as account values are not reduced for policy loans taken and outstanding, the cash value amount reported in this disclosure should not be reduced for policy loans taken and outstanding. This will ensure the difference between account value and cash value is the actual surrender charge.

**SSAP No. 56—Separate Accounts** (Note -this revision adds a reference to the other withdrawal characteristics disclosures which included separate account products.)

Disclosures

30. Paragraphs 31-34 detail the separate account disclosure requirements that shall be included within the Life, Accident and Health Annual Statement Blank. Paragraphs 3536-38 detail the separate account disclosure requirements that shall be included within the Separate Account Annual Statement Blank.

**NOTE: paragraphs 31-34 omitted for brevity.**

35. The disclosures in **SSAP No. 51R—Life Contracts, and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance** related to the withdrawal characteristics of products include separate account products and shall be completed in the general account disclosures.

**SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance**

69. For the disclosures noted below, disclose the amount of annuity actuarial reserves and deposit liabilities by withdrawal characteristics for the categories of general account, separate account with guarantees, separate account nonguaranteed as well as the total and percentage of the total, include a separate section for Individual Annuities, Group Annuities, and Deposit-Type Contracts (with no life contingencies). Supplementary contracts with life contingencies are reported in the appropriate Annuities section (Individual or Group).

a. Subject to discretionary withdrawal:

i. With market value adjustment, where withdrawal of funds is payable at all times, or prior to specified maturity dates where such dates are more than one year after the statement date and;

   (a) In a lump sum with adjustments to reflect general changes in interest rates, or asset values since receipt of funds by the entity;

   (b) In installments over five years or more, with or without a reduction in the interest rate during the installment period.

ii. At book value less current surrender charge, where the withdrawal of funds is payable at all times, or at any time within one year from the statement date in a lump sum subject to a current fixed surrender charge of 5% or more and it does not contain a meaningful bail out rate as described in paragraph 69.a.v.(d) below;

iii. At fair value, where the withdrawal of funds is payable at current market value of the assets supporting the liabilities, the assets are stated at current fair value, and the liabilities are stated at the current fair value or per unit value of the assets supporting the
liabilities. These liabilities are for contracts where the customer bears the entire investment risk;

iv. Total with adjustment or at fair value;

v. At book value without adjustment (minimal or no charge or adjustment), where the withdrawal of funds is either payable at all times, or at any time (including a withdrawal on a scheduled payment date) within one year from the statement date and:

(a) In a lump sum without adjustment;

(b) In installments over less than five years, with or without a reduction in interest rate during the installment period;

(c) In a lump sum subject to a fixed surrender charge of less than 5%;

(d) In a lump sum subject to surrender charge, but such charge is waived if the credited rate falls below a specified “bail out” rate and the “bail out” rate is more than the maximum statutory valuation rate for life insurance policies for more than 20 years for new issues.

b. Not subject to discretionary withdrawal;

c. Total gross (Direct + Assumed);

d. Reinsurance ceded;

e. Total net (Net: Total gross (paragraph 69.c.) less Reinsurance ceded (paragraph 69.d.)); and

f. Amount with current surrender charge of 5% or more included in the current year in paragraph 69.a.ii. that will have less than a 5% surrender charge (and thus be reported with the amounts at book value with minimal or no charge or adjustment noted in paragraph 69.a.v.) for the first time within the year subsequent to the balance sheet year. (Note that percentage of total is not required for this item.)

Staff Review Completed by: Robin Marcotte – August 2019 - NAIC Staff

Status: On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts, and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, as illustrated in the staff recommendation, to:

- Add a consistency revision to SSAP No. 51R to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosures;

- Correct an identified inconsistency in one of the new disclosures that was added regarding products that will move from the reporting line of having surrender charges at 5% or more to the reporting line of surrender charges at less than 5%. A clarification is being recommended to ensure consistency in annual statement reporting; and

- Add a cross-reference from SSAP No. 56 to the existing disclosures by withdrawal characteristics in SSAP No. 51R and SSAP No. 61R as the disclosure include separate account products.
On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts, and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, as detailed above under “proposed revisions.”
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2017-11, Financial Instruments with Down Round Features

Check (applicable entity):

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<td>Interpretation</td>
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Description of Issue: ASU 2017-11, Accounting for Certain Financial Instruments with Down Round Features; Replacement of the Indefinite Deferral for Mandatorily Redeemable Financial Instruments of Certain Noncontrolling Interests with a Scope Exception to address issues identified with applying U.S. GAAP for certain financial instruments with characteristics of liabilities and equity. The purpose of this agenda item is to review ASU 2017-11 and to consider statutory accounting guidance on distinguishing liabilities from equity.

This ASU addresses the complexity of accounting for certain freestanding financial instruments (or embedded features such as a conversion option) with down round features. A down round feature is a provision in certain financial instruments (most often warrants or convertible instruments) that allows for the reduction in the strike price of the financial instrument if the issuer sells additional shares of common stock for an amount less than the financial instrument’s stated strike price, or if the issuer issues another equity-linked instrument with a strike price below the current strike price of the original financial instrument. Down (financing) rounds typically occur when additional capital is required, but the company’s valuation is now lower than it was in an earlier stock offering. Financial instruments with down round features help protect the holder from declines in the issuer’s share price because if a company issues additional equity shares at a lower price than had been previously sold, the holder is allowed to exercise its purchase option at a lower strike price than was originally stated on the financial instrument.

Existing U.S. GAAP for financial instruments with down round features requires fair value measurement of the entire instrument or conversion option. Stakeholders asserted that accounting for freestanding and embedded instruments with down round features as liabilities, subject to fair value measurement, created a reporting burden and associated income statement volatility due to changes in an entity’s share price. Stakeholders also suggested that this accounting may not reflect the economics of the down round feature, which exist to protect certain investors from declines in the issuer’s share price. With the current accounting guidance, changes in fair value of an instrument with a down round feature are recognized in earnings for both increases and decreases in share price. However, down round features are only likely to be exercised in the event the share price decreases and the issuer engages in a subsequent equity offering.

Prior to this ASU’s issuance under U.S. GAAP, a free-standing financial instrument or embedded feature was not considered indexed to the issuer’s stock if it has a down round feature. Thus, the instrument was classified as a liability and if it meets the definition of a derivative, it must be measured at fair value with changes recorded through current period earnings. ASU 2017-11 changes the guidance in that a down round feature shall no longer be considered when determining whether the instrument is indexed to a company’s stock. As a result of the ASU, if the instrument is now deemed to be indexed and settled in company stock, a free-standing or embedded equity-linked financial instrument will be classified as equity and the embedded feature that was originally bifurcated and accounted for as a derivative may qualify for scope exception to also be treated as equity.
Revisions in ASU 2017-11 also include earning per share (EPS) guidance detailing that the effect of exercising a
down round feature shall be treated as a dividend to reduce the income available to common shareholders for
computing and reporting basic EPS. Recognition of the value of the down round feature is calculated when triggered
and is measured as the difference between the fair value of the instrument (without regarding the down round
feature) of the pre-trigger exercise price and the fair value of the instrument (again, without regarding the down
round feature) using the reduced and executed exercise price.

Existing Authoritative Literature:

1. Earnings per share – Rejected as Not Applicable for Statutory Accounting:

   The concept of earnings per share (Topic 260) has previously been reviewed with the following U.S. GAAP
   standards rejected as not applicable in Appendix D—Nonapplicable GAAP Pronouncements:

   • FASB Statement No. 128, Earnings per Share (FAS 128)
   • EITF 07-04, Application of the Two-Class Method under FASB Statement No. 128 to Master
     Limited Partnerships

2. Distinguishing Liabilities from Equity / Derivatives and Hedging:

   With ASU 2017-11, entities will no longer consider a down round feature when determining whether a freestanding
   financial instrument is indexed to an entity’s stock. Consequently, upon adoption, these instruments which are
   currently being reported as a liability may be reclassified as equity. Additionally, fewer embedded features will
   likely have to be bifurcated and accounted for as a derivative and may qualify for scope exemption to be treated as
   equity.

   NAIC staff believes the spirit of freestanding down round features represents a quantifiable liability of the issuing
   company and should remain accounted for as a liability and not as equity. Down round features embedded in
derivatives would not be separated from the host contract pursuant to SSAP No. 86—Derivatives.

   As detailed below, the down round feature satisfies the definition of a liability and recognition as a liability would
   be consistent with existing guidance for share-based payments.

SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, defines a liability with excerpts below:

2. A liability is defined as certain or probable future sacrifices of economic benefits arising from
   present obligations of a particular entity to transfer assets or to provide services to other entities in the
   future as a result of a past transaction(s) or event(s).

3. A liability has three essential characteristics: (a) it embodies a present duty or responsibility to one
   or more other entities that entails settlement by probable future transfer or use of assets at a specified or
determinable date, on occurrence of a specified event, or on demand, (b) the duty or responsibility
   obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (c) the
   transaction or other event obligating the entity has already happened. This includes, but is not limited
to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves
for incurred but not reported claims). Liabilities shall be recorded on a reporting entity’s financial statements
when incurred.
SSAP No. 104R—Share-Based Payments, Exhibit A – Classification Criteria: Liability or Equity, details circumstances under which certain financial instruments are to be identified as liabilities. While this guidance is limited to share-based payments, the overall accounting concepts are applicable in these situations. Specifically, Exhibit A, paragraph 7, supports recognition as a liability as the company is obligated to sell additional common stock for an amount less than the originally stated strike price as both circumstances require a unilateral outflow of assets or equity. The liability associated with a down round feature, although settled with the issuance of additional shares (without the receipt of assets), will adversely affect the economic interests of current equity shareholders by diluting ownership. Additionally, paragraph 10 broadly indicates instruments that obligate the issuer to transfer assets are to be reported as liabilities.

Excerpts from SSAP No. 104R, Exhibit A:

Mandatorily Redeemable Financial Instruments

3. A mandatorily redeemable financial instrument shall be classified as a liability unless the redemption is required to occur only upon the liquidation or termination of the reporting entity.

4. A financial instrument that embodies a conditional obligation to redeem the instrument by transferring assets upon an event not certain to occur becomes mandatorily redeemable if that event occurs, the condition is resolved, or the event becomes certain to occur.

5. In determining if an instrument is mandatorily redeemable, all terms within a redeemable instrument shall be considered. The following items do not affect the classification of a mandatorily redeemable financial instrument as a liability:
   a. A term extension option
   b. A provision that defers redemption until a specified liquidity level is reached
   c. A similar provision that may delay or accelerate the timing of a mandatory redemption.

6. If a financial instrument will be redeemed only upon the occurrence of a conditional event, redemption of that instrument is conditional and, therefore, the instrument does not meet the definition of mandatorily redeemable financial instrument in this statement. However, that financial instrument would be assessed at each reporting period to determine whether circumstances have changed such that the instrument now meets the definition of a mandatorily redeemable instrument (that is, the event is no longer conditional). If the event has occurred, the condition is resolved, or the event has become certain to occur, the financial instrument is reclassified as a liability.

Obligations to Repurchase Issuer’s Equity Shares by Transferring Assets

7. An entity shall classify as a liability (or an asset in some circumstances) any financial instrument, other than an outstanding share, that, at inception, has both of the following characteristics:
   a. It embodies an obligation to repurchase the issuer’s equity shares, or is indexed to such an obligation, and
   b. It requires or may require the issuer to settle the obligation by transferring assets.

8. In this statement, “indexed to” is used interchangeably with “based on variations in the fair value of.” The phrase “requires or may require” encompasses instruments that either conditionally or unconditionally obligate the issuer to transfer assets. If the obligation is conditional, the number of conditions leading up to the transfer of assets is irrelevant.
9. Examples of financial instruments that meet the criteria in paragraph 7 of this Exhibit include forward purchase contracts or written put options on the issuer's equity shares that are to be physically settled or net cash settled.

10. All obligations that permit the holder to require the issuer to transfer assets result in liabilities, regardless of whether the settlement alternatives have the potential to differ.

As noted in SSAP No. 86, paragraph 16, down round features embedded in derivative contracts (such as a warrant) would not be separated from the host contract. Such features would impact the fair value accounting for derivatives (assuming fair value accounting is followed) in recognizing the derivative asset or derivative liability. Recognizing freestanding down round features as a liability (and not as equity) would be consistent with the impact of such features embedded in a derivative contract.

**SSAP No. 86—Derivatives**

16. Contracts that do not in their entirety meet the definition of a derivative instrument, such as bonds, insurance policies, and leases, may contain “embedded” derivative instruments—implicit or explicit terms that affect some or all of the cash flows or the value of other exchanges required by the contract in a manner similar to a derivative instrument. The effect of embedding a derivative instrument in another type of contract (“the host contract”) is that some or all of the cash flows or other exchanges that otherwise would be required by the contract, whether unconditional or contingent upon the occurrence of a specified event, will be modified based on one or more underlyings. An embedded derivative instrument shall not be separated from the host contract and accounted for separately as a derivative instrument.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None**

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None**

**Convergence with International Financial Reporting Standards (IFRS):** *IAS 32 – Financial Instruments* outlines the accounting requirements for the presentation of certain financial instruments, particularly as to the classifications into assets, liabilities, or equity. The fundamental principle of IAS 32 is that a financial instrument should be classified as either a financial liability or as an equity instrument according to the substance of the contract, not its legal form. IAS 32.20 states a contractual right or obligation to receive or deliver a number of its own shares or other equity instruments that varies so that the fair value of the entity’s own equity instruments to be received or delivered equals the fixed monetary amount of the contractual right or obligation is a financial liability.

**Staff Recommendation:** NAIC staff recommends the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 86 to reject ASU 2017-11 (Topics 480 & 815) and expose revisions to SSAP No. 5R and SSAP No. 72 to incorporate guidance on when certain freestanding instruments shall be recognized as liabilities and not equity.

1) **Proposed Revisions to SSAP No. 86—Derivatives:**

63. This statement adopts with modification revisions to ASC 815 as reflected within ASU 2016-05, *Effect of Derivative Contract Novations on Existing Hedge Accounting Relationships*. This guidance is modified to require prospective application, as such it is only applicable to future counterparty changes in derivative instruments, and this guidance cannot be used to adjust derivative transactions previously terminated. This statement adopts revisions to ASC 815-20-25-15 as reflected within ASU 2010-08, *Technical Corrections to Various Topics*. This statement adopts revisions to ASC 815-10-50-4K as reflected within ASU 2010-11, *Derivatives and Hedging (Topic 815), Scope Exception Related to Embedded Credit Derivatives*. 

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This statement, but rejects all other GAAP revisions from ASU 2010-11 and ASU 2014-16, Derivatives and Hedging, Determining Whether the Host Contract in a Hybrid Financial Instrument Issued in the Form of a Share is More Akin to Debt or to Equity and ASU 2016-06, Derivatives and Hedging, Contingent Put and Call Options in Debt Instruments. These GAAP revisions are rejected as embedded derivatives are not separated from the host contract and recognized as derivatives under SSAP No. 86. Revisions are also incorporated to SSAP No. 86 to require disclosures on embedded credit derivatives that expose the holder of a financial instrument to the possibility of being required to make future payments. This disclosure is a modification to the GAAP disclosures specific to statutory accounting as embedded credit derivatives are not separately recognized under statutory accounting.

b. This statement rejects ASU 2017-11, Accounting for Certain Financial Instruments with Down Round Features; Replacement of the Indefinite Deferral for Mandatorily Redeemable Financial Instruments of Certain Noncontrolling Interests with a Scope Exception.

64. It should be noted that the conclusions reached in this statement are not intended to usurp the rules and regulations put forth by states in their respective investment laws. The contents of this statement are intended to provide accounting guidance on the use of derivatives as allowed by an insurer’s state of domicile. It is not intended to imply that insurers may use derivatives or cash instruments that the insurer’s state of domicile does not allow under the state’s insurance regulatory requirements, e.g., in replication transactions.

2) Proposed Revisions to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets:

Although NAIC previously believed that instruments with both characteristics of debt and equity were not commonly issued by insurance entities, NAIC Staff has recently received a state query focused on this issue. NAIC staff recommends introducing key concepts from ASC Topic 480, Distinguishing Liabilities from Equity, Subsection 25, (which are materially identified in SSAP No. 104R—Share-Based Payments) into SSAP No. 5R.

SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets.

Financial Instruments with Characteristics of both Liabilities and Equity

26. Issued, free-standing financial instruments with characteristics of both liability and equity shall be reported as a liability to the extent the instruments embodies an unconditional obligation of the issuer. (Pursuant to SSAP No. 86, embedded features in derivative contracts shall not be separated from the host contract for separate recognition.) Free-standing financial instruments that meet any of the criteria below meet the definition of a liability:

a. A mandatorily redeemable financial instrument shall be classified as a liability unless the redemption is required to occur only upon the liquidation or termination of the issuing reporting entity.

b. A financial instrument, other than an outstanding share, that at inception both 1) embodies an obligation to repurchase the issuer’s equity shares or is indexed to such an obligation and 2) requires or may require the issuer to settle the obligation by transferring assets.

c. Obligations that permit the holder to require the issuer to transfer assets.

d. A financial instrument is a liability if the issuer must settle the obligation by issuing a variable number of its equity shares and the obligation’s monetary value is based solely or predominantly on: 1) a fixed monetary amount, 2) variation in something other than the fair
value of the issuer’s equity shares, or 3) variations inversely related to changes in the fair value of the issuer’s equity shares.

e. Instruments in which the counterparty (holder) is not exposed to the risks and benefits that are similar to those of a holder of an outstanding share of the entity’s equity shall be classified as a liability.

27. If a free-standing financial instrument will be redeemed only upon the occurrence of a conditional event, redemption of that instrument is conditional and, therefore, the instrument does not meet the definition of mandatorily redeemable financial instrument. However, that financial instrument shall be assessed each reporting period to determine whether circumstances have changed such that the instrument meets the definition of a mandatorily redeemable instrument (that is, the event is no longer conditional). If the event has occurred, the condition is resolved, or the event has become certain to occur, the financial instrument shall be reclassified as a liability.

28. The classification of a free-standing financial instrument as a liability or equity shall only apply to the instrument issuer. Holders or purchasers of such instruments shall refer to the appropriate investment statement for valuation and reporting.

For brevity, the remaining paragraphs for SSAP No. 5R have been omitted but will be renumbered accordingly.

3) Proposed Revisions to SSAP No. 72—Surplus and Quasi-Reorganizations:

While proposed key concepts from ASC Topic 480 are detailed in SSAP No. 5R, additional reference language for the statutory accounting of capital stock is detailed below.

SSAP No. 72—Surplus and Quasi-Reorganizations

Capital Stock

3. The articles of incorporation set forth the number of authorized shares of capital stock and the par value of each share. The capital stock account represents the number of shares issued times the par value of each share. When no par value is set forth, the reporting entity shall declare a “stated value” and record such amount in the capital stock account. Changes in the par value of a reporting entity’s capital stock shall be reflected as a reclassification between the capital stock account and gross paid-in and contributed surplus. Issued, free-standing financial instruments with characteristics of both liability and equity shall be reported as a liability to the extent described in SSAP No. 5R.

Staff Review Completed by: Jim Pinegar – October 2019

Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions, as illustrated above, to SSAP No. 86—Derivatives to reject ASU 2017-11, Earning Per Share, Distinguishing Liabilities from Equity, Derivatives & Hedging and incorporate guidance into SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets and SSAP No. 72—Surplus and Quasi-Reorganizations for when certain freestanding instruments shall be recognized as liabilities and not as equity.
On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions, as illustrated above, to SSAP No. 86—Derivatives to reject ASU 2017-11, Earning Per Share, Distinguishing Liabilities from Equity, Derivatives & Hedging and incorporate guidance into SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets and SSAP No. 72—Surplus and Quasi-Reorganizations for when certain freestanding instruments shall be recognized as liabilities and not as equity.
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**Issue: ASU 2013-11, Presentation of an Unrecognized Tax Benefit**

**Check (applicable entity):**

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**Description of Issue:**

Topic 740, *Income Taxes* did not include explicit guidance for the financial statement presentation of an “unrecognized tax benefit” when a net operating loss carryforward, a similar tax loss, or a tax credit carryforward exists. An unrecognized tax benefit generally reflects a tax position that does not meet the ASC 740 more-likely-than-not recognition threshold, but to a certain extent owes its existence to an uncertain tax position. A more-likely-than-not threshold requires a recognized benefit of having a greater than 50 percent likelihood of being realized upon settlement. Prior to ASU 2013-11, *Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists*, there was diversity in the U.S. GAAP presentation of unrecognized tax benefits. Some entities reported unrecognized tax benefits as a liability in certain circumstances, while others presented unrecognized tax benefits as a reduction of a deferred tax asset for net operating loss or tax credit carryforwards.

The objective of ASU 2013-11 is to eliminate the reporting diversity to better reflect the manner in which an entity would settle additional income taxes that would result from the disallowance of a tax position when a net operating loss carryforward, similar tax loss, or tax credit carryforward exists.

ASU 2013-11 states that unrecognized tax benefits should generally be presented in the financial statements as a reduction to a deferred tax asset when a net operating loss carryforward, a similar tax loss, or a tax credit carryforward exists. This presentation should be followed except in circumstances in which a net operating loss / tax credit carryforward is not available as of the reporting date to settle any additional income taxes that would result from the disallowance of a tax position, or the entity does not intend to use the deferred tax asset for such purpose. In these cases, the unrecognized tax benefit should be presented in the financial statements as a liability and not combined with deferred tax assets.

The assessment of whether a deferred tax asset is available is based on the unrecognized tax benefit and deferred tax asset that exists at the reporting date and should be made presuming disallowance of the tax position at that reporting date.

The FASB definition of an Unrecognized Tax Benefit (per the FASB Codification Glossary) is as follows:

**Unrecognized Tax Benefit** - The difference between a tax position taken or expected to be taken in a tax return and the benefit recognized and measured pursuant to Subtopic 740-10.

**Existing Authoritative Literature:**

By definition, unrecognized tax benefits have a lower than 50 percent likelihood of being realized upon final settlement. As required in *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets* and again referenced in *SSAP No. 101—Income Taxes*, for the purposes of determining a tax contingency, it shall be presumed that the reporting entity will be examined by a relevant taxing authority. Further, as there is a lower than 50 percent
likelihood of these items being sustained, they should be recognized in current income taxes as covered in SSAP No. 101.

**SSAP No. 101, paragraph 3 excerpts:**

3. "Income taxes incurred" shall include current income taxes, the amount of federal and foreign income taxes paid (recovered) or payable (recoverable) for the current year. Current income taxes are defined as:

a. Current year estimates (including quarterly estimates) of federal and foreign income taxes payable or refundable, based on tax returns for the current and prior years, except as addressed in paragraph 3.b., and tax loss contingencies (including related interest and penalties) for current and all prior years, computed in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets with the following modifications:

i. The term "probable" as used in SSAP No. 5R shall be replaced by the term "more likely than not (a likelihood of more than 50 percent)" for federal and foreign income tax loss contingencies only.

ii. For purposes of the determination of a federal and foreign income tax loss contingency, it shall be presumed that the reporting entity will be examined by the relevant taxing authority that has full knowledge of all relevant information.

iii. If the estimated tax loss contingency is greater than 50% of the tax benefit originally recognized, the tax loss contingency recorded shall be equal to 100% of the original tax benefit recognized.

b. Amounts incurred or received during the current year relating to prior periods, to the extent not previously provided, as such amounts are deemed to be changes in accounting estimates as defined in SSAP No. 3—Accounting Changes and Corrections of Errors.

c. In determining when tax loss contingencies associated with temporary differences should be included in current income taxes under paragraph 3.a., and therefore included in deferred taxes under paragraph 7, a reporting entity is not required to "gross-up" its current and deferred taxes until such time as an event has occurred that would cause a re-evaluation of the contingency and its probability of assessment, e.g., the IRS has identified the item as one which may be adjusted upon audit. Such an event could be the reporting entity's (or its affiliate or parent in a consolidated income tax return) receipt of a Form 5701, Proposed Audit Adjustment, or could occur earlier upon receipt of an Information Document Request. At such time, the company must reassess the probability of an adjustment, reasonably re-estimate the amount of tax contingency as determined in accordance with paragraph 3.a., make any necessary adjustment to deferred taxes, and re-determine the admissibility of any adjusted gross deferred tax asset as provided in paragraph 11.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** N/A

IFRS does not include specific guidance on the presentation of unrecognized tax benefits.
Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 101 to reject ASU 2013-11 for statutory accounting.

By definition, unrecognized tax benefits have a lower than 50 percent likelihood of being utilized (resulting in future tax savings), and as such, should be recognized in current income taxes as required by SSAP No. 101, paragraph 3. This ASU allows, as an election of the reporting entity, reporting of unrecognized tax benefits on the balance sheet (as a reduction to deferred tax assets) while statutory accounting requires immediate recognition through current income tax expense. As these unrecognized tax benefits are not deferred tax items and NAIC SAP tries to limit optionality in the financial statements, NAIC staff proposes to reject the ASU and retain existing statutory accounting guidance.

Proposed Revisions to SSAP No. 101:


Staff Review Completed by Jim Pinegar – August 2019

Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 101—Income Taxes, illustrated above, to reject ASU 2013-11, Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists for statutory accounting.

Consideration for the 2020 Spring National Meeting:
While not affecting statutory guidance, NAIC staff support the removal of the IFRS convergence statement as proposed by interested parties, in the agenda item. (This is shown as a tracked change in the agenda item and does not impact the proposed statutory accounting resolution.)

On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 101—Income Taxes, as illustrated above, to reject ASU 2013-11, Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists for statutory accounting.
Issue: Disclosure Update for Reciprocal Jurisdiction Reinsurers

Check (applicable entity):

- Modification of Existing SSAP: X
- New Issue or SSAP: 
- Interpretation: 

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X | | X

Description of Issue:
On June 25, 2019, NAIC Executive Committee and Plenary adopted revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to incorporate relevant provisions from the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” and the “Bilateral Agreement Between the United States of America and the United Kingdom Regarding Insurance and Reinsurance” (collectively referred to as the Covered Agreement). The purpose of this agenda item is to revise one disclosure in SSAP No. 62R—Property and Casualty Reinsurance to reference “reciprocal jurisdictions.”

Existing Authoritative Literature:
The Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786), as they are adopted by the states are the primary legal guidance for credit for reinsurance.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Revisions to Appendix A-785 were exposed at the Summer National Meeting, and a Blanks proposal will be exposed at the Reinsurance (E) Task Force at the Fall National Meeting and by the Blanks (E) Working Group after the Fall National Meeting.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None.


Staff Recommendation:
NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions SSAP No. 62R to incorporate disclosure updates for reinsurers from Reciprocal Jurisdictions. The proposed revisions are illustrated below:

106. Unsecured Reinsurance Recoverables:

a. If the entity has with any individual reinsurers, authorized, reciprocal jurisdiction, unauthorized, or certified an unsecured aggregate recoverable for losses, paid and unpaid including IBNR, loss adjustment expenses, and unearned premium, that exceeds 3% of the entity’s policyholder surplus, list each individual reinsurer and the unsecured aggregate recoverable pertaining to that reinsurer; and

Staff Review Completed by: Jake Stultz—July 2019

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Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 62R—Property and Casualty Reinsurance, as illustrated above, to incorporate disclosure updates for reinsurers from Reciprocal Jurisdictions.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, the revisions to SSAP No. 62R—Property and Casualty Reinsurance, as illustrated below, to incorporate disclosure updates for reinsurers from Reciprocal Jurisdictions.

106. Unsecured Reinsurance Recoverables:

a. If the entity has with any individual reinsurers, authorized, reciprocal jurisdiction, unauthorized, or certified an unsecured aggregate recoverable for losses, paid and unpaid including IBNR, loss adjustment expenses, and unearned premium, that exceeds 3% of the entity’s policyholder surplus, list each individual reinsurer and the unsecured aggregate recoverable pertaining to that reinsurer; and

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Issue: ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities

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Description of Issue: The FASB issued ASU 2016-14 to provide more useful information to donors, grantors, creditors, and other financial statements users of not-for-profit (NFP) entities. This update is to improve the current net asset classification requirements and the information presented in financial statements regarding liquidity, financial performance, and cash flows. While several changes were implemented within this ASU, the main provisions include:

- The presentation of two classes of net assets – with donor restrictions and without donor restrictions. Due to complexities regarding the appropriate use of the previous three classes of net assets (unrestricted, temporarily restricted, and permanently restricted) that focused on the absence or presence of donor-imposed restrictions and whether those restrictions were temporary or permanent, this ASU designates presentation of two classes of net assets. Changes in these two classes of net assets are to be reported on the statement of activities.

- The presentation of operating cash flows may continue to use the direct or indirect method of reporting, but no longer require the presentation or disclosure of the indirect method (reconciliation) if using the direct method.

Additionally, numerous disclosures enhancements were included this update, several are highlighted below:

- The composition of net assets with donor restrictions and how the restrictions affect the use of such resources.
- For resources without donor-imposed restrictions, the applicable amounts and designated purposes, appropriations, and similar actions that result in self-imposed limits on the use of such resources.
- Information that communicates how the NFP manages liquid resources to meet its cash needs for general expenditures for one year following the balance sheet date.
- Regarding ‘underwater endowment funds’ (a fund in which its fair value is less than the original gift amount or the amount required to be maintained by donor restrictions); disclosures concerning the NFP’s policy, and any actions taken during the period concerning appropriation from underwater endowment funds and the fair value of such funds. Additionally, disclosures regarding the original gift amounts (or level required by donor or law) to be maintained and amount by which the funds are deficient.
- Use, in the absence of donor restrictions, the placed-in-service approach for reporting expirations of restrictions on gifts of cash or other assets to be used to acquire or construct a long-lived asset, thus reclassifying amounts from “net assets with donor restrictions” to “net assets without donor restrictions” as long-lived assets that have been placed in service as of the beginning of the period of adoption (eliminating
the previous option to release the donor-imposed restriction over the estimated useful life of the acquired asset).

**Existing Authoritative Literature:** While there is SAP guidance for the financial statement presentation of assets, the concept of separating assets based on imposed donor restrictions and the inclusion of other similar related disclosures is not a presentation format that is applicable for statutory accounting purposes.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** None - There are no specific NFP accounting and reporting standards in IFRS.

**Staff Recommendation:** NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject *ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities* as not applicable to statutory accounting.

This item is proposed to be rejected as not applicable as statutory accounting guidance does not separately present assets based on donor restrictions. If assets are restricted, they must be identified as restricted in the investment schedules and captured in the restricted note disclosure. Furthermore, the concept of donor-restrictions for insurance reporting entities is not identified to be a prevalent concept.

**Staff Review Completed by: Jim Pinegar – August 2019**

**Status:**
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject *ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities* as not applicable to statutory accounting.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject *ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities* as not applicable to statutory accounting.
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Issue: Update Reporting Deposit-Type Contracts

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Description of Issue: This agenda item has been drafted in response to questions identified by the Financial Stability (EX) Task Force in developing liquidity disclosure changes to the 2019 life blank, and the noted inability to fully identify and assess deposit-type contracts - (particularly guaranteed investment contracts) - within the statutory financial statements. From information received, it appears that in some instances deposit-type contracts are being reported along with life contracts in Exhibit 5 – Aggregate Reserves for Life Contracts or in Exhibit 6 – Aggregate Reserves for Accident and Health Contracts, rather than in Exhibit 7 – Deposit-Type Contracts.

This issue has been raised as payout requests for deposit-type contracts are significantly different than payouts generated by an insured event (mortality or morbidity). The Task Force identified that information on liabilities, particularly those that can be called with little or no surrender penalty, must be known to properly complete liquidity assessments.

After various discussions, it is anticipated that guaranteed investment contracts (GICs) are reported as a life contract or accident and health contract (and not a deposit-type contract) for one of the following reasons:

- The GIC was a “supplemental” contract formed from the proceeds of a life / A&H insurance contract.
- The GIC, although absent mortality or morbidity risk, was written on a life / A&H insurance “paper.”
- The state insurance department has approved the GIC to be classified as a life / A&H insurance contract.
- Contracts may be designed as GICs, but could potentially have mortality / morbidity components, which qualifies the contract to be reported as a life or A/H insurance contract.

The purpose of this agenda item is to solicit information regarding the reporting of GICs (and other deposit-type contracts) as life or A/H contracts in the reporting exhibits, and consider revisions to statutory accounting and reporting instructions to ensure that information regarding all GICs can be separately identifiable and aggregated from the financial statements.

Existing Authoritative Literature:

SSAP No. 50—Classifications of Insurance or Managed Care Contracts

5. Insurance contracts providing any protection against death, disability, accident or illness in which the reporting entity assumes mortality or morbidity risk shall be classified as life or accident and health contracts, as applicable. Managed care contracts provide defined health care services to subscribers, members or policyholders, collectively referred to hereafter as subscribers, in return for fixed, periodic premiums (usually paid monthly) that are generally due at or before the beginning of the coverage period and shall be classified as health contracts. Contracts which insure against damage to property by an insured peril or damage or injury to the insured or third parties, generally over a fixed/limited period of time, shall be classified as property and casualty contracts.
Contracts in which the reporting entity does not assume any mortality, morbidity, health benefit costs incurred, or casualty risk and which act exclusively as investment vehicles shall be classified as deposit-type contracts. Such classification shall be made at the inception of the contract and shall not change.

14. Supplementary contracts with life contingencies are a type of agreement between the insurance company and either the insured or the beneficiary, usually to provide for full or partial settlement of the amount payable upon the termination of an original contract. Generally, the proceeds are paid over the lifetime of one or more beneficiaries. This differs from a supplementary contract without life contingencies under which the proceeds are paid over a definite period without regard to the life of the beneficiary.

Deposit-Type Contracts

43. Deposit-type contracts do not incorporate insurance risk. Contracts issued by insurers that do not incorporate risk from the death or disability of policyholders (mortality or morbidity risk) are more comparable to financial or investment instruments issued by other financial institutions than to insurance contracts.

44. Deposit-type contracts shall include contracts without any life or disability contingencies, including, but not limited to, certain types of the following policy categories:

a. Supplemental contracts
b. Lottery payouts
c. Structured settlements
d. Guaranteed interest contracts
e. Income settlement options
f. Dividend and coupon accumulations
g. Annuities certain
h. Premium and other deposit funds
i. Funding Agreements without well-defined class-based (e.g. age, gender) annuity purchase rates defining either specific or maximum purchase rate guarantees (see SSAP No. 15, paragraph 19, paragraph 20 of this statement and SSAP No. 52—Deposit-Type Contracts, paragraph 21.)

45. Under deposit-type contracts, the policyholder may assume all, some, or none of the investment risk, depending on the contract terms. Amounts can be deposited in lump sum, or periodically as allowed by the policy contract. Deposit-type contracts would include annuities certain, whose income payments have no reference to life contingencies and benefits are paid over a specified period (i.e., 10 years, 20 years, etc.).

SSAP No. 51R—Life Contracts

Policy Reserves

15. Statutory policy reserves shall be established for all unmatured contractual obligations of the reporting entity arising out of the provisions of the insurance contract. Where separate benefits are included in a contract, a reserve for each benefit shall be established as required in Appendix A.
These statutory policy reserves have historically been calculated as the excess of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. For policies issued on or after the operative date of the Valuation Manual, these formulaic calculations will be supplemented for some policies with more advanced deterministic and stochastic reserve methodologies to better reflect company experience, possible economic conditions and inherent policy risks. Statutory policy reserves meet the definition of liabilities as defined in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R). The actuarial methodologies referred to in paragraph 16 meet the criteria required for reasonable estimates in SSAP No. 5R.

The reserving methodologies and assumptions used in computation of policy reserves shall meet the provisions of Appendices A-820 and A-822. Policies written prior to the operative of the Valuation Manual shall additionally follow the actuarial guidelines found in Appendix C of this Manual. Policies written on or after operative of the Valuation Manual shall additionally follow the Valuation Manual and be subject to the actuarial guidelines referenced therein. Further, policy reserves shall be in compliance with those Actuarial Standards of Practice promulgated by the Actuarial Standards Board.

Supplemental Benefits

40. In addition to the basic policy benefit, the insurance contract may provide supplemental benefits. Supplemental benefits include, but are not limited to, accidental death benefits and waiver of premium benefits. If the terms of the contract provide for these benefits, appropriate reserves shall be established in accordance with the applicable standards within the Accounting Practices and Procedures Manual.

SSAP No. 52—Deposit-Type Contracts

2. As discussed in SSAP No. 50, deposit-type contracts are those contracts that do not subject the reporting entity to any risks arising from policyholder mortality or morbidity. A mortality or morbidity risk is present if, under the terms of the contract, the reporting entity is required to make payments or forego required premiums contingent upon the death or disability (in the case of life and disability insurance contracts) or the continued survival (in the case of annuity contracts) of a specific individual or group of individuals.

3. Deposit-type contracts frequently grant policyholders significant discretion over the amount and timing of deposits and withdrawals. Reporting entities are frequently granted significant discretion over amounts that accrue to or that are assessed against policyholders.

4. Due to the absence of mortality and/or morbidity risk and the discretionary characteristics noted in paragraph 3, the accounting principles for income recognition and policy reserves for deposit-type contracts differ from the accounting for life contracts set forth in SSAP No. 51R—Life Contracts, accident and health contracts established in SSAP No. 54R—Individual and Group Accident and Health Contracts, and credit insurance contracts as discussed in SSAP No. 59—Credit Life and Accident and Health Insurance Contracts.

5. Categories of contracts that may not subject the reporting entity to risks arising from policyholder mortality or morbidity include, but are not limited to, certain types of the following policy categories:

   a. Supplemental contracts
   b. Lottery payouts
   c. Structured settlements
   d. Guaranteed interest contracts
   e. Income settlement options
f. Dividend and coupon accumulations

g. Annuities certain

h. Premium and other deposit funds

**Income Recognition**

6. Contracts issued by a reporting entity that do not incorporate mortality or morbidity risk shall not be accounted for as insurance contracts. Amounts received as payments for such contracts shall not be reported as revenues but shall be recorded directly to an appropriate policy reserve account.

**Policy Reserves**

7. Statutory policy reserves shall be established for all contractual obligations of the reporting entity arising out of the provisions of the contract. Where separate benefits are included in a contract, a reserve for each benefit shall be established as required in Appendix A-820. Statutory policy reserves meet the definition of liabilities as defined in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R). The actuarial methodologies referred to in paragraph 8 meet the criteria required for reasonable estimates in SSAP No. 5R.

8. The reserving methodologies and assumptions used in computation of policy reserves shall meet the provisions of Appendices A-820 and A-822, and the actuarial guidelines found in Appendix C of this Manual. Further, policy reserves shall be in compliance with those Actuarial Standards of Practice promulgated by the Actuarial Standards Board.

9. The policy reserve for contracts without life contingencies where the future benefits are fixed and guaranteed (e.g., certain supplemental contracts, lottery payouts, structured settlements, guaranteed interest contracts, income settlement options, annuities certain, and unmatured coupon accumulations) shall be based on the present value of the future guaranteed benefits discounted at the valuation interest rate. The policy reserve for all other contracts (e.g., certain premium and other deposit funds, and dividend and matured coupon accumulations) shall be based on the accumulated amounts paid plus an income accumulation based on the contract provisions, less any withdrawals and applicable surrender charges.

10. Statutory policy reserves for those group annuity contracts or other contracts that, in whole or in part, establish the insurer’s obligations by reference to a segregated portfolio of assets not owned by the insurer shall be established in accordance with the guidance in Appendix A-695. Statutory policy reserves for those contracts with nonlevel premiums or benefits, or contracts with secondary guarantees shall be established in accordance with the guidance in Appendix A-830. Statutory policy reserves for those group life contracts utilizing a separate account that meet the requirements outlined in paragraph 1 of Appendix A-200 shall be computed in accordance with the guidance in that appendix.

11. Policy reserves shall be increased for reinsurance assumed and decreased for reinsurance ceded as further described in SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** Agenda Item 2018-28: Updates to Liquidity Disclosures, and proposed revisions to SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, were adopted by the SAPWG during the Fall 2018 National Meeting. This agenda item was developed in response to Financial Stability (Ex) Task Force recommendations to enhance existing disclosures on annuity actuarial reserves and deposit-type liabilities.
Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose this agenda item with a request for comments on why GICs, or other deposit-type contracts, are reported in Exhibit 5 – Life Contracts or Exhibit 6 – Accident and Health Contract, instead of Exhibit 7 – Deposit Type Contracts. With exposure, a referral will be sent to the Life Actuarial Task Force to inform them of the inquiry and request their comments. Although NAIC staff recommends delaying revisions to statutory accounting or reporting instructions until better knowing why these classifications occur, it is anticipated that clarification may be considered to ensure that separate reserve recognition, which is already required in SSAP No. 51R, requires separate reporting on the appropriate exhibit.

Staff Review Completed by:
Julie Gann, NAIC Staff – January 2019

Status:
On April 6, 2019, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed this agenda item with a request for comments on why guaranteed investment contracts (GICs), or other deposit-type contracts, are reported in Exhibit 5 – Life Contracts or Exhibit 6 – Accident and Health Contract, instead of Exhibit 7 – Deposit Type Contracts. With exposure, the Working Group directed a referral to the Life Actuarial (A) Task Force to inform them of the exposure and request comments.

On August 3, 2019, the Statutory Accounting Principles (E) Working Group exposed this agenda item with the inclusion of the items and questions noted below, with a request for additional comments from industry and state insurance regulators, and directed notifications of the exposure with a request for comments to the Financial Stability (EX) Task Force and the Life Actuarial (A) Task Force on the reporting of insurance contracts that do not have a mortality or morbidity risk.

1. **Classification at Issuance** – The interested parties noted that because a contract was life-contingent at issue, it is reported in Exhibit 5, and then it remains in Exhibit 5 after the death of the annuitant.

   **Question** – Is it appropriate to classify products based on original issuance when the original risks are no longer present in the contract? Is this simply past industry practice, or is there direction that prevents reclassification to the category that most appropriately reflects the risk? Preliminary information received from the Financial Stability (EX) Task Force (FSTF) staff has noted that this practice will make it more difficult to properly aggregate and assess deposit-type contracts, and that this assessment is important as the payouts for deposit-type contracts are significantly different than payouts generated by an insured event. The Task Force has identified that information on liabilities, particularly those that can be called quickly with little or no surrender penalty, is of critical importance to liquidity assessments.

2. **State Approval** – The interested parties noted that state insurance departments have the discretion to approve or require a contract to be classified as a life or A/H insurance contract.

   **Question** – If a state directs reporting differently than what is stipulated in the AP&P Manual, is that being captured as a permitted or prescribed practice? (The provisions in SSAP No. 1 require permitted /
prescribed practice reporting when it results in different statutory reporting. Examples included in SSAP No. 1 include gross or net presentation, financial statement reporting lines, etc.)

3. **Annuity Guidance** – The interested parties cited existing annuity guidance in paragraph 20 of *SSAP No. 50—Classifications of Insurance or Managed Care Contracts*. Per this guidance, contracts containing well-defined class-based (e.g., age / gender) annuity purchase rates used in defining either a specific or maximum purchase rate guarantee would constitute an annuity contract containing a life contingency that would require it to be classified as a life contract.

**Question** – NAIC staff agrees with the citation from interested parties on annuities in paragraph 20 of *SSAP No. 50—Classifications of Insurance or Managed Care Contracts*. However, with the intent to have more explicit product breakouts to allow for better assessment, is it time to clarify / revise this guidance to result with the appropriate breakouts created by FSTF? It was noted that the current concepts were established a long time ago and there is a focus on non-traditional insurance liabilities (which includes funding agreements) for liquidity risk assessment as they can have higher run risk.

4. **Materiality of Issue** – Although the interested parties cite a “common” scenario, without information in the financial statements, there is no current ability to identify the extent contracts with no remaining mortality or morbidity risk are reflected as life contracts.

**Question** – To what extent are deposit-type contracts captured in an exhibit other than Exhibit 7? Is it possible to receive information from companies regarding this population for assessment purposes?

*Excerpt from SSAP No. 50, paragraph 20:*

1. An annuity contract is an arrangement whereby an annuitant is guaranteed to receive a series of stipulated amounts commencing either immediately or at some future date. The contract shall be issued to or for the benefit of an identifiable individual or group of individuals. **Such a contract containing well-defined class-based (e.g., age, gender) annuity purchase rates used in defining either a specific or maximum purchase rate guarantee would constitute an annuity contract containing a life contingency that would require it to be classified as a life contract.** Some examples of contracts issued for the benefit of a group of individuals include pension plan sponsors purchasing contracts for the benefit of their plan participants, employers or associations purchasing contracts for the benefit of their employees or members, and collective trusts purchasing contracts for the benefit of participating pension plans and their plan participants. **The main types of annuity contracts with life contingencies are discussed below.**

   a. A deferred annuity provides for the accumulation of funds to be applied at some future period designated by the policyholder. Premium payments can be made in a lump sum amount (single premium deferred annuity), or periodically (flexible or fixed premium deferred annuity) as allowed by the policy contract. At the end of the accumulation period, the policyholder may elect to receive a lump sum distribution or may elect to receive periodic payments for life, or over a specific period, or some combination thereof;

   b. A variable annuity is an annuity which includes a provision for benefit payments which vary in accordance with the rate of return of the underlying investment portfolio selected by the policyholder. The considerations for a variable annuity are usually invested in a separate account in which the value of the contract share varies according to the performance of the separate account before the commencement of annuity payments as well as after. Premium payments can be made in lump sum amounts or periodically as allowed by the policy contract. A minimum death benefit is often guaranteed during the annuity consideration accumulation period and these contracts are, therefore, classified as life contracts;
c. A straight-life annuity provides for periodic payments to the annuitant as long as the annuitant lives. Death of the annuitant constitutes completion of the contract and no further payments are made by the insurance company;

d. A life annuity with a period certain works essentially the same way as the straight-life annuity as the annuitant receives periodic payments for as long as the annuitant lives. However, if the annuitant dies before the end of the specified “certain” period, payments are continued to a beneficiary until the specified number of “certain” payments (i.e., the specified period in the contract) is completed;

e. A refund annuity is similar to the life annuity with a period certain in which the annuitant receives periodic payments for as long as the annuitant lives. There are two variants of this type of annuity. Under the cash refund annuity, a lump-sum payment is made at the death of the annuitant equal to the excess, if any, of the purchase price of the annuity over the sum of the annuity payments made to date of death. The installment refund annuity provides that annuity payments are to continue to a beneficiary after the death of the annuitant until the sum of all payments made equals the purchase price;

f. A joint and survivorship annuity provides for the continuation of payments after the death of one of the annuitants during the lifetime of the surviving annuitant.

Updates for 2019 Fall National Meeting:

NAIC staff recommend exposing agenda item 2019-08 to: 1) request feedback on the inclusion of a footnote excerpt for Exhibit 5 to disclose cases when a mortality risk is no longer present or a significant factor – i.e. due to a policyholder electing a payout benefit, 2) request feedback on circumstances where a morbidity risk is no longer present or a significant factor for Exhibit 6 items and whether a similar footnote disclosure would be appropriate, and 3) industry input for instruction clarifications regarding the classifications of deposit-type contracts captured in Exhibit 7.

Proposed Exhibit 5 Footnote Disclosure:

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<td>Miscellaneous Reserves</td>
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</tbody>
</table>

(a) Included in the above table are amounts that originally contained a mortality risk. Amounts that no longer contain a mortality risk are $_______ in Column 2 (Life Insurance), $_______ in Column 2 (Annuities), $_______ (Supplementary Contracts with Life Contingencies), $_______ (Accidental
Exhibit 7 Classification Instructions:

Instructions for Exhibit 7 (Deposit-Type Contracts) are detailed below. NAIC staff believes ambiguity exists in reporting categories and definition improvements would benefit financial statement preparers and users. NAIC staff request industry input on the definitional terms and suggestions for improvement/clarification to ensure items are appropriately captured and reported without the risk of category (column) crossover.

This exhibit is intended to capture information about the activity, before and after any reinsurance, for deposit-type contracts. Include supplementary contracts without life contingencies, annuities certain, income settlements options, premium and deposit funds, and other contracts as defined in SSAP No. 52—Deposit-Type Contracts.

- Column 2: Guaranteed Interest Contracts – contracts that do not subject the reporting entity to any mortality or morbidity risk
- Column 3: Annuities Certain – amounts settled under contracts without any mortality or morbidity risk, e.g., certain immediate annuity contracts amounts associated with lottery payouts, structured settlements, income settlement options or other amounts where payments are for a fixed period or amount. To exclude amounts reported in Column 2 or 4.
- Column 4: Supplemental Contracts (without life contingencies) - amounts resulting from proceeds settled under a settlement option provision of a life or annuity contract without any mortality or morbidity risk.
- Column 5: Dividend Accumulations or Refunds - amounts held on account related to contracts without any mortality or morbidity risk.
- Column 6: Premium and Other Deposit Funds - amounts not reported elsewhere in this exhibit for contracts that do not incorporate any mortality or morbidity risk.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group exposed this agenda item to: 1) request feedback on the inclusion of a footnote excerpt for Exhibit 5 (as shown above) to disclose cases when a mortality risk is no longer present or a significant factor - i.e. due to a policyholder electing a payout benefit, 2) request feedback on circumstances where a morbidity risk is no longer present or a significant factor for Exhibit 6 items and whether a similar footnote disclosure would be appropriate, and 3) requested industry and regulator input for instruction clarifications regarding the classifications of deposit-type contracts captured in Exhibit 7. With this exposure, there are no proposed edits for statutory accounting. The Working Group directed NAIC staff to notify the Financial Stability (Ex) Task Force of this exposure.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted a recommendation for annual statement revisions to Exhibit 5, Life Contracts, including minor edits from the exposure which are illustrated below. This adopted Exhibit 5 footnote recommendation will disclose when mortality risk is no longer present. The proposal will also be forwarded to the Blanks (E) Working Group. There are no statutory accounting revisions from this agenda item.

The previously exposed Exhibit 5 Footnote, with shaded revisions highlighting the changes from the original exposure, are shown below:

Included in the above table are amounts that originally contained a mortality risk. Amounts in Column 2, that no longer contain a mortality risk are $_________ in Column 2 (Life Insurance), $_________ in
The following Exhibit 5 Footnote, as adopted is as follows:

Included in the above table are amounts that originally contained a mortality risk. Amounts in Column 2, that no longer contain a mortality risk are $ ________ (Life Insurance), $ ________ (Annuities), $ ________ (Supplementary Contracts with Life Contingencies), $ ________ (Accidental Death Benefits), $ ________ (Disability – Active Lives), $ ________ (Disability – Disabled Lives), $ ________ (Miscellaneous Reserves).
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Reporting of Installment Fees and Expenses

Check (applicable entity):

<table>
<thead>
<tr>
<th>Modification of existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Issue or SSAP</td>
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<tr>
<td>Interpretation</td>
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Description of Issue:
NAIC staff has recently received questions regarding whether certain fees shall be reported as policy premium. SSAP No. 53—Property Casualty Contracts—Premiums, paragraph 6, provides specific guidance that allows for installment fees that meet specified criteria to be excluded from premium and reported as other income. An installment fee is the amount the policyholder pays if they make the choice to pay their premium on an installment basis. This fee is allowed to be excluded from premium income if it is an avoidable amount by the policyholder and the policy would not be cancelled for nonpayment of the installment fee.

NAIC staff has received regulator requested clarifications regarding potential diversity in the application of the SSAP No. 53 installment fee guidance on the following issues:

1. The first issue recommends additional language to ensure that the installment fee guidance continues to be narrowly applied, because the regulator became aware of some reporting entities seeking to analogize the application of the installment fee guidance to exclude other fees from premium income. Given the historical discussion on this paragraph, NAIC staff notes that the installment fee guidance is intended to be applied narrowly to a specific instance described in SSAP No. 53, footnote 1 and it should not be used to exclude other fees from being reported as premium.

2. The second issue pertains to the reporting of expenses related to the installment fee (other revenue). The regulator noted that while reporting entities were reporting the installment fees in other income, there was diversity in practice for the related installment fee expenses. Most entities were reporting the installment fee expenses in underwriting expenses where there are clear reporting lines for such expenses in the underwriting exhibits. Other entities were reporting the installment fee expenses either as a contra amount to finance and service charges not included in premium or as a contra amount to “aggregate write-ins for miscellaneous income.” The amounts are being reported as “contra” to other income because there is not an explicit reporting line in the property and casualty statement of income for expenses not related to underwriting (See Authoritative Literature). This agenda item requests feedback to address potential diversity in reporting.

Note that SSAP No. 35R—Guaranty Fund and Other Assessments also provides guidance regarding when a reporting entity is acting as an agent on behalf of a state or federal agency. This guidance is different than the installment fee guidance under discussion.

Existing Authoritative Literature:

SSAP No. 53—Property Casualty Contracts—Premiums (bolding added for emphasis)

3. Except as provided for in paragraph 4, written premium is defined as the contractually determined amount charged by the reporting entity to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses associated with the
coverage provided by the terms of the insurance contract. Frequently, insurance contracts are subject to audit by the reporting entity and the amount of premium charged is subject to adjustment based on the actual exposure. Premium adjustments are discussed in paragraphs 10-13 of this statement.

4. For workers' compensation contracts, which have a premium that may periodically vary based upon changes in the activities of the insured, written premiums may be recorded on an installment basis to match the billing to the policyholder. Under this type of arrangement, the premium is determined and billed according to the frequency stated in the contract, and written premium is recorded on the basis of that frequency.

5. Premiums for prepaid legal expense plans shall be recognized as income on the gross basis (amount charged to the policyholder or subscriber exclusive of copayments or other charges) when due from policyholders or subscribers, but no earlier than the effective date of coverage, under the terms of the contract. Due and uncollected premiums shall follow the guidance in SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers (SSAP No. 6), to determine the admissibility of premiums and related receivables.

6. Written premiums for all other contracts shall be recorded as of the effective date of the contract. Upon recording written premium, a liability, the unearned premium reserve, shall be established to reflect the amount of premium for the portion of the insurance coverage that has not yet expired. Flat fee service charges on installment premiums1 (fees charged to policyholders who pay premiums on an installment basis rather than in full at inception of contract) are reported in the Other Income section of the Underwriting and Investment Exhibit as Finance and Service Charges. Flat fee service charges on installment premiums, which do not meet the requirements outlined in footnote 1 (e.g., policy may be cancelled for non-payment of fee or fee is refundable), shall be recorded as written premium on the effective date of the contract and subject to the unearned premium guidelines included in paragraph 8.

Footnote: 1 If the policyholder elects to pay an installment rather than the full amount or the full remaining balance, the policyholder is traditionally charged a flat fee service charge on the subsequent billing cycle(s). The amount charged is primarily intended to compensate the insurer for the additional administrative costs associated with processing more frequent billings and has no relationship to the amount of insurance coverage provided, the period of coverage, or the lost investment income associated with receiving the premium over a period of time rather than in a lump sum. As described, there is no underwriting risk associated with this service charge. If a policyholder does not pay the service charge, the policy is not cancelled (unlike non-payment of premium), but instead the policy is converted back to an annual pay plan. If a policyholder cancels coverage, the premium is returned but the service charge is not, as the service charge is not a part of premium. Clarification of finance and service charges as other income should not be construed as having any bearing on whether such charges are subject to premium taxation, which remains an issue of state law and regulation.

**SSAP No. 35R—Guaranty Fund and Other Assessments**

Acting as an Agent for Collection and Remittance of Fees and Assessments

15. In certain circumstances, a reporting entity acts as an agent for certain state or federal agencies in the collection and remittance of fees or assessments. In these circumstances, the liability for the fees and assessments rests with the policyholder rather than with the reporting entity. The reporting entity’s obligation is to collect and subsequently remit the fee or assessment. (INT 02-22) When both the following conditions are met, an assessment shall not be reported in the statement of operations of a reporting entity:
a. The assessment is reflected as a separately identifiable item on the billing to the policyholder; and

b. Remittance of the assessment by the reporting entity to the state or federal agency is contingent upon collection from the insured.

16. The impact to the statement of operations depends on the nature of the charge:

a. For charges which are the ultimate responsibility of the policyholder, follow existing guidance in paragraph 15, and pass these charges and recoveries through the balance sheet with no impact to the statement of operations

b. For charges which are the ultimate responsibility of the reporting entity and may be recovered all or in part, apply gross or net reporting in the statement of operations as appropriate based on the nature of the charge and recovery. For example, charges which are considered in rate development or for which the recovery is classified as premium should be reported gross, charges for which recovery is considered a reduction of the expense should be reported net.

c. For collection or administrative fees, report such fees as revenue in the statement of operations as “Finance and Service Charges Not Included in Premiums” or “Aggregate Write-Ins for Miscellaneous Income”.

**SSAP No. 71—Policy Acquisition Costs**

2. Acquisition costs are those costs that are incurred in the **acquisition of new and renewal insurance contracts** and include those costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). **Acquisition costs and commissions shall be expensed as incurred.** Determination of when acquisition costs and commissions have been incurred shall be made in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets.

**Property/Casualty Annual Statement Instructions**

**Statement of Income**

Line 13 – Finance and Service Charges Not Included in Premiums

Report finances and service charges pursuant to the recognition guidance in **SSAP No. 53—Property Casualty Contracts—Premiums**. If a company cedes 100% of its business to an affiliate or utilizes an intercompany pooling arrangement and pools finance and service charges, include intercompany assumed and ceded amounts (i.e., report such income net of intercompany pooling). Charges should also be reported on Schedule T by jurisdiction.

**Schedule T EXHIBIT OF PREMIUMS WRITTEN ALLOCATED BY STATES & TERRITORIES**

Column 8 – Finance and Service Charges Not Included in Premiums

Report finance and service charges on direct business pursuant to the recognition guidance in SSAP No. 53—Property Casualty Contracts-Premiums. If a company cedes 100% of its business to an pooling arrangement and pools such charges, exclude the intercompany assumed and ceded amount incorporated in Page 4, Line 13.
APPENDIX

PROPERTY AND CASUALTY LINES OF BUSINESS

These definitions should be applied when reporting all applicable amounts for the following schedules: Underwriting and Investment Exhibit Parts 1, 1A, 1B, 2, and 2A; Exhibit of Premiums and Losses (Statutory Page 14); and the Insurance Expense Exhibit. Policy fees, service charges or membership charges are to be included with the line of business or in Other Income, as determined by SSAP No. 53—Property Casualty Contracts—Premiums.

Property and Casualty Annual Statement Blank

STATEMENT OF INCOME

UNDERWRITING INCOME

1. Premiums earned (Part 1, Line 35, Column 4) .................................................................
2. Deductions:
   2a. Losses incurred (Part 2, Line 35, Column 7) .............................................................
   2b. Loss adjustment expenses incurred (Part 3, Line 25, Column 1) ..............................
   2c. Other underwriting expenses incurred (Part 3, Line 25, Column 2) .......................
   2d. Write-ins for underwriting deductions .................................................................
3. Total underwriting deductions (Lines 2 through 5) .....................................................
4. Net income of protected cells ...................................................................................
5. Net underwriting gain (loss) (Line 1 minus Line 6 plus Line 7) .................................

INVESTMENT INCOME

6. Net investment income earned (Exhibit of Net Investment Income, Line 17) ...........
7. Net realized capital gains (losses) less capital gains tax of $ (Exhibit of Capital Gains (Losses)) .................................................................
8. Net investment gain (loss) (Lines 9 + 10) ..............................................................

OTHER INCOME

9. Net gain (loss) from agents' or premium balances charged off
   (amount recovered $ .......................................................... amount charged off $ ...........)
10. Finance and service charges not included in premiums ...........................................
11. Aggregate write-ins for miscellaneous income .......................................................
12. Total other income (Lines 12 through 14) ..............................................................
13. Net income before dividends to policyholders, after capital gains tax and before all other federal and foreign income taxes (Lines 8 + 11 + 15) .................................................................
14. Dividends to policyholders ....................................................................................
15. Net income, after dividends to policyholders, after capital gains tax and before all other federal and foreign income taxes (Line 16 minus Line 17) .................................................................
16. Federal and foreign income taxes incurred ..........................................................
17. Net income (Line 18 minus Line 19) (to Line 22) .......................................................

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): The footnote to SSAP No. 53, paragraph 6 was previously updated by agenda item 2001-34: SSAP No. 53 and reporting of installment fees which was adopted in June 2002.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None.

Staff Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose proposed revisions to SSAP No. 53 and request comments as detailed below. In addition, it is recommended that the Working Group request comments on reporting installment fee expenses as detailed below.

1. Installment fee and services charges guidance should be applied narrowly to the specific situation described and not analogized to exclude other fees from written premium.
2. Request comments on incurred installment fee expenses and notify the Casualty Actuarial (C) Task Force and the Property and Casualty Risk Based Capital (E) Working Group of the exposure, particularly regarding installment fee expenses.

**Detailed Recommendations:**

Issue 1 – The installment fee and services charges guidance in *SSAP No. 53—Property Casualty Contracts—Premiums*, paragraph 6, footnote 1, for evaluating flat fee service charges on installment premiums, should be applied narrowly to the specific situation described and not analogized to exclude other fees from written premium.

Prior Working Group revisions (in agenda item 2001-34) to footnote 1 in SSAP No. 53 illustrate that the installment premium processing fee guidance is meant to be interpreted narrowly and that the payment in full or by installment is a choice by the policyholder and represents an avoidable amount. The criteria is intentionally narrow and specific to installment fees. It is incorrect to apply this guidance to other fees. **Key underlying points to this response are:**

**Reporting** - All insurance reporting entities bear the cost of issuing a policy, issuing endorsements, and cancelling or reinstating policies whether that is accomplished directly or indirectly through an outside party. SSAP No. 71 provides that policy acquisition costs are expensed as incurred. Costs of issuing and servicing a policy are part of underwriting expenses therefore most “fees” are not intended to be excluded from premium.

**Premium tax** - NAIC staff notes that classifying amounts collected from policyholders by agents / managing general agents or third-party administrators as fees, which are excluded from written or earned premium, is an issue that many jurisdictions are familiar with as an attempt to avoid paying premium taxes. In addition, SSAP No. 53, paragraph 6, footnote 1 provides that “Clarification of finance and service charges as other income should not be construed as having any bearing on whether such charges are subject to premium taxation, which remains an issue of state law and regulation.”

**Risk Based Capital** - The classification of amounts out of premium revenue and into other income and other expense instead of underwriting expenses changes the risk-based capital charges for insurance risk. The RBC charge on insurance risk is based on the loss / loss adjustment expense ratio and the combined ratio which includes underwriting expenses.

**Issue 2 – Should incurred installment fee expenses be reported in other expenses?**

- SSAP No. 53 allows for installment fee income that meets specified criteria to be excluded from premium and reported as other income with finance and service charges, however it does not separately address the related installment fee expenses incurred by the reporting entity.
- The annual statement instructions provide that the expenses that are most commonly associated with installment expense such as postage printing and stationery are reported in underwriting expenses. These expenses and their related revenue are typically immaterial for most property and casualty products but are material for some nonstandard product writers. Having a mismatch between underwriting revenue / underwriting expenses and other revenue / other expenses can affect a reporting entity’s combined ratio as the combined ratio considers the losses, loss adjusting expenses and underwriting expenses.
- From a purely conceptual basis, it might be more consistent if the installment fee expenses are reported in other expenses. This is because it is a theoretical mismatch in the annual statement to report the installment fees in other revenue and have the related expenses in underwriting expenses. While this might be better theoretical match to have both the revenue and expense in the same category, NAIC staff notes that not
having “other expenses” in the property and casualty income statement seems to be an intentional choice as there are no “other expense” reporting lines. Therefore an “other expense” would have to be reported as a contra revenue.

- If incurred installment fee expenses were to be reported in other expenses, a reporting location would need to be determined as there is not an annual statement line to accommodate such reporting. If it was reported, it would most likely have to be report as a contra amount in “Aggregate Write-Ins for Miscellaneous Income” (not in underwriting expenses) as netting it in Finance and service charges would not provide transparency. Further, if reported, limitations would need to be determined – i.e. expenses not to exceed installment fee revenue.

Questions for exposure:

a. Should the Working Group develop guidance to allow installment fee expenses associated with fees that are reported in other income according to the criteria in SSAP No. 53 be permitted reported in or as an expense in “Other Income?”

b. If included in Other Income, should the expense be classified as a contra revenue in or “Aggregate Write-Ins for Miscellaneous Income”?

c. Installment fees and expenses are often immaterial for property and casualty except for nonstandard writers. Comments are also requested on allowing diversity in reporting installment fee expenses (that is optional to report as other expense category of contra other revenue Aggregate Write-Ins for Miscellaneous Income”, particularly for immaterial amounts.

Ultimately adoption of any such guidance would also require updates to the existing annual statement instructions.

NAIC staff recommends that the Working Group expose the following revisions to the existing footnote in SSAP No. 53:

6. Written premiums for all other contracts shall be recorded as of the effective date of the contract. Upon recording written premium, a liability, the unearned premium reserve, shall be established to reflect the amount of premium for the portion of the insurance coverage that has not yet expired. Flat fee service charges on installment premiums1 (fees charged to policyholders who pay premiums on an installment basis rather than in full at inception of contract) are reported in the Other Income section of the Underwriting and Investment Exhibit as Finance and Service Charges. Flat fee service charges on installment premiums, which do not meet the requirements outlined in footnote 1 (e.g., policy may be cancelled for non-payment of fee or fee is refundable), shall be recorded as written premium on the effective date of the contract and subject to the unearned premium guidelines included in paragraph 8.

1 If the policyholder elects to pay an installment rather than the full amount or the full remaining balance, the policyholder is traditionally charged a flat fee service charge on the subsequent billing cycle(s). The amount charged is primarily intended to compensate the insurer for the additional administrative costs associated with processing more frequent billings and has no relationship to the amount of insurance coverage provided, the period of coverage, or the lost investment income associated with receiving the premium over a period of time rather than in a lump sum. As described, there is no underwriting risk associated with this service charge. If a policyholder does not pay the service charge, the policy is not cancelled (unlike non-payment of premium), but instead the policy is converted back to an annual pay plan. If a policyholder cancels coverage, the premium is returned but the service charge is not, as the service charge is not a part of premium. Note that this footnote on flat fee service charges on installment premium is intentionally narrow and specific and this guidance should not be applied to other fees or service charges. Clarification reporting of installment fees in of finance and service charges as other income should not be construed as having any bearing on whether such charges are subject to premium taxation, which remains an issue of state law and regulation.
Staff Review Completed by:
Robin Marcotte - October 2019

Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 53—Property Casualty Contracts—Premiums, as illustrated above. Comments are also requested on the reporting of installment fee expenses, as noted above. Additionally, the Casualty Actuarial (C) Task Force and Property and Casualty Risk Based (E) Working Group will be notified of this exposure.

For 2020 Spring National Meeting Discussion:

Because the items under discussion can impact loss ratios and information reported in Schedule P, during the 2019 Fall National Meeting exposure, the Working Group directed notice of the exposure and the request for comments to the Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk-Based Capital (E) Working Group. Both groups have indicated that they do not expect to have a response on the installment fee expense comments until after the Spring National Meeting. NAIC staff has forwarded the 2020 comments received to both groups.

NAIC staff recommends that the Working Group take the following actions:

1. Adopt the exposed revision with the minor edit from interested parties. This revision clarifies that existing installment fee revenue guidance should be narrowly applied.

2. When comments on the installment fee expense are received from the Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk-Based Capital (E) Working Group it is recommended that those comments be discussed as a separate agenda item (if needed).

Proposed Revisions:

6. Written premiums for all other contracts shall be recorded as of the effective date of the contract. Upon recording written premium, a liability, the unearned premium reserve, shall be established to reflect the amount of premium for the portion of the insurance coverage that has not yet expired. Flat fee service charges on installment premiums1 (fees charged to policyholders who pay premiums on an installment basis rather than in full at inception of contract) are reported in the Other Income section of the Underwriting and Investment Exhibit as Finance and Service Charges. Flat fee service charges on installment premiums, which do not meet the requirements outlined in footnote 1 (e.g., policy may be cancelled for non-payment of fee or fee is refundable), shall be recorded as written premium on the effective date of the contract and subject to the unearned premium guidelines included in paragraph 8.

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should not be applied to other fees or service charges. **Clarification** reporting of installment fees in **of** finance and service charges as other income should not be construed as having any bearing on whether such charges are subject to premium taxation, which remains an issue of state law and regulation.

On March 18, 2020, The Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 53—*Property and Casualty Contracts—Premiums*, as illustrated below, with the minor edit of deleting the word “clarification” in the exposed footnote. The adopted revisions specify that existing installment fee revenue guidance should be narrowly applied. When comments on the installment fee expense are received from the Casualty Actuarial and Statistical (C) Force and the Property and Casualty Risk-Based Capital (E) Working Group, they will be discussed in a separate agenda item.

**Adopted Revisions:**

6. Written premiums for all other contracts shall be recorded as of the effective date of the contract. Upon recording written premium, a liability, the unearned premium reserve, shall be established to reflect the amount of premium for the portion of the insurance coverage that has not yet expired. Flat fee service charges on installment premiums1 (fees charged to policyholders who pay premiums on an installment basis rather than in full at inception of contract) are reported in the Other Income section of the Underwriting and Investment Exhibit as Finance and Service Charges. Flat fee service charges on installment premiums, which do not meet the requirements outlined in **footnote 1** (e.g., policy may be cancelled for non-payment of fee or fee is refundable), shall be recorded as written premium on the effective date of the contract and subject to the unearned premium guidelines included in paragraph 8.

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Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SSAP No. 25 – Disclosures

Check (applicable entity):

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<th>Modification of existing SSAP</th>
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Description of Issue:
This agenda item has been drafted to data-capture disclosures from SSAP No. 25—Affiliates and Other Related Parties. Currently, all disclosures from SSAP No. 25 are completed in a narrative (pdf) format. With the proposal to data-capture disclosures, the regulators can aggregate and query related party relationships.

This item is separate from an agenda item (Ref #2019-34) that is considering revisions to SSAP No. 25 to clarify the identification of related parties and consider enhanced disclosures for when there is a disclaimer of control approved by a domiciliary state and when a company outside of the holding company group owns more than 10% of the insurance reporting entity. This agenda item will follow a separate work stream to allow for year-end 2020 data capturing. If the revisions being considered under the separate agenda item are adopted by June 2020 (blanks deadline), then those disclosures may modify or expand the data templates proposed in this agenda item.

Existing Authoritative Literature:
(Note: The entire SSAP No. 25 has been included for ease of reference of existing guidance.)

SSAP No. 25—Affiliates and Other Related Parties

1. Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny. This statement establishes statutory accounting principles and disclosure requirements for related party transactions.

2. This statement shall be followed for all related party transactions, even if the transaction is also governed by other statutory accounting principles. Furthermore, this statement shall be followed in all transactions which involve unrelated parties as intermediaries between related parties. In determining whether a transaction is a related party transaction, consideration shall be given to the substance of the agreement and the parties whose actions or performance materially impact the insurance reporting entity under the transaction. For example, an investment acquired from a non-related intermediary in which the investment return is predominantly contingent on the performance of a related party shall be considered a related party investment. As a general principle, it is erroneous to conclude that the mere inclusion of a non-related intermediary eliminates the requirement to assess and properly identify the related party transaction in accordance with the provisions of this statement. It is also erroneous to conclude that the presence of non-related assets in a structure predominantly comprised of related party investments eliminates the requirement to assess and identify the investment transaction as a related party arrangement.

3. If a company receives the stock of an affiliated company as a capital contribution rather than through a purchase, the transaction shall be accounted for according to SSAP No. 25—Affiliates and Other Related Parties, SSAP No. 95—Nonmonetary Transactions, or SSAP No. 97—Investments in
Subsidiary, Controlled and Affiliated Entities, based on the details of each transaction. The statutory purchase method within SSAP No. 68—Business Combinations is not applicable for stock received as a capital contribution.

SUMMARY CONCLUSION

4. Related parties are defined as entities that have common interests as a result of ownership, control, affiliation or by contract. Related parties shall include but are not limited to the following:

a. Affiliates of the reporting entity, as defined in paragraph 5;

b. Trusts for the benefit of employees, such as pension and profit-sharing trusts and Employee Stock Ownership Plans that are managed by or under the trusteeship of management of the reporting entity, its parent or affiliates;

c. The principal owners of the reporting entity;

d. The management of the reporting entity, its parent or affiliates (including directors);

e. Members of the immediate families of principal owners and management of the reporting entity, its parent or affiliates and their management;

f. Parties with which the reporting entity may deal if either party directly or indirectly controls or can significantly influence the management or operating policies of the other to an extent that one of the transacting parties might be prevented from fully pursuing its own separate interest;

g. A party which can, directly or indirectly, significantly influence the management or operating policies of the reporting entity, which may include a provider who is contracting with the reporting entity. This is not intended to suggest that all provider contracts create related party relationships;

h. A party which has an ownership interest in one of the transacting parties and can significantly influence the other to an extent that one or more of the transacting parties might be prevented from fully pursuing its own separate interests;

i. Attorney-in-fact of a reciprocal reporting entity or any affiliate of the attorney-in-fact; and


5. An affiliate is defined as an entity that is within the holding company system or a party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. An affiliate includes a parent or subsidiary and may also include partnerships, joint ventures, and limited liability companies as defined in SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies. Those entities are accounted for under the guidance provided in SSAP No. 48, which requires an equity method for all such investments. An affiliate is any person that is directly or indirectly, owned or controlled by the same person or by the same group of persons, that, directly or indirectly, own or control the reporting entity.

6. Control is defined as the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the investee, whether through the (a) ownership of voting securities, (b) by contract other than a commercial contract for goods or nonmanagement services, (c) by contract for goods or nonmanagement services where the volume of activity results in a reliance relationship (d) by common management, or (e) otherwise. Control shall be presumed to exist if a reporting entity and
its affiliates directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% or more of the voting interests of the entity.

7. Control as defined in paragraph 6 shall be measured at the holding company level. For example, if one member of an affiliated group has a 5% interest in an entity and a second member of the group has an 8% interest in the same entity, the total interest is 13%, and therefore, each member of the affiliated group shall be presumed to have control. This presumption will stand until rebutted by an evaluation of all the facts and circumstances relating to the investment based on the criteria in FASB Interpretation No. 35, Criteria for Applying the Equity Method of Accounting for Investments in Common Stock, an Interpretation of APB Opinion No. 18. The corollary is required to demonstrate control when a reporting entity owns less than 10% of the voting securities of an investee. The insurer shall maintain documents substantiating its determination for review by the domiciliary commissioner. Examples of situations where the presumption of control may be in doubt include the following:

a. Any limited partner investment in a limited partnership, unless the limited partner is affiliated with the general partner.

b. An entity where the insurer owns less than 50% of an entity and there is an unaffiliated individual or group of investors who own a controlling interest.

c. An entity where the insurer has given up participation rights¹ as a shareholder to the investee.

8. Transactions between related parties must be in the form of a written agreement. The written agreement must provide for timely settlement of amounts owed, with a specified due date. Amounts owed to the reporting entity over ninety days from the written agreement due date shall be nonadmitted, except to the extent this is specifically addressed by other statements of statutory accounting principles (SSAPs). If the due date is not addressed by the written agreement, any uncollected receivable is nonadmitted.

Related Party Loans

9. Loans or advances (including debt, public or private) made by a reporting entity to its parent or principal owner shall be admitted if approval for the transaction has been obtained from the domiciliary commissioner and the loan or advance is determined to be collectible based on the parent or principal owner’s independent payment ability. An affiliate’s ability to pay shall be determined after consideration of the liquid assets or revenues available from external sources (i.e., determination shall not include dividend paying ability of the subsidiary making the loan or advance) which are available to repay the balance and/or maintain its account on a current basis. Evaluation of the collectibility of loans or advances shall be made periodically. If, in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, it is probable the balance is uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made. Pursuant to SSAP No. 72—Surplus and Quasi-Reorganization, forgiveness by a reporting entity of any debt, surplus note or other obligation of its parent or other stockholder shall be accounted for as a dividend.

10. Loans or advances by a reporting entity to all other related parties shall be evaluated by management and nonadmitted if they do not constitute arm’s-length transactions as defined in paragraph 13. Loans or advances made by a reporting entity to related parties (other than its parent or principal owner)

¹ The term “participating rights” refers to the type of rights that allows an investor to effectively participate in significant decisions related to an investee's ordinary course of business and is distinguished from the more limited type of rights referred to as “protective rights”. Refer to the sections entitled: “Protective Rights” and “Substantive Participating Rights” in EITF 96-16, Investor's Accounting for an Investee When the Investor Owns a Majority of the Voting Stock but the Minority Shareholder or Shareholders Have Certain Approval or Veto Rights. The term “participating rights” shall be used consistent with the discussion of substantive participating rights in this EITF.
that are economic transactions as defined in paragraph 13 shall be admitted. This includes financing arrangements with providers of health care services with whom the reporting entity contracts with from time to time. Such arrangements can include both loans and advances to these providers. Evaluation of the collectibility of loans or advances shall be made periodically. If, in accordance with SSAP No. 5R, it is probable the balance is uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made.

11. Any advances under capitation arrangements made directly to providers, or to intermediaries that represent providers, that exceed one month’s payment shall be nonadmitted assets.

12. Indirect loans are loans or extensions of credit to any person who is not an affiliate, where the reporting entity makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the reporting entity making the loans or extensions of credit. The admissibility of indirect loans made by a reporting entity for the benefit of its parent or principal owner shall be determined in accordance with the guidelines in paragraph 9. Indirect loans or advances made for the benefit of all other related parties shall be evaluated and accounted for consistent with loans or advances to related parties as described in paragraph 10 and paragraph 11.

Transactions Involving the Exchange of Assets or Liabilities

13. An arm’s-length transaction is defined as a transaction in which willing parties, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell, or loan, would be willing to participate. A transaction between related parties involving the exchange of assets or liabilities shall be designated as either an economic transaction or non-economic transaction. An economic transaction is defined as an arm’s-length transaction which results in the transfer of the risks and rewards of ownership and represents a consummated act thereof, i.e., “permanence.” The appearance of permanence is also an important criterion in assessing the economic substance of a transaction. In order for a transaction to have economic substance and thus warrant revenue (loss) recognition, it must appear unlikely to be reversed. If subsequent events or transactions reverse the effect of an earlier transaction prior to the issuance of the financial statements, the reversal shall be considered in determining whether economic substance existed in the case of the original transaction. Subsequent events are addressed in SSAP No. 9—Subsequent Events. An economic transaction must represent a bona fide business purpose demonstrable in measurable terms. A transaction which results in the mere inflation of surplus without any other demonstrable and measurable betterment is not an economic transaction. The statutory accounting shall follow the substance, not the form of the transaction.

14. In determining whether there has been a transfer of the risks and rewards of ownership in the transfer of assets or liabilities between related parties, the following—and any other relevant facts and circumstances related to the transaction—shall be considered:

   a. Whether the seller has a continuing involvement in the transaction or in the financial interest transferred, such as through the exercise of managerial authority to a degree usually associated with ownership;

   b. Whether there is an absence of significant financial investment by the buyer in the financial interest transferred, as evidenced, for example, by a token down payment or by a concurrent loan to the buyer;

   c. Whether repayment of debt that constitutes the principal consideration in the transaction is dependent on the generation of sufficient funds from the asset transferred;

   d. Whether limitations or restrictions exist on the buyer’s use of the financial interest transferred or on the profits arising from it;
e. Whether there is retention of effective control of the financial interest by the seller.

15. A transaction between related parties may meet the criteria for treatment as an economic transaction at one level of financial reporting, but may not meet such criteria at another level of financial reporting. An example of such a transaction is a reporting entity purchasing securities at fair value from an affiliated reporting entity that carried the securities at amortized cost. This transaction meets the criteria of an economic transaction at this level of financial reporting, and therefore, the selling reporting entity would record a gain and the acquiring reporting entity would record the securities at their cost (fair value on the transaction date). At the common parent level of reporting, this transaction has resulted in the mere inflation of surplus, and therefore, is a non-economic transaction. The parent reporting entity shall defer the net effects of any gain or increase in surplus resulting from such transactions by recording a deferred gain and an unrealized loss. The deferred gain shall not be recognized by the parent reporting entity unless and until arms-length transaction(s) with independent third parties give rise to appropriate recognition of the gain.

16. A non-economic transaction is defined as any transaction that does not meet the criteria of an economic transaction. Similar to the situation described in paragraph 15, transfers of assets from a parent reporting entity to a subsidiary, controlled or affiliated entity shall be treated as non-economic transactions at the parent reporting level because the parent has continuing indirect involvement in the assets.

17. When accounting for a specific transaction, reporting entities shall use the following valuation methods:

a. Economic transactions between related parties shall be recorded at fair value at the date of the transaction. To the extent that the related parties are affiliates under common control, the controlling reporting entity shall defer the effects of such transactions that result in gains or increases in surplus (see paragraph 15);

b. Non-economic transactions between reporting entities, which meet the definition of related parties above, shall be recorded at the lower of existing book values or fair values at the date of the transaction;

c. Non-economic transactions between a reporting entity and an entity that has no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the reporting entity or it’s affiliates, shall be recorded at the fair value at the date of the transaction; however, to the extent that the transaction results in a gain, that gain shall be deferred until such time as permanence can be verified;

d. Transactions which are designed to avoid statutory accounting practices shall be reported as if the reporting entity continued to own the assets or to be obligated for a liability directly instead of through a subsidiary.

Examples of transactions deemed to be non-economic include security swaps of similar issues between or among affiliated companies, and swaps of dissimilar issues accompanied by exchanges of liabilities between or among affiliates.

Transactions Involving Services

18. Transactions involving services between related parties can take a variety of different forms. One of the significant factors as to whether these transactions will be deemed to be arm’s length is the amount charged for such services. In general, amounts charged for services are based either on current market rates or on allocations of costs. Determining market rates for services is difficult because the circumstances surrounding each transaction are unique. Unlike transactions involving the exchange of assets and liabilities between related parties, transactions for services create income on one party’s books and expense on the second party’s books, and therefore, do not lend themselves to the mere inflation of surplus. These arrangements are generally subject to regulatory approval.
19. Transactions involving services provided between related parties shall be recorded at the amount charged. Regulatory scrutiny of related party transactions where amounts charged for services do not meet the fair and reasonable standard established by Appendix A-440, may result in (a) amounts charged being recharacterized as dividends or capital contributions, (b) transactions being reversed, (c) receivable balances being nonadmitted, or (d) other regulatory action. Expenses that result from cost allocations shall be allocated subject to the same fair and reasonable standards, and the books and records of each party shall disclose clearly and accurately the precise nature and details of the transaction. See SSAP No 70—Allocation of Expenses for additional discussion regarding the allocation of expenses.

Disclosures

20. The financial statements shall include disclosures of all material related party transactions. In some cases, aggregation of similar transactions may be appropriate. Sometimes, the effect of the relationship between the parties may be so pervasive that disclosure of the relationship alone will be sufficient. If necessary to the understanding of the relationship, the name of the related party should be disclosed. Transactions shall not be purported to be arm's-length transactions unless there is demonstrable evidence to support such statement. The disclosures shall include:

a. The nature of the relationships involved;

b. A description of the transactions for each of the periods for which financial statements are presented, and such other information considered necessary to obtain an understanding of the effects of the transactions on the financial statements. Exclude reinsurance transactions, any non-insurance transactions which involve less than ½ of 1% of the total admitted assets of the reporting entity, and cost allocation transactions. The following information shall be provided if applicable:

i. Date of transaction;

ii. Explanation of transaction;

iii. Name of reporting entity;

iv. Name of affiliate;

v. Description of assets received by reporting entity;

vi. Statement value of assets received by reporting entity;

vii. Description of assets transferred by reporting entity; and

viii. Statement value of assets transferred by reporting entity.

c. The dollar amounts of transactions for each of the periods for which financial statements are presented and the effects of any change in the method of establishing the terms from that used in the preceding period:

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2 The amount charged shall be reviewed when there are any modifications or waivers subsequent to the establishment of the contract terms. If waivers or modifications to amounts charged occur, the related party transaction shall be reassessed to determine whether the contract continues to reflect fair and reasonable standards. If the transaction was with a parent or other stockholder and the charge for services has been fully waived, then the guidance in SSAP No. 72 for recognition as contributed capital (forgiveness of reporting entity obligation) or as a dividend (forgiveness of amount owed to the reporting entity) shall apply.

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d. **Amounts due from or to related parties as of the date of each balance sheet presented and, if not otherwise apparent, the terms and manner of settlement:**

e. Any guarantees or undertakings, written or otherwise, shall be disclosed in accordance with the requirements of SSAP No. 5R. In addition, the nature of the relationship to the beneficiary of the guarantee or undertaking (affiliated or unaffiliated) shall also be disclosed;

f. **A description of material management or service contracts and cost-sharing arrangements involving the reporting entity and any related party.** This shall include, but is not limited to, sale lease-back arrangements, computer or fixed asset leasing arrangements, and agency contracts, which remove assets otherwise recordable (and potentially nonadmitted) on the reporting entity's financial statements;

g. The nature of the control relationship whereby the reporting entity and one or more other enterprises are under common ownership or control and the existence of that control could result in operating results or financial position of the reporting entity significantly different from those that would have been obtained if the enterprises were autonomous. The relationship shall be disclosed even though there are no transactions between the enterprises; and

h. The amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity, in accordance with the *Purposes and Procedure Manual of the NAIC Investment Analysis Office*, “Procedures for Valuing Common Stocks and Stock Warrants.”

**Current Annual Statement Illustrations for Completing Disclosures:**

**Illustration:**

A. The Company paid common stock dividends to the Parent Company, The ABC Insurance Company, on July 15, 20____, totaling $__________.

B. At December 31, 20____, the Company reported $_______ as amounts due to the Parent Company, The ABC Insurance Company. The terms of the settlement require that these amounts be settled within 30 days.

C. The Company has given XYZ Inc., an affiliated company, a standing commitment until January 1, 20____, in the form of guarantees in the event of a default of XYZ on various of its debt issues as disclosed in Note 14.

D. The Company has agreed to provide the Parent Company, The ABC Insurance Company, certain actuarial investment services with respect to the administration of certain large group insurance contracts that are subject to group experience rating procedures.

E. The Parent Company has agreed to provide collection services for certain contracts for the Company.

F. All outstanding shares of The Company are owned by the Parent Company, The ABC Insurance Company, an insurance holding company domiciled in the State of ________________.

G. The Company owns shares of the stock of its ultimate parent, The ABC Insurance Company. A wholly owned subsidiary of the Company, The XYZ Insurance Company, owns shares of The ABC Insurance Company. In accordance with Securities Valuation Office guidelines, the asset value of
The ABC Insurance Company has been reduced by $__________, and the asset value of the XYZ Insurance Company has been reduced by $__________.

1. The Company owns a ______ % interest in ABC Non-Insurance Company, whose carrying value is equal to or exceeds 10% of the admitted assets of The Company. The Company carries ABC Non-Insurance Company at GAAP equity plus the remaining Goodwill balance of $ ________. Goodwill is amortized on a straight-line basis over a ten-year period.

At 12/31/20___, The Company’s interest in ABC Non-Insurance Company per the New York Stock Exchange quoted price was valued at $__________, that was $ ________ in excess of the carrying value.

Based on The Company’s ownership percentage of ABC Non-Insurance Company, the statement value of ABC Non-Insurance Company assets and liabilities as of 12/31/20__ were $ ________ and $_______, respectively.

The Company’s share of net income of ABC Non-Insurance Company was $________ for the year ended 12/31/20__.

The Company has a 25% limited partnership interest in XYC Real Estate Partners. The partnership investment in office properties in the NE United States has been adversely affected by corporate restructuring. This has affected the value of the properties that resulted in the write-down of the Company’s investment in XYC Real Estate Partners of $__________ for the year ended 12/31/20__.

The amount of the impairment was determined using appraisals from third parties.

Activity to Date (issues previously addressed by the Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): On August 3, 2019, the Working Group adopted revisions to SSAP No. 25—Affiliates and Other Related Parties, SSAP No. 26R—Bonds, SSAP No. 32—Preferred Stock, SSAP No. 43R—Loan-backed and Structured Securities, and SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies to clarify the application of SSAP No. 25, as well as an “affiliated” classification, when a transaction is in substance a related party transaction. The revisions to SSAP No. 25 clarified that when determining a related party transaction, consideration shall be given to the substantive of the agreements, and the parties whose actions or performance materially impact the insurance reporting entity under the transaction. From these revisions, the following guidance was added as a new paragraph 2 to SSAP No. 25:

2. This statement shall be followed for all related party transactions even if the transaction is also governed by other statutory accounting principles. Furthermore, this statement shall be followed in all transactions which involve unrelated parties as intermediaries between related parties. In determining whether a transaction is a related party transaction, consideration shall be given to the substance of the agreement, and the parties whose actions or performance materially impact the insurance reporting entity under the transaction. For example, an investment acquired from a non-related intermediary, in which the investment return is predominantly contingent on the performance of a related party, shall be considered a related party investment. As a general principle, it is erroneous to conclude that the mere inclusion of a non-related intermediary eliminates the requirement to assess and properly identify the related party transaction in accordance with the provisions of this statement. It is also erroneous to conclude that the presence of non-related assets in a structure predominantly comprised of related party investments, eliminates the requirement to assess and identify the investment transaction as a related party arrangement.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS) and U.S. GAAP: None
Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose the proposed data-capture templates. A blanks proposal to expose is anticipated to occur concurrently with the Working Group exposure. With inclusion of the data templates, narrative (pdf) reporting shall still occur to provide additional information regarding the related party transactions. NAIC staff notes that the current narrative illustrations are fairly simple. NAIC staff requests comments on whether more robust illustrations are necessary, or whether the disclosures that historically have been provided in the financial statements have included the extent of information necessary and more detailed illustrations are not necessary in the annual statement instructions. **Note: Transactions with affiliates detailed in Schedule Y – Part 2, Summary of Insurer’s Transactions with Any Affiliates would not need to be duplicated in these data-captured charts. Narrative disclosure information regarding the transactions captured in Schedule Y-2 shall continue to be reported consistently with past reporting.**

Proposed Data Capture Templates:

1) **Detail of Material Related Party Transactions**

This data-template includes aspects from paragraphs 20, 20.b.i, 20.b.ii, 20.b.iii, 20.b.iv and 20.c.

Note – The information regarding the written agreement and due date are not specifically named in the SSAP No. 25 disclosure listing but are addressed in paragraph 7 of SSAP No. 25. Since paragraph 7 requires a written agreement with an established due date for admittance, these components are anticipated elements that would be disclosed in the 20.b provisions that require “description of the transactions for each of the periods in which financial statements are presented, and other such information considered necessary to obtaining an understanding of the effect of the transactions on the financial statements.”

Material related party transactions shall be captured in this template each year until the agreement / transaction has termination. (For example, if the agreement is a material service contract, it shall be disclosed in this template each year after origination of the contract until the contract is terminated.)

**Proposed Data-Capturing Templates:**

Each Material Related Party Transaction Listed Separately:

*(Related parties may be listed more than once if more than one material related party transaction.)*

**Note: Transactions involving affiliates captured on Schedule Y-2 do not need to be duplicated in these charts.**

<table>
<thead>
<tr>
<th>Date of Transaction</th>
<th>Name of Related Party</th>
<th>Nature of Relationship</th>
<th>Type of Transaction</th>
<th>Written Agreement (Y/N)</th>
<th>Due Date</th>
<th>Reporting Period Date Amount Due From (To)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Options for Type of Transaction:

- Loan
- Exchange of Assets or Liabilities (e.g., buys, sells and secured borrowing transactions)
- Management Services
- Cost-Sharing Agreement
2) **Detail of Material Related Party Transactions Involving Services**

This data-template includes aspects from paragraphs 20, 20.b.ii, 20.c and 20.f. (This chart provides additional information on service arrangements captured in chart 1.)

Note – The information regarding the amount charged, and whether the amount charged was based on an allocation of costs or market rates are not specifically named in the SSAP No. 25 disclosure listing but are addressed in paragraph 17 of SSAP No. 25. These components are anticipated elements that would be addressed in disclosure 20f with the “description of material management or service contracts and cost-sharing arrangements involving the reporting entity and any related party.”

**Transactions Involving Services:**
*Include transactions involving management services, cost-sharing agreements and other transactions involving services.*

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Overview Description</th>
<th>Amount Charged</th>
<th>Amount Based on Allocation of Costs or Market Rates</th>
<th>Amount Charged Modified or Waived (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3) **Detail of Material Related Party Transactions Involving Exchange of Assets and Liabilities**

This data-template includes aspects from paragraphs 20, 20.b.ii, 20.b.v, 20.b.vi, 20.b.vii, 20.b.viii, and 20.c. (This chart provides additional information on asset/liability exchanges captured in chart 1.)

**Transactions Involving Exchange of Assets and Liabilities:**
*Include loans, buys, sells and secured borrowing transactions.*

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Overview Description</th>
<th>Description of Assets Received</th>
<th>Description of Assets Transferred</th>
<th>Statement Value of Assets Received</th>
<th>Statement Value of Assets Transferred</th>
<th>Have Terms Changed from Preceding Period? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4) **Detail of Amounts Owed To/From a Related Party**

This data-template includes aspects from paragraph 20d. This data template shall include each related party that is identified with material transactions in chart 1 but shall include the total amount due from / to from that
related party. If there are transactions with the related party that were not captured in Chart 1 (perhaps as they were not material), they should be captured in the overall amount due from / to the related party.

This chart shall include related parties with immaterial transactions (not captured in Chart 1), if the aggregation of all transactions with the related party would be material to the reporting entity. (It is not required to include related parties in this chart if the transactions with the related party were individually immaterial and immaterial in the aggregate.)

Note: Pursuant to SSAP No. 64, paragraph 5 amounts due to or from affiliates shall be offset and reported net only when the provisions of paragraph 2 (valid right of setoff exists).

**Aggregate Reporting by Related Party**

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Aggregate Reporting Period Amount Due From</th>
<th>Aggregate Reporting Period (Amount Due To)</th>
<th>Amount Offset in Financial Statement (if qualifying)</th>
<th>Net Amount Recoverable / (Payable) by Related Party</th>
<th>Admitted Recoverable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Each related party shall be included only once.

**Staff Review Completed by: Julie Gann – October 2019**

**Status:**

On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed the proposed data-capture templates, as illustrated above. This exposure does not propose revisions to SSAP No. 25.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to **SSAP No. 25—Affiliates and Other Related Parties**, as illustrated below.

1. The exposed data-capture templates, as illustrated above, to data-capture disclosures from **SSAP No. 25—Affiliates and Other Related Parties**, which are currently in narrative format. A referral will be sent to the Blanks (E) Working Group to consider this for 2020 annual reporting.

2. Added an additional phrase to the existing disclosure in SSAP No. 25, paragraph 20, recommended by interested parties and illustrated below.

**Disclosures**

19. The financial statements shall include disclosures of all material related-party transactions. In some cases, aggregation of similar transactions, that on a stand-alone basis are not material, may be appropriate. Sometimes, the effect of the relationship between the parties may be so pervasive that disclosure of the relationship alone will be sufficient. If necessary to the understanding of the relationship, the name of the related party should be disclosed. Transactions shall not be purported to be arm's-length transactions unless there is demonstrable evidence to support such statement. The disclosures shall include:
a. The nature of the relationships involved;

b. A description of the transactions for each of the periods for which financial statements are presented, and such other information considered necessary to obtain an understanding of the effects of the transactions on the financial statements. Exclude reinsurance transactions, any non-insurance transactions which involve less than ½ of 1% of the total admitted assets of the reporting entity, and cost allocation transactions. The following information shall be provided if applicable:
Attachment One-H14
Accounting Practices and Procedures (E) Task Force
8/3/20
Ref #2019-39

Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Acceptable Collateral - Counterparty Exposure for Derivative Instruments.

Check (applicable entity):

<table>
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<th>P/C</th>
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</thead>
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<td>New Issue or SSAP</td>
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<td>☒</td>
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<tr>
<td>Interpretation</td>
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</tr>
</tbody>
</table>

Summary of Issue:
Potential misinterpretation for Blank instructions on Schedule DB-D, section 1, column 4 (Fair Value of Acceptable Collateral) exist as collateral is reported as 1) the fair value of collateral pledged by a counterparty, or 2) for central clearinghouses as the net positive variation margin received by the reporting entity.

NAIC staff believes the intent of net positive variation margin was originally meant to reflect net realizable margin. For example, if a reporting entity originally paid $5k as collateral to initiate a position, then subsequently received $15k in variation margin true-up, the reporting entity should report $10k in the fair value of acceptable collateral (assuming the counterparty has the legal right to offset the original $5k received). With the legal right to offset, in this example the holder can only realize a net $10k in collateral if liquidation were to occur. As the instructions indicate “net positive variation margin,” the variation collateral of $15k could be reported, disregarding the $5k initial margin.

Conversely, had the reporting entity received $5k in initial margin, and a subsequent $20k in variation margin, a total of $25k should be reported as collateral, thus giving credit for the initial margin received. NAIC staff believe this intent is articulated in SSAP No. 86, as collateral is defined in the disclosures as “net assets held.”

This agenda item included proposed clarification language that states collateral shall be determined by the summation of any assets held less any collateral paid/pledged from collateral received, if the counterparty has a legal right to offset as defined in SSAP No. 64.

Further Background:
Schedule DB – Part D, Section 1 of the Blanks facilitates reporting of counterparty exposure from open derivative instruments. As described in the Blanks instructions, counterparty exposure is credit risk associated with certain types of transactions; in relation to schedule DB, it is the credit risk associated with the use of derivative instruments. Schedule DB-D, Section 1 displays the book/adjusted carrying value and the fair value of counterparty exposure, net of acceptable collateral held by or pledged to the reporting entity. Due to the nature of risk being calculated and displayed net of collateral, this Form A is to facilitate a discussion regarding the technical definition regarding determination of value as it relates to collateral.

In 2012, the Blanks (E) Working Group adopted modifications to numerous derivative statements and related instructions. These updates were driven by differing clearing and collateral requirements for certain types of derivative investments as well as the need to ensure consistent and accurate reporting of derivative investment activity of insurers.

Various concepts were introduced including Schedule DB – Part D, Section 2, which captures detailed collateral information for open derivative instruments. Collateral held or received through a pledge typically covers some or all of the credit risk the holder possesses due to transactions exchanged with a counterparty. In terms of derivative
contracts, **collateral may be pledged** to exchanges, counterparties, clearing brokers or central clearinghouses **by the reporting entity or** pledged from these organizations **to the reporting entity**. While the specific items that are considered acceptable collateral are detailed herein, a common term for collateral is “margin.” There are typically three types of margin that apply to these financial instruments, broadly defined as:

- **Initial Margin** - the minimum amount of equity that must be held/pledged to **initiate** a position.
- **Maintenance Margin** - the minimum amount of equity that must be **maintained** in order to not have the position forcibly liquidated. Also defined as the net sum of initial and variation margin.
- **Variation Margin** - payments generally made based on adverse price movements, often paid by clearing members to reduce exposures created by open derivative positions. Variation margin could also be as a result of changes in maintenance margin requirements. The term **Variation Margin** for statutory purposes is defined below.

In the normal course of business, all applicable cashflows are typically utilized in the reporting of an activity. In the instance of margin, initial margin plus/minus variation margin equals total margin. Remaining within **SSAP No. 86—Derivatives**, there are many instances that demonstrate this principal. As described for the initial carrying value of a futures contact (reported as an asset), paraphrased guidance states that positions should be valued at the initial amount of cash deposits plus/minus any subsequent cash flows. Additionally, options, warrants, caps, and floors are initially valued at total premium paid or received. While subsequent valuations may differ (amortized cost or fair value depending on the reporting of the item being hedged), all associated cash flows were utilized for reporting.

**Existing Authoritative Literature:**
While described in general terms above, statutory accounting guidance for variation margin is as follows:

**SSAP No. 86 – Derivatives**
15. “Variation Margin” reflects the daily change in market value of derivative contracts (e.g., daily gain/loss on a derivative contract due to market movements). Amounts received/paid to adjust variation margin on derivative contracts that are both cleared and settled on an exchange shall be recognized as an adjustment to the carrying value of the derivative contract (e.g., futures). Amounts received/paid to adjust variation margin on all other derivative contracts shall be recognized on the balance sheet as an asset or liability separate from the carrying value of the derivative instrument. This treatment shall occur under statutory accounting regardless if the counterparty/exchange considers amounts exchanged for variation margin to be legal settlement or collateral. Changes in variation margin shall not be treated as realized gains or adjustments to the basis of the hedged item until the derivative contract has been sold, matured or expired.

Blanks instructions regarding the reporting of acceptable collateral, as it relates to counterparty exposures from open derivative investments, is as follows:

**Schedule DB – Part D – Section 1, Column 4 (Fair Value of Acceptable Collateral)**
- Fair Value of Acceptable Collateral
- Leave blank for the aggregate reporting of Exchange-Traded Derivatives (Line 0199999999).
- For OTC counterparties, show the Fair Value of acceptable collateral pledged by the counterparty.
- For central clearinghouses, this amount would be the **net positive variation margin received** by the reporting entity.

"**Acceptable collateral**" means cash, cash equivalents, securities issued or guaranteed by the United States or Canadian governments or their government-sponsored enterprises, letters of credit, publicly
traded obligations designated 1 by the SVO, government money market mutual funds, and such other items as may be defined as acceptable collateral in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. For purposes of this definition, the term “letter of credit” means a clean, irrevocable and unconditional letter of credit issued or confirmed by, and payable and presentable at, a financial institution on the list of financial institutions meeting the standards for issuing such letter of credit pursuant to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*. The letter of credit must have an expiration date beyond the term of the subject transaction.

SSAP No. 86 defines several disclosure items related to collateral. The primary intent of such disclosures is to reflect amounts available to cover exposure in the event the liquidation of collateral assets occurs. Key areas are highlighted herein.

**Disclosure Requirements**

59. Reporting entities shall disclose the following for all derivative contracts used:

   e. A seller of credit derivatives shall disclose information about its credit derivatives and hybrid instruments that have embedded credit derivatives to enable users of financial statements to assess their potential effect on its financial position, income and cash flows. The seller of a credit derivative shall disclose the following information for each credit derivative, or each group of credit derivatives, even if the likelihood of the seller’s having to make any payments under the credit derivative is remote. With respect to hybrid instruments that have embedded credit derivatives, the seller of the embedded credit derivative shall disclose the required information for the entire hybrid instrument, not just the embedded credit derivative.

      i. The nature of the credit derivative, including the approximate term of the credit derivative, the reason(s) for entering into the credit derivative, the events or circumstances that would require the seller to perform under the credit derivative, and the current status (that is, as of the date of the statement of financial position) of the payment/performance risk of the credit derivative. For example, the current status of the payment/performance risk of a credit derivative could be based on either recently issued external credit ratings or current internal groupings used by the seller to manage its risk. An entity that uses internal groupings shall disclose how those groupings are determined and used for managing risk.

      ii. The maximum potential amount of future payments (undiscounted) the seller could be required to make under the credit derivative. That maximum potential amount of future payments shall not be reduced by the effect of any amounts that may possibly be recovered under recourse or collateralization provisions in the credit derivative (which are addressed under paragraph 59.e.iv.). If the terms of the credit derivative provide for no limitation to the maximum potential future payments under the contract, that fact shall be disclosed. If the seller is unable to develop an estimate of the maximum potential amount of future payments under the credit derivative, the seller shall disclose the reasons why it cannot estimate the maximum potential amount.

      iii. The fair value of the credit derivative as of the date of the statement of financial position.

      iv. The nature of (1) any recourse provisions that would enable the seller to recover from third parties any of the amounts paid under the credit derivative and (2) any assets held either as collateral or by third parties that, upon the occurrence of any specified triggering event or condition under the credit derivative, the seller can obtain and liquidate to recover all or a portion of the amounts paid under the credit derivative. The seller shall indicate, if estimable, the approximate extent to which the proceeds from liquidation of those assets would be expected to cover the maximum potential amount of future payments under the credit derivative. In its estimate of potential recoveries, the seller of credit
A holder of a financial instrument with an embedded credit derivative that exposes the holder to the possibility (however remote) of being required to make future payments (not merely receive reduced cash inflows) because the possibility of those future payments is not caused by subordination (such as the subordination of one beneficial interest to another tranche of a securitization, thereby redistributing credit risk) shall provide the following disclosures for the entire hybrid instrument, not just the embedded credit derivative:

i. The nature of the embedded credit derivative, including the approximate term of the embedded credit derivative, the events or circumstances that would require the holder to perform under the embedded credit derivative, and the current status (that is, as of the date of the statement of financial position) of the payment/performance risk of the embedded credit derivative.

ii. The maximum potential amount of future payments (undiscounted) the holder could be required to make under the embedded credit derivative. That maximum potential amount of future payments shall not be reduced by the effect of any amounts that may possibly be recovered under recourse or collateralization provisions in the embedded credit derivative (which are addressed under paragraph 59.f.iv.). If the terms of the embedded credit derivative provide for no limitation to the maximum potential future payments under the contract, that fact shall be disclosed. If the holder is unable to develop an estimate of the maximum potential amount of future payments under the embedded credit derivative, the holder shall disclose the reasons why it cannot estimate the maximum potential amount.

iii. The fair value of the hybrid instrument containing the embedded credit derivative as of the date of the statement of financial position.

iv. The nature of (1) any recourse provisions that would enable the holder to recover from third parties any of the amounts paid under the embedded credit derivative and (2) any assets held either as collateral or by third parties that, upon the occurrence of any specified triggering event or condition under the embedded credit derivative, the holder can obtain and liquidate to recover all or a portion of the amounts paid under the credit derivative. The holder shall indicate, if estimable, the approximate extent to which the proceeds from liquidation of those assets would be expected to cover the maximum potential amount of future payments under the embedded credit derivative. In its estimate of potential recoveries, the holder of credit protection shall consider the effect of any purchased credit protection with identical underlying(s).

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 86 to clarify that the fair value of collateral received or held, for derivative disclosure purposes, shall be reported net of collateral paid/pledged, in the event a counterparty
has the legal right to offset against as defined in SSAP No. 64. Further, minor updates to applicable annual statement instructions are proposed to be concurrently exposed.

Disclosure Requirements

60. Reporting entities shall disclose the following for all derivative contracts used:

e. A seller of credit derivatives shall disclose information about its credit derivatives and hybrid instruments that have embedded credit derivatives to enable users of financial statements to assess their potential effect on its financial position, income and cash flows.

A seller of credit derivatives shall disclose information about its credit derivatives and hybrid instruments that have embedded credit derivatives to enable users of financial statements to assess their potential effect on its financial position, income and cash flows. The seller of a credit derivative shall disclose the following information for each credit derivative, or each group of credit derivatives, even if the likelihood of the seller’s having to make any payments under the credit derivative is remote. With respect to hybrid instruments that have embedded credit derivatives, the seller of the embedded credit derivative shall disclose the required information for the entire hybrid instrument, not just the embedded credit derivative.

i. The nature of the credit derivative, including the approximate term of the credit derivative, the reason(s) for entering into the credit derivative, the events or circumstances that would require the seller to perform under the credit derivative, and the current status (that is, as of the date of the statement of financial position) of the payment/performance risk of the credit derivative. For example, the current status of the payment/performance risk of a credit derivative could be based on either recently issued external credit ratings or current internal groupings used by the seller to manage its risk. An entity that uses internal groupings shall disclose how those groupings are determined and used for managing risk.

ii. The maximum potential amount of future payments (undiscounted) the seller could be required to make under the credit derivative. That maximum potential amount of future payments shall not be reduced by the effect of any amounts that may possibly be recovered under recourse or collateralization provisions in the credit derivative (which are addressed under paragraph 59.e.iv.). If the terms of the credit derivative provide for no limitation to the maximum potential future payments under the contract, that fact shall be disclosed. If the seller is unable to develop an estimate of the maximum potential amount of future payments under the credit derivative, the seller shall disclose the reasons why it cannot estimate the maximum potential amount.

iii. The fair value of the credit derivative as of the date of the statement of financial position.

iv. The nature of (1) any recourse provisions that would enable the seller to recover from third parties any of the amounts paid under the credit derivative and (2) any assets held either as collateral or by third parties that, upon the occurrence of any specified triggering event or condition under the credit derivative, the seller can obtain and liquidate to recover all or a portion of the amounts paid under the credit derivative. The seller shall indicate, if estimable, the approximate extent to which the proceeds from liquidation of those assets would be expected to cover the maximum potential amount of future payments under the credit derivative. In its estimate of potential recoveries, the seller of credit protection shall consider the effect of any purchased credit protection with identical underlying(s).

1 Collateral, as calculated on an individual derivative instrument basis, shall be determined by deducting collateral paid/pledged from collateral received if the counterparty has a legal right to offset as defined in SSAP No. 64.
f. A holder of a financial instrument with an embedded credit derivative that exposes the holder to the possibility (however remote) of being required to make future payments (not merely receive reduced cash inflows) because the possibility of those future payments is not caused by subordination (such as the subordination of one beneficial interest to another tranche of a securitization, thereby redistributing credit risk) shall provide the following disclosures for the entire hybrid instrument, not just the embedded credit derivative:

i. The nature of the embedded credit derivative, including the approximate term of the embedded credit derivative, the events or circumstances that would require the holder to perform under the embedded credit derivative, and the current status (that is, as of the date of the statement of financial position) of the payment/performance risk of the embedded credit derivative.

ii. The maximum potential amount of future payments (undiscounted) the holder could be required to make under the embedded credit derivative. That maximum potential amount of future payments shall not be reduced by the effect of any amounts that may possibly be recovered under recourse or collateralization provisions in the embedded credit derivative (which are addressed under paragraph 59.f.iv.). If the terms of the embedded credit derivative provide for no limitation to the maximum potential future payments under the contract, that fact shall be disclosed. If the holder is unable to develop an estimate of the maximum potential amount of future payments under the embedded credit derivative, the holder shall disclose the reasons why it cannot estimate the maximum potential amount.

iii. The fair value of the hybrid instrument containing the embedded credit derivative as of the date of the statement of financial position.

iv. The nature of (1) any recourse provisions that would enable the holder to recover from third parties any of the amounts paid under the embedded credit derivative and (2) any assets held either as collateral or by third parties that, upon the occurrence of any specified triggering event or condition under the embedded credit derivative, the holder can obtain and liquidate to recover all or a portion of the amounts paid under the credit derivative. The holder shall indicate, if estimable, the approximate extent to which the proceeds from liquidation of those assets would be expected to cover the maximum potential amount of future payments under the embedded credit derivative. In its estimate of potential recoveries, the holder of credit protection shall consider the effect of any purchased credit protection with identical underlying(s).

Proposed Blank Instructions Updates – Schedule DB-B, Section 1, Column 4

Fair Value of Acceptable Collateral

Leave blank for the aggregate reporting of Exchange-Traded Derivatives (Line 0199999999).

For OTC counterparties, show the Fair Value of acceptable net collateral pledged by the counterparty.

For central clearinghouses, this amount would be the total net positive variation margin received by the reporting entity.

Staff Review Completed by: Jim Pinegar, October 2019

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2 See footnote 1.
**Status:**
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 86—Derivatives, as illustrated above, to clarify that the fair value of collateral received or held, for derivative disclosure purposes, shall be reported net of collateral paid/pledged, in the event a counterparty has the legal right to offset against, as defined in SSAP No. 64—Offsetting and Netting of Assets and Liabilities. Minor updates to the applicable annual statement instructions were also proposed to be concurrently exposed.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group disposed this agenda item without statutory revisions. The original intent was to facilitate a discussion regarding whether a reporting entity should report or potentially receive ‘credit’ for initial margin pledged from a counterparty in central clearinghouse transactions, but it is noted that third-party derivative exposure is appropriately captured in the existing disclosure requirements and in the annual statements.
### Comment Letters Received for Items Exposed for the 2020 Summer National Meeting

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<thead>
<tr>
<th>COMMENTER / DOCUMENT</th>
<th>PAGE REFERENCE</th>
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<tbody>
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<td>Interested Parties – May 29, 2020</td>
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<tr>
<td>- Ref #2019-04: SSAP No. 32 – Investment Classification Project</td>
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<td>- Ref #2019-14: Attribution of Goodwill</td>
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<td>- Ref #2019-38: Financing Derivatives</td>
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<td>- Ref #2020-02: Accounting for Bond Tender Offers</td>
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<td>- Ref #2020-03: Enhanced Goodwill Disclosures</td>
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<td>- Ref #2020-04: Commissioner Discretion in the <em>Valuation Manual</em></td>
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<td>- Ref #2020-05: Repeal of the Affordable Care Act Section 9010 Assessment</td>
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<td>America’s Health Insurance Plans (AHIP) – April 27, 2020</td>
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<td>- Ref #2020-13: Request on 2020 Health Insurance Assessment</td>
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<td>Interested Parties – July 23, 2020</td>
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<td>- INT 20-09T: Basis Swaps – LIBOR Transition</td>
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May 29, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment During the NAIC Spring National Meeting Conference call with Comments due May 29

Dear Mr. Bruggeman:

Interested parties thank the NAIC Statutory Accounting Principles (E) Working Group (the “Working Group”) for your continuing effort to address the various statutory accounting issues arising from the ongoing pandemic caused by the novel coronavirus, COVID-19. We appreciate the opportunity to comment on the exposure drafts released for comment by the Working Group during its discussion on March 18, 2020. We offer the following comments:

Ref #2019-04: SSAP No. 32 – Investment Classification Project

The Working Group exposed the Issue Paper No. 1XX—Preferred Stock and substantively-revised draft SSAP No. 32—Preferred Stock with edits to reflect comments received from interested parties as well as a January 1, 2021 effective date.

Interested parties agree with the revisions made in response to our comments and the January 1, 2021 effective date.

Interested parties acknowledge the proposed footnote regarding preferred units issued by SSAP 48 entities. However, we suggest the wording changes in underline below so not to introduce a change in accounting or diversity in practice since the issuance of preferred units that are similar to preferred stock of a corporation generally occur in LLCs that are more corporate-like.

“Certain legal entities captured in SSAP No. 48 such as LLCs that are corporate-like do not issue preferred stock in legal form, but instead issue identical instruments labeled preferred units, interests, or shares. These instruments shall be captured in this statement...
provided they meet the structural characteristics as defined in paragraph 3. Additionally, these instruments shall not be in-substance common stock in which the holder has risk and reward characteristics that are substantially similar to common stock.”

Ref #2019-14: Attribution of Goodwill

The Working Group exposed this agenda item, with a revision from the prior exposure to exclude “pushdown” goodwill until the decision from the Working Group on that issue has been addressed. Additionally, the proposed disclosure included in the last exposure has been slightly modified to detail the downstream holding company application and the attribution of goodwill.

Interested parties thank the NAIC staff for meeting with a group of us to discuss this proposal and the circumstances it is intended to address. After discussing the proposal further with additional companies, we believe the draft guidance is complex and should be supplemented with illustrative guidance, i.e., a decision tree and an expansion of the examples in the proposal, to fully illustrate how the guidance is to be applied and improve consistency of application. To that end, we request a three-week extension during which we can develop the illustrative guidance and bring it back to the Working Group for consideration.

Ref #2019-38: Financing Derivatives

The Working Group exposed this agenda item with slight revisions from the prior exposure to delete the proposed new paragraph 19.c., as recommended by interested parties. The exposed revisions are intended to ensure consistency in the gross reporting of derivatives, without inclusion of financing components, and in reporting amounts owned to/from the reporting entity from the acquisition or writing of derivatives. With this exposure, a blanks proposal will be sponsored and notice of the proposed edits will be provided to the Capital Adequacy (E) Task Force.

Interested parties have no comments on this item.

Ref #2020-02: Accounting for Bond Tender Offers

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds, to clarify that the accounting and reporting of investment income and capital gain/loss, due to the early liquidation either through a call or a tender offer, shall be similarly applied. The current guidance refers to “prepayment penalties or acceleration fees in the event the bond is liquidated prior to its schedule termination date,” and includes all dynamics in which an issuer provides a penalty/fee to the holder to terminate the bond.

Interested parties request that the effective date for the updated guidance be set at January 1, 2021, so that insurers have sufficient time to make necessary systems changes to treat the excess compensation over market as a prepayment penalty as described in the updated guidance.
Ref #2020-03: Enhanced Goodwill Disclosures

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 68—*Business Combinations and Goodwill*, as illustrated above, to add additional goodwill disclosures. The proposed disclosures will improve the validity and accuracy of numbers currently being reported and will assist with the regulators’ review of reported assets not readily available for the payment of policyholder claims. Revisions to Schedule D, Part 6, Section 1 - Valuation of Shares of Subsidiary, Controlled and Affiliated Companies and Schedule D, Part 6, Section 2 - Valuation of Shares of Subsidiary, Controlled and Affiliated Companies primarily focus on the current reference to intangible assets.

Interested parties request that the proposal be revised (similar to Ref #2019-14) to exclude “pushdown” goodwill until the Working Group concludes on that issue. We also note that item 3 of the Description of the Issue on page 1 should be corrected as follows:

The goodwill limitation of 10% of the insurance reporting entity’s goodwill capital and surplus is a calculation. . .

Ref #2020-04: Commissioner Discretion in the Valuation Manual

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 51R—*Life Contracts*, SSAP No. 52—*Deposit-Type Contracts* and SSAP No. 54R—*Individual and Group Accident and Health Contracts* to note that voluntary decisions to choose one allowable reserving methodology over another, which requires commissioner approval under the *Valuation Manual*, shall be reported as a change in valuation basis. A notification of this exposure will be sent to the Life Actuarial (A) Task Force.

Interested parties have no comment on this item.

Ref #2020-05: Repeal of the Affordable Care Act Section 9010 Assessment

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the intent to supersede SSAP No. 106—*Affordable Care Act Section 9010 Assessment* and nullify *INT 18-02: ACA Section 9010 Assessment Moratoriums* which would move both SSAP No. 106 and INT 18-02 to Appendix H—Superseded Statements of Statutory Accounting Principles and Nullified Interpretations, effective Jan. 1, 2021. .

Referrals will be sent to the Blanks (E) Working Group, to ensure the annual statement disclosures related to SSAP No. 106 in Note 22 are removed from the annual statement instructions and annual statement blank beginning in reporting year 2021, and to the Health Risk Based Capital (E) Working Group for RBC implications related to the 2021 removal of the federal ACA adjustment sensitivity test which uses data from the SSAP No. 106 disclosures.
Interested parties support the conclusion reached for this item. We note, however, that annual statement disclosures in the 2020 blanks would apparently still be required and recommend that the disclosures be simplified considering the repeal of the Assessment. Specifically, the disclosures should be moved to note 21.C as Other Disclosures for year-end 2020 (since not a subsequent event) and then removed entirely for year-end 2021 as proposed; the disclosures should be limited to the amount of the assessment paid in the current and prior year, the amount of premium written for the prior year that is the basis for the determination of the section 9010 fee assessment paid in the current year (net assessable premium), and the estimated amount of the assessment that was payable in the current year as of the end of the prior year.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell          Rose Albrizio
April 27, 2020

Dale Bruggeman, Chairman  
Statutory Accounting Principles (E) Working Group  
c/o National Association of Insurance Commissioners  

Attn: Robin Marcotte  
Via e-mail: RMarcotte@NAIC.org  

Ref: 2020-13 – Request on 2020 Health Insurance Assessment

Dear Chairman Bruggeman:

To confirm our recent email transmission, after discussion with members and review of the referenced exposure and the NAIC staff’s recommendation that SAPWG reject our request, please consider this letter as AHIP’s withdrawal of that request.

We appreciate NAIC Staff’s view (as expressed in SAPWG exposure 2020-13) that the subject of SSAP No. 106 interim reporting relief is a matter that could warrant domiciliary state regulator review for consideration as either a permitted or prescribed practice. We would be grateful if you would share with SAPWG members our concerns that the dynamic nature of the pandemic might make such action appropriate in some states, and that other issues may yet arise that would require involvement by SAPWG at the NAIC level.

As always, we appreciate the courtesies, accessibility, and candor extended to AHIP by you, Ms. Marcotte, and Ms. Gann.

Sincerely,

America’s Health Insurance Plans

Bob Ridgeway
July 23, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: INT 20-09T – Basis Swaps – LIBOR Transition

Dear Mr. Bruggeman:

Thank you for the opportunity to comment and provide suggested edits to INT 20-09, Basis Swaps – LIBOR Transition. We appreciate the ongoing collaboration with NAIC staff, in particular their efforts to bring this matter to the forefront so quickly.

Interested parties support the staff’s recommendation.

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell
Rose Albrizio

cc: Interested Parties
## Comment Letters Received

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January 31, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment During the NAIC Winter National Meeting with Comments due January 31

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the Statutory Accounting Principles (E) Working Group (the “Working Group”), during the NAIC Fall National Meeting in Austin. We offer the following comments:

Ref #2018-26: SCA Loss Tracking – Accounting Guidance

The Working Group exposed revisions, with modifications suggested by interested parties to SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets to expand guidance regarding financial guarantees and the use of the equity method for when losses exceed the equity value of an SCA investment. With the revisions, the equity value of an SCA would not go negative, and guaranteed liabilities would be reported to the extent that there is a financial guarantee or commitment. The “Illustration of the Application of INT 00-24” will also be inserted into SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

Interested parties have no comment on this item.

Ref #2018-38: Prepayments to Service and Claims Adjusting Providers

NAIC Staff recommended that the Working Group expose revisions incorporating the majority of interested parties’ comments to SSAP No. 55 (rather than the changes reflected in the draft for the Summer 2019 exposure). Interested parties’ comments primarily delete the exposed guidance and move the same or similar concepts into the broad product guidance for property and casualty, life and health or health in SSAP No. 55. These revisions are to reinstate annual statement references by entity type and to adjust scoping language and make the SSAP No. 29...
prepaid guidance consistent. (Staff proposed variations in wording are shaded to differentiate from the interested parties proposed wording that accomplishes a similar intent.)

The exposed revisions to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses incorporate interested parties’ previous recommendations to separate the guidance by product type and emphasize guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments). The revisions emphasize existing guidance that claims related liabilities are not recognized as paid until the losses are paid to claimants or claims are adjusted.

Interested parties have no comment on this item.

Ref #2019-04: SSAP No. 32 – Investment Classification Project

The Working Group exposed a revised Issue Paper No. 1XX—Preferred Stock and a substantively-revised draft SSAP No. 32—Preferred Stock as part of the Investment Classification Project.

Interested parties substantially agree with the objectives of the proposal and appreciate Staff’s inclusion of revisions for previously communicated comments. We have the following additional comments related to the issue paper:

Scope

Interested parties note that the scope retains, albeit edited, the guidance that preferred stock of subsidiary, controlled and affiliated entities is included and therefore accounted for under the guidance for preferred stock regardless of their SCA character. We acknowledge the current exposure added the requirement to file investments in response to our request. The existing wording in SSAP No. 32 and the exposed language for SSAP No. 32 is below with interested parties suggested clarifying sentence and additional wording (underlined).

Existing language in SSAP No. 32:

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for preferred stock.

2. Investments in preferred stock of subsidiaries, controlled or affiliated entities, including preferred stock interests of certified capital companies (CAPCO) per INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO) are included within the scope of this statement.

Exposed language in SSAP No. 32 and interested parties suggested additional sentence (underlined):
SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for preferred stock.

2. Investments in preferred stock of entities captured in SSAP No. 97—*Investments in Subsidiaries, Controlled or Affiliated Entities* or SSAP No. 48—*Joint Ventures, Partnerships and Limited Liability Companies*, as well as preferred stock interests of certified capital companies per INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO) are included within the scope of this statement. The requirement to file investments in preferred stock of certain subsidiaries, controlled or affiliated entities with the NAIC pursuant to SSAP No. 97 does not affect the application of the accounting, valuation or admissibility under this statement.

Definitions

We are opposed to the proposed edits to the definitions of redeemable and perpetual preferred stock for the following reasons:

a. The change would create a divergence from GAAP that does not exist under the current definitions. Both the definition and accounting for redeemable securities under the current definition aligns with the GAAP definition and accounting for debt securities. Preferred stock accounted for as debt securities under GAAP are those where ability for the holder to collect repayment is assured by the contract terms. We have not identified any benefit to diverging from this view for statutory reporting. The NAIC guidance is different from the GAAP ASC 480 guidance for issuers in multiple ways:

   • Preferred stock redeemable at the option of the holder for GAAP is classified as equity (mezzanine equity for SEC filers) but under statutory reporting currently (and proposed) is classified as debt-like in valuation. This conflicts with GAAP ASC 480 guidance for issuers and so it is more straight forward to use the GAAP ASC guidance for holders.
   • Alignment of statutory accounting with the ASC 320 guidance for holders results in more equity-like classification in the valuation of preferred stock which is generally more conservative than debt-like classification in valuation.
   • Preferred stock redeemable for other reasons outside of issuer’s control is equity (mezzanine equity for SEC filers) for GAAP but equity-like in valuation under current statutory reporting and debt-like in valuation under the proposed statutory reporting.

b. The definition that the NAIC staff has proposed to align to is used in GAAP only for compliance with SEC Regulation S-X, Rule 5-02, which is relevant only to the issuer of preferred stock and does not apply to nonpublic companies. Further, the definitions under Rule 5-02 were designed to include preferred stock with redemption features outside of the control of the issuer in order to provide investors information regarding
potential future cash obligations. This is not a relevant consideration for the holder of preferred stock, which is why GAAP does not consider this from the holder’s perspective. From the holder’s perspective, the only relevant consideration is whether the holder is able to redeem its investment, either through a fixed and determinable date, or through a redemption option that the holder can control.

c. Evaluation of whether there are any features that are outside the control of the issuer is a very complex and cumbersome analysis, even on an infrequent basis as is the case under GAAP (as it only applies to issuers). This is because there are a vast number of potential features that could be outside the control of the issuer (i.e., change in control, lapse in SEC registration, failure to pay dividend, etc.). Insurance companies frequently invest in preferred stock and often purchase many such securities each reporting period. Evaluating every preferred stock investment at this level of detail would be operationally burdensome and would provide no additional benefit as the investor is often economically indifferent to many of these low-probability redemption features that are outside of the control of both the issuer and investor.

As a result, we propose the following edits to the proposed definitions:

a. Redeemable preferred stock, which is preferred stock subject to mandatory redemption requirements or whose redemption is outside the control of the issuer holders. Redeemable preferred stock is any stock which 1) the issuer undertakes to redeem at a fixed or determinable price on the fixed or determinable date or dates, whether by operation of a sinking fund or otherwise; or 2) is redeemable at the option of the holders; or 3) has conditions for redemption which are not solely within the control of the issuer, such as stock which must be redeemed out of future earnings. Preferred stock which meet one or more of these three criteria would be classified as redeemable preferred stock regardless of other attributes such as voting rights or dividend rights;

b. Perpetual preferred stock, which is preferred stocks which are not redeemable or for which redemption is not at the option of the holder are redeemable solely at the option of the issuer (non-redeemable preferred stock). Perpetual preferred stock is any preferred stock which does not meet the criteria to be classified as redeemable preferred stock pursuant to paragraph 3.a.

Balance Sheet Amount

The issue paper discusses carrying perpetual preferred at fair value capped by any stated call price. However, it did not provide guidance on timing for application of the cap. Because the call may not be effective for a period of time, and to ensure that purchases of perpetual preferred stock could still be carried at values greater than par (assuming market values remain above par), we recommend the following revisions to paragraph 10.a.ii, 10.b.ii and the correspondingly to paragraph 11 (underlined):

Paragraphs 10.a.ii and 10.b.ii:
i. Perpetual preferred stocks shall be valued at fair value, not to exceed any currently effective call price.

Paragraph 11:

11. An other-than-temporary (INT 06-07) impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of the preferred stock in effect at the date of acquisition. An assessment of other-than-temporary impairment shall occur whenever mandatory redemption rights or sinking fund requirements do not occur. A decline in fair value which is other-than-temporary includes situations where the reporting entity has made a decision to sell the preferred stock prior to its maturity at an amount below its carrying value (i.e., amortized cost). If it is determined that a decline in the fair value of a redeemable preferred stock is other-than-temporary, an impairment loss shall be recognized as a realized loss equal to the entire difference between the redeemable preferred stock’s carrying value and its fair value, not to exceed any currently effective call price, at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR, realized losses shall be accounted for in accordance with SSAP No. 7.

Income

The issue paper clarifies the guidance on dividends on preferred stock. Specifically, paragraph 14 states:

“14. Dividends on preferred stock shall be recorded as investment income for qualifying preferred stock on the ex-dividend date with a corresponding receivable to be extinguished upon dividend settlement.”

Interested parties request clarification on the use of the term “qualifying” preferred stock as the term is not defined within the issue paper or within the new glossary of terms. If the inclusion of the word “qualifying” was unintentional, interested parties recommend deleting the word from paragraph 14 to avoid confusion.

Ref #2019-08: Update Reporting Deposit-Type Contracts

The Working Group exposed this agenda item to: 1) request feedback on the inclusion of a footnote excerpt for Exhibit 5 to disclose cases when a mortality risk is no longer present or a significant factor – i.e., due to a policyholder electing a payout benefit, 2) request feedback on circumstances where a morbidity risk is no longer present or a significant factor for Exhibit 6 items and whether a similar footnote disclosure would be appropriate, and 3) requested industry and regulator input for instruction clarifications regarding the classifications of deposit-type...
contracts captured in Exhibit 7. With this exposure, there are no proposed edits for statutory accounting. The Working Group directed NAIC staff to notify the Financial Stability (Ex) Task Force of this exposure.

Interested parties support the proposed Exhibit 5 footnote which, among other things, would provide clarification on contracts where a mortality risk is no longer present or a significant factor.

With respect to the implementation of additional disclosures for Exhibit 6, interested parties believe that the current product disaggregation in Exhibit 6 is sufficient to analyze the risks present in the subject contracts, and would suggest no changes.

Interested parties have no additional clarifications for Exhibit 7 instructions – we believe the current instructions are sufficiently clear for deposit type contracts

Ref #2019-12: ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force

The Working Group adopted, as final, a clarification edit to SSAP No. 68—Business Combinations and Goodwill to clarify that all goodwill from an insurance entity’s acquisition of SCAs, regardless of whether pushdown accounting is applied, is subject to the existing 10% admittance limitation. (With adoption of this edit, paragraph 9 was split into two separate paragraphs with the additional wording shown below.) The remainder of this agenda item was re-exposed to allow additional time for specific examples of pushdown accounting to be provided by interested parties, as well as consider comments received on pushdown.

9. Positive goodwill recorded under the statutory purchase method of accounting shall be admitted subject to the following limitation: Positive goodwill from all sources, including life, accident and health, and deposit-type assumption reinsurance and goodwill resulting from the acquisition of an SCA by the insurance reporting entity that is reported on the SCA’s financial statements (resulting from the application of pushdown accounting), is limited in the aggregate to 10% of the acquiring entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Additionally, all positive goodwill shall be nonadmitted when the underlying investment in the SCA or partnership, joint venture and limited liability company is nonadmitted. When negative goodwill exists, it shall be recorded as a contra-asset.

Interested parties is working on developing examples to illustrate the various ways in which goodwill can be generated and suggested approaches to how the statutory limitations could be applied. As a result of these efforts, we request an extension for this and the following item.
Ref #2019-14: Attribution of Goodwill

The Working Group re-exposed this agenda item to clarify that the “assignment” of goodwill is a disclosure element. The Working Group directed NAIC staff to prepare revisions to the Sub 1 Acquisition Overview template to capture this information for new SCA acquisitions.

Please see the comments on the preceding item.

Ref #2019-20: Rolling Short-Term Investments

The Working Group exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, as shown in the “Proposed Revisions for Fall 2019 Discussion” to incorporate additional principle concepts in classifying investments as cash equivalents or short-term investments to prevent the “rolling” of certain investments. Fall revisions to the prior Summer National Meeting exposure incorporate guidance to exclude qualifying cash pools from the short-term rolling provisions.

With the Fall exposure, comments were requested from regulators and industry representatives on whether other investments should be included / excluded from the short-term rolling provisions. In particular, comments are requested on whether short-term lending (both collateral loans and affiliated loans) should be permitted to be continuously rolled/renewed as short-term, whether non-affiliated SSAP No. 26R investments should be subject to the short-term rolling restrictions, and whether an assessment of “re-underwriting” could be used as support to allow the rolling of short-term investments.

Interested parties appreciate the staff’s exclusion of qualifying cash pools from the provisions of the short-term rolling re-exposure. There remain two types of short-term lending arrangements within the scope of the re-exposure that should be addressed separately. We respectfully request that the Working Group give consideration to the broader implications discussed below prior to moving forward with this proposal. Specifically, it might be advantageous to split the exposure into two work streams – one for affiliated investments and another for unaffiliated investments

Non-affiliate Short-Term Lending

In the case of non-affiliated loans (i.e., Schedule BA Other Invested Assets), in order to provide appropriate flexibility to both the lender and the borrower, a loan facility may be structured as a short-term obligation. Such short-term obligations permit an insurer to more efficiently deploy its capital and streamline its underwriting process. Specifically, short term, non-affiliated loans: (a) provide the insurer with the ability to review and consider credit and collateral on a regular basis, (b) allow the insurer to reevaluate each investment at maturity and make new investments based on current market conditions if desired, and (c) allow the insurer to consider a renewal with an existing base of knowledge about the borrower and collateral, making the underwriting
process more streamlined and allowing for better informed credit decisions. As with any investment, diligent underwriting of the borrower and the collateral, and structuring of the investment with appropriate safeguards is critical and should not deviate from standards used for longer-term investments. These facilities fill a market need for borrowers that require short-term or warehouse-type financings on assets prior to reaching the window for securitization and provide the insurer with attractive risk-adjusted returns relative to other short-term investments.

In this context, interested parties propose that all non-affiliated short-term obligations, obligations in scope of either SSAP No. 26 or SSAP No. 43R, where the counterparty is not an affiliate or related party of the reporting entity, including collateral loans, which meet certain objective criteria should be defined, reported, and monitored in the existing Schedule DA as a non-affiliated short-term investment. In order for a non-affiliated transaction to qualify as short term for reporting purposes, such investment must include the following features:

1) The loan includes a maturity date less than one year from closing at which the borrower has an unconditional repayment obligation and on which the lender has a reasonable expectation that the investment can be terminated and repaid if so desired by the insurer; and
2) Any subsequent renewal is only completed in the sole discretion of BOTH the borrower and the lender.

Given that the transaction is between unaffiliated counterparties, interested parties believe the terms of these transactions, including the interest rate and advance rate, are on arms’ length terms.

Finally, with no obligation at any time to renew a transaction, the reporting entity is required to re-evaluate and re-underwrite the transaction at maturity. If any of the relevant underwriting criteria have changed, the insurer can require repayment or can request adjustments to the terms and conditions to conform to market conditions. If, but only if, both the borrower and lender agree to renew the transaction on the same or adjusted terms, the transaction may be renewed. This process, however, requires an independent credit decision and results in a new transaction.

Interested parties acknowledges the NAIC staff’s concern about the ability of auditors and regulators to discern between renewals that have been re-underwritten and those that have not; however, without an appreciation for the nuanced economic differences of these transactions, interested parties have concerns about unintended consequences of the re-exposure. Consider a transaction in which an entity purchases a GNMA with less than a one-year maturity, which was classified as a short-term investment or cash equivalent and matures/is settled as expected. Shortly after, that entity decides to purchase another GNMA with less than a one-year maturity. As proposed, the guidance precludes short-term investment or cash equivalent reporting for reacquired investments (or substantially similar investments) when purchased within one year from the initial investment. Without further clarification regarding substantially similar investments, or alternative objective criteria like those proposed above, we anticipate that diversity in practice could result. Additionally, regarding the example described, operationally burdensome tracking requirements would be required for entities to ensure appropriate reporting.
Therefore, we believe that unaffiliated SSAP No. 26 investments should be excluded from the scope of this exposure for the reasons discussed above. The scope of this exposure should also continue to exclude other unaffiliated SSAP No. 26 investments such as treasury bills, commercial paper, certificates of deposits and other similar short-term investments since such investments are used for short-term liquidity and do not have long-term investment risk.

Affiliate Short-Term Lending

Interested parties believe that the same principles discussed above and in our previous letter apply to affiliated short-term investments to merit continued classification as short term in nature, even when a subsequent short-term investment is re-underwritten to the same borrower within a year. We believe there is already sufficient regulatory oversight on the fundamental objectives, usage and risks of material affiliated transactions to validate the alignment of these vehicles with the fundamental characteristics implied by the statutory short-term investment classification. In this case, prudently managed, governed and executed liquidity optimization across an insurance holding company system can be observed with the current regulatory oversight mechanisms. While re-underwriting may be warranted based on liquidity needs, the risk profile continues to be commensurate with that of short-term investments.

NAIC Guidance should not supersede regulatory oversight. The domiciliary commissioners already have authority to disapprove of material affiliated transactions as deemed necessary. The NAIC Model Holding Company Act (the “Act”), which has been broadly incorporated into state laws, requires filing and domiciliary commissioner approval of affiliated transactions over certain materiality thresholds. As the Act was promulgated by the NAIC, interested parties believe that through use of the Act, commissioners put in place filing and approval requirements they deemed satisfactory to address their regulatory needs. Through these filings, state regulators have oversight over both the risk elements considered and the methodology utilized by companies in underwriting each material extension of credit within the holding company system. It would run counter to state authority to implement requirements resulting in NAIC guidance that would effectively supersede the authority of domiciliary commissioners or cast doubt, even implicitly, upon states’ ability to appropriately regulate the domiciled insurers with which they are intimately familiar. Principally, the Act allows regulators to verify the appropriateness of the short-term classification of material affiliated investments, providing oversight to ensure consistency in classification between affiliated and unaffiliated short-term investments.

Prudent and appropriately governed liquidity management within a holding company structure enhances insurance company solvency. Appropriately managed, governed and regulator-approved affiliate lending programs create opportunities for liquidity optimization across a holding company system, essentially sharing objectives similar to that of affiliated liquidity pools. This management is necessary due to diversification of product offerings as timing of cash receipts and disbursements will vary across such products and different entities within a holding company system. The ability to prudently draw upon excess liquidity surplus within one entity at a time when another entity has a short-term need for liquidity serves as an immediate buffer against uneconomic alternatives such as forced asset sales or relatively costly external short-term
financing. If adopted as written, the exposed guidance could result in entities foregoing this powerful in-house liquidity tool, which enables companies within a holding company system to more effectively manage inherent cash flow timing mismatches, and instead resort to alternatives that would result in an unnecessary drain on capital available to support policyholder obligations.

SSAP 43R—Loan-backed and Structured Securities

Investments in the scope of SSAP 43R, *Loan-backed and Structured Securities*, have payments that are driven by underlying collateral with modifications that are driven by the performance of the underlying assets and typically overseen by a collateral manager or otherwise laid out in deal documents. In many cases, these instruments also have clean-up call provisions that would remove the investment from the market while the remaining underlying collateral may be repackaged into a re-securitization. The concept of rolling a short-term investment that would be in the scope of SSAP 43R is often-times outside the control of investors in these instruments and possibly part of the normal life cycle of a small portion of the underlying collateral. Because of these characteristics, the interested parties propose that any non-affiliated investment that would qualify within SSAP 43R—Loan-backed and Structured Securities be exempt from the proposed new concepts like what is proposed for non-affiliated investment that would qualify within SSAP 26R—Bonds. Further consideration of affiliated investments that fall within SSAP 43R is recommended, given the underlying assets drive these investments and the other considerations for affiliate short-term lending outlined previously in this response.

Interested parties respectfully requests that the Working Group give consideration to these broader implications prior to moving forward with this proposal. If the Working Group has lingering concerns or appetite for additional elaboration as to the character and traditional efficacy of existing regulatory oversight mechanisms, interested parties would request that staff work with industry to draft materials for future dialogue and examination of this topic.

Ref #2019-24: Levelized and Persistency Commission

The Working Group exposed revisions to *SSAP No. 71—Policy Acquisition Costs and Commissions*, to include additional NAIC staff modifications regarding persistency commission and levelized commission arrangements to address certain comments received and to allow for further discussion. With this exposure, the Working Group directed a notification of the exposure to be sent to the Life Actuarial (A) Task Force.

Interested parties appreciate staff’s availability to discuss the proposed revisions. Based on that discussion and the discussion at the Fall Meeting, interested parties propose suggested edits that we believe achieve the goal of a nonsubstantive change and clarify the original intent of SSAP 71. (Note: the NAIC Accounting Practices and Procedures Manual-Life which was in force prior to the effective date of current SAP includes the same wording as current SSAP No. 71). The suggested edits add a clear definition of a funding agreement. This will clarify the distinction between funding agreements and persistency-based commissions, without unintentionally changing the existing accounting. We welcome the opportunity to discuss the suggested edits further with the Working Group.
Ref #2019-25: Working Capital Finance Notes (WCFN)

The Working Group exposed substantive revisions to SSAP No. 105—*Working Capital Finance Investments* (SSAP No. 105) to incorporate industry revisions to program requirements, as previously directed by the Working Group during the Summer National Meeting. The Working Group directed NAIC staff to prepare an issue paper.

In 2016, the American Council of Life Insurers (ACLI) advised the NAIC that the implementation of SSAP No. 105 was not successful and that adoption had been low. ACLI began a dialogue with staff and regulators about both the shortcomings of the 2013 adopted rules and outlined required changes to make the rules suitable. As part of that process, ACLI marked up both the SSAP and NAIC SVO Purposes and Procedures Manual (P&P Manual) with the suggested changes which have subsequently been characterized as "10 required items", which staff have in turn opined on, and noted that four of the items are not supported by staff. Absent all 10 required items, WCFI adoption will remain low. Staff have noted an immaterial number of programs have been filed with only a subset of those approved, resulting in limited investments made. The existing Exposure provided to staff and regulators by ACLI and was utilized by staff to produce the current proposal, without addressing the proposed language by ACLI on the four required items not supported by staff.

Objections to the four required changes are:

1) evaluating non-rated subsidiaries of obligors (even though the existing SSAP already provides guidance to do).
2) expanding covered investment credit quality to include NAIC 3 and 4 investments,
3) requiring domiciliary regulator authorization for investment, and
4) requiring reporting on Schedule BA even though the asset class qualifies for look through RBC treatment.

In the ACLI draft provided to the NAIC, ACLI proposed an evaluation mechanism that is suitable for NAIC implementation on un-rated subsidiaries. With regard to NAIC objection on lower rated investments, such position is inexplicable as statutory RBC requirements reflect investment quality decisions in capital calculations limiting Industry investments to compliant assets. Domiciliary regulator prior approval for investment is a transfer of transaction review from staff to state insurance departments when, if regulators are concerned about the asset class, they can uniformly limit investment as a whole. Finally, Schedule BA reporting is both cumbersome and expensive for industry further exacerbating adoption without useful purpose. Regulators can track any specific asset class or investment by requiring the use of a specific investment code on the appropriate accounting schedule, which in the case of WCFI is Schedule DA).

Interested parties note that private placements, as opposed to public investments, are typically available only to large industry participants and that the economic impact of a $10,000 industry filing fee per issue per filing entity has an operating impact on a $1,000,000 investment in
WCFI, which for the avoidance of doubt would be sizable for most industry investors, of 1% of
the investment income in year 1 of that investment. Current investment yields for NAIC 1 and 2
investments in WCFI offer gross returns of 2 – 2.5%. Such a high cost to a small industry
investor, coupled with the fact that dealers would unlikely choose to document such investments
bilaterally with small industry investors, limits access to the assets to large industry investors. In
summary, interested parties request that regulators re-consider ACLI markup with the additional
four requirements as originally submitted by ACLI and ultimately, after appropriate exposure
and review, to direct staff to implement these changes.

Ref #2019-32: Look-Through with Multiple Holding Companies

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP
No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, to clarify that a more-than-
one holding company structure is permitted as a look-through if each of the holding companies
within the structure complies with the requirements in SSAP No. 97.

Interested parties have no comment on this item.

Ref #2019-33: SSAP No. 25 – Disclosures

The Working Group moved this agenda item to the active listing and exposed the proposed data-
capture templates. This exposure does not propose revisions to SSAP No. 25.

Interested parties believe that clarifications to paragraph 20 of SSAP No. 25 are necessary. We
believe that the aggregation of similar transactions may result in immaterial transactions
becoming material, meeting the threshold of 1/2 of 1% of the total admitted assets of the
reporting entity. Therefore, we propose the edits highlighted below to ensure that aggregation
occurs subsequent to the application of the criteria in paragraph 20.b. for materially identified
transactions.

**Proposed Edits to the exposure**

Disclosures

20. The financial statements shall include disclosures of all material related-party
transactions. In some cases, aggregation of similar transactions, that on a stand-alone basis
are not material, may be appropriate. Sometimes, the effect of the relationship between the
parties may be so pervasive that disclosure of the relationship alone will be sufficient. If
necessary to the understanding of the relationship, the name of the related party should be
disclosed. Transactions shall not be purported to be arm’s-length transactions unless there
is demonstrable evidence to support such statement. The disclosures shall include:

a. **The nature of the relationships involved;**

b. **A description of the transactions for each of the periods for which
financial statements are presented, and such other information
considered necessary to obtain an understanding of the effects of the**
transactions on the financial statements. Exclude reinsurance transactions, any non-insurance transactions which involve less than ½ of 1% of the total admitted assets of the reporting entity, and cost allocation transactions. The following information shall be provided if applicable:

Ref #2019-34: Related Parties, Disclaimers of Affiliation and Variable Interest Entities

The Working Group Staff exposed revisions to SSAP No. 25—Affiliates and Other Related Parties. Key elements for discussion in the exposure draft are to:

- Clarify the identification of related parties and ensure that any related party identified under U.S. generally accepted accounting principles (GAAP) or Securities Exchange Commission (SEC) reporting requirements would be considered a related party under statutory accounting principles (SAP).

- Clarify that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation.

- Clarify the impact of a disclaimer of control or disclaimer of affiliate under SAP. As detailed, such disclaimers impact holding company group allocation and reporting as an SCA under SSAP No. 97, but do not eliminate the classification as a “related party” and the disclosure of material transactions as required under SSAP No. 25.

- Incorporate a new disclosure of known non-arm’s-length transactions with any entity not identified as a related party.

- Propose rejection of several U.S. GAAP standards addressing variable interest entities.

Interested parties understand and agree with the need for transparency in disclosures of related party transactions. However, we have significant concerns with the proposal as it is not very clear based on the proposed changes to SSAP No. 25 what it is that will be required going forward based on the expansion of the definition of a related party. We include some of our observations below.

Interested parties would like clarity around the new proposed wording that states that non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or disclaimer of affiliation. One of our concerns in this area relates to limited partnership/joint ventures/limited liability company (LPs/JVs/LLCs) investments where the insurer owns more than 10% of the equity of the investee but has no affiliation to the investee’s general partner/asset manager. SSAP No. 97 currently includes a possible scope exception in paragraph 6 for these types of investments so that they are not considered affiliated or controlled investees of the insurer. It is not clear from the proposal what the expected impact is from now having to consider all investments in unaffiliated LPs/JVs/LLCs where the insurer owns more than 10% of the equity but has no other affiliation, as related parties. If the intent is just to have insurers disclose material transactions with these entities other than the equity
investment held in each entity, we believe that this needs to be more clearly stated in the proposal so that there is no misrepresentation of what needs to be disclosed or whether these investments need to be reported in a different section of Schedule BA (i.e., affiliated vs. non-affiliated).

Another, but similar concern relates to certain entities consolidated under U.S. GAAP based on the Variable Interest Entity (VIEs) guidance. For some of these consolidated VIEs, the insurer has no control or affiliation with the VIE other than its debt investment in the entity. The insurer is simply a passive investor in the structure. However, under the VIE rules, the insurer must consolidate the entity as the insurer may be able to make decisions for the VIE if there is ever an event of default of the assets at some point in the future. These rights are given to certain classes of bonds issued by the securitization as a protection to the investors, but do not give the investors any type of power or control over the VIE at inception or on a day-to-day basis. It is important to note that consolidation rules under FASB Codification Topic 810 are very complex with some insurers concluding consolidation is required under a set of fact and circumstances and others concluding consolidation is not required under the same set of facts and circumstances. In the example just shared, some insurers have concluded consolidation is required because when no day-to-day decisions are being made for the VIE, decisions upon the occurrence of a certain event which may be unlikely to occur, rise to the point where they are the decisions that have the most significant impact on the economic results of the VIE. We believe that even though insurers have to consolidate these entities, there is no true related party affiliation. The proposal requires that any entity identified as a related party under U.S. GAAP will also be considered a related party for statutory reporting. Since these entities are consolidated for GAAP, the presumption would be that they are a related party of the insurer. If these entities will be considered related parties on a statutory basis going forward, the exposure needs to clarify that the inclusion of these types of entities only impacts related party disclosures for any material transactions held with these entities other than the debt investment held by the insurer in the VIE and that the debt instrument is still reported on Schedule D as unaffiliated.

Interested parties also have concerns with SSAP No. 25 including references to U.S. GAAP and SEC reporting for mutual insurers that do not prepare U.S. GAAP financial statements and do not file with the SEC. Therefore, interested parties recommend that the specific guidance from the GAAP and SEC be stated in SSAP No. 25 (rather than incorporated by reference) so that any future changes in GAAP and SEC guidance are subject to NAIC review prior to being applicable. Also, it is important to note that even when an entity is considered a related party under U.S. GAAP, disclosure of that relationship is only required when there are material transactions with that party. U.S. GAAP allows reporting entities to evaluate the significance of a relationship and determine when disclosure of that relationship is material/significant enough for disclosure to a user of the financial statements. As a result, we suggest this be clarified in the exposure as well so that it is clear that the reference to related parties under GAAP and SEC rules is only relevant if the insurer has material transactions with such parties outside of the insurer’s investment in the entity.
Ref #2019-35: Update Withdrawal Disclosures

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts, and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance, as illustrated in the staff recommendation, to:

- Add a consistency revision to SSAP No. 51R to ensure separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosures;

- Correct an identified inconsistency in one of the new disclosures that was added regarding products that will move from the reporting line of having surrender charges at 5% or more to the reporting line of surrender charges at less than 5%. A clarification is being recommended to ensure consistency in annual statement reporting; and

- Add a cross-reference from SSAP No. 56 to the existing disclosures by withdrawal characteristics in SSAP No. 51R and SSAP No. 61R as the disclosure include separate account products.

Interested parties have no comment on this item.

Ref #2019-36: Expand MGA and TPA Disclosures

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 51R—Life Contracts, paragraph 50, SSAP No. 53—Property Casualty Contracts—Premiums, paragraph 19, SSAP No. 54R—Individual and Group Accident and Health Contracts, paragraph 33 and SSAP No. 59—Credit Life and Accident and Health Insurance Contracts, paragraph 19, as illustrated in the staff recommendation above, to expand the MGA/TPA note as follows:

- Aggregate direct written premium and total premium written by MGA/TPA;
- Aggregate dollar amount of claims process / total claims processed by MGA/TPA; and
- Information on related party / affiliate status and if the MGA/TPA is independently audited and / or bonded.

Interested parties note that the proposal does not define a TPA. It just states that TPAs “that write direct policies or provide claims adjusting or other services”. That is overly broad and could include a variety of entities that provide services. The NAIC model (NAIC Third Party Administrator Act, or NAIC model) guidelines define TPAs as it relates to life/health and workers compensation. Also, the NAIC model definition has a long list of activities that are excluded from the definition, such as self-insured employers administering its own workers’ compensation, insurers administering coverage, producers engaged in selling insurance, attorneys handling claims, MGAs, etc. We recommend that the proposed disclosure reference the NAIC model so that there is consistency in the definition used in applying the guidance.
Additionally, it is unclear how the reporting threshold should be applied. The reporting applies to TPAs if “the claims adjusting services are greater than 5% of annual average claims volume”. Is that threshold based on the amount of claim dollars paid or the number of claims handled? Is that measured across all lines of business for the company? Would claims paid within insureds’ deductibles/SIRs be included? Depending on how this is defined, it could be quite burdensome for insurers to monitor. We recommend that the threshold be based on written premium, consistent with how other thresholds have been applied.

Ref #2019-37: Surplus Notes – Enhanced Disclosures

During the 2018 Spring National Meeting, the Working Group exposed revisions to SSAP No. 41R – Surplus Notes (“SSAP No. 41R”) to indicate that surplus notes, where the proceeds from the issuance of the surplus note were used to purchase an asset directly or indirectly from the holder of the surplus note, are not subordinate and do not qualify for reporting as surplus and should be classified as debt. Furthermore, the exposure draft stated that these assets were not considered available for policyholder claims and should be non-admitted. The exposure was the result of a referral from a Subgroup of the Reinsurance Task Force that was more narrowly focused on whether specific securities could be considered Primary Securities.

At the 2019 Summer National Meeting, the Working Group agreed to have an industry data call, due by December 31, 2019, to determine what financing structures existed that utilized the types of surplus notes described above.

At the 2019 Fall National Meeting, the Working Group exposed additional disclosures that should be captured in SSAP No. 41R. The Working Group does intend, later in 2020, to continue discussions on how to treat surplus notes where an associated asset is received by the surplus note issuer. This discussion will occur after a review and analysis of the data call.

General Comments

Interested parties understand regulators’ concerns that the details of certain transactions involving surplus notes may not be transparent to regulators who were not involved in the initial approval or ongoing review of such transactions. However, these transactions and the related pricing represent confidential information that we believe is inappropriate for public disclosure and may be misleading if presented in the proposed format.

Our concerns with the proposed disclosures are outlined in detail below, followed by our suggested revisions.

The proposed disclosures may not provide the desired transparency or consistency

Throughout the discussion on any potential revisions to SSAP No. 41R over the past twenty-two months, interested parties have agreed that robust disclosures should be added to SSAP No. 41R to fully reflect situations where a reporting entity receiving proceeds from the issuance of surplus notes used those proceeds to purchase an asset directly or indirectly from the holder of the
surplus note. However, we also believe that these disclosures should be included in the financial statements of a ceding company, which would provide a much greater level of transparency and consistency in disclosure. We believe that in most situations where a surplus note issuer uses proceeds from the issuance to purchase an asset directly or indirectly from the holder of the surplus note, the surplus note issuer is an affiliated captive reinsurer. As some captive financial statements are not provided to the NAIC, we believe disclosure in the financial statements of the ceding company would provide a much greater level of transparency and consistency in disclosure for these transactions. Our proposed revisions include suggested language for this disclosure requirement.

The proposed disclosure goes beyond the stated regulatory concern and requires additional information that may be incorrectly interpreted.

We believe that the proposed disclosure departs from the original regulatory concern expressed in the public meetings of the Working Group, namely that a reporting entity should not be permitted to circumvent regulatory authority as it relates to the preservation of capital at a regulated entity by contractually linking the cash outflows associated with a surplus note to cash inflows from another financial instrument held by the surplus note issuer. However, rather than identify such transactions, the proposed disclosure would require detailed information about surplus note interest regardless of whether cash flows are contractually linked. We are concerned that the operational burden of compiling this information for all surplus notes with netting provisions exceeds the benefit to regulators of providing information on the few transactions of concern.

Interested parties note that the scope of the proposed disclosure is substantially identical to that of the recent surplus note data call issued by the NAIC. The stated intent of this data call was to obtain information on surplus note transactions without regard to whether offsetting of cash flows was due to: a) contractual linkage or b) administrative offset provisions. While we agree that this scope was appropriate to assess the universe of affected transactions, we do not believe it is the appropriate scope for an Annual Statement disclosure and could be misleading in certain cases as outlined below.

The proposed disclosure includes confidential information that is not appropriate for public filings.

The proposal would require the disclosure of surplus note interest paid, net of any payments made by the surplus note holder. As a practical matter, for many captive structures, this amount often corresponds to the fees paid to the financing provider(s) to provide liquidity in the event of adverse experience or other conditions with respect to the subject policies, as defined in the applicable agreement.

The pricing and terms of the subject transactions were heavily vetted, negotiated, and submitted to state regulators for approval with the reasonable understanding that this information was subject to robust confidentiality protections. We do not object to this information being made available to regulators in the context of a confidential data call or regulator communication.
However, we are concerned with its inclusion in public filings. The primary focus should be on whether the surplus note issuer is statutorily solvent rather than its surplus note pricing terms.

**The net presentation of interest paid could be misleading for some transactions**

We also believe that the change to the current disclosure to replace surplus note interest paid with interest paid net of amounts offset is problematic. We believe this disclosure could be misleading for many of the transactions in the scope of the disclosure, given that the full amount of surplus note interest paid was/would be due regardless of whether a portion is offset pursuant to an administrative netting arrangement.

**Proposed Revisions**

Interested parties recommend revisions to the proposed disclosures which would provide regulators who are not involved in the approval and ongoing review of a surplus note transaction with information to assess the nature of the transaction and to determine whether more detailed review is needed. Specifically, our revisions would require disclosure of whether cash flows are offset but would differentiate between administrative offsetting and the contractual “linkage” that is of concern to regulators. These revisions would also remove information that we believe is confidential in nature and would not be appropriate for public disclosure. Finally, we have proposed several additions to the required disclosures, which we believe would provide useful information about transactions involving surplus notes.

Our suggested revisions to the disclosures are included in Exhibit A and summarized below. For ease of review, revisions proposed by NAIC staff have been accepted, and interested parties’ comments are presented as tracked changes.

**Summary of Proposed Revisions**

- Expand the disclosure requirement to the financial statements of the ceding company as well as the surplus note issuer.
- Retain the current disclosure of total interest paid (gross of any administrative or other netting)
- Replace quantitative disclosure of “interest remitted” and “cost of liquidity” with three Y/N disclosure columns which correspond to the criteria used in the data call scoping:
  1. Do surplus note / associated asset terms negate or reduce cash flow exchanges, and/or are amounts payable under surplus notes and amounts receivable under other agreements contractually linked? (For example, the asset provides interest payments only when the surplus note provides interest payments.)
  2. Are any amounts due under surplus notes and associated assets netted or offset (partially or in full) thus eliminating or reducing the exchange of cash or assets
that would normally occur throughout the duration, or at maturity, of the agreement. (This may be referred to as administrative offsetting.)?

3. Were the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note?

- Replace confidential information about 3rd party liquidity (e.g. maximum liquidity amount and cost of liquidity source) with a description of terms under which liquidity would be provided should a triggering event occur.
- Add requirement for narrative disclosure of any related guarantees or support agreements.

Ref #2019-38: Financing Derivatives

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 86—Derivatives, to clarify the reporting of derivatives with financing premiums. The reporting revisions propose allowing the present value of the derivative premium receivable (and payable) for financed derivatives to be factored into the counterparty risk assessment for life RBC. (If supported, RBC changes would be subsequently referred to the Capital Adequacy (E) Task Force for consideration.) Comments are also requested as to whether derivatives and related financing provisions that would generally not meet the SSAP No. 64—Offsetting and Netting of Assets and Liabilities right to offset criteria and if explicit guidance allowing offset should be considered.

Interested parties request the exposure be given an effective date of at least January 1, 2021. The exposure represents a significant change to how certain companies account for derivatives and must be implemented in our investment systems prior to adoption. Interested parties do not believe the assets and liabilities under this exposure meet the right to offset criteria in SSAP No. 64—Offsetting and Netting of Assets and Liabilities, because they originate within the same contract. Additionally, we believe the netting guidance outlined in paragraph 19c would be difficult to implement and recommend it be removed.

Ref #2019-39: Acceptable Collateral - Counterparty Exposure for Derivative Instruments

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 86—Derivatives, to clarify that the fair value of collateral received or held, for derivative disclosure purposes, shall be reported net of collateral paid/pledged, in the event a counterparty has the legal right to offset against, as defined in SSAP No. 64—Offsetting and Netting of Assets and Liabilities. Minor updates to the applicable annual statement instructions were also proposed to be concurrently exposed.

Interested parties fully support the appropriate depiction within the statutory financial statements and schedules of the availability of insurance company assets to fulfill policyholder obligations, including consideration of a reporting entity’s access to and control over the assets and any contingencies pertaining to the attendant rights & benefits of ownership. We appreciate the opportunity to dialogue further on this matter and ensure the regulatory objective is achieved.
regarding both financial statement presentation and the risk-based assessment of capital. The ability to make efficient use of derivative instruments as part of hedging transactions, income generation transactions and replication (synthetic asset) transactions, in accordance with SSAP No. 86 – Derivatives (“SSAP No. 86”), is a crucial component of insurers’ ability to effectively manage risk and prudently maintain yields in support of our ability to deliver on promises to our policy and contract holders. With broader federal regulation now driving a migration for many of the interest rate and credit derivatives insurers use to these ends towards the central clearinghouse or “cleared” space, the significance of appropriately depicting the specific economic substance and attendant risks associated with each of the various forms of collateral posted to central clearinghouses has never been greater.

Given this backdrop, our concerns with exposure 2019-39 are as follows:

1) The language in the proposal does not provide clear, consistent definition of scope or objective(s);
2) The exchange of initial margin on cleared trades represents a contingency distinct from that associated with the exchange of variation margin; and
3) The existing statutory accounting, reporting and risk-based capital models already appropriately depict the economic substance and inherent risk associated with the exchange of initial margin, and the proposed changes would result in inappropriate duplication of risk-based capital charges.

In terms of intended scope, the narrative commentary and proposed updates to existing guidance make it unclear as to whether the proposal aims to refine accounting & reporting guidance for:

- initial margin, variation margin, or both;
- bilateral (over-the-counter, “OTC”) trades, trades executed with central clearinghouses, or both;
- exchanges of cash collateral, non-cash collateral (e.g. securities) or both.

The summary introduction to the proposal appears to target a perceived issue with the Schedule DB-D, Section 1 reporting of initial margin exchanged with central clearinghouses. The narrative commentary provided does not identify specific concerns pertaining to the reporting of collateral associated with bilateral OTC trades or variation margin. However, the attendant proposed edits to SSAP No. 86 and the Blank Instructions for Schedule DB-D, Section 1 encompass collateral exchanges with both bilateral OTC counterparties and central clearinghouses...inherently scoping in both OTC and cleared trades as well as all forms of collateral (variation margin, initial margin and traditional margin on legacy bilateral OTC trades). In addition, the proposal makes no clear distinction between proposed updates regarding exchanges of cash collateral vs exchanges of non-cash collateral, often using the terms collectively and interchangeably, whereas the guidance within the AP&P Manual makes clear distinctions regarding their respective accounting and reporting - as they have distinct implications for users of statutory financial statements. The guidance for cash collateral exchanges under SSAP No. 103R – Transfers and Servicing of Financial Assets and Extinguishments of Liabilities (“SSAP 103R”) paragraphs 19 & 20 is distinct from that of non-
cash collateral exchanges, which is also further detailed in INT 01-31 – *Assets Pledged as Collateral* (“INT 01-31”). Anecdotally, though the SSAP No. 86 Appendix C guidance for the initial carrying value on futures paraphrased in the 2019-39 exposure commentary applies to exchange traded derivatives (which do not appear to be within the scope of this current exposure), it maintains conceptual symmetry with the distinct cash collateral guidance from SSAP No. 103R; classifying only cash postings of initial margin as a form of basis deposit necessitating distinct accounting and financial statement presentation. Additional clarification regarding both the perceived issue(s) and the objective(s) underlying the proposed updates is requested in order to ensure industry can assist in fully and appropriately addressing each underlying concern in light of the applicable regulatory objective(s).

The exchange of initial margin with central clearinghouses is clearly distinct in function from the exchange of variation margin. As referenced in the proposal, initial margin is a minimum amount of equity that must be provided to a clearinghouse to initiate a position. It effectively represents the deposit of chips required to play at the table (“table stakes”), and is required from both respective parties entering into the derivative transaction as protection for the clearinghouse against the potential that either respective party will not make good on its respective commitments (i.e., initial and continuing participation in the transaction and the associated exchanges of variation margin driven by the derivative price movements until expiry or novation) – leaving the clearinghouse exposed, as intermediary, to the remaining party. Once such a trade expires or is novated, assuming the respective party has made good on all its variation margin payments during the course of the trade being open, the asset(s) posted to the clearinghouse as initial margin is returned to that exiting party. In the instance that a party exiting the derivative transaction has not stayed current with its respective variation margin obligations, the clearinghouse will return the remaining value of the initial margin after settling up the unpaid variation margin obligations. As such, the contingencies associated with maintenance of exclusive control over the rights and benefits of asset ownership for an entity posting initial margin are primarily a function of the entity’s continuing involvement in the trade with the clearinghouse, which is distinct from the derivative price movement contingencies directly associated with variation margin.

Reporting entities often utilize non-cash collateral (e.g., US Treasuries) for posting as initial margin to clearinghouses, as the required initial margin value can be comparatively high (driven by risk adjusted trailing price volatility of the underlying derivative and overcollateralization conventions) but the reporting entity maintains the full rights & benefits of ownership over an already held yield generating asset – in many instances preferable to locking up a chunk of otherwise investible cash. The ability to maintain full control over the rights and benefits of ownership on this yield generating non-cash collateral posted (e.g., avoiding forced sales of the non-cash collateral to satisfy unfulfilled variation margin obligations) also incentivizes a reporting entity to remain current on variation margin obligations while the trade remains open. Existing statutory accounting guidance (e.g., the previously referenced SSAP No. 103R and INT 01-31) already provides for appropriate classification, measurement and presentation of collateral posted as initial margin. In the much more likely instance that non-cash collateral has been posted to a clearinghouse as initial margin, the pledging insurer continues to record the pledged collateral as an admitted asset until they have committed a contract default that has not
been cured. In the unlikely instance that the non-cash collateral has to be liquidated in order to
satisfy unmet variation margin payment obligations associated with a trade being exited, any
associated realized loss would be recognized and the reclassification of the remaining initial
margin value due back from the clearing house will be recorded – likely as either cash or a
receivable - in accordance with applicable statutory guidance. The Blanks instructions require
that any such non-cash or cash collateral posted as initial margin be marked as such on the
attendant investment schedule, identified at the specific asset level on Schedule DB-D Section 2
(complete with an identifier indicating that the posting represents initial margin) and summarized
within Note 5 (Restricted Assets). As such, the availability of the assets to fulfill policyholder
obligations, as well as identification at the specific asset level of the unique and specific
contingencies associated with initial margin posting are already presented appropriately for the
consideration of financial statement users. Altering the presentation of initial margin postings on
the summary Schedule DB-D Section 1 would not augment a financial statement user’s
understanding of the reporting entity’s solvency or financial condition, as the “net realizable
margin” associated with the open derivative contracts is already appropriately presented – initial
margin posted is not directly or typically subject to the derivate price movement contingencies
inherent in arriving at an appropriate “Exposure Net of Collateral” total on Schedule DB-D
Section 1.

Equally as important, incorporation of initial margin posted into the “Exposure Net of Collateral”
total on Schedule DB-D Section 1 would lead to inappropriate and misleading downstream
consequences for a reporting entity’s Risk Based Capital calculation. Any collateral (whether
non-cash or cash) posted as initial margin is already captured in the Life RBC formula on LR017
(Off Balance Sheet and Other Items), where all collateral postings are pulled directly from
Schedule DB-D Section 2 and assessed RBC charges associated with the specific contingency of
pledging of the assets to an external counterparty. Thus, netting initial margin postings into the
“Exposure Net of Collateral” total on Schedule DB-D Section 1 would make the total derivative
exposure (net of collateral) that flows through to LR012 in the Life RBC formula too high –
inappropriately double counting the RBC charges associated with the posting of initial margin to
a clearinghouse. In addition, the understatement of net realizable collateral (Fair Value of
Acceptable Collateral) on Schedule DB-D Section 1 would also, in many instances, mechanically
carry through to overstate the “Off Balance Sheet Exposure” reported on the same schedule –
which would result in even further overstatement of RBC charges as this “Off Balance Sheet
Exposure” flows through the Life RBC formula to be assessed charges on LR017. Doubling,
and possibly tripling the RBC charges associated with the posting of initial margin to a central
clearinghouse is not an appropriate depiction of true risk for such margin.

Given the ambiguities in the exposure language, the appropriate depiction of economic substance
and inherent risk associated with exchanging initial margin within the existing statutory
accounting, reporting and RBC frameworks, and the importance of maintaining insurers’ ability
to utilize cleared derivatives to effectively manage risk and prudently support yields, we
respectfully request that the Working Group withdraw the current proposal and direct NAIC
Staff to collaborate with industry to specify and appropriately address any remaining concerns.
We stand ready to work through any lingering misgivings the Working Group may have with
regard to financial statement presentation but request that such endeavors be empirically
grounded in specific observed instances of incomplete or inappropriate reporting.

**Ref #2019-40: Reporting of Installment Fees and Expenses**

The Working Group proposed revisions to SSAP No. 53 – *Property and Casualty Contracts* (SSAP No. 53) to clarify that the installment fee reporting guidance should be narrowly applied. Comments are also requested on whether guidance should be developed to allow expenses associated with installment fees to be reported as a contra revenue in “aggregate write-ins for miscellaneous income” and whether diversity should be permitted in reporting installment fee expenses. Additionally, the Casualty Actuarial (C) Task Force and Property and Casualty Risk Based (E) Working Group will be notified of this exposure.

With regard to the proposed change to emphasize that current guidance in SSAP No. 53 should be interpreted narrowly, interested parties recommend the following revision to the last sentence of the proposed wording in the footnote to SSAP No. 53 paragraph 6:

> Clarification reporting of installment fees in finance and service charges as other income should not be construed as having any bearing on whether such charges are subject to premium taxation, which remains an issue of state law and regulation.

Although interested parties did not survey companies, we believe the assertion by NAIC staff that expenses associated with installment fees are often immaterial is reasonable. We also believe that current reporting of the related installment fee expenses in other underwriting expenses is appropriate. For practical purposes, we do not see the benefit of isolating the expense related to processing the relatively small fee component of a premium billing for separate expense reporting purposes. We believe the reporting of expenses should be consistent and would not support the reporting of the related expenses as an “aggregate write-ins for miscellaneous income” or as a contra revenue to “finance and service charges not included in premiums.”

**Ref #2019-41: Eliminating Financial Modeling Process**

The Working Group moved this agenda item to the active listing and exposed revisions to *SSAP No. 43R—Loan-backed and Structured Securities*, to eliminate the multi-step financial modeling designation guidance in determining final NAIC designations for residential mortgage-backed securities (RMBS) / commercial mortgage-backed securities (CMBS) securities. Exposure was contingent upon the Valuation of Securities (E) Task Force’s concurrent exposure, which occurred on December 8, 2019. The Working Group noted that final action on this would not be taken until the Valuation of Securities (E) Task Force takes action on their related item.

Interested parties have no comment on this item at this time.
Ref #2019-42: Inclusion of Cash / Liquidity Pools - Cash Equivalents as defined in SSAP No. 2R

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments to specify that cash pooling structures that meet specified criteria qualify as cash equivalents.

Interested parties appreciate that a separate Form A (Ref #2019-42) was written related to Cash/Liquidity Pools (“pools”) to clarify the accounting associated with them. We agree with the addition of a paragraph, similar to paragraph 8, to SSAP No. 2R to provide guidance related to pools; however, given that the characteristics of pools differ by company, we propose some modifications to paragraph 8 in order to address those varied characteristics.

Interested parties’ comments related to the proposed paragraph 8 are as follows:

1) Regarding the proposal to look through the ownership structure to report the assets held as cash equivalents, we agree that look through is appropriate. Some pools, as approved by regulators, consist of assets that meet the Statutory definition of cash equivalents and thus the interest held in the pools are reported as cash equivalents on Schedule E2. However, other pools, also approved by regulators, include assets that meet the definition of short-term investments in SSAP No. 2 and thus the interest held in the pools are reported as short-term investments on Schedule DA. Some pools may include both short-term investments and cash equivalents.

Given the varied characteristic discussed above, we recommend paragraph 8 be modified to state that, if the requirements of paragraph 8 are met, the reporting entity may look through the ownership structure and report the assets as either cash equivalents or short-term assets based on the predominant characteristic of the underlying assets. This would allow companies the flexibility to report their investments in the pools in the Statutory statement schedule that is more reflective of the type of underlying investments in their pool and prevent the need for companies to reclassify/change their existing reporting to Schedule E2 from DA if they currently report the pools in DA due to the underlying assets.

2) Regarding paragraph 8d (i.e., the requirement to produce annual U.S. GAAP audited report of the pools including schedules showing each affiliate’s prorata share of the investments), insurance companies already receive an independent audit under Statutory Accounting Principles (“SAP”), which would include the insurance company’s investment in a pool. Requiring cash pools to be separately audited under U.S. GAAP would come at a cost, in time and resources, to insurers with pools. In addition, some insurers have pools which are not in the form of legal entities.

An alternative to the U.S. GAAP audit requirement of paragraph 8d. is to require a footnote disclosure at the reporting date for each insurer that participates in a pool, which identifies that the insurer is invested in a cash pool, provides the reporting entity’s share
of the pool, and the insurers dollar share of cash equivalents and short-term investments in the pool. This disclosure would be subject to audit on an SAP basis of accounting. IPs believe the audit of the disclosure along with the audit of the insurance company would be adequate to meet the objectives of ensuring that the pool allocation process is accurate. Other alternatives include targeted financial examination procedures for pools, which could include procedures to confirm the balance of the pool and verify the individual legal entities’ balances for participating in the pool.

3) We note that the addition of the proposed pool language in SSAP No. 2 does not specifically address the reporting and accounting for the interests held in the pool. We recommend, if the pool is managed on a fair value basis (i.e., interest in the pool are bought and sold at fair value), that the book/adjusted carrying value for the interest held in the pool would be reported at fair value with changes in fair value reported in unrealized gains and losses. If the pool is not managed on a fair value basis, the interest held in the pool would be reported at amortized cost. It is important to note that pools managed on a fair value basis may use amortized cost as the best estimate of fair value, depending on the characteristics of the underlying assets.

Finally, in the issue paper, NAIC staff questioned whether changes to SSAP No. 48, Joint Ventures, Partnerships and Limited Liability Companies are needed, since many pools are held in a Limited Liability Company (“LLC”). Interested parties do not believe such changes are needed to SSAP No. 48; however, it would be helpful to users of the SSAPs to add a footnote to paragraph 8 of proposed SSAP No. 2R stating that pools may be held in LLCs, for example, and if so, SSAP No. 2 is to be applied and not SSAP No. 48.

Ref #2019-43: ASU 2017-11 - Financial Instruments with Down Round Features

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 86—Derivatives to reject ASU 2017-11, Earning Per Share, Distinguishing Liabilities from Equity, Derivatives & Hedging and incorporate guidance into SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets and SSAP No. 72—Surplus and Quasi-Reorganizations for when certain freestanding instruments shall be recognized as liabilities and not equity.

Interested parties have no comment on this item.

Ref #2019-45: ASU 2013-11, Presentation of an Unrecognized Tax Benefit

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 101—Income Taxes to reject ASU 2013-11, Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists for statutory accounting.

Interested parties support adoption of this item but note that the following statement should be removed from the document as it is incorrect (see IFRC 23, Uncertainty over Income Tax Treatments):
Convergence with International Financial Reporting Standards (IFRS):
IFRS does not include specific guidance on the presentation of unrecognized tax benefits.

Ref #2019-46: ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities

The Working Group moved this agenda item to the active listing and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities as not applicable to statutory accounting.

Interested parties have no comment on this item.

Ref #2019-47: Grade in of Variable Annuity Reserves

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 51R—Life Contracts and SSAP No. 3—Accounting Changes and Corrections of Errors. The revisions add reference, disclosures and accounting for Section 21 of the Valuation Manual, Requirements for Principle-Based Reserves for Variable Annuities, and grade-in requirements for reporting changes in the valuation basis for years beginning January 1, 2020.

This exposure consists of several parts, some of which we agree with and others we find both confusing and unnecessary. We agree that documentation of the choices made among the options for phase-in in VM-21 and the impact of those choices is important. The exposed edits focus on the adoption of the new reserve requirements for variable annuities (revised VM-21 and AG-43). Information on those choices and impacts will be provided to regulators through the PBR Actuarial Memorandum required by VM-31. This includes highlighting the elements of any Phase-in in the executive summary of the PBR Actuarial Memorandum. Given the current requirements of SSAP3 and SSAP51, documentation in the notes to the Annual Statement is also appropriate.

In Recommendation #2, the proposal would require the amounts from the Phase-in to be designated as “special surplus”. We disagree with this recommendation for the following reasons:

- This is a new requirement whose need has not been established. Disclosure of the amounts will provide information necessary for users of the financial statements to understand the basis of the reported financials.
- SSAP72 defines Special Surplus as amounts designated for specific contingencies. Recommendation #2 would be a change to the definition and purpose of special surplus that is inappropriate and would create an undesirable precedent.

Finally, the proposed language is unnecessary, and possibly confusing. VM-21 defines the minimum reserve requirement. Within that requirement, the company has the option to compute the reserves using the Phase-in provision of Section 2.B. Whichever option is elected, VM-21 defines the reserve. SSAP51 defines the amount of the “Change in Basis” as the difference
between the amount under the prior VM-21 and the amount required by the current VM-21 as of 1/1/2020. If the Phase-in has been elected, that difference will generally be zero. The change in basis amount as defined in SSAP51 paragraph 39 is not being graded in – it is what it is following the VM-21 reserve requirements as stated. As such, SSAP51 does not need to make provision for a grade in. We propose the attached language as being clearer in defining the amounts to be disclosed, to use language consistent with VM-21, and to recognize the role of VM-21 to define the reserve requirement.

Ref #2019-48: Disclosure Update for Reciprocal Jurisdiction Reinsurers

The Working Group moved this agenda item to the active listing and exposed revisions to SSAP No. 62R—Property and Casualty Reinsurance, to incorporate disclosure updates for reinsurers from Reciprocal Jurisdictions.

Interested parties have no comment on this item.

Ref #2019-49: Retroactive Reinsurance Exception

The Working Group moved this agenda item to the active listing with a request for comments on the preferred approaches to reporting and the advantages and disadvantages to each approach being used, including impacts on the Schedule P (and related loss analysis) and risk-based capital. Industry and state insurance regulator volunteers are requested to assist with developing guidance to clarify both the accounting and reporting for retroactive contracts which are accounted for prospectively. The Working Group directed NAIC staff to notify the Casualty Actuarial and Statistical (C) Task Force of the request for comments.

With regard to retroactive portfolio transfer deals within the same group that qualify for prospective treatment, interested parties identified the following issues related to reporting transactions in Schedule P.

Main Issues

- Should there be a requirement to have offsetting entries for the ceding and assuming entity within the group, such that the group Schedule P is not impacted (and industry Schedule P is not impacted)? (If so, then the ceding entity can’t record ceded amounts for prior AYs while the assuming company records assumed amounts all in the current CY/AY.)

- Should retroactive changes in previous premium amounts be allowed? (If no, and there is a desire to have both entities record the ceded/assumed in the affected older AYs, then the reinsurance premium would need to be treated as a paid loss – positive paid for the ceding entity and negative paid for the assuming entity.)

- Should the reporting prevent “cliffs” in the historic development reported in Schedule P. (If the cede transaction is reported as a premium and spreading to prior CYs, effectively changing prior values retroactively, then the prior incurred loss amounts in
Schedule P, Part 2 would need to be adjusted to avoid a “cliff”.) Note that cliffs in Schedule P, Part 2 can have a material RBC impact with regard to the company experience adjustment.

Two Alternative Approaches

Interested parties identified two alternative approaches to recording intercompany, retroactive reinsurance:

- Record the reinsurance premium as a paid loss (positive paid for the cedant, negative for the assuming company), spreading the “premium” to the same AYs as the ceded losses. This avoids cliffs and avoids restating past CY Earned Premium, although it produces unusual results for the assuming company’s Schedule P.

- Record the reinsurance premium as premium, restating prior CY Earned Premium. Spread losses to the impacted AYs. This would create cliffs in Schedule P unless prior AYs are restated for the impact by AY of the reinsurance contract at inception.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell

Rose Albrizio
Disclosures

18. The notes to the financial statements of a reporting entity that issues surplus notes shall disclose the following as long as the surplus notes are outstanding:

a. Date issued;
b. Description and fair value of the assets received;
c. Holder of the note or if public, the names of the underwriter and trustee, with identification on whether the holder of the surplus note is a related party per SSAP No. 25;
d. Original issue amount of note;
e. Carrying value of note;
f. The rate at which interest accrues;
g. Maturity dates or repayment schedules, if stated;
h. Unapproved interest and/or principal;
i. Life-to-date and current year approved interest and/or principal recognized;
j. Disclosure of whether the surplus note was issued as "paid part of a transaction with identification of any of the amount of approved following attributes:
   i. Do surplus note / associated asset terms negate or reduce cash flow exchanges, and/or are amounts payable under surplus notes and amounts receivable under other agreements contractually linked (For example, the asset provides interest and/or principal remitted payments only when the surplus note provides interest payments)?
   ii. Are any amounts due under surplus notes and associated assets netted or offset (partially or in full) thus eliminating or reducing the exchange of cash or assets that would normally occur throughout the duration, or at maturity of the agreement. (This may be referred to as administrative offsetting)?
   iii. Were the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note (actual transfer of cash / assets) and the amount of approved interest and/or principal not remitted to the holder of the surplus note (no transfer of cash / assets)? If so, was the asset issuer a related party per SSAP 25?
   iv. Information regarding a third party liquidity source including name, identification if a related party, cost of the liquidity guarantee, and maximum amount available should a triggering event occur.

1 Interest and principal reported pursuant to 18.i include amounts offset by amounts receivable under other agreements, unless the reporting entity has a legal right of offset. Such offsetting arrangements shall be disclosed pursuant to paragraph 18.j.i through 18.j.iii
Exhibit A: DRAFT – Markup of Disclosure and Table

k. ______ Principal amount and fair value of assets received upon Surplus Note issuance, if applicable;

l. ______ Subordination terms;

m. ______ Liquidation preference to the reporting entity’s common and preferred shareholders;

n. ______ The repayment conditions and restrictions;

o. ______ Information about any guarantees, support agreements, or related party transactions associated with the surplus note issuance, and whether payments have been made under such agreements.

19. ______ If a reporting entity has ceded business to a surplus note issuer that is not remitting actual cash or assets to a related party as part of a reinsurance transaction in which the surplus note meets any of the criteria in 18.1 above, the ceding entity shall provide a description of the transaction, including whether the criteria in 18.1 above were met with respect to the surplus note issuance, as long as the reinsurance agreement remains in force. The ceding entity should provide a description of the risks reinsured, the related party reinsurer, any guarantees or support agreements and the amount of notes outstanding.

49-20. If the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note for approved interest or principal (as reported under paragraph 18.h), because the reporting entity is offsetting the amount owed under the surplus note with an amount receivable from a reported asset, the following information shall be disclosed regarding the offsetting asset/assets received:

a. Identification of asset, including the investment schedule where the asset is reported and reported NAIC designation;

b. ______ Book/ adjusted carrying value of asset and interest income recognized in as of the current year,

c. ______ Amount of principle return and interest income from the asset not received by the reporting entity as the amounts were offset with approved amounts owed by the reporting entity’s issued surplus note’s date.

d. ______ A description of terms under which liquidity would be provided should a triggering event occur.

20-21. In addition to the above, a reporting entity shall identify all affiliates that hold any portion of a surplus debenture or similar obligation (including an offering registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933), and any holder of 10% or more of the outstanding amount of any surplus note registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933.
## Exhibit A: DRAFT – Markup of Disclosure and Table

### Proposed Blanks Disclosures:

<table>
<thead>
<tr>
<th>Date Issued</th>
<th>Interest Rate</th>
<th>Original Issue Amount of Note</th>
<th>Is Surplus Note Holder a Related Party (Y/N)</th>
<th>Fair Value of Assets Received Upon Issuance</th>
<th>Carrying Value of Note Prior Year</th>
<th>Carrying Value of Note Current Year</th>
<th>Unapproved Interest And/or Principal Interest</th>
<th>Approved Interest Recognized Interest Paid Current Year</th>
<th>Life To Date Total Interest Remitted (Actual Transfer of Cash/Assets) Paid</th>
<th>Principal Paid Current Year</th>
<th>Life To Date Total Principal (Actual Transfer of Cash/Assets) Remitted Paid</th>
<th>Date of Maturity</th>
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- Current Year Approved Interest Remitted (Actual Transfer of Cash/Assets) Are Surplus Note Payments contractually linked? (Y/N)
- Current Year Approved Principal Remitted (Actual Transfer of Cash/Assets) Are Surplus Note Payments subject to administrative offsetting provisions? (Y/N)
- Current Year Approved Interest Net Remitted Since Issuance (No Transfer of Cash/Assets) = Were Surplus Note Proceeds used to purchase an asset directly from the holder of the surplus note? (Y/N)
- Current Year Approved Principal Net Remitted Since Issuance (No Transfer of Cash/Assets) = Is Asset Issuer a Related Party (Y/N)
- Type of Assets Received Upon Issuance = Non-Remitted Interest or Principal Offset with Amounts Owed from Surplus Note Holder (Y/N) = Principal Amount of Assets Received Upon Issuance
- Does Remitted Interest or Principal Payments Result with Acquisition of a Source of Liquidity Through the Surplus Note Holder? (Y/N) = Maximum Amount Surplus Note Issuer Can Receive from Liquidity Source

* Include amounts offset with amounts owed from the holder of the surplus note.

### Table: Accounting Practices and Procedures (E) Task Force

#### Name of 3rd Party Liquidity Source Acquired

<table>
<thead>
<tr>
<th>Name of 3rd Party Liquidity Source Acquired</th>
<th>Is Liquidity Source a Related Party to the Surplus Note Issuer?</th>
<th>Current Year Total Cost of Liquidity Source</th>
<th>Current Year Cost of Liquidity Source Reported as Surplus Note Interest</th>
<th>Total Cost of Liquidity Source Since Acquisition</th>
<th>Total Cost of Liquidity Source Reported as Surplus Note Interest Since Acquisition</th>
<th>Maximum Amount Surplus Note Issuer Can Receive from Liquidity Source</th>
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NAIC Proceedings – Summer 2020

Attachment One (E) Task Force 8320

10-709
SSAP No. 51R:

Change In Valuation Basis

36. A change in valuation basis for reserves determined under paragraphs 18-21, except for reserves defined under Actuarial Guideline XLIII—CARVM: For Variable Annuities (AG 43), as detailed in Appendix C of this Manual, shall be defined as a change in the interest rate, mortality assumption, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors (SSAP No. 3).

37. Changes in reserves developed under paragraph 22 or AG 43 shall be reviewed to determine whether the change represents a change in valuation basis and if it meets the definition of a change in accounting as defined in SSAP No. 3.

a. Changes in principle-based reserving assumptions are often the result of updating assumptions and other factors required by the existing reserving methodology. Reserve changes resulting from the application of principle-based reserving methodology including, but not limited to, updating assumptions based on reporting entity, industry or other experience, and having the reported reserve transition between net premium reserve, deterministic reserve or stochastic reserve, as required under existing guidance, shall not be considered a change in valuation basis. These types of changes also include, but are not limited to, periodic updates in Valuation Manual tables, such as industry valuation basic tables, asset spread tables and default cost tables.

b. A change in valuation basis for principle-based reserves shall include cases where the required reserve methodology has changed, or the insurer makes a voluntary decision to choose one allowable reserving method over another. These types of changes include, but are not limited to, new standardized mortality tables such as Commissioners Standard Ordinary tables and regulatory changes in methodology.

38. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus (under changes to surplus in the change in valuation basis annual statement line) rather than as a part of the reserve change recognized in the summary of operations.

39. The impact of a change in valuation basis on surplus is based on the difference between the reported reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless this statement or the Valuation Manual in section VM-21 Requirements for Principle Based Reserves for Variable Annuities (VM-21) prescribes a new method and a specific transition that allows for grading. If the grading permitted by this statement or Valuation Manual section VM-21 represents an increase in the reserve liabilities, the unrecognized change in valuation basis reserve increase shall initially be reflected as an allocation from unassigned funds to special surplus until fully recognized in reserving and unassigned funds. The reclassification from unassigned funds to special surplus does not reduce total surplus, but
highlights the ungraded in amount for transparency as it represents an unrecognized adjustment (decrease) to total surplus. The allocation to special surplus is reversed to unassigned funds as the grading of the increase in reserving is recognized as a decrease to total surplus. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements.

Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements.

Effective January 1, 2020, if the phase-in provision of the Valuation Manual section VM-21 (on variable annuities) is elected or this statement prescribes or permits a grading-in period or provides the option of multiple grading periods, reporting entities shall also include in the change in accounting disclosures required by SSAP No. 3, disclosure of the following:

a. the grade-phase-in period being applied, and the remaining time period of the grade phase-in

b. any adjustments to the grade-phase-in period.

c. The phase-in amount as defined in VM-21 of change in valuation basis grade-in, which has been recognized in unassigned funds and

d. the remaining amount to be graded phase-in amount (reflected in special surplus if the ungraded in amount represents an increase in reserving).

40. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. While the Valuation Manual is effective prospectively for policies written on or after the operative date, subsequent changes may be applied retroactively to all business issued since that operative date however, as the CARVM methodology was already principles based, some changes to the CARVM methodology in section VM-21 (on variable annuities) and to the related AG 42, which may result in retroactive application to the reserving for existing contracts. Therefore, upon the initial prospective adoption of principle-based reserving, the change in valuation basis reflected as an adjustment to surplus will be zero. After initial adoption of the Valuation Manual, changes in valuation basis will need to be evaluated to determine the amount of any surplus adjustments.
SSAP No. 3—Accounting Changes and Corrections of Errors

Disclosures

Disclosure of material changes in accounting and correction of errors shall include:

a. A brief description of the change, encompassing a general disclosure of the reason and justification for change or correction;

b. The impact of the change or correction on net income, surplus, total assets, and total liabilities for the two years presented in the financial statements (i.e., the balance sheet and statement of income and operations); and

c. The effect on net income of the current period for a change in estimate that affects several future periods, such as a change in the service lives of depreciable assets or actuarial assumptions affecting pension costs. Disclosure of the effect on those income statement amounts is not necessary for estimates made each period in the ordinary course of accounting for items such as uncollectible accounts; however, disclosure is recommended if the effect of a change in the estimate is material;

d. Changes in accounting that are changes in reserve valuation basis as described in SSAP No. 51R—Life Contracts which have elected grade phase-in or other optional application features defined in the Valuation Manual, shall also include in the change in accounting disclosures information regarding the application of any grade phase-in as provided for in SSAP No. 51R, and

e. When subsequent financial statements are issued containing comparative restated results as a result of the filing of an amended financial statement, the reporting entity shall disclose that the prior period has been restated and the nature and amount of such restatement.
February 18, 2020

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment During the NAIC Winter National Meeting with Comments due January 31 Regarding Goodwill

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts regarding the recognition of goodwill for statutory accounting that was released for comment by the Statutory Accounting Principles (E) Working Group (the “Working Group”), during the NAIC Fall National Meeting in Austin.

Interested parties note that in October 2018, the FASB decided to add to its technical agenda a broad project to revisit the subsequent accounting for goodwill. In 2019, the FASB issued an Invitation to Comment, Identifiable Intangible Assets and Subsequent Accounting for Goodwill, and held public roundtable meetings to discuss the topics included in the Invitation to Comment. The FASB is still in the initial deliberations phase of this project. Given the broad scope of the FASB project and the potential for changes to the current GAAP goodwill accounting model, interested parties recommend that any changes to statutory accounting that impact the accounting for goodwill be limited in their nature in recognition that the Working Group will need to consider the applicability of the changes to GAAP accounting for goodwill once the FASB completes the project.

We offer the following comments to the exposure drafts released for comment by the Working Group:

Ref #2019-12: ASU 2014-17, Business Combinations – Pushdown Accounting, a Consensus of the FASB Emerging Issues Task Force

The Working Group adopted, as final, a clarification edit to SSAP No. 68—Business Combinations and Goodwill to clarify that all goodwill from an insurance entity’s acquisition of SCAs, regardless of whether pushdown accounting is applied, is subject to the existing 10% admittance limitation.
Interested parties recommend that paragraph 5 of SSAP No. 68 be revised further as marked below to clarify the appropriate valuation that should be used for an acquired entity:

5. A business combination accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with paragraphs 8.b.ii., 8.b.iii. or, 8.b.iv. of SSAP No. 97 shall determine the amount of positive goodwill or negative goodwill created by the combination using the reporting entity's share of the GAAP net book value of the acquired entity, adjusted to a statutory basis of accounting in accordance with paragraph 9 of SSAP No. 97 in the case of acquired entities valued in accordance paragraphs 8.b.ii. or 8.b.iv. of SSAP No. 97. The GAAP net book value of the acquired entity used in this determination shall reflect the acquisition-date fair values of identifiable assets acquired and liabilities assumed, and goodwill, as recognized in the post pushdown GAAP financial statements of the acquired entity, if applicable. Business combinations accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with, paragraph 8.b.i. of SSAP No. 97 shall determine the amount of positive or negative goodwill created by the business combination using the insurer's share of the statutory book value of the acquired entity.

**Pushdown Accounting**

Interested parties note that the GAAP guidance in ASU 2014-17, which was adopted by the SEC in Staff Accounting Bulletin (SAB) 115, provides clear guidance that an acquired entity has the option to apply pushdown accounting in its separate financial statements upon the occurrence of an event in which an acquirer obtains control of the acquired entity. Under applicable GAAP guidance, control generally results when one entity obtains, either directly or indirectly, more than 50 percent of the outstanding voting shares of another entity. This differs from the definition of control under statutory guidance which uses a threshold of 10 percent or more of voting control. As such, under GAAP, there would not be a scenario where an entity would be controlled by multiple owners with 10% or more ownership of outstanding shares.

Whether a company chooses to apply pushdown accounting depends on the facts and circumstances of a particular transaction. In certain situations, pushdown is preferable to eliminate the basis difference between an acquirer and the acquired entity. In other situations, a company may prefer pushdown accounting to better reflect the actual values of the acquired assets and assumed liabilities based on the purchase price of the entity.

When the SEC required pushdown for SEC registrants, there was limited guidance for non-registrants under GAAP which resulted in some non-registrants also applying the SEC pushdown guidance. We believe retaining the optionality for statutory reporting allows for consistency and comparability across both SEC registrants and non-registrants and provides operational efficiency.

The option of not allowing subsequent elections for pushdown accounting is not practicable for SEC registrants that previously elected to use pushdown accounting. In order for such companies to
discontinue use of pushdown accounting, a preferable letter would be required for a change in accounting policy to discontinue the use of pushdown accounting. Given that an election to discontinue use of pushdown accounting is not likely preferable, the insurer would be in the position of having to continue using pushdown accounting in order to receive a clean audit opinion on the GAAP financial statements of the SCA. Additionally, while ASC 805, *Business Combinations*, allows the election to be made for each change in control event, acquirers that report consolidated results may as a practical matter choose pushdown accounting at the subsidiary level to avoid separately tracking assets, and liabilities at two different values in two different ledgers.

As noted in the examples below, and in accordance with the guidance adopted during the December 7, 2019 Working Group meeting, interested parties understand the guidance clarified that all goodwill from an insurance entity’s acquisition of SCAs, regardless of whether pushdown accounting is applied, is subject to the existing 10% admittance limitation. Interested parties have summarized the interpretation of this clarification for an insurance entity’s acquisition of an 8.b.i (example 1), 8.b.ii (example 2a and 2b), 8.b.iii (example 3a and 3b) or 8.b.vi (example 2a and 2b) entity as follows:

<table>
<thead>
<tr>
<th>Example</th>
<th>Type of acquired SCA</th>
<th>Is Pushdown elected?</th>
<th>Where does Goodwill resides?</th>
<th>Admissibility of goodwill limited to 10% of</th>
<th>Is Goodwill required to be amortized?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8.b.i</td>
<td>Not permitted per SSAP No. 68 para 6</td>
<td>Insurance entity (Statutory goodwill)</td>
<td>Insurance Entity's Surplus per SSAP No. 68 para 7</td>
<td>Yes per SSAP No. 68 para 8</td>
</tr>
<tr>
<td>2a</td>
<td>8.b.ii or 8.b.iv</td>
<td>No</td>
<td>Insurance entity (Statutory goodwill)</td>
<td>Insurance Entity's Surplus per SSAP No. 68 para 7</td>
<td>Yes per SSAP No. 68 para 8</td>
</tr>
<tr>
<td>2b</td>
<td>8.b.ii or 8.b.iv</td>
<td>Yes</td>
<td>SCA (GAAP goodwill)</td>
<td>SCA's GAAP equity per SSAP No. 97 para 9.d</td>
<td>Yes per SSAP No. 97 para 9.c.iii</td>
</tr>
<tr>
<td>3a</td>
<td>8.b.iii</td>
<td>No</td>
<td>Insurance entity (Statutory goodwill)</td>
<td>Insurance Entity's Surplus per SSAP No. 68 para 7</td>
<td>Yes per SSAP No. 68 para 8</td>
</tr>
<tr>
<td>3b</td>
<td>8.b.iii</td>
<td>Yes</td>
<td>SCA (GAAP goodwill)</td>
<td>Insurance Entity's Surplus per SSAP No. 68 para 7</td>
<td>No *</td>
</tr>
</tbody>
</table>

* See further discussion below related to amortization

After evaluating the accounting for goodwill from the various entities described in paragraph 8.b, we concluded that the NAIC should continue to allow insurers to elect pushdown accounting for acquisitions of non-insurance entities (Option 2) for the following reasons:

1. Statutory goodwill, created when the insurer is the acquirer, is subject to an existing 10% admittance limitation as clarified in the changes adopted by the Working Group during the Fall National Meeting and demonstrated above; therefore, the resulting goodwill from pushdown accounting is subject to the statutory thresholds.
2. Pushdown accounting is consistent with GAAP, prior to ASU 2014-17, for SEC registrants and non-registrants that used pushdown accounting. As noted above, it is not practical to discontinue use of pushdown accounting as an insurer would need to continue the use of pushdown accounting in order to obtain a clean audit opinion on the GAAP financial statements of the SCA.

3. It is important to maintain consistency with current GAAP. Under ASU 2014-17, pushdown accounting may be elected in a later reporting period, after the initial acquisition date. We understand that there may be concerns with electing pushdown at a later reporting period after goodwill was originally determined and reported at initial acquisition date. However, rather than disallowing a later election to apply pushdown accounting, which creates a variance to GAAP, we suggest this could be addressed through changes to SSAP No. 97 to ensure that goodwill is not subsequently increased for statutory reporting, in the event pushdown accounting is elected after the initial acquisition date.

4. The recommendations above would allow the continued use of audited GAAP equity as the statutory carrying value for all non-insurance entities for insurers that previously elected pushdown accounting (both SEC registrants and non-registrants). Additionally, the ability to elect pushdown accounting for future acquisitions retains GAAP equity as the statutory valuation basis for SCAs and avoids restrictions that can impact insurers’ ability to obtain an unqualified opinion on the stand-alone financial statements of SCAs.

If a restriction were placed on the use of pushdown accounting at a future date, those entities that have previously elected pushdown will be forced to separately track assets, and liabilities at two different values in two different ledgers as well as address the issue of making a change in accounting policy that may not have preferability.

As a separate point, we suggest changing the heading for Option 2 from “Permission to use pushdown for all non-insurance entities” to “Use of pushdown for all non-insurance entities”, as the term “permission” implies that use of pushdown accounting is a permitted practice under the statutory accounting framework.

**Amortization**

Interested parties reiterate the concern that the revisions from the adopted language (new SSAP No. 68 paragraph 10) would inadvertently require amortization of pushdown goodwill. While staff has noted that amortization may be the proper approach, interested parties believes as it relates to paragraph 8.b.iii entities acquired by an insurance entity where pushdown is applied, there has been diversity in practice.

Interested parties concur with the NAIC’s staff’s position described in the December 2019 Public Hearing Agenda materials:

“(As detailed in the earlier discussion, the minor edit being discussed only focuses on nonadmittance for insurer entity acquired SCAs that have been pushdown. The edit would not mandate amortization for those pushdown situations. The discussion on whether amortization should be required for those situations is proposed to occur after the next exposure.)”
Ref #2019-14: Attribution of Goodwill

The Working Group re-exposed this agenda item to clarify that the “assignment” of goodwill is a disclosure element. The Working Group directed NAIC staff to prepare revisions to the Sub 1 Acquisition Overview template to capture this information for new SCA acquisitions.

Recommended Action:

NAIC staff identifies that the comments received on the proposed disclosure enhancement under this agenda item are limited, but generally request additional time before adoption. NAIC staff believes the disclosure information requested under this agenda item will be necessary regardless of the decision involving pushdown accounting. As a reminder, the proposed disclosure only details the amount of goodwill recognized from the acquisition of a downstream holding company and the assignment of the goodwill to the entities owned by the holding company. This information is necessary in determining the amount of goodwill that would need to be nonadmitted, or derecognized, if an underlying company in the downstream holding company was nonadmitted or sold.

Interested parties note that the December 2019 Public Hearing Agenda materials state:

“It is important to highlight that the clarification edit proposed for adoption consideration is specific to insurance entity acquisitions of SCAs. As such, if an acquisition occurred downstream from the insurance company (by a non-insurance holding company), and the holding company applied pushdown accounting, so that the goodwill was reported at the holding company’s acquired SCA, the proposed edit would not require that push down goodwill to be brought up to the insurance entity’s level and included in the 10% limit.”

Requiring attribution would be onerous and misleading to the users of the financial statements, particularly if the disclosure included detailing GAAP goodwill that is not subject to the 10% limit. Interested parties do not believe it is necessary to “attribute” goodwill to downstream SCAs of downstream holding companies. We believe that any concerns about the carrying value of the downstream holding company being overstated because it did not push down GAAP goodwill to a downstream SCA that was subsequently sold is mitigated by the fact that GAAP already requires the attribution and derecognition of goodwill associated with the business or SCA that is sold. To layer in a statutory attribution of goodwill is not necessary, overly complex, and may distort the accounting impact of a sale of a downstream SCA.

Therefore, we recommend that the disclosure of GAAP goodwill attributed to downstream SCAs of downstream holding companies focus on actual GAAP goodwill that was pushed down to the

ASC 350-20-40, Intangibles – Goodwill and Other - Goodwill – Derecognition, paragraphs 1 and 2:

40-1: When a reporting unit is to be disposed of in its entirety, goodwill of that reporting unit shall be included in the carrying amount of the reporting unit in determining the gain or loss on disposal.

40-2: When a portion of a reporting unit that constitutes a business (see Section 805-10-55) or nonprofit activity is to be disposed of, goodwill associated with that business or nonprofit activity shall be included in the carrying amount of the business or nonprofit activity in determining the gain or loss on disposal.
downstream SCAs and any statutory goodwill that occurred when the insurer is the acquirer, subject to the existing 10% admittance limitation as illustrated and discussed in the examples above.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell                          Rose Albrizio
January 31, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners

Re: Ref #2019-20, Rolling Short-Term Investments

Dear Mr. Bruggeman:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to comment on the Statutory Accounting Principles (E) Working Group’s exposed revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities relating to rolling short-term investments. APCIA is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

APCIA writes to highlight our support for the recommendations on this proposal provided in the comment letter of the “Interested Parties” coalition. APCIA and our members regularly participate in the Interested Parties’ discussions and drafting process.

SSAP No. 2R generally requires debt obligations with a maturity date of less than one year to be reported on Schedule DA. However, the proposed revisions to SSAP No. 2R would specify that any investment reported as a short-term obligation which was renewed or extended past its original maturity date would need to be reported as a long-term obligation, and a reporting entity would not be permitted to acquire the same or a substantially similar security within a 1-year time frame unless such security is reported as a long-term obligation. APCIA believes appropriate safeguards already exist, or could be put in place, to address the concerns underlying this proposal. We support the recommendations of the Interested Parties in the context of both unaffiliated and affiliated short-term loans.

Unaffiliated short-term loans provide important flexibility and efficiencies for insurers. So long as the lender has a reasonable expectation that the investment can terminate and be repaid on the maturity date, and both the borrower and lender have the ability to reevaluate and renew the loan at maturity, we believe unaffiliated short-term loans are properly reported on Schedule DA as a short-term risk asset. As such, APCIA supports the objective criteria proposed by the Interested Parties for determining when an unaffiliated loan qualifies as short term:

1) The loan includes a maturity date less than one year from closing at which the borrower has an unconditional repayment obligation and on which the lender has a reasonable expectation that the investment can be terminated and repaid if so desired by the insurer; and
2) Any subsequent renewal is only completed in the sole discretion of both the borrower and the lender.

In the context of short-term loans between affiliates, the Model Holding Company Act already requires regulatory filing and approval of loans exceeding a materiality threshold. Further, as the Interested Parties’ letter also points out, loans between affiliates are an important mechanism for meeting short-term liquidity needs for an entity within a broader group. Given the importance of insurers being able to utilize loans from affiliates to meet short-term needs and the regulatory oversight of these transactions that already exists, APCIA agrees with Interested Parties that short-term loans between affiliates should continue to be classified as short term.
Thank you for considering our comments. If you have any questions or would like to discuss this further, please contact Steve Broadie at steve.broadie@apci.org or 847.553.3606.

Sincerely,

Stephen W. Broadie
Vice President, Financial & Counsel
Dale Bruggeman  
Chair of Statutory Accounting Principles (E) Working Group  

We have reviewed the proposed changes to SSAP No. 71 – Policy Acquisition Costs and Commissions as outlined in Ref. #2019-24 as revised on December 7, 2019.

The most effective way to appreciate the unintended consequences of the proposal is to start with a basic understanding of a typical distribution structure. Reporting entities execute distribution agreements, including compensation structure, with distribution partners (IMO, BGA, TPM, MGA, BD, for example). These distribution partners recruit, contract, train, supervise, and compensate smaller organizations (agencies, selling groups, brokerages, etc.) and individual producers (agents, brokers, etc.).

SSAP No. 71 proscribes statutory accounting treatment for reporting entity compensation agreements entered for the sale, distribution, and servicing of policies. The revisions proposed in Exposure Draft 2019-24 (as revised December 7, 2019) focus on two areas: (1) levelized commissions or “trail” payments paid directly to distribution partners or individual producers by a reporting entity and (2) levelized commissions or other installment payments paid to “third parties” by the reporting entity solely in exchange for the third party making non-levelized payments to the distribution partners or individual producers in place of the reporting entity (sometimes called “funding agreements”).

The proposed Exposure Draft relating to the first are in Paragraph 2 and call for “…commission shall be accrued based on experience to date for the policy period that the commission relates.” This specifically relates to the required timing or obligating event of a reporting entity’s liability for the cost of a commission payment specifically linked to persistency or policy renewal upon the anniversary of a policy issue date or some other future date or event.

The proposed Exposure Draft revisions relating to the second are (a) in paragraph 4, “...regardless of how the payment to the third party is characterized.”, (b) in paragraph 5, “...paid by a third party to the agents...by the reporting entity.”, and (c) in a footnote to paragraph 5, “The guidance in this paragraph notes that levelized commissions which use a third party to pay agents that are linked to traditional elements require establishment of a liability for the amounts that have been paid to the agents and any interest accumulated to date.”

The proposed revisions have different implications for different constituencies. We have endeavored to capture the essence of the concern from each party below. The proposed revisions have substantive implications for each of the noted constituencies, contrary to the non-substantive assertion in the revised exposure draft 2019-24. As a direct result of the inequity of the proposed changes upon various constituencies and the potential for substantial
financial and economic harm incurred by the adoption of these changes to a variety of constituencies, we strongly recommend and request that the proposal not go forward.

Reporting Entity/Carrier perspective:

1. Levelized commission programs are economic equivalents to “normal (non-level) commissions.” Levelized commission programs are preferable as they create a virtuous cycle linking the interests of consumers, agents, distribution partners and carriers to maintain ongoing servicing relationships, improving consumer support and policy persistency. Distribution relationships are multi-faceted, including agent recruitment and oversight, sales, sales support, underwriting support, premium collection, policy delivery and agent payment. Characterizing distribution partners as a ‘third party’ under the proposed footnote to paragraph 5 of SSAP No. 71 discounts the complexity of these relationships and the value of these vital roles dramatically altering carrier dynamics with distribution partners.

2. Reporting entities or carriers will be unduly penalized for economic transactions negotiated under existing accounting principles as a direct result of this proposal. The value of those transactions is retroactively altered by the introduction of a modified accounting principle which neither party initially anticipated, negotiated or priced.

3. Higher required capital and lower returns resulting from an arbitrary modification to an existing accounting practice will drive product design reviews and likely product redesigns modifying or eliminating levelized commission options or reducing value to the consumer through higher premiums and/or lower benefits.

4. The proposal to require reserves for future persistency based levelized commissions creates a disconnect with GAAP accounting where there is no reserve requirement. Moreover, the proposal creates new uncertainty around which other long standing accounting treatment will be changed next

Distributor/Agent perspective

1. The trail compensation approach incentivizes all parties to maintain a long-term relationship based upon ongoing agent support of consumer needs. Reducing or removing recurring compensation in the form of persistency based levelized commissions, shifts distributor economic motivation to new product sales, further degrading product level returns for the carrier. Reducing benefit levels or increasing premiums for the same benefit levels will lower the value proposition for effected products very likely reducing sales and consumer protection delivered by the products.

Consumer perspective:

1. The fallout from the changes will diminish value of insurance products through higher premiums and/or lower benefits enacted by carriers seeking to make up lost economic value and from lower service levels provided by brokers or agents as their incentives shift from ongoing consumer service relating to in-force policies to selling new policies (whether to the individual policyholder or other prospective clients).
January 30, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street
Kansas City, MO 64106

Re: SSAP No. 71—Policy Acquisition Costs and Commissions

Dear Mr. Bruggeman:

Thank you for the opportunity to provide comments on Proposal 2019-24 from the Statutory Accounting Principles Working Group regarding Policy Acquisition Costs and Commissions. The Working Group voted to re-expose revisions to SSAP 71 – Policy Acquisition Costs and Commissions - for comment at the NAIC Fall Meeting on December 7, 2019, continued to categorize the revisions as non-substantive, and further clarified levelized commission guidance and direction regarding certain commission obligations. I offer comments on behalf of our client, DRB Insurance Solutions, LLC, a licensed insurance producer (“DRB”).

SSAP No. 71 provides that levelized commissions occur in situations in which a third party, such as a funding agent, pays agents non-levelized commissions and the reporting entity pays the third party by levelized payments. The Working Group notes that it is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third-party would ultimately be repaid to the third-party from the reporting entity. SSAP No. 71 identifies such arrangements as “funding agreements” between the reporting entity and the third-party. SSAP No. 71 further provides that the use of a commission arrangement where commission payments are not linked to traditional elements (such as premium payments and policy persistency) requires the establishment of a liability for the full amount of the unpaid principal and accrued interest which is payable to a third-party related to levelized commissions.

While revisions were made to several paragraphs and footnote 1 in the initial proposal at the Working Group’s meeting in December, the current exposure language remains overly broad to address the issue identified and intended to be clarified by the Working Group. Regulators have identified levelized commissions as funding arrangements to bypass recognition of acquisition costs by insurers and believe recognizing the full acquisition expense at the time of policy issuance is appropriate accounting treatment pursuant to SSAP No. 5R and the Statement of Concepts.
focusing on Recognition. Notably, the Working Group intended to restrict intercompany and affiliated transfers of trailing commission structures as pure accounting transactions solely for the purpose of deferring expense recognition of commission obligations, which is a laudable goal.

However, the language exposed to classify trailing commission transactions as funding arrangements is so broad, it encompasses practically every broker contract with an insurer that allows for any alternative payment arrangement between the broker and the issuing agent. DRB Insurance Solutions is an independent third-party master producer which uses various contracts between DRBIS and its sub-agents for commission payment, including trailing, heaped, partially heaped and trailing commissions, etc. The agreements between DRBIS and reporting entities are arms-length transactions, include the transfer of lapse risk, mortality risk and the commission expense obligation. The proposal requiring all insurers to accrue the full commission expense under these circumstances is illogical when the insurer no longer has the legal obligation to pay the expense and therefore, no longer has legally incurred the expense.

While regulators have opined that affiliated transactions shrouded as commission arrangements appear to circumvent accrual of commission expense at policy issuance, the goal to affect those transactions may continue to be addressed while narrowing the language to clarify that non-affiliated third-party contracts are not included. Accordingly, DRBIS offers the following amendment to the exposure draft to narrow the applicability to those affiliated transactions. Suggested language for Paragraph 4 and the footnote to Paragraph 5 is shown as shaded text as follows:

4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party under the control of the reporting entity, its parent, and/or any subsidiary or affiliate of the reporting entity or its parent. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity. (Note: levelized repayments made by the reporting entity extend the repayment period but might not be a straight-line repayment.) These transactions are, in fact, funding agreements between a reporting entity and a third party, regardless of how the payment to the third party is characterized. The continuance of the stream of payments specified in the levelized commission contract is a mechanism to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent’s license with the reporting entity is not maintained with respect to the payment stream.

5. The use of an arrangement such as a levelized commission arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency, but rather are linked to the repayment of an advance amount paid by a third party under the control of the reporting entity, its parent, and/or any subsidiary or affiliate of the reporting entity or its parent to the agents requires the establishment of a liability by the reporting entity for the full amount of the unpaid principal and accrued interest which is payable to a third party under the control of the reporting entity, its parent, and/or any subsidiary or affiliate of the reporting entity or its parent related to levelized commissionsFN.

New Footnote – The guidance in this paragraph notes that levelized commissions which use a third party to pay agents does not imply that levelized commissions that are linked to traditional
The proposed language requires recognition of commission expense in situations where affiliated companies trade lapse and mortality risk amongst and between affiliated reporting entities using a commonly owned master producer while excepting unaffiliated third-party transactions from similar treatment. In these unaffiliated contractual arrangements, where risk and liability is transferred, the reporting entity may not even be aware of the payment schedule between the master producer and its sub-agents and certainly should not be required to accrue the full amount of the commission expense at policy issuance when the insurer is no longer legally required to pay that expense.

**Non-Substantive Change**

Finally, DRBIS would like to restate its opposition to consideration of the exposure draft as a non-substantive change. As previously stated, levelized commission programs began over thirty years ago, before the 1998 publication of Statutory Issue Paper No. 71 and the January 1, 2001 codification of Statutory Accounting Principles. The primary objectives of a levelized commission structure include aligning the interests of the customer, the agent, and the company and improved persistency from providing ongoing customer service. There is a duty to act in the best interests of the policyholder, as well as a compensation incentive, to make sure policies are well serviced so they stay in-force.

The proposed revisions to SSAP No. 71 are designated as non-substantive and deemed to be a clarification of intent of the codified statutory guidance. However, levelized commission programs were implemented more than a decade before the codification in 2001. Therefore, this is a material change to historical accounting practices and not a clarification of original intent. Even after codification, levelized commission programs continued for years and were not identified as applying statutory accounting incorrectly.

In conclusion, the current exposure draft of SSAP 71 is clearly not “non-substantive” and would have substantial unintended consequences without the amendments proposed above. Additionally, the expansive effect of this policy decision should be subject to open deliberation and public comment as the Working Group considers adoption. Thank you for the opportunity to comment.

Very truly yours

GREENBERG TRAURIG, P.A.

Julie Mix McPeak

Julie Mix McPeak
January 14, 2020

Mr. Dale Bruggeman, Chair
NAIC Statutory Accounting Principles (E) Working Group
1100 Walnut Street, Suite #1500
Kansas City, MO 64106-2197

RE: REPORTING OF INSTALLMENT FEES AND EXPENSES – REQUESTS FOR COMMENTS

Dear Mr. Dale Bruggeman,

At the December 2019 meeting, the NAIC exposed and requested comments on the “Reporting of Installment Fees and Expenses” in the financial statements. This guidance allows for installment fees that meet specified criteria to be excluded from premium income, if it is an avoidance amount by the policyholder and the policy would not be cancelled for nonpayment of the installment fees. The guidance is consistent with the footnote in SSAP No.53 (“Property Casualty Contracts – Premiums”) and in line with our current industrywide reporting of this item in the financial statements.

With respect to the reporting of the corresponding “Installment fees related Expenses”, we believe that these associated Expenses should be reported as part of the Other Underwriting Expenses Incurred (“OUE”) on Line 4 of the Statement of Income and as an ancillary to the normal underwriting activities primarily due to immateriality. Such a presentation will allow insurers to report and reconcile the gross Installment fees amount to the corresponding balance reflected in Schedule T, Column 8 as well as in the Write-ins amount on the Statutory Page 14, along with premium tax payments. Currently, there is inconsistency in reporting in the industry, with some companies reflecting these associated Expenses as part of the Other Underwriting Expenses Incurred on Line 4 of the Statement of Income while others reflect such Expenses as part of the Aggregate write-ins for miscellaneous income on Line 14 of the Statement of Income.

However, as we believe others have also pointed out, this guidance specifically addresses fees charged on Installment premiums, but there are other equally nonrefundable “Other fees” charged by many companies, as part of the billing and collection process, but that are not specifically mentioned in this guidance. That is to say, there are “Other Fees” charged by insurers as part of the collection process, all of which, like Installment fees, are not only non-refundable, but are also avoidance amount by the policyholder and would not be cancelled for non-payment of the installment fees, similar to Installment fees.

These nonrefundable “Other fees”, include, but are not limited to:

1. Late fees - fees and expenses charged on flexible/installment plans that are received after a specified cut-off period e.g. 30 days
2. Non-sufficient funds ("NSF") fees - fees and expenses collected on returned payments due to non-sufficient funds

3. Reinstatement fees - fees and expenses received on policies that expired and are subsequently reinstated, among others etc.

Currently, there is divergence in reporting in this area of this relatively immaterial amounts for nonstandard and standard writers and therefore need for clarification for consistency in reporting going in.

The reporting issue here then is, where and how to report all of these “Other fees”, excluding Installment fees. Should all these “Other fees” be reported as part of:

   a) Other underwriting expense incurred on Line 4 of the Statement of Income
   b) Finance and service charges on Line 13 of the Statement of income, akin to installment fees
   c) Aggregate write-ins for miscellaneous income on Line 14 of the Statement of income

Typically, most companies report these nonrefundable “Other fees” as “Other income” on Line 14 of the Statement of Income

Consistent with current practice, we also believe all these “Other fees”, net of applicable expenses, if any, should be reported as part of the Aggregate-write-ins for miscellaneous income on Line 14 of the Statement of Income. However, if for some reason this first preference is determined to be untenable, then we believe the next viable alternative could be the “Other underwriting expenses incurred” on Line 4 of the Statement of Income, under the assumption that all these other fees are ancillary to the normal underwriting activities, but defer ultimately decision to the NAIC staff for review and consideration.

We appreciate the opportunity to comment on this and related issues. Thank you.

Sincerely,

Joseph Hammond, CPA, FLMI
Director of P&C Accounting
Farmers Insurance Group
(818) 876-7924

"Internal Use Only"

cc: Robin Marcotte File
February 27, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners

Via email

Dear Mr. Bruggeman:

I am writing on behalf of the American Academy of Actuaries\(^1\) Committee on Property and Liability Financial Reporting (COPLFR). We are following up on previous correspondence regarding Schedule P Instructions for Retroactive Reinsurance between Affiliates and Non-Affiliates.

COPLFR appreciates that the Statutory Accounting Principles Working Group (SAPWG) is looking into certain inconsistencies that were identified in our May 21, 2019, letter to you. In July, Julie Lederer, acting in her capacity as a member of the Casualty Actuarial and Statistical (C) Task Force, posed several questions about specific details in our initial comment letter. Her comments and COPLFR’s replies are presented here.

**Julie Lederer’s Comment**

1. I’m not sure what Allianz/Allianz Re agreement the letter is referring to. The letter suggests that this agreement was enacted in 2015 and that the accounting changed between year-ends 2015 and 2016, but Allianz Re’s 2018 MD&A (which is said to be included as an attachment to COPLFR’s letter but is not) suggests that the agreements between Allianz and Allianz Re weren’t enacted until 2016. Allianz Re did assume retroactive business from a different entity, Fireman’s Fund, in 2015:

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
There’s hardly any workers comp data in Allianz’s 2015 Schedule P. There’s a lot of WC data at year-end 2016, which appears to be due to the addition of Firemen’s Fund to the pooling agreement.

When I compare Allianz Re’s 2015 and 2016 Schedule Ps, I don’t see major changes. There is significant assumed premium reported in CY 2015 in both statements, and both statements show assumed reserves only for AYs 2012 and prior. I think this is related to Allianz Re’s transaction with FFIC (as mentioned in the MD&A above), not with Allianz.

COPLFR’s Response

The May 21, 2019, COPLFR letter is referring to the July 1, 2015, reinsurance agreement between FFIC and Allianz Reinsurance America (“Allianz Re”), where Allianz Re agreed to reinsure certain workers’ compensation (WC) and construction defect liabilities. The 2015 Schedule P, Part 1 of Allianz Re (page 4 of the May 21 letter PDF) shows $1.1 billion of 2015 accident year direct and assumed WC earned premium, presumably this Loss Portfolio Transfer. The 2016 Schedule P of Allianz Global Risk US Ins Co. (“Allianz or FFIC”) (page 7 of the May 21 letter PDF) shows $1.1 billion of 2015 accident year WC ceded earned premium, about equal to the assumptions of the Allianz Re premium discussed in the prior sentence. Allianz Global Risk US is synonymous with FFIC, as we understand it.

In our May 21, 2019, letter, we did state that “Initially, as of December 31, 2015, Allianz included all of the ceded losses in accident year (‘AY’) 2015.” We did only include the 2016 Allianz Schedule P; it would have been clearer to include the 2015 Allianz Schedule P as well, which we have attached as page 15 of the May 21 letter PDF (Attachment A). We agree with the comment in a. above that the additional data is due to the addition of Fireman’s Fund in the pooling agreement. Similarly, for b., we only show Allianz Re’s 2015 Schedule P.; we should additionally obtain Allianz Re’s 2016 Schedule P. We would not expect much change from the 2015 to 2016 Schedule P. Finally, our comments were not intended to suggest that the agreement between Allianz and Allianz Re was not enacted until 2016. We did, however, want to point out that as of Dec. 31, 2015, Allianz included all of the ceded losses in AY 2015, and in the following year, as of Dec. 31, 2016, Allianz recorded the ceded losses across the subject AY’s 2012 and prior, as shown in Schedule P, Part 2 of Allianz (see page 8 of the PDF).

Julie Lederer’s Comment

2. I believe some of the attachments noted in the letter are missing:
   a. The letter includes Allianz Re’s 2015 Schedule P and Allianz’s 2016 Schedule P, but the text of the letter suggests that Allianz’s 2015 and 2016 Schedule Ps are included.
Regardless, it’s pretty hard to compare Allianz’s 2015 and 2016 Schedule Ps anyway, since Fireman’s Fund was added to the intercompany pool in 2016 and the historical AYs in Allianz’s 2016 Schedule P were adjusted accordingly.

When I compare Allianz Re’s 2015 and 2016 Schedule Ps, I don’t see major changes. The assumed premium is reported in CY 2015 in both statements, and both statements show assumed reserves only for AYs 2012 and prior.

b. Attachment A1SAO (Allianz Re’s 2018 SAO) is missing. I looked up the SAO myself and found this passage, which is rather vague, doesn’t name the counterparties, and doesn’t discuss the accounting for the agreements:

The Company entered into several significant reinsurance arrangements during calendar years 2015 – 2018, some of which serve to mitigate the risk factors discussed above.

1. Effective January 1, 2015, the Company entered into a reinsurance agreement whereby the Company assumed and agreed to reimburse certain A&E reserves. Effective July 1, 2015, the Company further assumed and agreed to reimburse certain WC and CD reserves.

2. Effective January 1, 2016, the Company entered into a reinsurance agreement whereby the Company ceded 50% of the Company’s carried A&E, WC, and CD liabilities acquired in 2015.

Additionally, effective January 1, 2016, the Company entered into reinsurance agreements whereby the Company assumed and agreed to reimburse certain Professional Healthcare liabilities and certain A&E, GL/Excess and WC liabilities. Effective July 1, 2016, the Company entered into another reinsurance agreement by which the Company assumed and agreed to reimburse certain GL/Excess exposure.

c. Attachment A2MDA (Allianz Re’s 2018 MD&A) is missing. I looked this up myself and included a relevant passage above in item #1.

COPLFR’s Response

The attachments were in the Academy’s submission to the CASTF and were in the CASTF materials for a call in June, but apparently were omitted by NAIC staff in materials provided for subsequent calls and referrals.

We too consider the excerpt you provided to be vague. To help clarify the issue, we are attaching MD&As from 2015 and 2016 that include Fireman’s Fund Insurance Company in their scope (attachments B and C). One of the difficulties in tracking this issue is the series of actions taken by Allianz since 2015.

Julie Lederer’s Comment

3. GEICO’s Note 21, included as an attachment, is useful, but it’s not clear what we should take away from GEICO’s 2014 Schedule P alone. It might have been useful to attach the 2013 Schedule P as well. By comparing the 2013 and 2014 Schedule Ps, it’s clear that GEICO made significant cessions in 2014 and that these were spread among older AYs.

COPLFR’s Response

Our takeaway from GEICO’s 2014 Schedule P alone is that Schedule P, Part 2 (page 13 of the PDF) shows $3.3 billion of decreased development. This is a distortion as we understand it and is supported
by the 2013 and 2014 comparison noted above. That distortion would carry over to the RBC filings of the respective entities (based on our understanding of the RBC formula and related instructions). Industry Schedule P data can also be distorted based on what is and is not included in industry totals based on the data scrubbing performed.

We believe that this additional information clarifies our original comments and will help SAPWG to move forward with its own analysis. If you have additional questions, contact Marc Rosenberg, the Academy’s senior casualty policy analyst, at 202-785-7865 or rosenberg@actuary.org.

Sincerely,

Kathy Odomirok, MAAA, FCAS
Chairperson, COPLFR
American Academy of Actuaries

3 attachments
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Financing Derivatives

Check (applicable entity):

- Modification of existing SSAP
- New Issue or SSAP
- Interpretation

G

P/C   Life   Health

Description of Issue:
This agenda item has been prepared to reconsider the accounting and reporting of financing derivative transactions pursuant to a review of information from the 2018 year-end statutory financial statements.

Note: Although the proposed revisions in this agenda item would impact common SSAPs, from the year-end 2018 detail, there are no P/C or health entities acquiring or writing derivatives with financing arrangements. As such, the changes proposed may not impact P/C and health entities and should only impact a limited number of life insurers (16 as of year-end 2018) that engage in derivative financing arrangements.

A financing derivative transaction is one in which the premium to acquire the derivative is paid throughout the derivative term or at maturity of the derivative. With the accounting and reporting that has been utilized by some companies, the “cash flows” (the derivative obtained and the premium liability owed) are netted, generally resulting with zero-value reporting at inception. Over the course of the derivative term, an unrealized loss is recognized for changes in the present value of the premium liability (increase), which may be offset by any value change in the underlying derivative (increase or decrease). (With derivative financing, a gain would only ever be recognized if the fair value change of the derivative exceeded the cost of the derivative.) When the derivative matures, the calculation of realized gains and losses reflects the deferred cost (amount owned), adjusted for any actual fair value change.

For example, if paying $5,000 at the end of a 5-year derivative, a 1,000 unrealized loss would be recognized each year for the present value of premium due, and at maturity, the reporting entity would recognize the 5,000 as a realized loss. If the derivative had a $500 fair value gain, this would decrease the extent of the premium owed recognized as a realized loss. The financial statement presentation of a derivative with financing premiums is significantly different from traditional recognition in which the reporting entity would recognize the $5,000 derivative at acquisition and ultimately recognize a realized gain for the $500 change in fair value.

Several key concerns are noted in the agenda item; however, a few are highlighted as follows:

- Reporting is inconsistent, as not all insurers utilizing financing derivatives report using the net approach. Additionally, insurers acquiring (or writing) similar derivatives would represent the financial statement impact in substantially different ways based solely on when the cost to acquire the derivative is due.

- The amounts reported when derivative assets and liabilities are netted with financing components do not reflect actual derivative assets or liabilities, and the corresponding unrealized gains / losses do not solely reflect changes in derivative value. The amounts reported are impacted by both changes in fair value and the present value change in the premium cost for the derivative. (This approach, particularly with the
The impact of financing derivatives can have a significant impact on the reported derivative amounts, which impacts the assessment of derivatives and the activity reported in regulator tools (e.g., profile reports / financial analysis assessments). For example, in one instance where financing derivatives were reflected, if the derivative had been reported without the financing components, the reported derivatives assets would have increased 50%, and the derivative liabilities would have decreased 60%. These two changes would have doubled the amount of overall net derivatives used in the company’s profile report. With a net presentation, the use of financing derivatives may artificially mask derivative activity, causing difficulty in regulator review to ensure derivative limitations have not been exceeded.

After reviewing the information reported in the 2018 year-end financial statements, it was noted that some entities both acquire and write derivatives using financing derivative components. For entities that are writing these derivatives, the entity has a receivable for the amount due, but the receivable is not subject to nonadmission requirements as it is being commingled with the derivative. Under standard reporting (with premium provided at origination), the premium received would have been reported as a derivative liability (showcasing the obligation to perform under the derivative), but with financing derivatives, the written derivative is reported as a net asset as the receivable owed to the reporting entity is combined with the issued derivative. In the prior discussion of this topic, it was unknown that reporting entities were writing derivatives without collecting premium upon issuance or requiring collateral. This information was only identified with review of the new Schedule DB electronic columns.

From discussions with other NAIC staff, “financing” premiums are non-standard derivative components. Derivatives with these components are generally not marketable (without the entity providing payment of any remaining deferred or financing premium), as any new party would essentially be acquiring the initial company’s debt (liability) to pay the cost of the derivative.

**Proposed Accounting and Reporting Concepts:**
This agenda item intends to incorporate specific direction for the accounting and reporting of derivatives with financing components that are acquired and/or written. The proposed revisions reflect the following:

- **The BACV and fair value columns of derivatives acquired and/or written in Schedule DB-A or Schedule DB-B shall reflect the value without inclusion of any impact from financing provisions.**
  
  With this change, the Schedule DB column that currently captures “fair value of derivative, excluding impact of financing premiums” will be revised to reflect the “fair value of the derivative, including impact of financing premiums.”

Note: This proposal will result in a change from U.S. GAAP, however, derivatives reported under SAP already vary from U.S. GAAP as statutory accounting does not currently allow offsetting in accordance with master netting agreements. Under U.S. GAAP, the cash inflows / outflows (derivative and financing components) are netted to arrive at the fair value of the derivative.

This practice is not appropriate for statutory accounting because: The netting of derivatives with financing components 1) hinders the ability to assess whether derivative activity is within state investment limitations; 2) hinders the ability to utilize financial analysis tools in assessing activity or fair value changes; 3) impacts RBC and IMR calculations and 4) does not adequately present component items for admissibility.
• **Recognition of interest-related unrealized gains/losses (and then realized gains/losses at termination),** shall reflect the fair value fluctuation changes in the derivative and shall not be impacted by the present value change of premium owed or premium receivable from the derivative. This will impact past practice in which present value change of the premium owed / receivable has impacted gains / losses, resulting with impacts to AVR (unrealized) and IMR (realized).

• **The resulting balance sheet derivative assets and liabilities shall reflect the fair value of the derivatives without inclusion of the impact from** financing derivatives unless the amount owed or the amount due from a derivative with financing elements meets the requirements for a valid right to setoff under SSAP No. 64. If this valid right of setoff exists, the amount shall be captured in Schedule DB-D with disclosures captured pursuant to SSAP No. 64.

• **Amounts owed to / from the reporting entity for derivatives written or acquired shall be separately captured in the balance sheet, unless the amounts qualify under the legal right to offset.** To the extent amounts owed by the reporting entity for derivatives acquired do not meet the legal right to offset, the amount shall be recognized separately from the acquired derivative as a payable for security. To the extent amounts owed to the reporting entity for derivatives written do not meet the legal right to offset, the amount shall be recognized separately from the written derivative as a receivable for security and subject to admissibility requirements in SSAP No. 5R and SSAP No. 21R.

  > **Note:** Under SSAP No. 21R, receivables for securities are not admitted if not received within 15 days from the settlement date. If the valid right to offset provisions are not met, consideration could be given to incorporate specific guidance for these derivative premium receivables.

**Proposed RBC and AVR Concepts:**
In addition to the changes in the Schedule DB reporting for BACV and FV and the separate reporting of the amounts due to / from, the proposed concepts in this agenda item will result with key changes to AVR and RBC:

1. **Acquired Derivatives with Amount Owed to Derivative Counterparty**

   With separate reporting of the derivative asset and amount owed from the acquisition of the derivative, the BACV for the derivative asset and “net exposure” (Schedule DB-D) by counterparty will increase. (As the AVR reserve does not factor in the impact if there is legal right to offset, this AVR impact will occur regardless of offsetting provisions.) From the 2018 year-end detail reviewed, in most instances, reporting entities with financing derivatives will no longer report these derivatives as liabilities and will report the derivatives as assets.

   - The AVR reserve and the RBC impact for derivatives is based on derivative counterparty “net exposure.” As such, unless other adjustments are made, the reporting entity will either need to obtain additional collateral or engage in another offsetting derivative with the counterparty to eliminate the reported increased exposure (increased RBC charge). **To address concerns with RBC, since exposure is not actually increasing, this agenda item proposes adjustments to Schedule DB-D to incorporate the amount owed by the reporting entity to the counterparty in determining net exposure.** This adjustment would eliminate the need to obtain additional collateral or engage in another offsetting derivative to reduce counterparty exposure.

   (There is an RBC charge for off-balance sheet collateral (.0039) and collateral on-balance sheet is assessed the corresponding asset charge. As such, by using financing derivatives instead of acquiring collateral, the reporting entity mitigates these collateral charges.)
With the proposed changes, the present value change of the premium owed will not be recognized as an unrealized loss in AVR (and impact the determination of realized interest-related capital losses/gains at termination in the IMR). These changes will result in a greater AVR reserve as the liability owed for the derivative recognized over time (present value over term of derivative) will no longer reduce the AVR as an unrealized loss. **The present value change of the premium owed for acquiring a derivative should not be considered an unrealized loss or impact AVR, therefore this change is appropriate.**

2. **Written Derivatives with Amount Owed to Reporting Entity**

With separate reporting of a derivative written by the reporting entity and the premium amount owed to the reporting entity, the BACV for the derivative asset and “net exposure” (Schedule DB-D) by counterparty will decrease. (This will likely result in a currently-reported derivative asset reversing to reflect a derivative liability.) Furthermore, the present value change of the premium due to the reporting entity will not be recognized as an unrealized gain and will no longer impact AVR (or IMR). The amount due for the written derivative will likely be considered a “receivable for security” within scope of SSAP No. 21R—Other Admitted Asset. Current guidance requires nonadmittance for these items not received within 15 days from the settlement date.

- In this situation, the derivative is currently being reported as an asset, because the amount due to the reporting entity (receivable) is increasing the derivative value. Without the amount due to the reporting entity, the derivative would be in a liability position. This approach does not seem to provide derivative RBC relief (as the RBC charge is focused on derivative assets) but the current netting approach could prevent potential nonadmittance for receivables owed to the reporting entity. In reviewing examples from the year-end 2018 reporting, premium owed to the reporting entity may not be received for a few years (until derivative maturity), which is beyond the time allotted for admittance under SSAP No. 21R. There is an RBC charge for “receivable for securities” (.014 life and 0.25 p/c & health), but this would only apply if the receivable was admitted. (This charge would be less than the charge for the derivative asset.)

- If the right to offset provisions in SSAP No. 64 are met, there would be no net impact to the financial statements by reporting the written derivative asset without the financing provisions. In these situations, the BACV and fair value on Schedule DB-A would detail the derivative without the financing components, and on Schedule DB-D, the reported amount that ties to the balance sheet would be adjusted for the offsetting receivable. With the offset, the receivable for security would be eliminated from the balance sheet. With the offset / balance sheet elimination, the receivable is essentially given “admitted asset” status (as it reduces a liability) and is not assessed for RBC. (Under SSAP No. 64, this offset would be disclosed in the financial statements.) If the right to offset provisions are not met, then the “receivable for security” would be nonadmitted after 15 days under SSAP No. 21R. This would cause a financial statement impact for any nonadmitted asset. If the asset was admitted, there would be an RBC charge for the admitted receivable.

**NAIC staff is interested in whether the premium due to the reporting entity from a written derivative would generally meet the “valid right to setoff” provisions from SSAP No. 64. If the conditions would not generally be met, consideration could occur to allow offsetting presentation in Schedule DB-D for these specific situations. This would allow the amount owed to the reporting entity to decrease the derivative obligation regardless of when the amount due would be received. **If this was supported, provisions may be warranted that allow the derivative liability to be reduced to zero, but not permit the derivative to reverse into an asset position without being nonadmitted.**
Illustration of RBC Charges to Derivative Assets / Liabilities:

**RBC Impact – P/C and Health Entities**

As detailed below for property/casualty and health entities, the RBC charge is solely driven by the amount of derivative assets reported on the balance sheet. (This is a distinctly different from life reporting entities.) For these entities, the charge does not vary if the derivative is in a liability position or if the entity has received collateral from the counterparty. (The amount reported on balance sheet is impacted by offsetting provisions, but only if there is a valid right to offset.)

If these entities were to engage in financing derivatives, and the impact was to reverse the presentation of the derivative from an asset to a liability, this would have a direct change to the RBC calculation.

<table>
<thead>
<tr>
<th>P/C &amp; Health</th>
<th>RBC Factor</th>
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<tbody>
<tr>
<td>Assets</td>
<td>Balance Sheet</td>
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<tr>
<td>Liabilities</td>
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<tr>
<td>Collateral</td>
<td>Investment Schedules</td>
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<tr>
<td>Net Exposure</td>
<td>Schedule DB</td>
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**RBC Impact – Life Insurance Entities**

As detailed below for life entities, the RBC charge is not driven by the amount of derivative assets reported on the balance sheet. Instead, the RBC charge is driven by the “net exposure” after considering collateral. In both situations (asset exposure and off-balance sheet exposure), if the derivative is in a liability position, there is no RBC charge. Since the removal of financing components will generally result with previously reported derivative liabilities flipping to represent derivative assets, this could have an RBC impact unless the premium owed to the reporting entity is considered as part of the RBC calculation. The proposal in this agenda item would consider amounts owed from the counterparty for the derivative in determining net exposure.

<table>
<thead>
<tr>
<th>Life</th>
<th>RBC Factor</th>
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<tbody>
<tr>
<td>Asset</td>
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<tr>
<td>Liabilities</td>
<td>Balance Sheet</td>
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<td>On BS Collateral</td>
<td>Investment Schedules</td>
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<td>Off BS Collateral</td>
<td>Manually Entered in RBC</td>
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<td>Net Exposure</td>
<td>Collateral less Net Asset</td>
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<td>Net Asset = BACV Assets less Liabilities</td>
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<td>Liability &gt; Asset = No Charge</td>
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<td></td>
<td>Collateral &gt; Net Asset = No Charge</td>
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<td></td>
<td>Collateral &lt; Net Assets = Charge based on NAIC designation of counterparty</td>
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<tr>
<td>Off BS Exposure</td>
<td>Ex Traded &amp; CC</td>
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</table>

| Off-BS | Calculated Amount: [Gross Assets Less Gross Liabilities Less Collateral Add Calculated Potential Exposure] Less Exposure Net of Collateral | |
|--------|-------------------------------------------------| |
| | .0039 (NAIC 1) | |
| | .0126 (NAIC 2) | |
| | .0446 (NAIC 3) | |
| | .0970 (NAIC 4) | |
| | .2231 (NAIC 5) | |
| | .300 (NAIC 6) | |
Derivative Liability > Derivative Asset = No Charge
Derivative Collateral > Net Derivative Asset = Charge Based on Collateral Not on Derivative
Derivative Collateral < Net Derivative Asset = Derivative Charge Based on NAIC designation of Counterparty

Existing Authoritative Literature:

- SSAP No. 64—Offsetting and Netting of Assets and Liabilities
- SSAP No. 86—Derivatives
- SSAP No. 100—Fair Value

Key aspects from the standards cited above:

**SSAP No. 64—Offsetting and Netting of Assets and Liabilities**

2. Assets and liabilities shall be offset and reported net only when a valid right of setoff exists except as provided for in paragraphs 3 and 4. A right of setoff is a reporting entity’s legal right, by contract or otherwise, to discharge all or a portion of the debt owed to another party by applying an amount that the other party owes to the reporting entity against the debt. A valid right of setoff exists only when all the following conditions are met:
   a. Each of the two parties owes the other determinable amounts. An amount shall be considered determinable for purposes of this provision when it is reliably estimable by both parties to the agreement;
   b. The reporting party has the right to set off the amount owed with the amount owed by the other party;
   c. The reporting party intends to setoff; and
   d. The right of setoff is enforceable at law.

3. Assets and liabilities that meet the criteria for offset shall not be netted when prohibited by specific statements of statutory accounting principles. An example of such is in the case of reinsurance recoverables on paid losses and ceded premiums payable as provided for in SSAP No. 62R—Property and Casualty Reinsurance.

4. Netting of assets and liabilities for reporting purposes when no valid right of setoff exists shall be allowed only when provided for by specific statements of statutory accounting principles. An example of such is in the case of real estate investments required to be shown net of encumbrances as provided for in SSAP No. 40R—Real Estate Investments.

5. Amounts due to or from affiliates shall be offset and reported net only when the provisions of paragraph 2 are met.

**Disclosures**

6. The following quantitative information shall be disclosed (separately for assets and liabilities) at the end of each reporting period (interim and annual) when derivative, repurchase and reverse repurchase, and securities borrowing and securities lending assets and liabilities are offset and reported net in accordance with paragraph 2 (valid right to offset):
   a. The gross amounts of recognized assets and recognized liabilities
   b. The amounts offset in accordance with paragraph 2 (valid right to offset)
c. The net amounts presented in the statement of financial positions.

7. Assets and liabilities that have a valid right to offset under paragraph 2, but are not netted as they are prohibited under paragraph 3, are not required to be captured in the disclosures in paragraph 6.

**Relevant Literature**

8. This statement adopts paragraphs 1, 7 and 13 of APB Opinion No. 10, Omnibus Opinion—1966 and FASB Interpretation No. 39, Offsetting of Amounts Related to Certain Contracts with modifications (1) to prohibit offsetting as provided in specific statements and require netting when provided in specific statements, and (2) to reject guidance in paragraphs 10, 10A, and 10B of FIN 39, as amended by FSP FIN 39-1, that permits a reporting entity election to offset fair value amounts recognized for derivative instruments and fair value amounts recognized for the right to reclaim cash collateral or the obligation to return cash collateral arising from the derivative instruments with the same counterparty under a master netting agreement. Offsetting for statutory accounting purposes is limited to situations meeting the conditions in paragraph 2 and 4 of this SSAP. This statement adopts FASB Emerging Issues Task Force No. 86-25, Offsetting Foreign Currency Swaps.

9. This statement rejects FSP FIN 39-1, Amendment of FASB Interpretation 39. This statement rejects FASB Interpretation No. 41, Offsetting of Amounts Related to Certain Repurchase and Reverse Repurchase Agreements. FIN 41 has an offsetting exception for repurchase and reverse repurchase agreements and permits offsetting when the reporting parties do not intend to set off. This guidance is rejected for statutory accounting, and payables under repurchase agreements may only be offset against amounts recognized as receivables under reverse repurchase agreements if there is a valid right to offset meeting all the conditions, including the intent to offset, detailed in paragraph 2. This statement rejects ASU 2011-11, Disclosures about Offsetting Assets and Liabilities and ASU 2013-01, Clarifying the Scope of Disclosures about Offsetting Assets and Liabilities. Statutory disclosure requirements for assets and liabilities reported net under a valid right to offset are detailed in paragraph 6.

**SSAP No. 86—Derivatives**

11. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and are permitted to be valued and reported in a manner that is consistent with the hedged asset or liability (referred to as hedge accounting). For instance, assume an entity has a financial instrument on which it is currently receiving income at a variable rate but wishes to receive income at a fixed rate and thus enters into a swap agreement to exchange cash flows. If the transaction qualifies as an effective hedge and a financial instrument on a statutory basis is valued and reported at amortized cost, then the swap would also be valued and reported at amortized cost. Derivative instruments used in hedging transactions that do not meet or no longer meet the criteria of an effective hedge, or that meet the required criteria but the entity has chosen not to apply hedge accounting, shall be accounted for at fair value and the changes in the fair value shall be recorded as unrealized gains or unrealized losses (referred to as fair value accounting).

**Disclosure Requirements**

12. Reporting entities shall disclose the following for all derivative contracts used:

   a. For derivative contracts with financing premiums:

      i. Disclose the aggregate, non-discounted total premium cost for these contracts and the premium cost due in each of the following four years, and thereafter. Include the aggregate fair value of derivative instruments with financing premiums excluding the impact of the deferred or financing premiums.
For each derivative contract with financing premiums:

(a) Whether premium cost is paid throughout the contract, or at derivative maturity;
(b) Next premium cost payment date;
(c) Total premium cost;
(d) Premium cost paid in prior years;
(e) Current year premium cost paid;
(f) Future unpaid premium cost;
(g) Fair value of derivative, excluding impact of financing premiums; and
(h) Unrealized gain/loss, excluding impact of financing premiums.

b. All derivatives are required to be shown gross on Schedule DB. However, derivatives may be reported net in the financial statements (pages 2 and 3 of the statutory financial statements) in accordance with SSAP No. 64—Offsetting and Netting of Assets and Liabilities when a valid right to offset exists. Derivatives offset in accordance with SSAP No. 64 and reported net in the financial statement shall follow the disclosure requirements in SSAP No. 64, paragraph 6. (Derivative Assets and Derivative Liabilities reported on the balance sheet shall agree to columns 5 and 6, respectively, after netting, on Schedule DB – Part D – Section 1.)

c. The disclosure requirements of paragraphs 59.a., 59.b., and 59.g. shall be included in the annual statement. Refer to the Preamble for further discussion regarding interim disclosure requirements. The disclosure requirements of paragraphs 59.a. through 59.g. shall be included in the annual audited statutory financial reports. The disclosure requirements in paragraph 59.h. shall be included in statutory financial statements (annual and quarterly). Paragraph 62 of the Preamble states that disclosures made within specific schedules or exhibits to the annual statement need not be duplicated in a separate note.

SSAP No. 100—Fair Value

Definition of Fair Value

4. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

5. Asset/Liability – A fair value measurement is for a particular asset or liability. Therefore, the measurement should consider attributes specific to the asset or liability, for example, the condition and/or location of the asset or liability and restrictions, if any, on the sale or use of the asset at the measurement date. The asset or liability might be a standalone asset or liability (for example, a financial instrument or an operating asset) or a group of assets and/or liabilities (for example, an asset group, a reporting unit, or a business).

6. Price – A fair value measurement assumes that the asset or liability is exchanged in an orderly transaction between market participants to sell the asset or transfer the liability at the measurement date. An orderly transaction is a transaction that assumes exposure to the market for a period prior to the measurement date to allow for marketing activities that are usual and customary for transactions involving such assets or liabilities; it is not a forced transaction (for example, a forced liquidation or distress sale).
The transaction to sell the asset or transfer the liability is a hypothetical transaction at the measurement date, considered from the perspective of a market participant that holds the asset or owes the liability. Therefore, the objective of a fair value measurement is to determine the price that would be received to sell the asset or paid to transfer the liability at the measurement date (an exit price).

11. Application to Assets – A fair value measurement assumes the highest and best use of the asset by market participants, considering the use of the asset that is physically possible, legally permissible, and financially feasible at the measurement date. In broad terms, highest and best use refers to the use of an asset by market participants that would maximize the value of the asset or the group of assets within which the asset would be used. Highest and best use is determined based on the use of the asset by market participants, even if the intended use of the asset by the reporting entity is different.

14. Application to Liabilities – Consideration of non-performance risk (own credit-risk) should not be reflected in the fair value calculation for liabilities (including derivative liabilities) at subsequent measurement. At initial recognition, it is perceived that the consideration of own-credit risk may be inherent in the contractual negotiations resulting in the liability. The consideration of non-performance risk for subsequent measurement is inconsistent with the conservatism and recognition concepts as well as the assessment of financial solvency for insurers, as a decrease in credit standing would effectively decrease reported liabilities and thus seemingly increase the appearance of solvency. Furthermore, liabilities reported or disclosed at “fair value” shall not reflect any third-party credit guarantee of debt.

**Fair Value at Initial Recognition**

15. When an asset is acquired or a liability is assumed in an exchange transaction for that asset or liability, the transaction price represents the price paid to acquire the asset or received to assume the liability (an entry price). In contrast, the fair value of the asset or liability represents the price that would be received to sell the asset or paid to transfer the liability (an exit price). Conceptually, entry prices and exit prices are different. Entities do not necessarily sell assets at the prices paid to acquire them. Similarly, entities do not necessarily transfer liabilities at the prices received to assume them.

16. In many cases, the transaction price will equal the exit price and, therefore, represent the fair value of the asset or liability at initial recognition. In determining whether a transaction price represents the fair value of the asset or liability at initial recognition, the reporting entity shall consider factors specific to the transaction and the asset or liability. For example, a transaction price might not represent the fair value of an asset or liability at initial recognition if:

a. The transaction is between related parties.

b. The transaction occurs under duress or the seller is forced to accept the price in the transaction. For example, that might be the case if the seller is experiencing financial difficulty.

c. The market in which the transaction occurs is different from the market in which the reporting entity would sell the asset or transfer the liability, that is, the principal or most advantageous market. For example, those markets might be different if the reporting entity is a securities dealer that transacts in different markets, depending on whether the counterparty is a retail customer (retail market) or another securities dealer (inter-dealer market).

d. For liabilities, differences may exist as non-performance risk (own credit risk) is not reflected in the fair value (i.e., exit price) determination of all liabilities (including derivatives).

**Disclosures about Fair Value of Financial Instruments**

54. A reporting entity shall disclose in the notes to the financial statements, as of each date for which a statement of financial position is presented in the quarterly or annual financial statements, the
aggregate fair value or NAV for all financial instruments and the level within the fair value hierarchy in which the fair value measurements in their entirety fall. This disclosure shall be summarized by type of financial instrument, for which it is practicable to estimate fair value, except for certain financial instruments identified in paragraph 55. Fair value disclosed in the notes shall be presented together with the related admitted values in a form that makes it clear whether the fair values and admitted values represent assets or liabilities and to which line items in the Statement of Assets, Liabilities, Surplus and Other Funds they relate. Unless specified otherwise in another SSAP, the disclosures may be made net of encumbrances, if the asset or liability is so reported. A reporting entity shall also disclose the method(s) and significant assumptions used to estimate the fair value of financial instruments. If it is not practicable for an entity to estimate the fair value of the financial instrument or a class of financial instruments, and the investment does not qualify for the NAV practical expedient, the aggregate carrying amount for those items shall be reported as "not practicable" with additional disclosure as required in paragraph 48.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

Agenda item 2016-48 considered accounting and reporting revisions for derivatives with financing premiums. Although discussion occurred proposing a gross accounting and reporting approach, the revisions adopted within that agenda item incorporated aggregate disclosures and new electronic columns in Schedule DB to capture the impact of financing premiums in derivative reporting. With the disclosure adoptions, the Working Group directed NAIC staff to reassess this issue once the impact identified from the data-captured disclosures would be available for review, noting that the earliest for this re-assessment would be Summer 2019.

Agenda item 2013-07, which considered ASU 2013-01: Clarifying the Scope of Disclosures About Offsetting Assets and Liabilities, was finalized on August 24, 2013. This ASU was issued to clarify that the scope of ASU 2011-11 applies to derivatives (including embedded derivatives), repurchase and reverse repurchase agreements, and securities borrowing and securities lending transactions that are either netted as they meet the right of setoff under ASC 210-20-45 or ASC 815-10-45, or are subject to a master netting agreement or similar agreement. The SAP adopted revisions allowed reporting entities to continue offsetting derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending transactions with a valid right of offset, but incorporated disclosures to illustrate the netting impact. This adoption action included a referral to the Blanks (E) Working Group for annual statement instruction revisions and to recommend development of additional schedules to reconcile the amount reported gross on DB to the amount reported net on the balance sheet.

Agenda item 2012-17, which considered ASU 2011-22, Disclosures about Offsetting Assets and Liabilities, was finalized by the Working Group on November 29, 2012. This agenda item adopted revisions to SSAPs No. 64, 86 and 103. The adopted revisions, effective January 1, 2013, 1) revise and clarify that offsetting is only allowed in accordance with SSAP No. 64, paragraphs 2-4; 2) modify the adoption of FIN 39 rejecting the ability to offset in accordance with master netting agreements and rejecting FSP FIN 39-1 and FIN 41; and 3) rejecting ASU 2011-11 for statutory accounting. The Working Group deferred adoption of the disclosures proposed to paragraphs 6-8 of SSAP No. 64 in the exposure as the FASB has recently exposed guidance to narrow the scope GAAP disclosures.

Overview of ASU 2011-11:
ASU 2011-11 was issued in December 2011 to require entities to disclose both gross information and net information about both instruments and transactions eligible for offset in the statement of financial position and instruments and transactions subject to an agreement similar to a master netting agreement. This ASU was issued as the differences in the offsetting requirements between U.S. GAAP and IFRS accounted for a significant difference in the amounts presented under those standards. These differences reduce the comparability of between U.S. GAAP and IFRS, and the users of financial statements requested that these differences be addressed expeditiously. The objective of the ASU 2011-11
amendments is to facilitate comparison between entities that prepare financial statements under U.S. GAAP and those prepared under IFRS. Reporting entities are required to apply the ASU 2011-11 amendments for annual reporting periods beginning on or after Jan. 1, 2013, and interim periods within those annual periods. Entities are required to provide the disclosures required by those amendments retrospectively for all comparative periods presented.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Staff Recommendation:
NAIC staff recommends that statutory accounting revisions be considered to ensure consistency in the gross reporting of derivatives - without inclusion of financing components - and consistency in reporting amounts owed to / from the reporting entity from the acquisition or writing of derivatives. NAIC staff highlights that the concepts are consistent with existing statutory accounting guidelines but require clarification changes to ensure uniform application across the industry. **NAIC staff recommends that the Working Group move this item to the active listing, classified as nonsubstantive, and expose revisions to SSAP No. 86 to clarify the reporting of derivatives with financing premiums.** With the proposed revisions, NAIC staff is suggesting reporting revisions that would allow the present value of the derivative premium receivable (and payable) for financed derivatives to be factored into the counterparty risk assessment for life RBC.

In addition to the proposed revisions, comments are requested as to whether derivatives and related financing provisions would generally not meet the SSAP No. 64 right to offset criteria and if explicit guidance allowing offset should be considered. (Allowing offset only impacts the amount reported on balance sheet and does not impact the gross amount reported on Schedule DB-A or DB-B. The offset provision would impact RBC for p/c and health companies but would not impact the RBC for life reporting entities.)

(Regulator Inquiry) - Derivative profile reports are only provided for life reporting entities. These reports provide assessments on the overall net derivative position (assets less liabilities). **Would it be beneficial to regulators if derivative profile reports were available for p/c and health entities and if the reports completed assessments based on derivative assets and derivative liabilities separately?** (For example, a life company with $2.1 billion in derivative assets and $2.0 billion in derivative liabilities would currently have a derivative profile report for the $100 million net derivative asset. This report would detail changes in the net asset, but if derivative assets increased to $3.1 assets and derivative liabilities increased to $3.0, the profile report would not detail the change as the net asset would still reflect $100 million) It is staff’s interpretation that the limits on derivative activity per NAIC Model 280 are anticipated to be “absolute value” of derivative assets and derivative liabilities (and not the net between assets and liabilities). The language in the Model is consistent with the Supplemental Investment Risk Interrogatory that requests “aggregate” amounts with a percentage of admitted assets, with identification that the amount should agree to Schedule DB. **NAIC staff requests regulator comment on the interpretation of the word “aggregate” (and whether it is intended to be “absolute value” and whether the information in the statutory financials or ISITE tools (profile reports) provide the information needed for regulator assessments of derivative activity.**

Excerpt from Model 280, Investments of Insurers Model Act (Defined Limits Version):

**B. Limitations on Hedging Transactions**

An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:
(1) The aggregate statement value of options, caps, floors and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed seven and one half percent (7.5%) of its admitted assets;

(2) The aggregate statement value of options, caps and floors written in hedging transactions does not exceed three percent (3%) of its admitted assets; and

(3) The aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions does not exceed six and one-half percent (6.5%) of its admitted assets.

As noted in the recommendation, the revisions are in line with existing SAP concepts. These concepts and excerpts are specifically detailed below:

1. Gross Reporting – SSAP No. 86, and the reporting instructions for Schedule DB, is explicit that derivatives are required to be shown gross on Schedule DB. Net reporting is permitted on the balance sheet when a valid right to offset exists, but derivatives offset under SSAP No. 64 are required to follow the disclosure requirements in SSAP No. 64:

   54.h. All derivatives are required to be shown gross on Schedule DB. However, derivatives may be reported net in the financial statements (pages 2 and 3 of the statutory financial statements) in accordance with SSAP No. 64—Offsetting and Netting of Assets and Liabilities (SSAP No. 64) when a valid right to offset exists. Derivatives offset in accordance with SSAP No. 64 and reported net in the financial statement shall follow the disclosure requirements in SSAP No. 64, paragraph 6. (Derivative Assets and Derivative Liabilities reported on the balance sheet shall agree to columns 5 and 6, respectively, after netting, on Schedule DB – Part D – Section 1.)

2. Accounting at Date of Acquisition – SSAP No. 86, and the reporting instructions for Schedule DB, is explicit that the premium paid or received for writing a derivative shall either be recorded as an asset (purchase) or liability (written) on the derivative line on the assets or liability page:

   Exhibit C:

   1. Call and Put Options, Warrants, Caps, and Floors:

      a. Accounting at Date of Acquisition (purchase) or Issuance (written): The premium paid or received for purchasing or writing a call option, put option, warrant, cap or floor shall either be (i) recorded as an asset (purchase) or liability (written) on the Derivative line on the Assets (or) Liabilities pages or (ii) combined with the hedged item(s) individually or in the aggregate;

3. Liability Recognition - The deferred premium (or financing premium) is a cost to acquire / enter into the derivative contract and is not impacted by an underlying interest of the derivative agreement (the cost to acquire is not impacted by derivative instrument performance). Upon entering the derivative contract the financing premium owed by the reporting entity meets the definition of a liability under SSAP No. 5R:

   10. A liability is defined as certain or probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s).

   11. A liability has three essential characteristics: (a) it embodies a present duty or responsibility to one or more other entities that entails settlement by probable future transfer or use of assets at a specified or determinable date, on occurrence of a specified
event, or on demand, (b) the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (c) the transaction or other event obligating the entity has already happened. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity’s financial statements when incurred.

NOTE: The deferred premium is a contractual element of the derivative contract and does not fluctuate or change as a result of the underlying derivative.

Recognizing the liability is also consistent with the Statutory Accounting Statement of Concept of Recognition detailed in the Preamble (paragraph 37):

Recognition

35. The principal focus of solvency measurement is determination of financial condition through analysis of the balance sheet. However, protection of the policyholders can only be maintained through continued monitoring of the financial condition of the insurance enterprise. Operating performance is another indicator of an enterprise’s ability to maintain itself as a going concern. Accordingly, the income statement is a secondary focus of statutory accounting and should not be diminished in importance to the extent contemplated by a liquidation basis of accounting.

36. The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet but rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

37. Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., interest maintenance reserves, asset valuation reserves, and others).

4. Derivative Instrument - The deferred premium (or financing premium) is the cost to acquire a derivative and is not a “derivative instrument” per the definition in SSAP No. 86:

4. “Derivative instrument” means an agreement, option, instrument or a series or combination thereof:

a. To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

b. That has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

13. An “underlying” is a specified interest rate, security price, commodity price, foreign exchange rate, index of prices or rates, or other variable (including the occurrence or nonoccurrence of a specified event such as a scheduled payment under contract). An underlying may be a price or rate of an asset or liability but is not the asset or liability itself.
5. **Offsetting Disclosures:** Guidance exists in SSAP No. 64 for the offsetting when there is a valid right to offset, and this guidance specifically references derivative transactions. This disclosure was added to ensure effective comparability across reporting entities, and ensure that the gross information reported on Schedule DB could be agreed to the information reported on the balance sheet:

6. The following quantitative information shall be disclosed (separately for assets and liabilities) at the end of each reporting period (interim and annual) when derivative, repurchase and reverse repurchase, and securities borrowing and securities lending assets and liabilities are offset and reported net in accordance with paragraph 2 (valid right to offset):
   
   d. The gross amounts of recognized assets and recognized liabilities
   
   e. The amounts offset in accordance with paragraph 2 (valid right to offset)
   
   f. The net amounts presented in the statement of financial positions.

**Staff Review Completed by:**
Julie Gann – NAIC Staff – October 2019

**October 2019 - Proposed Revisions to SSAP No. 86:**

4. “Derivative instrument” means an agreement, option, instrument or a series or combination thereof:
   
   a. To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or
   
   b. That has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

5. Derivative instruments include, but are not limited to; options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, structured notes with risk of principal/original investment loss based on the terms of the agreement (in addition to default risk), and any other agreements or instruments substantially similar thereto or any series or combination thereof.

   a. “Caps” are option contracts in which the cap writer (seller), in return for a premium, agrees to limit, or cap, the cap holder’s (purchaser) risk associated with an increase in a reference rate or index. For example, in an interest rate cap, if rates go above a specified interest rate level (the strike price or the cap rate), the cap holder is entitled to receive cash payments equal to the excess of the market rate over the strike price multiplied by the notional principal amount. Because a cap is an option-based contract, the cap holder has the right but not the obligation to exercise the option. If rates move down, the cap holder has lost only the premium paid. A cap writer has virtually unlimited risk resulting from increases in interest rates above the cap rate.

   b. “Collar” means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.

   c. “Floors” are option contracts in which the floor writer (seller), in return for a premium, agrees to limit the risk associated with a decline in a reference rate or index. For example, in an interest rate floor, if rates fall below an agreed rate, the floor holder (purchaser) will receive cash payments from the floor writer equal to the difference between the market rate and an agreed rate multiplied by the notional principal amount.
d. “Forwards” are agreements (other than futures) between two parties that commit one party to purchase and the other to sell the instrument or commodity underlying the contract at a specified future date. Forward contracts fix the price, quantity, quality, and date of the purchase and sale. Some forward contracts involve the initial payment of cash and may be settled in cash instead of by physical delivery of the underlying instrument.

e. “Futures” are standardized forward contracts traded on organized exchanges. Each exchange specifies the standard terms of futures contracts it sponsors. Futures contracts are available for a wide variety of underlying instruments, including insurance, agricultural commodities, minerals, debt instruments (such as U.S. Treasury bonds and bills), composite stock indices, and foreign currencies.

f. “Options” are contracts that give the option holder (purchaser of the option rights) the right, but not the obligation, to enter into a transaction with the option writer (seller of the option rights) on terms specified in the contract. A call option allows the holder to buy the underlying instrument, while a put option allows the holder to sell the underlying instrument. Options are traded on exchanges and over the counter.

g. “Structured Notes” in scope of this statement are instruments (often in the form of debt instruments), in which the amount of principal repayment or return of original investment is contingent on an underlying variable/interest. Structured notes that are “mortgage-referenced securities” are captured in SSAP No. 43R—Loan-backed and Structured Securities.

h. “Swaps” are contracts to exchange, for a period of time, the investment performance of one underlying instrument for the investment performance of another underlying instrument, typically, but not always, without exchanging the instruments themselves. Swaps can be viewed as a series of forward contracts that settle in cash and, in some instances, physical delivery. Swaps generally are negotiated over-the-counter directly between the dealer and the end user. Interest rate swaps are the most common form of swap contract. However, foreign currency, commodity, and credit default swaps also are common.

i. “Swaptions” are contracts granting the owner the right, but not the obligation, to enter into an underlying swap. Although options can be traded on a variety of swaps, the term “swaption” typically refers to options on interest rate swaps. A swaption hedges the buyer against downside risk, as well as lets the buyer take advantage of any upside benefits. That is, it gives the buyer the benefit of the agreed-upon rate if it is more favorable than the current market rate, with the flexibility of being able to enter into the current market swap rate if it is preferable. Conversely, the seller of swaptions assumes the downside risk, but benefits from the amount paid for the swaption, regardless if it is exercised by the buyer and the swap is entered into.

j. “Warrants” are instruments that give the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement, or to facilitate divestiture of the

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1 The “structured notes” captured within scope of this statement is specific to instruments in which the terms of the agreement make it possible that the reporting entity could lose all or a portion of its original investment amount (for other than failure of the issuer to pay the contractual amounts due). These instruments incorporate both the credit risk of the issuer, as well as the risk of an underlying variable/interest (such as the performance of an equity index or the performance of an unrelated security). Securities that are labeled “principal-protected notes” are captured within scope of this statement if the “principal protection” involves only a portion of the principal and/or if the principal protection requires the reporting entity to meet qualifying conditions in order to be safeguarded from the risk of loss from the underlying linked variable. Securities that may have changing positive interest rates in response to a linked underlying variable or the passage of time, or that have the potential for increased principal repayments in response to a linked variable (such as U.S. Treasury Inflation-Indexed Securities) that do not incorporate risk of original investment /principal loss (outside of default risk) are not captured as structured notes in scope of this statement.
securities of another business entity. Publicly traded stock warrants are captured in scope of SSAP No. 30R—Unaffiliated Common Stock. All other warrants, including non-publicly traded stock warrants, shall be captured in scope of SSAP No. 86.

6. "Derivative Premium" is the cost to acquire or write a derivative contract. Derivative premium is not an "underlying" in a derivative contract and is not impacted by changes in an underlying interest of the derivative agreement. A derivative with contract terms that finance the derivative premium, so that the cost is paid or received throughout the derivative term or at derivative maturity, does not result with an "embedded derivative" addressed in paragraph 16.

6.7. "Firm commitment" is an agreement with an unrelated party, binding on both parties and expected to be legally enforceable, with the following characteristics:

a. The agreement specifies all significant terms, including the quantity to be exchanged, the fixed price, and the timing of the transaction. The fixed price may be expressed as a specified amount of an entity’s functional currency or of a foreign currency. It may also be expressed as a specified interest rate or specified effective yield;

b. The agreement includes a disincentive for nonperformance that is sufficiently large to make performance probable; and

c. For investments in subsidiary, controlled, and affiliated entities (as defined by SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities (SSAP No. 97)) and investments in limited liability companies (as defined by SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies) it must be probable that acquisition will occur within a reasonable period of time.

7.8. A hedging transaction is defined as a derivative(s) transaction which is entered into and maintained to reduce:

a. The risk of a change in the fair value or cash flow of assets and liabilities which the reporting entity has acquired or incurred or has a firm commitment to acquire or incur or for which the entity has forecasted acquisition or incurrence; or

b. The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which a reporting entity has acquired or incurred or has a firm commitment to acquire or incur or for which the entity has forecasted acquisition or incurrence.

8.9. "Income generation transaction" is defined as derivatives written or sold to generate additional income or return to the reporting entity. They include covered options, caps, and floors (e.g., a reporting entity writes an equity call option on stock that it already owns).

9.10. "Replication (Synthetic Asset) transaction" is a derivative transaction entered into in conjunction with other investments in order to reproduce the investment characteristics of otherwise permissible investments. A derivative transaction entered into by an insurer as a hedging or income generation transaction shall not be considered a replication (synthetic asset) transaction.

40.11. "Forecasted transaction" is a transaction that is expected to occur for which there is no firm commitment. Because no transaction or event has yet occurred and the transaction or event when it occurs will be at the prevailing market price, a forecasted transaction does not give an entity any present rights to future benefits or a present obligation for future sacrifices.

41.12. An "underlying" is a specified interest rate, security price, commodity price, foreign exchange rate, index of prices or rates, or other variable (including the occurrence or nonoccurrence of a
specified event such as a scheduled payment under contract). An underlying may be a price or rate of an asset or liability but is not the asset or liability itself.

12.13. “Benchmark Interest Rate” is a widely recognized and quoted rate in an active financial market that is broadly indicative of the overall level of interest rates attributable to high-credit-quality obligors in that market. It is a rate that is widely used in a given financial market as an underlying basis for determining the interest rates of individual financial instruments and commonly referenced in interest-rate-related transactions. In theory, the benchmark interest rate should be a risk-free rate (that is, has no risk of default). In some markets, government borrowing rates may serve as a benchmark. In other markets, the benchmark interest rate may be an interbank offered rate. In the United States, the interest rates on direct Treasury obligations of the U.S. government, the London Interbank Offered Rate (LIBOR) swap rate, the Fed Funds Effective Rate, the Securities Industry and Financial Markets Association (SIFMA) Municipal Swap Rate, and the Secured Overnight Financing Rate (SOFR) Overnight Index Swap Rate are considered to be benchmark interest rates.

13.14. “Weather derivatives” are defined as a forward-based or option-based contract for which settlement is based on a climatic or geological variable. One example of such a variable is the occurrence or nonoccurrence of a specified amount of snow at a specified location within a specified period of time.

14.15. “Notional amount” is defined as the face value of a financial instrument in a derivatives transaction as of a reporting date which is used to calculate future payments in the reporting currency. Notional amount may also be referred to as notional value or notional principal amount. The notional amount reported should remain static over the life of a trade unless the instrument is partially unwound or has a contractually amortizing notional. The notional amount shall apply to derivative transactions as follows:

a. For derivative instruments other than futures contracts (e.g., options, swaps, forwards), the notional amount is either the amount to which interest rates are applied in order to calculate periodic payment obligations or the amount of the contract value used to determine the cash obligations. Non-U.S. dollar contracts must be multiplied or divided by the appropriate inception foreign currency rate.

b. For futures contracts, with a U.S. dollar-denominated contract size (e.g., Treasury note and bond contracts, Eurodollar futures) or underlying, the notional amount is the number of contracts at the reporting date multiplied by the contract size (value of one point multiplied by par value).

c. For equity index and similar futures, the number of contracts at the reporting date is multiplied by the value of one point multiplied by the transaction price. Non-U.S. dollar contract prices must be multiplied or divided by the appropriate inception foreign currency rate.

15.16. “Variation Margin” reflects the daily change in market value of derivative contracts (e.g., daily gain/loss on a derivative contract due to market movements). Amounts received/paid to adjust variation margin on derivative contracts that are both cleared and settled on an exchange shall be recognized as an adjustment to the carrying value of the derivative contract (e.g., futures). Amounts received/paid to adjust variation margin on all other derivative contracts shall be recognized on the balance sheet as an asset or liability separate from the carrying value of the derivative contract.

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2 The definition in paragraph 14 is intended to be a principle for determining notional for all derivative instruments. To the extent a derivative type is not explicitly addressed in paragraph 14.a. through paragraph 14.c., notional should be reported in a manner consistent with this principle.
derivative instrument. This treatment shall occur under statutory accounting regardless if the counterparty/exchange considers amounts exchanged for variation margin to be legal settlement or collateral. Changes in variation margin shall not be treated as realized gains or adjustments to the basis of the hedged item until the derivative contract has been sold, matured or expired.

**Embedded Derivative Instruments**

46.17. Contracts that do not in their entirety meet the definition of a derivative instrument, such as bonds, insurance policies, and leases, may contain “embedded” derivative instruments—implicit or explicit terms that affect some or all of the cash flows or the value of other exchanges required by the contract in a manner similar to a derivative instrument. The effect of embedding a derivative instrument in another type of contract (“the host contract”) is that some or all of the cash flows or other exchanges that otherwise would be required by the contract, whether unconditional or contingent upon the occurrence of a specified event, will be modified based on one or more underlyings. An embedded derivative instrument shall not be separated from the host contract and accounted for separately as a derivative instrument.

**Impairment**

47.18. This statement adopts the impairment guidelines established by SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R) for the underlying financial assets or liabilities.

**Derivative Premium (New Section – All Other Sections Renumbered Accordingly)**

19. Derivative premium is the amount paid (acquired derivative) or received (written derivative) to enter into a derivative contract. At inception, the premium generally represents the fair value of the derivative. Derivative premium that is not paid or received at inception represents a liability or receivable for the reporting entity. Derivatives with premiums not remitted at acquisition are considered “financed derivatives.” Financed derivatives shall be reported in accordance with the following provisions:

a. At acquisition and subsequently, the gross reported fair value of the derivative shall exclude the impact of financing premiums. Only market changes in the actual fair value of the derivative shall be reflected as unrealized gains or losses.

b. At acquisition and subsequently, premiums payable (acquired derivative) and premiums receivable (written derivatives) shall be separately reported as “payable for securities” and “receivables for securities.”

c. If premium payable or receivable meet the requirement for a valid right of setoff with the derivative in accordance with SSAP No. 64, the derivative asset can be reduced by a premium payable, and a derivative liability can be reduced by a premium receivable for overall reporting on the balance sheet. This offset provision does not permit a derivative asset to be reported as a derivative liability (or vice versa) due to premium payable or receivable. Rather, once a derivative asset (or liability) is fully reduced by a premium liability (or receivable), any remaining premium liability (or receivable) shall be reported as a “payable for security” or “receivable for security” pursuant to paragraph 19.b. This net balance sheet reporting does not impact the gross presentation of open derivatives on Schedule DB-A or Schedule DB-B. If reported net on the balance sheet due to a valid right to offset, the offsetting adjustment shall be shown on schedule DB-D and the SSAP No. 64 disclosures are required.

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1 This paragraph does not include derivative premium financing arrangements. Derivatives and financed premiums are subject to separate reporting as detailed in paragraph 19.
Recognition and Measurement of Derivatives Used in Hedging Transactions

48.20. Derivative instruments represent rights or obligations that meet the definitions of assets (SSAP No. 4—Assets and Nonadmitted Assets) or liabilities (SSAP No. 5R) and shall be reported in financial statements. In addition, derivative instruments also meet the definition of financial instruments as defined in SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures (SSAP No. 27). Should the cost basis of the derivative instrument be undefined (i.e., no premium is paid), the instrument shall be disclosed in accordance with paragraphs 44-47 of SSAP No. 100—Fair Value (SSAP No. 100). Derivative instruments are admitted assets to the extent they conform to the requirements of this statement.

49.21. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and are permitted to be valued and reported in a manner that is consistent with the hedged asset or liability (referred to as hedge accounting). For instance, assume an entity has a financial instrument on which it is currently receiving income at a variable rate but wishes to receive income at a fixed rate and thus enters into a swap agreement to exchange the cash flows. If the transaction qualifies as an effective hedge and a financial instrument on a statutory basis is valued and reported at amortized cost, then the swap would also be valued and reported at amortized cost. Derivative instruments used in hedging transactions that do not meet or no longer meet the criteria of an effective hedge, or that meet the required criteria but the entity has chosen not to apply hedge accounting, shall be accounted for at fair value and the changes in the fair value shall be recorded as unrealized gains or unrealized losses (referred to as fair value accounting).

Staff Note: Paragraphs 22-38 not duplicated.

Documentation Guidance

39. At inception of the hedge, documentation must include:

a. A formal documentation of the hedging relationship and the entity’s risk management objective and strategy for undertaking the hedge, including identification of the hedging instrument, the hedged item, the nature of the risk being hedged, and how the hedging instrument’s effectiveness in offsetting the exposure to changes in the hedged item’s fair value or variability in cash flows attributable to the hedged risk will be assessed. There must be a reasonable basis for how the entity plans to assess the hedging instrument’s effectiveness;

b. An entity’s defined risk management strategy for a particular hedging relationship may exclude certain components of a specific hedging derivative’s change in fair value, such as time value, from the assessment of hedge effectiveness, as discussed in paragraph 38 and Exhibit B;

c. Signature of approval, for each instrument, by person(s) authorized, either by the entity’s board of directors or a committee authorized by the board, to approve such transactions; and

d. A description of the reporting entity’s methodology used to verify that opening transactions do not exceed limitations promulgated by the state of domicile.

Staff Note: Paragraphs 40-58 not duplicated.

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\[\text{Pursuant to paragraph 19, the gross reported value of a derivative and the determination of unrealized gains or losses shall exclude the impact of financing premiums. Premiums payable or receivable from the acquisition or writing of a derivative shall not be reflected in the gross reporting of derivatives or in determining the fair value change in a derivative.}\]
Disclosure Requirements

59. Reporting entities shall disclose the following for all derivative contracts used:

h. For derivative contracts with financing premiums:

i. Disclose the aggregate, non-discounted total premium cost for these contracts and the premium cost due in each of the following four years, and thereafter. Also disclose include the aggregate fair value of derivative instruments with financing premiums excluding the impact of the deferred or financing premiums.

ii. For each derivative contract with financing premiums:

(a) Whether premium cost is paid throughout the contract, or at derivative maturity;
(b) Next premium cost payment date;
(c) Total premium cost;
(d) Premium cost paid in prior years;
(e) Current year premium cost paid;
(f) Future unpaid premium cost;
(g) Fair value of derivative, excluding impact of financing premiums; and
(h) Unrealized gain/loss, excluding impact of financing premiums.

Staff Note: With the proposed revisions to clarify gross reporting without financing premiums, these disclosures will not be considered necessary. Comments are requested whether it would be beneficial to retain these columns and capture the fair value of the derivative with the impact of financing premiums.

i. All derivatives are required to be shown gross on Schedule DB. However, derivatives may be reported net in the financial statements (pages 2 and 3 of the statutory financial statements) in accordance with SSAP No. 64—Offsetting and Netting of Assets and Liabilities when a valid right to offset exists. Derivatives offset in accordance with SSAP No. 64 and reported net in the financial statement shall follow the disclosure requirements in SSAP No. 64, paragraph 6. (Derivative Assets and Derivative Liabilities reported on the balance sheet shall agree to columns 5 and 6, respectively, after netting, on Schedule DB – Part D – Section 1.)
Proposed Revisions to Schedule DB-D – Counterparty Exposure

As detailed in this agenda item, NAIC staff suggests consideration on whether premiums due to / from a counterparty should be used in determining the net derivative exposure. This approach would allow the clarifications for gross reporting (excluding financing derivatives) to not impact a life insurer’s RBC calculation for derivative activity as the financing premiums owed by the reporting entity would be considered similar to collateral received.

Below is a simplified version of Schedule DB-D with the potential column.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>4</th>
<th>New Column</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of Exchange, Counterparty or Central Clearinghouse</td>
<td>Master Agreement (Y / N)</td>
<td>Fair Value of Acceptable Collateral</td>
<td>Present Value of Financing Premiums</td>
<td>Contracts with BACV &gt; 0</td>
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<td>Gross Totals</td>
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<td></td>
<td>Offset Per SSAP No. 64</td>
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<td></td>
<td>Net After Right to Offset</td>
</tr>
</tbody>
</table>

If this column was added, and the derivatives reported in column 5 and 6 were gross of financing premiums, the amount reported in column 7 would be determined as follows:

Column 7 – Exposure Net of Collateral (Book/Adjusted Carrying Value)

For the aggregate reporting of Exchange-Traded Derivatives (Line 0199999999), show the amount in Column 5.

For OTC counterparties, if no master agreement is in place, show the sum of the Book/Adjusted Carrying Values of all derivative instruments with the counterparty that has a positive Book/Adjusted Carrying Value, less any Acceptable Collateral and the Present Value of Financing Premiums (Column 5 – Column 4 – New Column).

For OTC counterparties with a master agreement in place and central clearinghouses, show the net sum of the Book/Adjusted Carrying Values of all derivative instruments, less any acceptable collateral and the present value of financing premiums (Column 5 + Column 6 – Column 4 – New Column).

This amount should not be less than zero.

For life insurance entities, the positive amount reported in column 7 is then accessed RBC based on the NAIC designation of the counterparty. When reporting the gross fair value of derivatives with capturing the financing premiums, the premiums due from or owed to the counterparty is factored into the calculation to reflect net counterparty exposure. This reporting will not impact P/C or Health entities (regardless if they engage in financing derivatives), as their RBC is based on derivative assets as reported on the balance sheet.
Status:
On December 7, 2019, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 86—Derivatives, as illustrated above, to clarify the reporting of derivatives with financing premiums. The reporting revisions propose allowing the present value of the derivative premium receivable (and payable) for financed derivatives to be factored into the counterparty risk assessment for life RBC. (If supported, RBC changes would be subsequently referred to the Capital Adequacy (E) Task Force for consideration.) Comments are also requested as to whether derivatives and related financing provisions that would generally not meet the SSAP No. 64—Offsetting and Netting of Assets and Liabilities right to offset criteria and if explicit guidance allowing offset should be considered.

On March 18, 2020, the Statutory Accounting Principles (E) Working Group exposed this agenda item with slight revisions from the prior exposure (shaded) to delete the proposed new paragraph 19.c., as recommended by interested parties. The exposed revisions, as illustrated below, ensure consistency in the gross reporting of derivatives, without inclusion of financing components, and in reporting amounts owned to/from the reporting entity from the acquisition or writing of derivatives. With this exposure, a blanks proposal will be sponsored and notice of the proposed edits will be provided to the Capital Adequacy (E) Task Force. This item has a comment period deadline ending May 29, 2020.

Proposed Revisions to SSAP No. 86:

6. “Derivative Premium” is the cost to acquire or write a derivative contract. Derivative premium is not an “underlying” in a derivative contract and is not impacted by changes in an underlying interest of the derivative agreement. A derivative with contract terms that finance the derivative premium, so that the cost is paid or received throughout the derivative term or at derivative maturity, does not result with an “embedded derivative” addressed in paragraph 16.

Impairment

18. This statement adopts the impairment guidelines established by SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R) for the underlying financial assets or liabilities.

Derivative Premium (New Section – All Other Sections Renumbered Accordingly)

19. Derivative premium is the amount paid (acquired derivative) or received (written derivative) to enter into a derivative contract. At inception, the premium generally represents the fair value of the derivative. Derivative premium that is not paid or received at inception represents a liability or receivable for the reporting entity. Derivatives with premiums not remitted at acquisition are considered “financed derivatives.” Financed derivatives shall be reported in accordance with the following provisions:

a. At acquisition and subsequently, the gross reported fair value of the derivative shall exclude the impact of financing premiums. Only market changes in the actual fair value of the derivative shall be reflected as unrealized gains or losses.

b. At acquisition and subsequently, premiums payable (acquired derivative) and premiums receivable (written derivatives) shall be separately reported as “payable for securities” and “receivables for securities.”

c. If premium payable or receivable meet the requirement for a valid right of setoff with the derivative in accordance with SSAP No. 64, the derivative asset can be reduced by a premium payable, and a derivative liability can be reduced by a premium receivable for overall reporting on the balance sheet. This offset provision does not permit a derivative asset to be reported as a derivative liability (or vice versa) due to premium payable or receivable. Rather, once a derivative asset (or liability) is fully reduced by a premium...
liability (or receivable), any remaining premium liability (or receivable) shall be reported as a “payable for security” or “receivable for security” pursuant to paragraph 19.b. This net balance sheet reporting does not impact the gross presentation of open derivatives on Schedule DB-A or Schedule DB-B. If reported net on the balance sheet due to a valid right to offset, the offsetting adjustment shall be shown on schedule DB-D and the SSAP No. 64 disclosures are required.

Recognition and Measurement of Derivatives Used in Hedging Transactions

49.20. Derivative instruments represent rights or obligations that meet the definitions of assets (SSAP No. 4—Assets and Nonadmitted Assets) or liabilities (SSAP No. 5R) and shall be reported in financial statements. In addition, derivative instruments also meet the definition of financial instruments as defined in SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures (SSAP No. 27). Should the cost basis of the derivative instrument be undefined (i.e., no premium is paid), the instrument shall be disclosed in accordance with paragraphs 44-47 of SSAP No. 100—Fair Value (SSAP No. 100). Derivative instruments are admitted assets to the extent they conform to the requirements of this statement.

20.21. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and are permitted to be valued and reported in a manner that is consistent with the hedged asset or liability (referred to as hedge accounting). For instance, assume an entity has a financial instrument on which it is currently receiving income at a variable rate but wishes to receive income at a fixed rate and thus enters into a swap agreement to exchange the cash flows. If the transaction qualifies as an effective hedge and a financial instrument on a statutory basis is valued and reported at amortized cost, then the swap would also be valued and reported at amortized cost. Derivative instruments used in hedging transactions that do not meet or no longer meet the criteria of an effective hedge, or that meet the required criteria but the entity has chosen not to apply hedge accounting, shall be accounted for at fair value and the changes in the fair value shall be recorded as unrealized gains or unrealized losses (referred to as fair value accounting)5.

Staff Note: Paragraphs 22-38 not duplicated.

Documentation Guidance

39. At inception of the hedge, documentation must include:

a. A formal documentation of the hedging relationship and the entity’s risk management objective and strategy for undertaking the hedge, including identification of the hedging instrument, the hedged item, the nature of the risk being hedged, and how the hedging instrument’s effectiveness in offsetting the exposure to changes in the hedged item’s fair value or variability in cash flows attributable to the hedged risk will be assessed. There must be a reasonable basis for how the entity plans to assess the hedging instrument’s effectiveness;

b. An entity’s defined risk management strategy for a particular hedging relationship may exclude certain components of a specific hedging derivative’s change in fair value, such as time value, from the assessment of hedge effectiveness, as discussed in paragraph 38 and Exhibit B;

5 Pursuant to paragraph 19, the gross reported value of a derivative and the determination of unrealized gains or losses shall exclude the impact of financing premiums. Premiums payable or receivable from the acquisition or writing of a derivative shall not be reflected in the gross reporting of derivatives or in determining the fair value change in a derivative.
c. Signature of approval, for each instrument, by person(s) authorized, either by the entity's board of directors or a committee authorized by the board, to approve such transactions; and

d. A description of the reporting entity's methodology used to verify that opening transactions do not exceed limitations promulgated by the state of domicile.

Staff Note: Paragraphs 40-58 not duplicated.

Disclosure Requirements

59. Reporting entities shall disclose the following for all derivative contracts used:

h. For derivative contracts with financing premiums:

i. Disclose the aggregate, non-discounted total premium cost for these contracts and the premium cost due in each of the following four years, and thereafter. Also disclose the aggregate fair value of derivative instruments with financing premiums excluding the impact of the deferred or financing premiums.

ii. For each derivative contract with financing premiums:

(a) Whether premium cost is paid throughout the contract, or at derivative maturity;
(b) Next premium cost payment date;
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Staff Note: With the proposed revisions to clarify gross reporting without financing premiums, these disclosures will not be considered necessary. Comments are requested whether it would be beneficial to retain these columns and capture the fair value of the derivative with the impact of financing premiums.

i. All derivatives are required to be shown gross on Schedule DB. However, derivatives may be reported net in the financial statements (pages 2 and 3 of the statutory financial statements) in accordance with SSAP No. 64—Offsetting and Netting of Assets and Liabilities when a valid right to offset exists. Derivatives offset in accordance with SSAP No. 64 and reported net in the financial statement shall follow the disclosure requirements in SSAP No. 64, paragraph 6. (Derivative Assets and Derivative Liabilities reported on the balance sheet shall agree to columns 5 and 6, respectively, after netting, on Schedule DB – Part D – Section 1.)

Proposed Revisions to Schedule DB-D – Counterparty Exposure

As detailed in this agenda item, NAIC staff suggests consideration on whether premiums due to / from a counterparty should be used in determining the net derivative exposure. This approach would allow the clarifications for gross reporting (excluding financing derivatives) to not impact a life insurer’s RBC calculation.
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Column 7 – Exposure Net of Collateral (Book/Adjusted Carrying Value)
For the aggregate reporting of Exchange-Traded Derivatives (Line 0199999999), show the amount in Column 5.

For OTC counterparties, if no master agreement is in place, show the sum of the Book/Adjusted Carrying Values of all derivative instruments with the counterparty that has a positive Book/Adjusted Carrying Value, less any Acceptable Collateral and the Present Value of Financing Premiums (Column 5 – Column 4 – New Column).

For OTC counterparties with a master agreement in place and central clearinghouses, show the net sum of the Book/Adjusted Carrying Values of all derivative instruments, less any acceptable collateral and the present value of financing premiums (Column 5 + Column 6 – Column 4 – New Column).

This amount should not be less than zero.

For life insurance entities, the positive amount reported in column 7 is then accessed RBC based on the NAIC designation of the counterparty. When reporting the gross fair value of derivatives with capturing the financing premiums, the premiums due from or owed to the counterparty is factored into the calculation to reflect net counterparty exposure. This reporting will not impact P/C or Health entities (regardless if they engage in financing derivatives), as their RBC is based on derivative assets as reported on the balance sheet.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 86—Derivatives, as illustrated below, to ensure consistency in the gross reporting of derivatives without inclusion of financing components and in reporting amounts owed to/from the reporting entity from the acquisition or writing of derivatives. The adopted nonsubstantive revisions are effective Jan. 1, 2021 to allow for corresponding blanks changes. (Note – Changes in paragraphs from the prior exposure just showcase the adopted revisions in accordance with the current SSAP No. 86 paragraphs to reflect changes from other agenda items that revised SSAP No. 86.)
Adopted Revisions to SSAP No. 86:

6. "Derivative Premium" is the cost to acquire or write a derivative contract. Derivative premium is not an "underlying" in a derivative contract and is not impacted by changes in an underlying interest of the derivative agreement. A derivative with contract terms that finance the derivative premium, so that the cost is paid or received throughout the derivative term or at derivative maturity, does not result with an "embedded derivative" addressed in paragraph 16.

Impairment

17. This statement adopts the impairment guidelines established by SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R) for the underlying financial assets or liabilities.

Derivative Premium (New Section – All Other Sections Renumbered Accordingly)

18. Derivative premium is the amount paid (acquired derivative) or received (written derivative) to enter into a derivative contract. At inception, the premium generally represents the fair value of the derivative. Derivative premium that is not paid or received at inception represents a liability or receivable for the reporting entity. Derivatives with premiums not remitted at acquisition are considered "financed derivatives." Financed derivatives shall be reported in accordance with the following provisions:

a. At acquisition and subsequently, the gross reported fair value of the derivative shall exclude the impact of financing premiums. Only market changes in the actual fair value of the derivative shall be reflected as unrealized gains or losses.

b. At acquisition and subsequently, premiums payable (acquired derivative) and premiums receivable (written derivatives) shall be separately reported as "payable for securities" and "receivables for securities."

Recognition of Derivatives

48-19. Derivative instruments represent rights or obligations that meet the definitions of assets (SSAP No. 4—Assets and Nonadmitted Assets) or liabilities (SSAP No. 5R) and shall be reported in financial statements. In addition, derivative instruments also meet the definition of financial instruments as defined in SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures. Should the cost basis of the derivative instrument be undefined (i.e., no premium is paid), the instrument shall be disclosed in accordance with paragraphs 44-48 of SSAP No. 100R—Fair Value. Derivative instruments used in hedging, income generation or replication (synthetic asset) transactions shall be recognized and measured in accordance with the specific provisions within this statement and are admitted assets to the extent they conform to the requirements of this statement.

49-20. Derivative instruments that are not used in hedging, income generation or replication (synthetic asset) transactions shall be considered “Other” derivatives. These derivatives shall be accounted for at fair value and the changes in fair value shall be recorded as unrealized gains or losses. These derivatives do not qualify as admitted assets.

Derivatives Used in Hedging Transactions

20-21. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and are permitted to be valued and reported in a manner that is consistent with the hedged asset or liability (referred to as hedge accounting). For instance, assume an entity has a financial instrument on which it is currently receiving income at a variable rate but wishes to receive income at a fixed rate and thus enters into a swap agreement to exchange the cash flows. If the transaction qualifies as an effective hedge and a financial instrument on a statutory basis is valued and reported at amortized cost, then the swap would also be valued and reported at amortized cost. Derivative instruments used in hedging transactions that do not meet or no longer meet the criteria of an effective hedge, or that meet the required criteria but the entity has chosen not to apply hedge
accounting, shall be accounted for at fair value and the changes in the fair value shall be recorded as unrealized gains or unrealized losses (referred to as fair value accounting) §.

Staff Note: Paragraphs 22-38 not duplicated.

Documentation Guidance

39. At inception of the hedge, documentation must include:

   a. A formal documentation of the hedging relationship and the entity’s risk management objective and strategy for undertaking the hedge, including identification of the hedging instrument, the hedged item, the nature of the risk being hedged, and how the hedging instrument’s effectiveness in offsetting the exposure to changes in the hedged item’s fair value or variability in cash flows attributable to the hedged risk will be assessed. There must be a reasonable basis for how the entity plans to assess the hedging instrument’s effectiveness;

   b. An entity’s defined risk management strategy for a particular hedging relationship may exclude certain components of a specific hedging derivative’s change in fair value, such as time value, from the assessment of hedge effectiveness, as discussed in paragraph 38 and Exhibit B;

   c. Signature of approval, for each instrument, by person(s) authorized, either by the entity’s board of directors or a committee authorized by the board, to approve such transactions; and

   d. A description of the reporting entity's methodology used to verify that opening transactions do not exceed limitations promulgated by the state of domicile.

Staff Note: Paragraphs 40-58 not duplicated.

Disclosure Requirements

60. Reporting entities shall disclose the following for all derivative contracts used:

   h. For derivative contracts with financing premiums:

      i. Disclose the aggregate, non-discounted total premium cost for these contracts and the premium cost due in each of the following four years, and thereafter. Also disclose include the aggregate fair value of derivative instruments with financing premiums excluding the impact of the deferred or financing premiums.

      ii. For each derivative contract with financing premiums:

         (a) Whether premium cost is paid throughout the contract, or at derivative maturity;

         (b) Next premium cost payment date;

         (c) Total premium cost;

§ Pursuant to paragraph 19, the gross reported value of a derivative and the determination of unrealized gains or losses shall exclude the impact of financing premiums. Premiums payable or receivable from the acquisition or writing of a derivative shall not be reflected in the gross reporting of derivatives or in determining the fair value change in a derivative.
(d) Premium cost paid in prior years;
(e) Current year premium cost paid;
(f) Future unpaid premium cost;
(g) Fair value of derivative, excluding impact of financing premiums; and
(h) Unrealized gain/loss, excluding impact of financing premiums.

i. All derivatives are required to be shown gross on Schedule DB. However, derivatives may be reported net in the financial statements (pages 2 and 3 of the statutory financial statements) in accordance with SSAP No. 64—**Offsetting and Netting of Assets and Liabilities** when a valid right to offset exists. Derivatives offset in accordance with SSAP No. 64 and reported net in the financial statement shall follow the disclosure requirements in SSAP No. 64, paragraph 6. (Derivative Assets and Derivative Liabilities reported on the balance sheet shall agree to columns 5 and 6, respectively, after netting, on Schedule DB – Part D – Section 1.)

**Effective Date and Transition**

71. This statement is effective for derivative transaction entered into or modified on or after January 1, 2003. A modification is any revision or change in contractual terms of the derivative. SSAP No. 31 applies to derivative transaction prior to January 1, 2003. Alternatively, an insurer may choose to apply this statement to all derivatives to which the insurer is a party as of January 1, 2003. In either case, the insurer is to disclose the transition approach that is being used. Revisions adopted to paragraph 62 to reject FSP FIN 39-1 is effective January 1, 2013, for companies that have previously reported a position in the balance sheet that was net of counterparty agreements. (Companies that have previously reported derivative instruments and/or related collateral gross shall not be impacted by these revisions.) Revisions adopted in paragraph 15 clarify the reporting for amounts received/paid to adjust variation margin until the derivative contract has ended and are effective January 1, 2018, on a prospective basis, for reporting entities that have previously considered these amounts to reflect settlement or realized gains/losses. (Companies that have previously reported variation margin changes in line with the revisions shall not be impacted by these revisions.) Revisions to incorporate limited provisions from ASU 2017-12 pertaining to the documentation of hedge effectiveness (detailed in paragraph 63) are effective January 1, 2019, with early adoption permitted for year-end 2018. However, if the reporting entity is a U.S. GAAP filer, the reporting entity may only elect early adoption if the entity has also elected early adoption of ASU 2017-12 for year-end 2018. Revisions adopted April 2019 to explicitly include structured notes in scope of this statement are effective December 31, 2019. Revisions adopted July 2020 to define “derivative premium,” require gross reporting of derivatives without the impact of financing premiums and require separate recognition of premiums payable and premiums receivable, are effective January 1, 2020.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Update / Remove References to SVO Listings

Check (applicable entity):

<table>
<thead>
<tr>
<th>Modification of Existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
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<tr>
<td>Interpretation</td>
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1. The first proposal was to rename the “U.S. Direct Obligations/Full Faith and Credit Exempt List” to the “NAIC U.S. Government Money Market Fund List.” No revisions to the NAIC Accounting Practices and Procedures (AP&P) Manual would be required, as this list is not specifically identified. (Revisions would likely be needed in the Blanks and RBC filings / instructions.)

2. The second proposal was to discontinue the “NAIC Bond Fund List.” Items which were on this list would be eligible for consideration for the “NAIC Fixed Income-Like SEC Registered Funds List.” The discontinuance of usage of the NAIC Bond Fund List will require an update in the AP&P Manual. (Although the “bond list,” this listing requires 100% government securities in the fund.)

Edited excerpt from the VOSTF referral:
The NAIC Bond Fund List (Bond List), published monthly by the SVO, is a list limited to funds that maintain the highest credit quality rating, maintain the highest market risk rating, and invests 100% of its total assets in U.S. Government securities along with several other restrictive criteria. Only four funds qualify for this list and only four insurers invest in any of the funds. According to the SVO, a combined exposure of $11.8 million BACV was noted in any of the four qualifying funds as of December 31, 2018. Given the limited number of insurers investing in these specific funds, the SVO proposed eliminating this list when the four funds come up for renewal in 2020. Upon renewal, the funds on the NAIC Bond Fund List would be eligible for the “NAIC Fixed Income-Like SEC Registered Funds List.” Elimination of the “bond fund list” would result in migrating these funds over to the NAIC Fixed Income-Like SEC Registered Funds List, which will be reported on Schedule D, Part 2 under SSAP No. 30R – Unaffiliated Common Stock.

Existing Authoritative Literature:
The Bond List is specifically noted in two SSAP’s as detailed below:

SSAP No. 26R—Bonds

3. Bonds shall be defined as any securities representing a creditor relationship, whereby there is a fixed schedule for one or more future payments. This definition includes:

   a. U.S. Treasury securities;
   b. U.S. government agency securities;
c. Municipal securities;

d. Corporate bonds, including Yankee bonds and zero-coupon bonds;

e. Convertible bonds, including mandatory convertible bonds as defined in paragraph 11.b;

f. Fixed-income instruments specifically identified:
   i. Certifications of deposit that have a fixed schedule of payments and a maturity date in excess of one year from the date of acquisition;
   ii. Bank loans issued directly by a reporting entity or acquired through a participation, syndication or assignment;
   iii. Hybrid securities, excluding: surplus notes, subordinated debt issues which have no coupon deferral features, and traditional preferred stocks.
   iv. Debt instruments in a certified capital company (CAPCO)

4. The definition of a bond, per paragraph 3, does not include equity/fund investments, such as mutual funds or exchange-traded funds. However, the following types of SVO-identified investments are provided special statutory accounting treatment and are included within the scope of this statement. These investments shall follow the guidance within this statement, as if they were bonds, unless different treatment is specifically identified in paragraphs 23-29.

   a. Exchange traded funds (ETFs), which qualify for bond treatment, as identified in Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page of www.NAIC.org. (SVO-identified ETFs are reported on Schedule D – Part 1.)

   b. Bond mutual funds which qualify for the Bond List, as identified in Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page of www.NAIC.org. (SVO-identified bond mutual funds are reported on Schedule D – Part 1.)

**SSAP No. 30R—Unaffiliated Common Stock**

3. Common stocks (excluding investments in affiliates) are securities which represent a residual/subordinate ownership in a corporation. This definition includes:

   a. Publicly traded common stocks;

   b. Common stocks that are not publicly traded; and

   c. Common stocks restricted as to transfer of ownership

4. In addition, the following equity investments are captured within scope of this statement:

   a. Master limited partnerships trading as common stock and American deposit receipts only if the security is traded on the New York or NASDAQ exchange;

   b. Publicly traded common stock warrants;

   c. Shares of SEC registered Investment Companies captured under the Investment Company Act of 1940 (open-end investment companies (mutual funds), closed-end funds and unit
investment trusts), regardless of the types or mix of securities owned by the fund (e.g., bonds or stocks), except for Bond Mutual Funds which qualify for bond treatment, as identified in Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page of www.NAIC.org;

d. Exchange Traded Funds, except for those identified for bond or preferred stock treatment, as identified in Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page of www.NAIC.org; and

e. Foreign open-end investment funds governed and authorized in accordance with regulations established by the applicable foreign jurisdiction. Other foreign funds are excluded from the scope of this statement.

f. Equity interests in certified capital companies in accordance with INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO).

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:

NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to 1) SSAP No. 26R—Bonds and SSAP No. 30R—Unaffiliated Common Stock to eliminate references to the NAIC Bond Fund List (Bond List) and 2) add reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R.

Although the Working Group is recommended to proceed with exposure on this agenda item and solicit comments for consideration, final action and determination of an effective date will not occur until revisions have first been adopted by the Valuation of Securities (E) Task Force. NAIC SAPWG staff will coordinate with the VOSTF staff to stay current on their discussion and action on this item. NAIC staff also notes that referrals to the Blanks (E) Working Group and the Capital Adequacy (E) Task Force will be needed to reflect the title change in Blanks and RBC.

NAIC staff also highlights that the reference to the SVO “bond fund list” often causes confusion as this listing only includes funds with 100% of their investments in U.S. Government Securities. If the action to delete the listing does not occur at the Task Force, NAIC staff would recommend that the listing name be revised to reflect the “U.S. Government Fund” to eliminate confusion through reference as a “bond fund” listing.

Proposed Revisions to SSAP No. 26R—Bonds

4. The definition of a bond, per paragraph 3, does not include equity/fund investments, such as mutual funds or exchange-traded funds. However, the following types of SVO-identified investments are provided special statutory accounting treatment and are included within the scope of this statement. These investments shall follow the guidance within this statement, as if they were bonds, unless different treatment is specifically identified in paragraphs 23-29.
Proposed Revisions to SSAP No. 30R—Unaffiliated Common Stock

4. In addition, the following equity investments are captured within scope of this statement:

a. Master limited partnerships trading as common stock and American deposit receipts only if the security is traded on the New York or NASDAQ exchange;

b. Publicly traded common stock warrants;

c. Shares of SEC registered Investment Companies captured under the Investment Company Act of 1940 (open-end investment companies (mutual funds), closed-end funds and unit investment trusts), regardless of the types or mix of securities owned by the fund (e.g., bonds or stocks), including shares of funds referenced in the “NAIC Fixed Income-Like SEC Registered Funds List” as identified in Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page of www.NAIC.org; except for Bond Mutual Funds which qualify for bond treatment, as identified in Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page of www.NAIC.org;

d. Exchange Traded Funds, except for those identified for bond or preferred stock treatment, as identified in Part Three of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page of www.NAIC.org; and

e. Foreign open-end investment funds governed and authorized in accordance with regulations established by the applicable foreign jurisdiction. Other foreign funds are excluded from the scope of this statement.

f. Equity interests in certified capital companies in accordance with INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO).

Staff Review Completed by: Jim Pinegar, NAIC Staff – January 2020

Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds and SSAP No. 30R—Unaffiliated Common Stock, as detailed above, to eliminate references to the NAIC Bond Fund List. The revisions also add reference to the “NAIC Fixed-Income Like SEC Registered Funds List” in SSAP No. 30R. This item has a shortened comment period deadline ending May 1, 2020.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, nonsubstantive revisions to SSAP No. 26R—Bonds and SSAP No. 30R—Unaffiliated Common Stock, as illustrated above under proposed revisions, to eliminate references to the NAIC Bond Fund List (Bond List) in SSAP No. 26R—Bonds and add reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R—Unaffiliated Common Stock.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Commissioner Discretion in the Valuation Manual

Check (applicable entity):

- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

P/C  | Life  | Health
---|-------|-------
| X    |       | X     |

Description of Issue:
The Valuation Manual became operative on January 1, 2017 and is required to be used for all applicable products effective January 1, 2020. This agenda item has been drafted to maintain comparability by providing disclosures regarding the use of commissioner discretion pursuant to the Valuation Manual.

The Authoritative Literature section in the agenda item has examples of items that require commissioner approval in the Valuation Manual. The items involve making a voluntary choice between various acceptable methods, which is subject to commissioner approval. The identified instances in the Valuation Manual are consistent with a change in valuation basis. Examples identified may include characteristics similar to the following:

1. Voluntarily moving between different commonly accepted methods of determining an amount;
2. The change of method is generally infrequent;
3. Changing methods is a voluntary choice, not an automatic change required by the methodology;
4. Change in valuation which must be typically justified to the commissioner prior to approval.

Because these changes are voluntary and not required to change by the methodology, this agenda item recommends disclosing the use of commissioner discretion required for choosing between acceptable methods, consistent with a change in valuation basis.

Existing Authoritative Literature:

SSAP No. 3—Accounting Changes and Corrections of Errors

Change in Accounting Principle

3. A change in accounting principle results from the adoption of an accepted accounting principle, or method of applying the principle, which differs from the principles or methods previously used for reporting purposes. A change in the method of applying an accounting principle shall be considered a change in accounting principle.

4. A characteristic of a change in accounting principle is that it concerns a choice from among two or more statutory accounting principles. However, a change in accounting principle is neither (a) the initial adoption of an accounting principle in recognition of events or transactions occurring for the first time or previously immaterial in their effect, nor (b) the adoption or modification of an accounting principle necessitated by transactions or events that are clearly different in substance from those previously occurring.
5. The cumulative effect of changes in accounting principles shall be reported as adjustments to unassigned funds (surplus) in the period of the change in accounting principle. The cumulative effect is the difference between the amount of capital and surplus at the beginning of the year and the amount of capital and surplus that would have been reported at that date if the new accounting principle had been applied retroactively for all prior periods.

1 If additional changes are identified in subsequent quarters of a fiscal year related to a change in accounting principles recognized initially during the first quarter, such changes shall be considered part of the cumulative effect of the change in accounting principle. The cumulative effect is the difference between the amount of capital and surplus at the beginning of the year and the amount of capital and surplus that would have been reported at that date if the new accounting principle had been applied retroactively for all prior periods. For example, adjustments to an amount recorded as of January 1, 2001, would be recorded as changes in accounting principle rather than corrections of an error through the period of 2001.

**SSAP No. 51R—Life Contracts**

22. For life and annuity policies issued on or after the operative date of the *Valuation Manual*, reserves shall use the requirements of the *Valuation Manual*. As required by Appendix A-820, reserves are required to be determined using the methodologies and processes described in the *Valuation Manual*. For policies unable to meet the *Valuation Manual* criteria for exemption from deterministic or stochastic reserves, the *Valuation Manual* supplants formulaic life insurance policy reserve methodologies with more advanced deterministic and stochastic reserve methodologies to produce reserves that better reflect company experience, possible economic conditions and inherent policy risks.

**Change In Valuation Basis**

36. A change in valuation basis for reserves determined under paragraphs 18-21, except for reserves defined under Actuarial Guideline XLI—CARVM: For Variable Annuities (AG 43), as detailed in Appendix C of this Manual, shall be defined as a change in the interest rate, mortality assumption, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors (SSAP No. 3).

37. Changes in reserves developed under paragraph 22 or AG 43 shall be reviewed to determine whether the change represents a change in valuation basis and if it meets the definition of a change in accounting as defined in SSAP No. 3.

   a. Changes in principle-based reserving assumptions are often the result of updating assumptions and other factors required by the existing reserving methodology. Reserve changes resulting from the application of principle-based reserving methodology including, but not limited to, updating assumptions based on reporting entity, industry or other experience, and having the reported reserve transition between net premium reserve, deterministic reserve or stochastic reserve, as required under existing guidance, shall not be considered a change in valuation basis. These types of changes also include, but are not limited to, periodic updates in Valuation Manual tables, such as industry valuation basic tables, asset spread tables and default cost tables.

   b. A change in valuation basis for principle-based reserves shall include cases where the required reserve methodology has changed or the insurer makes a voluntary decision to choose one allowable reserving method over another. These types of changes include, but are not limited to, new standardized mortality tables such as Commissioners Standard Ordinary tables and regulatory changes in methodology.

38. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus
(under changes to surplus in the change in valuation basis annual statement line) rather than as a part of the reserve change recognized in the summary of operations.

39. The impact of a change in valuation basis on surplus is based on the difference between the reported reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless this statement prescribes a new method and a specific transition that allows for grading. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies in force for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The changes remain subject to the disclosures prescribed in SSAP No. 3. The Valuation Manual is effective prospectively for policies written on or after the operative date. Therefore, upon the initial prospective adoption of principle-based reserving, the change in valuation basis reflected as an adjustment to surplus will be zero. After initial adoption of the Valuation Manual, changes in valuation basis will need to be evaluated to determine the amount of any surplus adjustments.

SSAP No. 52—Deposit-Type Contracts

Change In Valuation Basis

14. A change in valuation basis shall be defined as a change in the interest rate assumption or other factor affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus rather than as a part of the reserve change recognized in the summary of operations. The impact on surplus is based on the difference between the reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless an actuarial guideline adopted by the NAIC prescribes a specific transition that allows for grading.

SSAP No. 54R—Individual and Group Accident and Health Contracts

12. The reserving methodologies and assumptions used in calculating individual and group accident and health reserves shall meet the provisions of Appendices A-010, A-641, A-820, A-822 (as applicable), the Valuation Manual and the actuarial guidelines found in Appendix C of this Manual (as applicable). Further, policy reserves shall be in compliance with those Actuarial Standards of Practice promulgated by the Actuarial Standards Board.

Change In Valuation Basis

22. A change in valuation basis shall be defined as a change in the interest rate, mortality and morbidity assumptions, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors (SSAP No. 3). Changing morbidity assumptions regarding the length of claim continuance based on regularly updated credible experience as required for products subject to Actuarial Guideline XLVII—The Application of Company Experience in the Calculation of Claim Reserves Under the 2012 Group Long-Term Disability Valuation Table (AG 47) and Actuarial Guideline L—2013 Individual Disability Income Valuation Table (AG 50) are not considered a change in valuation basis. Other uses of regularly updated credible experience required to be used for morbidity assumptions by Appendix A-010 regarding continuing claim payments are generally not considered a change in valuation basis. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus (under changes to surplus in the change in valuation basis annual statement line) rather than as a part of the reserve change recognized in the summary of operations.
line for life, accident and health, and health reporting entities) rather than as a part of the reserve change recognized in the summary of operations. The impact on surplus is based on the difference between the reserve under the old and new methods as of the beginning of the year. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in this paragraph, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The changes remain subject to the disclosures prescribed in SSAP No. 3. This difference shall not be graded in over time unless this statement prescribes a new method and a specific transition that allows for grading.

The *Valuation Manual* is referenced in the following places in the *Accounting Practices and Procedures Manual*:

- SSAP No. 51R—Life Contracts
- SSAP No. 54R—Individual and Group Accident and Health Contracts
- SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees
- Appendix A-010: Minimum Reserve Standards for Individual and Group Health Insurance Contracts
- Appendix A-820: Minimum Life and Annuity Reserve Standards
- Appendix C- Actuarial Guidelines-- Multiple Places

The *Valuation Manual* provides the following instances of commissioner discretion:

**VM-20**

Section 9C3d(iii)

iii. In taking into account factors that are not recognized in the Relative Risk Tool, a company may, to the extent it can justify, adjust the industry basic tables up or down two Relative Risk Tables from that determined by application of the Relative Risk Tool. Further adjustments to reflect risk characteristics not captured within the Relative Risk Tool may be allowed upon approval by the insurance commissioner.

Section 9C5a

For valuations in which the industry basic mortality table is the 2015 VBT, determine an aggregate level of credibility following either the Limited Fluctuation Method by amount, such that the minimum probability is at least 95% with an error margin of no more than 5% or Bühlmann Empirical Bayesian Method by amount. Once chosen, the credibility method must be applied to all business subject to VM20 and requiring credibility percentages. A company seeking to change credibility methods must request and subsequently receive the approval of the insurance commissioner. The request must include the justification for the change and a demonstration of the rationale supporting the change.

**VM-21 (Note that agenda item 2019-47 addresses this exercise of discretion).**

Section 2B

These requirements apply for valuation dates on or after Jan. 1, 2020. A company may elect to phase in these requirements over a 36-month period beginning Jan. 1, 2020. A company may elect a longer phase-in period, up to seven years, with approval of the domiciliary commissioner. The election of whether to phase in and the period of phase-in must be made prior to the Dec. 31, 2020, valuation. At the company's option, a phase-in may be terminated prior to the originally elected end of the phase-in period; the reserve would then be equal to the unadjusted reserve calculated according to the requirements of VM-21 applicable for valuation dates on or after Jan. 1, 2020. If there is a material decrease in the book of business by sale or reinsurance ceded, the company shall adjust the amount of the phase-in provision. The phase-in...
in amount \((C = R1 - R2, \text{ as described below})\) must be scaled down in proportion to the reduction in the excess reserve, measured on the effective transaction date as the reserve amount in excess of cash surrender value before and after the impact of the transaction. The company must obtain approval for any other modification of the remaining phase-in amount. The method to be used for the phase-in calculation is as follows.

Section 2C - The Additional Standard Projection Amount

The additional standard projection amount is determined by applying one of the two standard projection methods defined in Section 6. The same method must be used for all contracts within a group of contracts that are aggregated together to determine the reserve, and the additional standard projection amount excluding any contracts whose reserve is determined using the Alternative Methodology. The company shall elect which method they will use to determine the additional standard projection amount. The company may not change that election for a future valuation without the approval of the domiciliary commissioner.

Section 3E - Alternative Methodology

For a group of variable deferred annuity contracts that contain either no guaranteed benefits or only GMDBs—i.e., no VAGLBs—the reserve may be determined using the Alternative Methodology described in Section 7 rather than using the approach described in Section 3.C and Section 3.D. However, in the event that the approach described in Section 3.C and Section 3.D has been used in prior valuations for that group of contracts, the Alternative Methodology may not be used without approval from the domiciliary commissioner.

Section 4A4a(ii)b - Modeling of Hedges

a. For a company that does not have a CDHS:

i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling.

ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets. The hedge assets may then be considered in one of two ways:

a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or

b) No hedge positions – in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy. A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

Section 6B2

The company shall determine the Prescribed Projections Amount by following either the CSMP Method or the CTEPA Method below. A company may not change the method used from one valuation to the next without the approval of the domiciliary commissioner.
Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Several updates to the Accounting Practices and Procedures Manual were adopted to address the operative date of the Valuation Manual.

- 2015-47: PBR SSAP
- 2016-10: Changes to A-820 Standard Valuation Law for Principle-based Reserving
- 2016-15: Change in Valuation Basis for Life Contracts
- 2016-34: Health Valuation Manual Updates
- 2016-17: A-010 Minimum Reserve Standards for Individual and Group Health Insurance Contracts

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): None

Staff Recommendation:
NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts and SSAP No. 54R—Individual and Group Accident and Health Contracts as illustrated below. The proposed disclosure notes that voluntary decisions to choose one allowable reserving methodology over another, which require commissioner approval under the Valuation Manual shall be reported as a change in valuation basis. As part of the coordination process with the Valuation Manual, the Life Actuarial (A) Task Force should also be notified of the exposure.

Proposed revisions for Spring 2020 Discussion:

SSAP No. 51R—Life Contracts:

Change In Valuation Basis

36. A change in valuation basis for reserves determined under paragraphs 18-21, except for reserves defined under Actuarial Guideline XLIII—CARVM: For Variable Annuities (AG 43), as detailed in Appendix C of this Manual, shall be defined as a change in the interest rate, mortality assumption, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—Accounting Changes and Corrections of Errors (SSAP No. 3).

37. Changes in reserves developed under paragraph 22 or AG 43 shall be reviewed to determine whether the change represents a change in valuation basis and if it meets the definition of a change in accounting as defined in SSAP No. 3.

a. Changes in principle-based reserving assumptions are often the result of updating assumptions and other factors required by the existing reserving methodology. Reserve changes resulting from the application of principle-based reserving methodology including, but not limited to, updating assumptions based on reporting entity, industry or other experience, and having the reported reserve transition between net premium reserve, deterministic reserve or stochastic reserve, as required under existing guidance, shall not be considered a change in valuation basis. These types of changes also include, but are not limited to, periodic updates in Valuation Manual tables, such as industry valuation basic tables, asset spread tables and default cost tables.
b. A change in valuation basis for principle-based reserves shall include cases where the required reserve methodology has changed or the insurer makes a voluntary decision to choose one allowable reserving method over another. These types of changes include, but are not limited to, new standardized mortality tables such as Commissioners Standard Ordinary tables and regulatory changes in methodology. Voluntary decisions to choose one allowable reserving methodology over another, which require commissioner approval under the *Valuation Manual* shall be reported as a change in valuation basis.

38. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus (under changes to surplus in the change in valuation basis annual statement line) rather than as a part of the reserve change recognized in the summary of operations.

39. The impact of a change in valuation basis on surplus is based on the difference between the reported reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless this statement prescribes a new method and a specific transition that allows for grading. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in paragraphs 36-38 of this statement, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies inforce for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The changes remain subject to the disclosures prescribed in SSAP No. 3. The Valuation Manual is effective prospectively for policies written on or after the operative date. Therefore, upon the initial prospective adoption of principle-based reserving, the change in valuation basis reflected as an adjustment to surplus will be zero. After initial adoption of the Valuation Manual, changes in valuation basis will need to be evaluated to determine the amount of any surplus adjustments.

**SSAP No. 52—Deposit-Type Contracts:**

**Change In Valuation Basis**

14. A change in valuation basis shall be defined as a change in the interest rate assumption or other factor affecting the reserve computation of policies inforce and meets the definition of an accounting change as defined in SSAP No. 3—*Accounting Changes and Corrections of Errors*. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus rather than as a part of the reserve change recognized in the summary of operations. The impact on surplus is based on the difference between the reserve under the old and new methods as of the beginning of the year. This difference shall not be graded in over time unless an actuarial guideline adopted by the NAIC prescribes a specific transition that allows for grading. Voluntary decisions to choose one allowable reserving methodology over another, which require commissioner approval under the *Valuation Manual* shall be reported as a change in valuation basis.

**SSAP No. 54R—Individual and Group Accident and Health Contracts:**

**Change In Valuation Basis**

22. A change in valuation basis shall be defined as a change in the interest rate, mortality and morbidity assumptions, or reserving method (e.g., net level, preliminary term, etc.) or other factors affecting the reserve computation of policies in force and meets the definition of an accounting change as defined in SSAP No. 3—*Accounting Changes and Corrections of Errors* (SSAP No. 3). Changing morbidity assumptions regarding the length of claim continuance based on regularly updated credible experience as required for products subject to Actuarial Guideline XLVII—The Application of Company Experience in the Calculation of Claim Reserves Under the 2012 Group Long-Term Disability Valuation Table (AG 47) and
Actuarial Guideline L—2013 Individual Disability Income Valuation Table (AG 50) are not considered a change in valuation basis. Other uses of regularly updated credible experience required to be used for morbidity assumptions by Appendix A-010 regarding continuing claim payments are generally not considered a change in valuation basis. Voluntary decisions to choose one allowable reserving methodology over another, which require commissioner approval under the *Valuation Manual* shall be reported as a change in valuation basis. Consistent with SSAP No. 3, any increase (strengthening) or decrease (destrengthening) in actuarial reserves resulting from such a change in valuation basis shall be recorded directly to surplus (under changes to surplus in the change in valuation basis annual statement line for life, accident and health, and health reporting entities) rather than as a part of the reserve change recognized in the summary of operations. The impact on surplus is based on the difference between the reserve under the old and new methods as of the beginning of the year. Some changes will meet the definition of a change in accounting as defined in SSAP No. 3 and a change in valuation basis as described in this paragraph, but the adjustment to surplus will be zero. This can happen when the change in valuation basis is prospective and only applies to new policies and reserves meaning that policies in force for the prior year-end are not affected, or situations in which the change in reserving methodology did not change the reserves reported in the financial statements. The changes remain subject to the disclosures prescribed in SSAP No. 3. This difference shall not be graded in over time unless this statement prescribes a new method and a specific transition that allows for grading.

**Staff Review Completed by:**
Robin Marcotte - NAIC Staff
February 2020

**Status:**
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to *SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts* and *SSAP No. 54R—Individual and Group Accident and Health Contracts*, as illustrated above, to note that voluntary decisions to choose one allowable reserving methodology over another, which requires commissioner approval under the *Valuation Manual*, shall be reported as a change in valuation basis. A notification of this exposure will be sent to the Life Actuarial (A) Task Force. This item has a comment period deadline ending May 29, 2020.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, nonsubstantive revisions to *SSAP No. 51R—Life Contracts, SSAP No. 52—Deposit-Type Contracts* and *SSAP No. 54R—Individual and Group Accident and Health Contracts*, as illustrated above, to specify that voluntary decisions to choose one allowable reserving methodology over another, which require commissioner approval under the *Valuation Manual*, shall be reported and disclosed as a change in valuation basis. This revision is effective immediately.
Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A

Issue: Repeal of Affordable Care Act Section 9010 Assessment

Check (applicable entity):
- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

P/C Life Health

Description of Issue:
SSAP No. 106—Affordable Care Act Section 9010 Assessment addresses the Affordable Care Act (ACA) Section 9010 assessment for entities that issue health insurance. This assessment was effective for calendar years beginning on January 1, 2014. This assessment is also known as the health insurer’s tax (HIT).

The Section 9010 assessment has had more than one moratorium, as addressed in INT 18-02: ACA Section 9010 Assessment Moratoriums. The following is a history of years in which the assessment was in effect and payable:

- 2014 – Paid
- 2015 – Paid
- 2016 – Paid
- 2017 – NOT Paid - Moratorium
- 2018 – Paid
- 2019 – NOT Paid - Moratorium
- 2020 – To Be Paid
- 2021 – Repealed

The assessment is required to be paid for calendar year 2020. In December 2019, the House of Representatives and Senate passed year-end spending bills which repealed the Section 9010 assessment for calendar years beginning January 1, 2021. This bill was subsequently signed into law. This agenda item addresses the impacts of the repeal for calendar years beginning on January 1, 2021 by recommending the following actions:

- Superseding SSAP No. 106—Affordable Care Act Section 9010 Assessment
- Nullifying INT 18-02: ACA Section 9010 Assessment Moratoriums

Existing Authoritative Literature:

- SSAP No. 106—Affordable Care Act Section 9010 Assessment
- INT 18-02: ACA Section 9010 Assessment Moratoriums

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Although prior one-year moratoriums have been discussed by the Working Group, this is the first discussion of a repeal.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Staff Recommendation:
NAIC Staff recommends that the Working Group move this item to the active listing, categorized as substantive and expose the intent to supersede SSAP No. 106—Affordable Care Act Section 9010 Assessment and nullify INT 18-02: ACA Section 9010 Assessment Moratoriums. Both actions are proposed to be effective January 1, 2021. With these actions, both SSAP No. 106 and INT 18-02 would be moved to Appendix H - Superseded Statements of Statutory Accounting Principles and Nullified Interpretations for the 2021 publication of the NAIC Accounting Practices and Procedures Manual.

With these actions, NAIC staff should also be directed to coordinate the related impacts with the following NAIC Groups:

1. Blanks (E) Working Group – Ensure the annual statement disclosures related to SSAP No. 106 currently reported in Note 22 are removed from the annual statement instructions and annual statement blank beginning in reporting years 2021.


Staff Review Completed by:
Robin Marcotte - NAIC Staff
February 2020

Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the intent to supersede SSAP No. 106—Affordable Care Act Section 9010 Assessment and nullify INT 18-02: ACA Section 9010 Assessment Moratoriums which would move both SSAP No. 106 and INT 18-02 to Appendix H—Superseded Statements of Statutory Accounting Principles and Nullified Interpretations, effective Jan. 1, 2021. This item has a comment period deadline ending May 29, 2020.

Referrals will be sent to the Blanks (E) Working Group, to ensure the annual statement disclosures related to SSAP No. 106 in Note 22 are removed from the annual statement instructions and annual statement blank beginning in reporting year 2021, and to the Health Risk Based Capital (E) Working Group for RBC implications related to the 2021 removal of the federal ACA adjustment sensitivity test which uses data from the SSAP No. 106 disclosures.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, substantive revisions to supersede SSAP No. 106—Affordable Care Act Section 9010 Assessment and to nullify INT 18-02: ACA Section 9010 Assessment Moratoriums. This action will move this guidance to Appendix H—Superseded SSAPs and Nullified INTs of the Accounting Practices and Procedures Manual. A proposal will be sent to the Blanks (E) Working Group to incorporate reporting changes for 2021 reporting. NAIC staff will also draft additional instructions on how to complete the disclosure for year-end 2020 as there will not be an ACA fee assessment in 2021. This instruction will be posted as additional narrative guidance on the Blanks (E) Working Group webpage.
**Statutory Accounting Principles (E) Working Group**
**Maintenance Agenda Submission Form**
**Form A**

**Issue: Health Industry Request on 2020 Health Insurance Assessment**

**Check (applicable entity):**

- [ ] Modification of Existing SSAP
- [ ] New Issue or SSAP
- [X] Interpretation

**Description of Issue:**
This agenda item addresses an April 2020 request from America’s Health Insurance Plans (AHIP) to the Statutory Accounting Principles (E) Working Group regarding SSAP No. 106—Affordable Care Act Section 9010 Assessment. The ACA Section 9010 fee is also known as the health insurance tax (HIT). The payable amount is based on the volume of premium from 2019, and becomes due once the reporting entity provides health insurance in January 2020. Under SSAP No. 106, the amount payable which is based on prior year premium is disclosed in special surplus during the “data year” and reported as a liability during the “fee year.” The year 2020 is a fee year and the assessment based on 2019 premium is due to the U.S. Treasury in September 2020.

A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities have issued “stay home” orders and forced all non-essential businesses to temporarily close. This has led to a significant increase in unemployment and, in certain states, mandatory closure of many businesses. NAIC staff agrees that the COVID-19 crisis is placing stress on the insurance industry and is supportive of some temporary relaxation of conservatism in statutory accounting such as the proposed relaxation of the 90-day rule as currently exposed interpretation related to COVID-19, such as: INT 20-02T: Extension of Ninety-Day Rule for the Impact of COVID-19.

The SSAP No. 106 request is noted as temporary surplus relief, which was requested in conjunction with many concessions that health plans are being asked to make due to the anticipated impacts on operations and surplus. The AHIP request notes that, “For some members, the HIT liability to be reported as a liability and expense in the first quarterly interim reports is estimated to be 10% of group-wide surplus.”

The key accounting changes requested in the AHIP letter are as follows:

- Amend SSAP No. 106 to permit insurers to accrue the tax liability on a monthly or quarterly basis. However, to the extent that health plans have recognized in 2019 earned premium amounts attributable to inclusion of the HIT in determining premium rates, that amount will be accrued as a liability and a corresponding expense at the beginning of 2020; the difference between that amount and the total estimated HIT to be paid in 2020 would then be accrued on a monthly or quarterly basis through September 2020.
- For first and second quarterly interim reporting in 2020, the portion of the estimated tax that has not yet been accrued will remain in special surplus to clearly document its designated purpose.
- Because the full amount of the HIT will be accrued when paid in September 2020, there will be no impact on year-end 2020 reporting or RBC filings.
NAIC staff notes that the Section 9010 fee due in September 2020 meets the definition of a liability under SSAP No.5R—Liabilities, Contingencies and Impairments of Assets for the full amount on January 1, 2020. It is a present duty payable in September 2020; there is no discretion to avoid payment, and the obligating events (providing health insurance in 2020 and writing premium in 2019) have already occurred.

Existing Authoritative Literature:

- **SSAP No. 5 – Revised—Liabilities, Contingencies and Impairments of Assets**

  2. A liability has three essential characteristics: (a) it embodies a present duty or responsibility to one or more other entities that entails settlement by probable\(^1\) future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, (b) the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (c) the transaction or other event obligating the entity has already happened. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity's financial statements when incurred.

\(^1\) FASB Statement of Financial Accounting Concepts No. 6, Elements of Financial Statements, states: Probable is used with its usual general meaning, rather than in a specific accounting or technical sense (such as that in FASB Statement 5, Accounting for Contingencies, paragraph 3), and refers to that which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.

- **SSAP No. 106—Affordable Care Act Section 9010 Assessment**

Determining timing of the recognition of the Section 9010 liability was a matter of extensive debate at the Statutory Accounting Principles (E) Working Group. This issue was initially discussed in November 2011 through June 2014 when SSAP No. 106 was adopted. As noted in Issue Paper No. 148—Affordable Care Act Section 9010 Assessment, this topic was discussed at the Statutory Accounting Principles (E) Working Group with input from the Financial Condition (E) Committee. In addition, the Health Insurance and Managed Care (B) Committee and the Accounting Practices and Procedures (E) Task Force were invited to participate in a number of the discussions via conference call.

The issue debated was whether to recognize the amount payable in the data year, which is the year the premium volume used to calculate the assessment payable is written, or in the fee year when the assessment is paid. Because this amount seemed to function similar to premium tax which is accrued when the premium is written, one side was supportive of accruing the liability in the data year. However, because of how the law was written, in that it applied to health insurers’ data year premium but was due from issuers that provided subject health business in the fee year, the other side believed the liability should be recognized in the fee year.

SSAP No. 106 ultimately delayed full recognition of the expense and liability until the Jan. 1 of the fee year, with the additional transparency of having the amount reflected in special surplus during the data year. In addition, the impact on risk-based capital as of January 1 of the fee year was disclosed in the data year financial statements. This following excerpt from SSAP No. 106 was part of an extensive compromise process.

**Affordable Care Act Section 9010 Assessment**

3. The Affordable Care Act (ACA) imposes an assessment on entities that issue health insurance for each calendar year beginning on or after January 1, 2014. Pursuant to Section 9010 of the ACA, a reporting entity’s portion of the assessment is paid no later than September 30 of the applicable calendar year (the fee year) beginning in 2014 and is not tax deductible. The amount of the assessment for the reporting entity is based on the ratio of the amount of an entity’s subject net health premiums written for any U.S. health
risk during the preceding calendar year (data year) to the aggregate amount of subject net health premiums written by all subject U.S. health insurance providers during the preceding calendar year. The ACA includes some significant exclusions regarding which entities are required to pay the assessment. The guidance in this statement applies to all reporting entities that are subject to the fee. The guidance in this statement applies to the unique facts and circumstances in the ACA; accordingly, an entity should apply judgment when evaluating the facts and circumstances of other assessments arrangements before analogizing the guidance for Section 9010 of the ACA.

4. Throughout this discussion of the Section 9010 assessment of the ACA, the following terms apply:
   a. The term “data year” means the calendar year immediately before the fee year. For example, 2014 is the data year for fee year 2015.
   b. The term “fee year” means the calendar year in which the assessment must be paid to the U.S. Treasury.

5. A reporting entity’s portion of the annual assessment becomes payable to the U.S. Treasury once the reporting entity provides health insurance (in the fee year) for any subject U.S. health risk for each calendar year beginning on or after January 1, 2014.

6. The liability related to the Section 9010 ACA assessment shall be estimated and recorded in full once the entity provides qualifying health insurance (typically January 1) in the applicable calendar year in which the assessment is paid (fee year) with a corresponding entry to expense. The Section 9010 ACA assessment shall be recognized in full on January 1 of the fee year, in the operating expense category of Taxes, Licenses and Fees (INT 18-02)

7. Liability recognition of the Section 9010 fee is not required in the data year. In the data year, the reporting entity is required to reclassify from unassigned surplus to special surplus an amount equal to its estimated subsequent fee year assessment. This segregation in special surplus is accrued monthly throughout the data year. The reclassification from unassigned surplus to special surplus does not reduce total surplus. On January 1 of the fee year, the prior year segregation in special surplus is reversed and the full current fee year assessment liability shall be accrued.

8. The Section 9010 ACA annual assessment does not represent a cost related to the acquisition of policies that is consistent with the definition of acquisition costs in SSAP No. 71—Policy Acquisition Costs and Commissions.

Disclosures

9. For the Section 9010 ACA assessment:
   a. For the annual reporting period ending December 31, 2013, and thereafter, a reporting entity subject to the assessment under section 9010 of the Affordable Care Act, shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided under SSAP No. 9—Subsequent Events (SSAP No. 9) for a Type II subsequent event. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its risk-based capital position as if it had occurred on the balance sheet date. In accordance with SSAP No. 9, paragraph 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment.
   b. Additionally, for annual reporting periods ending on or after December 31, 2014, the disclosure in paragraph 9.a. is expanded to include information on the amounts reflected in special surplus in the data year.
The reporting entity shall disclose the amount of premium written for the current year that is the basis for the determination of the section 9010 fee assessment to be paid in the subsequent year (net assessable premium). Prior year amounts shall also be included for comparative purposes;

Reporting entities shall provide information regarding the nature of the assessment, the estimated amount of the assessment payable in the upcoming year (current and prior year) and the amount of assessment paid (current and prior year), and;

The disclosure shall also provide the Total Adjusted Capital (before and after adjustment as reported in its estimate of special surplus applicable to the 9010 fee) and Authorized Control Level (in dollars) to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The disclosure shall also provide a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

The Section 9010 fee was repealed effective January 1, 2021. The Working Group currently has agenda item 2020-05: Repeal of Affordable Care Act Section 9010 Assessment exposed for comment, which would nullify SSAP No. 106 effective January 1, 2021.


Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Review Completed by:
Robin Marcotte - NAIC Staff
April 7, 2020

Staff Recommendation:
AHIP requests an amendment to SSAP No. 106—Affordable Care Act Section 9010 Assessment to delay liability recognition of the Section 9010 fee payable in September 2020. The request would remove the requirement to recognize the full amount of liability on January 1, 2020 and instead recognize amounts not previously collected as a liability monthly or quarterly over 2020. NAIC staff has been proactive in drafting responses to requests to allow temporary relaxation of the statutory accounting conservative rules in response to COVID-19 including INT 20-02: Extension of Ninety-Day Rule for the Impact of COVID-19. However, NAIC staff is concerned with the material distortions to the financial statements that could occur by delaying liability recognition.

NAIC staff recommends that the Working Group reject the AHIP request to modify SSAP No. 106 for all reporting entities and move this item to the rejected listing for the following reasons:

1. The 2020 Section 9010 fee / HIT meets the definition of a liability requiring full recognition under SSAP No. 5R on January 1, 2020. It is a present duty payable in September 2020, there is no discretion to avoid
payment, and the obligating events (writing premium in 2019 and providing health insurance in 2020) have already occurred. In addition, the amount can be reasonably estimated.

2. It would, therefore, be distorting to the financial statements to not recognize a liability. In the comment letter provided, it was noted that for one group the Section 9010 fee payable represents over 10% of surplus. In this instance, it would be materially distorting to the financial statements to not recognize the liability.

3. The 2020 Section 9010 fee payable amount was also disclosed in the notes at year end 2019 along with the impact on surplus and risk-based capital (RBC). So, it is a known and previously disclosed amount.

4. Recording a monthly amount is inconsistent with the cash flows. Almost all of this assessment should have been collected in 2019 as it was included in the 2019 health rates. The vast majority of the obligation would have been collected as part of 2019 premium and even if there was a delay, amounts related to 2019 should have been collected prior to the declaration of emergency.

As noted above, this request has the potential to materially distort the financial statements, as a known liability would not be fully recognized. In times of financial stress, it is important to be able to accurately assess the financial solvency of reporting entities. With the potential impact of the financial statements, any consideration for such a request warrants domiciliary state regulator review. Any state specific considerations would be either permitted practices (individual requests) or prescribed practices (state bulletins, etc.). If granted by the domestic state, such practices would be disclosed in the financial statements.

Status:

On April 17, 2020, the Statutory Accounting Principles (E) Working Group conducted an e-vote to expose this agenda item for a one-week comment period ending on April 24, 2020. The exposed recommendation is to reject the request to defer liability recognition of the federal ACA fee due in September 2020 and move the agenda item to the rejected listing. The exposure would not result in any statutory accounting revisions.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group rejected this agenda item without statutory revisions.
Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual*, such as editorial corrections, reference changes and formatting.

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<thead>
<tr>
<th>SSAP/Appendix</th>
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<tr>
<td>SSAP No. 2R</td>
<td>1) Paragraph 9: Update reporting line instructions for qualified cash pools.</td>
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<td>2) Paragraph 14: Correct verbiage and sentence structure for ease of readability.</td>
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**Recommendation:**
NAIC staff recommends that the Statutory Accounting Principles (E) Working Group move this agenda item to the active listing, categorized as nonsubstantive, and expose editorial revisions, as illustrated below.

**SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments**

Staff Note: A separate agenda item is being proposed to clarify that “disclosure” of cash equivalents that remain on schedule E2 for more than one consecutive reporting period. This item will also clarify that this disclosure is satisfied by a code on the investment schedule. (These revisions are in line with comments received during the May 20 conference call but go beyond editorial revisions.)

9. Cash pooling is a technique utilized by some companies under common control by which several entities’ cash accounts are aggregated for numerous purposes, including liquidity management, optimizing interest or investment returns and reducing investment or banking transaction fees. Cash pools can have numerous functions and structures; however, only those that have obtained domiciliary regulator approval and meet the following requirements are in scope of this statement.

   a. Members or participants in the pool are limited to affiliated entities as defined in SSAP No. 25—*Affiliates and Other Related Parties*.

   b. Investments held by the pool are limited to non-affiliated entities investments (non-affiliated to the insurance reporting entity).

   c. The pool must permit each participant to withdraw, at any time, cash up to the amount it has contributed to the pool. Each participant must own an undivided interest in the underlying assets of the pool in proportion to the aggregate amount of cash contributed. All affiliates’ interests in the pool shall be of the same class, with equal rights, preferences, and privileges. All membership interests shall be fully paid and non-assessable and shall have no preemptive, conversion or exchange rights. The liability of a participant’s debts and obligations of the pool shall be limited to the amount of its contributions and no participant shall be obligated to contribute money to the pool for any reason other than to participate in the pool’s investments. Additionally, participants shall not cover the debits or credits of another participant (commonly referred to as notional cash pooling).

   d. A reporting entity shall receive monthly reports from the pool manager, which identifies the participant’ investment (share) in the cash pool and the dollar value of its share of cash, cash equivalents and short-term investments. The reporting entity shall report their total balances in the cash pool on Schedule E – Part 2, utilizing the line number [as specified in the Annual Statement](#).
**Instructions for “Other Cash Equivalents.”** The reporting entity shall independently if the investments would have qualified as cash, cash equivalents or short-term investments had the entity independently acquired the investments. To the extent the pool holds investments that do not meet the definition of cash, cash equivalents, short-term investments, the pool does not qualify within scope of this statement.

14. Short-term investments are investments that do not qualify as cash equivalents with remaining maturities (or repurchase dates under reverse repurchase agreements) of one year or less at the time of acquisition, (excluding derivatives and those investments classified as cash equivalents as defined in this statement), shall be considered short-term investments. Short-term investments can include, but are not limited to, bonds, commercial paper, reverse repurchase agreements, and collateral and mortgage loans, which meet the noted criteria. Short-term investments shall not include investments specifically classified as cash equivalents as defined in this statement, certificates of deposit, or derivatives. Regardless of maturity date, derivative instruments shall not be reported as short-term investments and shall be reported as derivatives on Schedule DB.

**Status:**
On June 15, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed the editorial maintenance revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments as detailed above. This item has a shortened comment period deadline ending July 15, 2020.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, editorial revisions to SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments, as illustrated above.
Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A

Issue: SSAP No. 32 – Investment Classification Project

Check (applicable entity):

<table>
<thead>
<tr>
<th>Modification of existing SSAP</th>
<th>P/C</th>
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<tr>
<td>New Issue or SSAP</td>
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Description of Issue: This agenda item has been drafted to consider SSAP No. 32—Preferred Stock, in accordance with the initiatives of the Investment Classification Project. This agenda item focuses on the following aspects:

1. Review existing definitions with market terms and assess whether terms should be retained or revised.
2. Consider clarifications to existing accounting and valuation guidance based on the type of preferred stock.
3. Assess guidance for dividends and the impact of dividends on impairment assessments.
4. Clarify application of SSAP No. 32 in conjunction with SSAP No. 48 and SSAP No. 97.

I – Definitions

SSAP No. 32 establishes statutory accounting principles for preferred stocks and includes preferred stocks that may or may not be publicly traded.

Preferred Stock:

SSAP No. 32, paragraph 3: Any class or shares of the holders of which have any preference, either as to the payment of dividends or distribution of assets on liquidation, over the holder of common stock issued by an entity.

FASB Definition: A security that has preferential rights compared to common stock.

NASDAQ Definition: A security that shows ownership in a corporation and gives the holder a claim, prior to the claim of common stockholders, on earnings and also generally on assets in the event of liquidation. Most preferred stock pays a fixed dividend that is paid prior to the common stock dividend, stated in a dollar amount or as a percentage of par value. This stock does not usually carry voting rights. Preferred stock has characteristics of both common stock and debt.

The scope of SSAP No. 32, paragraph 3, identifies that the definition of preferred stock includes:

a. Redeemable preferred stock, including mandatory sinking fund preferred stock and preferred stock redeemable by the holder;

b. Perpetual preferred stock, including nonredeemable preferred stock and preferred stock redeemable at the option of the issuer; and

c. Exchange traded funds, which qualify for preferred stock treatment, as identified in Part Six, Section 2, of the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

SSAP No. 32 then includes definitions for redeemable preferred stock, perpetual preferred stock, mandatory sinking fund preferred stock, payment-in-kind preferred stock, step-up preferred stock and restricted stock.
Redeemable Preferred Stock:

**SSAP No. 32, paragraph 4:** Preferred Stock that must be redeemed by the issuing enterprise or is redeemable at the option of the reporting entity. It includes mandatory sinking fund preferred stock and payment-in-kind (PIK) preferred stock.

**FASB ASC 480-10-S99 - (This guidance comes from SEC CFRR 211: Redeemable Preferred Stock):** Preferred Stock Subject to Mandatory Redemption Requirements or Whose Redemption is Outside the Control of the Issuer (“Redeemable Preferred Stock”). The term means any stock which (i) the issuer undertakes to redeem at a fixed or determinable price on the fixed or determinable date or dates, whether by operation of a sinking fund or otherwise; (ii) is redeemable at the option of the holders, or (iii) has conditions for redemption which are not solely within the control of the issuer, such as stocks which must be redeemed out of future earnings. Under this definition, preferred stock which meet one or more of the above criteria would be classified as redeemable preferred stock regardless of their other attributes such as voting rights, dividend rights or conversion features.

Perpetual Preferred Stock:

**SSAP No. 32, paragraph 7:** Perpetual preferred stock is defined as preferred stock with no redemption or sinking fund features or preferred stock redeemable at the option of the issuer.

**FASB ASC 480-10-S99 - (This guidance comes from SEC CFRR 211: Redeemable Preferred Stock):** Preferred Stocks Which Are Not Redeemable or Are Redeemable Solely at the Option of the Issuer (“Non-Redeemable Preferred Stock”). The term means any preferred stock which does not meet the criteria for classification as a "redeemable preferred stock."

**NAIC Staff Notes:**
From a review of preferred stock issuances, preferred stock may be labeled “redeemable perpetual preferred stock.” Generally, in these instances, it seems that the preferred stock is redeemable at the option of the issuer, perhaps after a certain timeframe, or when other conditions as stated in the prospectus are met. If the redemption is at the option of the issuer, these preferred stock issuances would be considered perpetual preferred stock. However, it does appear that in some instances, these issuances may be redeemable at the option of the holder after a certain timeframe. If the redemption is at the option of the holder, then it would be considered redeemable preferred stock. (Note – NAIC staff would like confirmation that preferred stock labeled as “redeemable perpetual” may meet the criteria as redeemable under FASB ASC 480-10-S99.)

Excerpts detailing a few identified instances are noted below:

**Prospectus excerpt:** We may offer and sell under this prospectus shares of our 9.375% Series A Cumulative Redeemable Perpetual Preferred Stock, $0.001 par value per share (the “Series A Preferred Stock”) having an aggregate offering price of up to $26,000,000 from time to time through the Agents. Our Series A Preferred Stock is traded on The Nasdaq Capital Market, or the Exchange, under the symbol “FBIOP.” The last reported sale price of our Series A Preferred Stock on April 4, 2018 was $22.89 per share. Dividends on our Series A Preferred Stock accrue daily and will be cumulative from, and including, the date of original issue and shall be payable quarterly every March 31, June 30, September 30, and December 31, at the rate of 9.375% per annum of its liquidation preference, which is equivalent to $2.34375 per annum per share. Generally, we may not redeem the Series A Preferred Stock until December 15, 2022. On and after December 15, 2022, we may, at our option, redeem the Series A Preferred Stock in whole, at any time, or in part, from time to time, for cash at a redemption price of $25.00 per share, plus any accrued and unpaid dividends to, but not including, the date of redemption.

(As redemption is at the option of the issuer, the above example reflects perpetual preferred stock.)
Prospectus excerpt: We are offering 204,000 shares of our 11% Series A Cumulative Redeemable Perpetual Preferred Stock, which we refer to as the Series A Preferred Stock. Dividends on the Series A Preferred Stock are cumulative from the date of original issue and will be payable on the fifteenth day of each calendar month commencing December, 2015 when, as and if declared by our board of directors. Dividends will be payable out of amounts legally available therefor at a rate equal to 11% per annum per $25.00 of stated liquidation preference per share, or $2.75 per share of Series A Preferred Stock per year. We will place proceeds equal to two years of dividends into a separate bank account to be used to pay Series A Preferred Stock dividends, however, after the first quarter in which our Adjusted EBIT DA is greater than the quarterly dividend, the proceeds then remaining in this account may be used for any corporate purpose. Commencing on November 4, 2020, we may redeem, at our option, the Series A Preferred Stock, in whole or in part, at a cash redemption price of $25.00 per share, plus all accrued and unpaid dividends to, but not including, the redemption date. The Series A Preferred Stock has no stated maturity, will not be subject to any sinking fund or other mandatory redemption, and will not be convertible into or exchangeable for any of our other securities. Holders of the Series A Preferred Stock generally will have no voting rights except for limited voting rights if dividends payable on the outstanding Series A Preferred Stock are in arrears for eighteen or more consecutive or non-consecutive monthly dividend periods.

(As redemption is at the option of the issuer, the above example reflects perpetual preferred stock.)

Prospectus excerpt: We are selling shares of our % Series B Cumulative Redeemable Perpetual Preferred Shares, par value $0.01 per share, liquidation preference $25.00 per share (the “Series B Preferred Shares”). Dividends on the Series B Preferred Shares will accrue and be cumulative from the date of original issue and will be payable quarterly in arrears on January 30, April 30, July 30 and October 30 of each year, commencing July 30, 2013, when, as and if declared by our board of directors. Dividends will be payable out of amounts legally available therefor at an initial rate equal to % per annum of the stated liquidation preference, subject to adjustment as described in this prospectus supplement. At any time on or after July 30, 2016, the Series B Preferred Shares may be redeemed, in whole or in part, out of amounts legally available therefor, at a redemption price of $25.00 per share plus an amount equal to all accumulated and unpaid dividends thereon to the date of redemption, whether or not declared. If (i) we fail to comply with certain covenants (a “Covenant Default”), (ii) we experience certain defaults under any of our credit facilities (a “Cross Default”), (iii) four quarterly dividends payable on the Series B Preferred Shares are in arrears (a “Dividend Payment Default”) or (iv) the Series B Preferred Shares are not redeemed in whole by July 30, 2018 (a “Failure to Redeem”), the dividend rate payable on the Series B Preferred Shares shall increase, subject to an aggregate maximum rate per annum of 25% prior to July 30, 2016 and 30% thereafter, to a rate that is 1.25 times the dividend rate payable on the Series B Preferred Shares as of the close of business on the day immediately preceding the Covenant Default, Cross Default, Dividend Payment Default or Failure to Redeem, as applicable, and on each subsequent Dividend Payment Date, the dividend rate payable shall increase to a rate that is 1.25 times the dividend rate payable on the Series B Preferred Shares as in effect as of the close of business on the day immediately preceding such Dividend Payment Date, until the Covenant Default, Cross Default or Dividend Payment Default is cured or the Series B Preferred Shares are no longer outstanding.

(As redemption is at the option of the holder, the above example reflects redeemable preferred stock.)

**Mandatory Sinking Fund:**

SSAP No. 32, paragraph 5: Mandatory sinking fund preferred stock is defined as redeemable preferred stock subject to a 100% mandatory sinking fund, annual installments of which will (a) commence not more than 10 years from the date of issue or December 31, 1978, if outstanding on that date; (b) be not less than 2% of the number of shares issued (or outstanding on December 31, 1978, if issued prior to that date); (c) provide for the redemption of the entire issue over a period not longer than 40 years from the date of issue, or December 31, 1978, if outstanding on that date. Redeemable preferred stock which is subject to a 100% mandatory sinking fund, but which does not, at date of issue or December 31, 1978, if outstanding at that...
time, meet one or more of the other requirements above, shall be considered as mandatory sinking fund preferred stock at the time the deficiency is cured through the passage of time or otherwise.

(NAIC staff highlights that the reference to 1978 in this paragraph is no longer applicable as all preferred stock outstanding as of that date would have had a maximum (40-year) redemption date in 2018. In reviewing the origin of this guidance, it was identified that it has been in place since original issuance of SSAP No. 32 and it came from the Purposes and Procedures Manual of the NAIC SVO. This guidance is no longer included in the P&P Manual.)

NASDAQ Definition “Sinking Fund”: A fund to which money is added on a regular basis that is used to ensure investor confidence that promised payments will be made and that is used to redeem debt securities or preferred stock issues.

U.S. GAAP Glossary – Mandatorily Redeemable Financial Instrument: Any of various financial instruments issued in the form of shares that embody an unconditional obligation requiring the issuer to redeem the instrument by transferring its assets at a specified or determinable date (or dates) or upon an event that is certain to occur.

NAIC Staff Notes:
NAIC staff is under the impression that the term “mandatory sinking fund preferred stock” is no longer prevalent. Rather, redeemable preferred stock with a mandatory redemption date is often referred to as “term preferred stock.” Although preferred stock may stipulate use of a sinking fund to provide assurance that preferred stock may be redeemed when due, failing to make deposits into a sinking fund as agreed by the company in the preferred stock’s provisions is not similar to an act of default on debt. Rather, such action would be subject to remedies specified in the preferred stock prospectus.

Even if preferred stock is considered to be “mandatory redeemable,” Section 160 of the Delaware General Corporation Law prohibits a corporation from redeeming its shares of capital stock when the capital of the corporation is impaired or when such redemption would cause any impairment of the capital. Under findings under this Law, it has been noted that the existence of a mandatory redemption right, even one that is ripened, does not convert the holder of preferred stock into a creditor. Specifically, a redemption right does not give the holder the absolute, unfettered ability to force the corporation to redeem its shares under any circumstances and recent case law establishes limitations on the ability of preferred stockholders to force redemption. It should be noted that preferred stock provides no guaranteed right of payment, and its redemption obligation is treated neither as debt nor as a current liability.

Under U.S. GAAP, issuers of “mandatorily redeemable financial instruments” may report the issuance as liability or as equity, depending on type of issuer. Public entities and SEC registrants are required to report mandatorily redeemable financial instruments as liabilities unless the redemption is required to occur only upon the liquidation or termination of the reporting entity (ASC 480-10-25-4). However, the guidance in ASC 480-10: Distinguishing Liabilities from Equities does not apply to instruments that are a) issued by nonpublic entities that are not SEC registrants and b) mandatorily redeemable, but not on fixed dates or not for amounts that either are fixed or are determined by reference to an interest rate index, currency index or another index (ASC 480-10-15-7A).

Payment-In-Kind (PIK) Preferred Stock:

SSAP No. 32, paragraph 6: PIK preferred stock is defined as redeemable preferred stock on which, at the option of the issuer, dividends can be paid in additional securities rather than cash.
General “in-kind” Definition: Payment-in-kind (PIK) is the use of a good or service as payment instead of cash. Payment in kind also refers to a financial instrument that pays interest or dividends to investors of bonds, notes or preferred stock with additional securities or equity instead of cash.

**NAIC Staff Notes:**

PIK stock dividends are not limited to redeemable preferred stock. Additionally, PIK provisions may not require PIK dividends to be provided in additional shares of the same preferred stock. Rather, the provisions of the preferred stock could specify that the PIK dividends are issued in other forms of preferred stock or in shares of common stock. Additionally, the preferred stock provisions can be designed to specify PIK dividends for a specific number of years, with subsequent conversion of cash dividends.

*(The existing SSAP No. 32 guidance for PIK preferred stock has been in place since original issuance of SSAP No. 32. Pursuant to Issue Paper No. 32, this information came from the “NAIC Technical Resource group Proposed Draft Life Codification.”)*

**Example Prospectus Excerpt 1:** Dividends on our perpetually convertible preferred stock will be payable on a cumulative basis when, as and if declared by our board of directors or an authorized committee of our board of directors, at an annual rate of 6.75% on the liquidation preference of $1,000 per share. We may pay declared dividends in cash or, subject to certain limitations, in shares of our common stock, par value $0.01 per share, or in any combination of cash and common stock on March 1, June 1, September 1 and December 1 of each year, commencing on December 1, 2015. Our perpetual convertible preferred stock has no maturity date, and we are not required to redeem our perpetual convertible preferred stock at any time. Accordingly, our perpetual convertible preferred stock will remain outstanding indefinitely unless a holder of shares of our perpetual convertible preferred stock converts it or we decide to convert or repurchase it as described herein.

**Example Prospectus Excerpt 2:** Each dividend shall be paid either in shares of Common Stock (“Payment-in-Kind”) or in cash, at the option of the Corporation on the respective Dividend Date; provided, however, that dividends may only be paid in cash following the fiscal year in which the Corporation has net income (as shown in its audited financial statements contained in its Annual Report on Form 10-K for such year) of at least $500,000, to the extent permitted under applicable law out of funds legally available therefor. For Payment-in-Kind dividends, each Holder on the record date for such divided will receive that number of shares of Common Stock equal to (i) the amount of the dividend payment due such stockholder divided by (ii) 90% of the average of the Per Share Market Values during the twenty (20) Trading Days immediately preceding a Dividend Date. No fractional shares shall be issued upon payment of such dividends pursuant to this Section 3.2 and the number of shares to be issued upon payment of such dividends will be rounded up to the nearest whole share; provided, that, in lieu of rounding up to the nearest whole share, the Corporation may, at its option, pay a cash adjustment in respect of such fractional interest equal to such fractional interest multiplied by the Per Share Market Value on the respective dividend date. Each dividend paid in cash shall be mailed to the Holders of record of the Corporation as their names appear on the share register of the Corporation or at the office of the Corporation’s transfer agent on the corresponding dividend payment date. Holders will receive written notification from the Corporation or the transfer agent if a dividend is paid in Common Stock, which notification will specify the number of shares of Common Stock paid as a dividend. Certificates representing the shares of Common Stock issuable upon payment of each Payment-In-Kind shall be delivered to each Holder entitled to receive such Payment-in-Kind (in appropriate denominations) as soon as reasonably practicable.

**Step-Up Preferred Stock:**

SSAP No. 32, paragraph 17: Step-up preferred stock (a security with the structure of a preferred stock, that has the cash flow characteristics of a debt instrument) is considered a security with characteristics of both debt and equity, and the accounting and valuation of such securities shall be consistent with SVO guidelines as stipulated in the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

General – A “step-up” feature is a component that increases over time or with stated provisions. For example, a “step-up divided” if a feature that increases the dividend rate. A “step-up call” is a feature that increases the call price for a security. A “step-up conversion” increases the conversion price in a convertible security. In review, no references were identified that limit “step-up” features to redeemable preferred stock.

The term Step-Up used with an income security means that the dividend or interest distributions will start at a lower level of income and then increase or Step-Up on a specified schedule. For example, a step-up security could start out paying a 5% dividend initially and then Step-Up to a 7% dividend after 5 years (assuming it is not called). The Step-Up or increase in the payout can occur on whatever schedule is specified in the IPO prospectus such as after 3 years, 5 years, 10 years, 15 years, etc. Currently there are only a handful of Step-Up securities on the markets.

Restricted Preferred Stock:

SSAP No. 32, paragraph 8: Restricted preferred stock is defined as a security for which sale is restricted by governmental or contractual requirement (other than in connection with being pledged as collateral) except where that requirement terminates within one year or if the holder has the power by contract or otherwise to cause that requirement to be met within one year. Any portion of the security that can be reasonably expected to qualify for sale within one year is not considered restricted.

NASDAQ Definition – Restricted Stock: Stock that must be traded in compliance with special SEC regulations concerning its purchase and resale. These restrictions generally result from affiliate ownership, M&A activity, and underwriting activity. Many firms are now using restricted stock as a reward for employees. The advantages to restricted stock are: employees get dividends, employees usually get voting rights, and employee gets something even if the stock price drops over the vesting period (whereas an option would be worthless).

SEC Definition – Restricted Securities: "Restricted" securities are securities acquired in an unregistered, private sale from the issuing company or from an affiliate of the issuer. They typically bear a “restrictive” legend clearly stating that you may not resell them in the public marketplace unless the sale is exempt from the SEC’s registration requirements. Rule 144 under the Securities Act of 1933 provides the most commonly used exemption for holders to sell restricted securities. To take advantage of this rule, you must meet several conditions, including a six-month or one-year holding period.

NAIC Staff Notes: The definition of restricted preferred stock in SSAP No. 32 is identical to the definition of common stock in SSAP No. 30. NAIC staff is researching the origin of the SSAP No. 30 and SSAP No. 32 restricted stock definition and request information regarding the source of this definition. (There is limited information in the issue paper and the definition has been in place since adoption.)

Convertible Preferred Stock:

SSAP No. 32: Convertible preferred stock is not currently defined in SSAP No. 32.

NASDAQ: Preferred stock that can be converted into common stock at the option of the holder.

SEC – Convertible Security: A "convertible security" is a security—usually a bond or a preferred stock—that can be converted into a different security—typically shares of the company's common stock. In most cases, the holder of the convertible determines whether and when to convert. In other cases, the company has the right to determine when the conversion occurs.
FASB Glossary – Convertible Security: A security that is convertible into another security based on a conversion rate. For example, convertible preferred stock that is convertible into common stock on a two-for-one basis (two shares of common for each share of preferred).

NAIC Staff Notes:
The terms for converting preferred stock may be optional or mandatory depending on the terms of the issuance. Also, both redeemable and perpetual preferred stock can be issued with convertible features. Although there is no current guidance in SSAP No. 32, the guidance in SSAP No. 26R—Bonds requires specific accounting guidance for mandatory convertible bonds to prevent overstating the value of the investment prior to the mandatory conversion. NAIC staff often receives questions regarding the appropriate valuation for mandatory convertible preferred stock.

Example - Convertible Redeemable Preferred Stock: WHEREAS, subject to the terms and conditions set forth in this Agreement, the Company desires to issue and sell to the Purchaser and the Purchaser desires to acquire from the Company [ ] shares of the Company’s Series A Convertible Redeemable Preferred Stock, (the “Series A Preferred Stock”), with a Stated Value of one dollar ($1) per share, which is part of a sale of Series A Preferred Stock with an aggregate Stated Value of $750,000.

Example - Convertible Perpetual Preferred Stock: RESOLVED, that the Corporation is authorized to issue 14,375,000 shares of 6.50% Series I Cumulative Convertible Perpetual Preferred Stock, $1.00 par value per share, which shall have the following powers, designations, preferences and other special rights:

Statutory Accounting Definition Overview and Assessment
After reviewing the existing SSAP No. 32 definitions to market terms, NAIC staff recommends that the Working Group consider revisions to update SSAP No. 32 accordingly. Consideration should be given as to the extent detailed definitions of various components of preferred stock should be included, particularly if an element would not alter the accounting or reporting of a preferred stock investment. (NAIC staff highlights that other key terms of preferred stock are not currently defined in SSAP No. 32 and only the terms currently defined and/or identified as potential impacting valuation are included in the discussion.)

2 – Clarifications to Existing Accounting and Valuation Guidance
The valuation methods utilized for preferred stock in SSAP No. 32 depends on the type of preferred stock (redeemable or perpetual), type of insurance entity and the NAIC designation. (Although perpetual stock is more akin to equity, the NAIC designation provides a credit assessment on the dividends. For example, guidance in the P&P Manual prohibits assigning an NAIC designation of 1, 2 or 3 to any preferred stock in which dividends have not been paid or sinking fund requirements have not been met.) Pursuant to SSAP No. 32, paragraphs 19-22:

   Reporting Entities that Do Not Maintain an AVR
   • Redeemable with NAIC Designation 1-2: Cost or Amortized Cost
   • Redeemable with NAIC Designations 3-6: Lower of Cost, Amortized Cost or Fair Value
   • Perpetual with NAIC designations 1-2: Fair Value
   • Perpetual with NAIC designations 3-6: Lower of Cost or Fair Value

   Reporting Entities that Do Maintain and AVR
   • Redeemable with NAIC Designation 1-3: Cost or Amortized Cost
   • Redeemable with NAIC Designations 4-6: Lower of Cost, Amortized Cost or Fair Value
   • Perpetual with NAIC designations 1-3: Cost
NAIC staff identifies that the existing guidance in SSAP No. 32 does not differentiate when a reporting entity should utilize “cost” or “amortized cost” in determining the measurement method.

The accounting under U.S. GAAP depends on whether the preferred stock is considered a debt or equity security:

**FASB Glossary - Equity Security (First Definition)**
Any security representing an ownership interest in an entity (for example, common, preferred, or other capital stock) or the right to acquire (for example, warrants, rights, and call options) or dispose of (for example, put options) an ownership interest in an entity at fixed or determinable prices. The term equity security does not include any of the following:

a. Written equity options (because they represent obligations of the writer, not investments)

b. Cash-settled options on equity securities or options on equity-based indexes (because those instruments do not represent ownership interests in an entity)

c. Convertible debt or preferred stock that by its terms either must be redeemed by the issuing entity or is redeemable at the option of the investor.

**FASB Glossary - Equity Security (Second Definition)**
Any security representing an ownership interest in an entity (for example common, preferred or other capital stock) or the right to acquire (for example, warrants, rights, forward purchase contracts, and call options) or dispose of (for example, put options and forward sale contracts) an ownership interest in an entity at fixed or determinable prices. However, the term does not include convertible debt or preferred stock that by its terms either must be redeemed by the issuing entity or is redeemable at the option of the investor.

**ASC 321-10-55-2** - If convertible preferred stock is not redeemable, it is considered an equity security and, therefore, this Topic would apply.

**FASB Glossary - Debt Security**
Any security representing a creditor relationship with an entity. The term debt security also includes all of the following:

(a) Preferred stock that by its terms either must be redeemed by the issuing entity or is redeemable at the option of the investor

**Overview of U.S. GAAP Accounting:**
Under U.S. GAAP (ASC 320-10-35-1), investments in “debt securities” are reported at either fair value or amortized cost. (Debt instruments identified as “held-to-maturity” are reported at amortized cost, and debt instruments classified as “trading” or “available-for-sale” are reported at fair value.) Under U.S. GAAP, use of historical cost for investments is not generally considered an acceptable measurement method.

Under U.S. GAAP (321-10-35-1) investments in “equity securities” are reported at fair value. If an investment does not have a readily determinable fair value, the security may qualify to use net asset value as a practical expedient to fair value (820-10-35-59). If an investment does not have a “readily determinable” fair value, and does not qualify for the net asset value practical expedient, U.S. GAAP (ASC 321-10-35-2) provides guidance for determining the measurement value as follows:

- An entity may elect to measure an equity security at cost minus impairment, plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar instrument of
the same issuer. An election to measure an equity security in accordance with these provisions shall be made for each investment separately. Once an entity elects to measure an equity security in accordance with this guidance, the entity shall continue to apply the measurement guidance until the investment does not qualify to be measured in accordance with this guidance (for example, if the investment has a readily determinable fair value or becomes eligible for the practical expedient to estimate fair value with 820-10-35-59). The entity shall reassess at each reporting period whether the equity investment without a readily determinable fair value qualifies to be measured with this guidance.

The U.S. GAAP fair value definition, as well as the definition for readily determinable fair value and the ability to use net asset value has been adopted for statutory accounting:

**U.S. GAAP Definition - Fair Value** *(Adopted in SSAP No. 100R, paragraph 4.)*: The price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

**U.S. GAAP Definition - Readily Determinable Fair Value** *(Adopted in SSAP No. 100R, paragraph 41)*: An equity security has a readily determinable fair value if it meets any of the following conditions:

a. The fair value of an equity security is readily determinable if sales prices or bid-and-asked quotations are currently available on a securities exchange registered with the U.S. Securities and Exchange Commission (SEC) or in the over-the-counter market, provided that those prices or quotations for the over-the-counter market are publicly reported by the National Association of Securities Dealers Automated Quotations systems or by OTC Markets Group Inc. Restricted stock meets that definition if the restriction terminates within one year.

b. The fair value of an equity security traded only in a foreign market is readily determinable if that foreign market is of a breadth and scope comparable to one of the U.S. markets referred to above.

c. The fair value of an equity security that is an investment in a mutual fund or in a structure similar to a mutual fund (that is, a limited partnership or a venture capital entity) is readily determinable if the fair value per share (unit) is determined and published and is the basis for current transactions.

**U.S. GAAP Guidance permitting NAV** *(Adopted with modification in SSAP No. 101, paragraphs 39-46): Limited Excerpt*; A reporting entity is permitted, as a practical expedient, to estimate the fair value of an investment within the scope of paragraphs 820-10-15-4 through 15-5 using the net asset value per share (or its equivalent, such as member units or an ownership interest in partners’ capital to which a proportionate share of net assets is attributed) of the investment, if the net asset value per share of the investment (or its equivalent) is calculated in a manner consistent with the measurement principles of Topic 946 as of the reporting entity’s measurement date.

**Statutory Accounting Measurement Overview and Assessment**

After reviewing the measurement methods for preferred stock, and comparing those methods to U.S. GAAP, NAIC staff recommends revisions to the permitted measurement methods for preferred stock. NAIC staff recommends eliminating references to “cost” as a measurement option, and clarify use of amortized cost (or the lower of amortized cost and fair value) for redeemable preferred stock and the use of fair value for perpetual preferred stock.

If there are concerns that perpetual preferred stock could not be measured at fair value (either as not readily determinable or with a NAV exception), consideration could be given to incorporate the FASB process that allows “adjusted cost”. However, NAIC staff believes that in most instances, fair value of perpetual preferred stock can be determined pursuant to SSAP No. 100R, even if that determination reflects a level 3 fair value measurement. (Under level 3, the reporting entity determines fair value without observable inputs using their assumptions about the assumptions market participants would use in pricing the asset or liability.)
3 – Assess Dividend Guidance and the Impact of Dividends on Impairment Guidance

Existing guidance in SSAP No. 32, paragraph 27, identifies that dividends, other than mandatorily redeemable preferred stock, shall be recorded as investment income on the ex-dividend date. The guidance in paragraph 28 identifies that mandatorily preferred stock shall be accrued to the redemption price, even if not declared, under the interest method over the period ending on the redemption date. The guidance also identifies that cash dividends paid on payment-in-kind (PIK) dividends shall be accounted for as a reduction in the investment.

Impairment guidance in SSAP No. 32 differentiates between redeemable and perpetual preferred stock. The guidance for redeemable preferred stock is similar to guidance for bonds, in which other-than-temporary impairment (OTTI) is considered to have occurred if a reporting entity will be unable to collect all amounts due according to the contractual terms of the security at the date of acquisition. This determination includes situations when a decision has been made to sell a security below its carrying value. The guidance for perpetual preferred stock is similar to guidance for common stock, with determination of OTTI based on INT 06-07: Definition of Phrase “Other Than Temporary” and if the entity has made a decision to sell a security below its carrying value.

Although NAIC staff believes the guidance for perpetual preferred stock dividends is appropriate, recognizing that dividends for redeemable preferred stock may not trigger an element a default, or a liability from an issuing entity, NAIC staff recommends clarification on the amortization of redeemable preferred dividends, potentially to highlight that failure to receive dividends should result with an OTTI assessment and may impact continued accrual (or admittance) for future dividends.

With regards to guidance on PIK dividends, NAIC staff recommends revisions to address recognition and reporting of differing types of PIK dividends. As noted, stock issuances may provide for either cash or PIK dividends, and it is likely not appropriate to require all cash dividends for these issuances to be recorded as a reduction in the investment. (With these revisions, NAIC staff also recommends similar guidance for PIK interest received.)

4 – Clarify application of SSAP No. 32 conjunction with SSAP No. 48 and SSAP No. 97

The existing guidance in SSAP No. 32 is specific that investments in preferred stock of subsidiaries, controlled or affiliated entities (SCA) are included within scope. However, recent questions received have questioned whether preferred stock held from a SSAP No. 48 entity shall be captured within scope of SSAP No. 32. (A SSAP No. 48 entity may or may not qualify as an SCA.) To eliminate future questions, NAIC staff suggests further clarification that preferred stock held from a SSAP No. 48 entity (joint venture, partnership or limited liability company) is in scope of SSAP No. 32.

Additionally, as the reported value of preferred stock held from an SCA may be impacted by guidance in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities and INT 00-24: EITF 98-12: Accounting by an Equity Method Investor for Investee Losses When the Investor Has Loans to and Investments in Other Securities of the Investee and EITF 99-10: Percentage Used to Determine the Amount of Equity Method Losses, NAIC staff suggests guidance in SSAP No. 32 that explicitly refers to those statutory provisions.

- Under SSAP No. 97, preferred stock in an SCA is measured and reported under SSAP No. 32. However, the reporting entity must reduce the total equity of the SCA by the SCA’s (issuer’s) value of the preferred stock to prevent double counting. For example, if an SCA issued preferred stock for $50,000, and the SCA value is $250,000 pursuant to SSAP No 97:
  - Reporting entity would report the SCA at $200,000. ($250,000 less $50,000)
  - Reporting entity would report the preferred stock under SSAP No. 32. (So, if perpetual preferred stock, issued at $50,000, has a current fair value was $75,000, the preferred stock would be reported at $75,000 on Schedule D-2-1.)
• Under INT 00-24, once an equity (common stock) investment in an SCA has been reduced to zero due to losses in the investee, the investor shall report its share of equity method losses as an adjustment to the other investments in the investee. Pursuant to this guidance, the reported investment in preferred stock (and other investments in an SCA) would be adjusted to reflect the statutory net loss. *(NAIC staff notes – This guidance is reflected in the FASB Codification in ASC 323-10-35 regarding equity method losses.)*

Existing Authoritative Literature:

SSAP No. 32—Preferred Stock provides the statutory accounting principles for preferred stock.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): A review of the investment SSAPs, including SSAP No. 32, was supported under the investment classification project detailed in agenda item 2013-36. Currently, the Working Group has reviewed and adopted revisions to SSAP No. 26R—Bonds and SSAP No. 30R—Common Stock.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None.

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as substantive, with a request to expose the agenda item for comments on suggested actions / proposals. With this exposure, NAIC staff recommends a referral to the Valuation of Securities (E) Task Force with a request for information on preferred stock and the suggested actions. After information is received and assessed, NAIC staff will proceed with drafting revisions to SSAP No. 32, along with a corresponding issue paper, for subsequent exposure.

NAIC staff recommended actions:

1) **Definitions:**

   A. Retain, with revisions to mirror FASB terminology, the definitions for redeemable and perpetual preferred stock. These definitions will be used to classify preferred stock for valuation and reporting purposes. With this action, the definition for restricted preferred stock is also proposed to be retained in the SSAP, with revisions to properly capture the intent of this definition with current market terms.

   B. Delete existing definitions for mandatory sinking fund preferred stock, payment-in-kind (PIK) preferred stock and step-up preferred stock. If preferred, revised terms to identify various elements of preferred stock may be considered for inclusion in a SSAP No. 32 glossary, but as these terms do not impact valuation or reporting, NAIC staff proposes to eliminate these terms from the SSAP. If terms are retained in a glossary, it is proposed that they be revised to reflect current market terminology. If terms will be retained, NAIC staff requests comments on additional terms that should be captured.

   C. Incorporate new guidance to define, and provide accounting guidance for mandatory convertible preferred stock. This guidance is proposed to mirror the mandatory convertible guidance in SSAP No. 26R—Bonds. With that approach, the reported value shall be equal to, or less than, the valuation that will be required upon mandatory conversion. *(For example, if redeemable preferred stock is mandatorily convertible to common stock, the value shall be the lower of amortized cost or fair value.)*
2) **Accounting and Valuation Guidance:**

   A. Delete all references to “cost” as a measurement method. Redeemable preferred stock shall be reported at amortized cost, or the lower of amortized cost or fair value depending on NAIC designation. (It is proposed that the existing NAIC designations allocations will be retained.) Perpetual preferred stock shall be reported at fair value.

   B. Incorporate new guidance to account for mandatory convertible redeemable preferred stock. Similar to the guidance for mandatory convertible bonds, this is proposed to reflect the lower of amortized cost or fair value without impact by an NAIC designation.

3) **Dividend Guidance and the Impact on Impairment Guidance**

   A. Incorporate revisions to clarify the reporting of PIK dividends and PIK interest. This guidance is proposed to direct recognition of dividends and interest pursuant to the nature of the item received. (For example, common stock dividends would be captured under SSAP No. 30.) A reduction of investment would only occur if consideration received was intended to reduce the preferred stock investment.

   B. Clarify OTTI assessment when dividends for redeemable preferred stock are not received, or when other redemption protections (e.g., sinking fund deposits) are not met by an issuer.

4) **Clarify application of SSAP No. 32 in conjunction with SSAP No. 48 and SSAP No. 97**

   A. Clarify that preferred stock held issued by a SSAP No. 48 entity is in scope of SSAP No. 32.

   B. Incorporate guidance / references to clarify the measurement and reporting of preferred stock held from an SCA pursuant to guidance in SSAP No. 97 and INT 00-24. As detailed, INT 00-24 requires a reduction in a preferred stock investment of an SCA once the equity basis of a common stock investment reaches zero.

**Staff Review Completed by: Julie Gann – February 2019**

**Status:**

On April 6, 2019, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as substantive, and directed NAIC staff to draft revisions to SSAP No. 32 for subsequent exposure. A referral to the Valuation of Securities (E) Task Force to review the proposed edits will occur when exposed.

On August 3, 2019, the Statutory Accounting Principles (E) Working Group exposed Issue Paper No. 1XX—Preferred Stock to revise the definitions, measurement guidance and impairment guidance for preferred stock pursuant to the investment classification project.

On December 7, 2019, the Statutory Accounting Principles (E) Working Group exposed a revised Issue Paper No. 1XX—Preferred Stock and a substantively-revised draft SSAP No. 32—Preferred Stock as part of the Investment Classification Project.

On March 18, 2020, The Statutory Accounting Principles (E) Working Group exposed the Issue Paper No. 1XX—Preferred Stock and substantively-revised draft SSAP No. 32—Preferred Stock with edits to reflect comments received from interested parties as well as a January 1, 2021 effective date. This item was exposed with a May 29, 2020 comment period deadline.
Statutory Issue Paper No. 164

Preferred Stock

STATUS
Finalized July 30, 2020

Original SSAP: SSAP No. 32; Current Authoritative Guidance: SSAP No. 32R

Type of Issue:
Common Area

SUMMARY OF ISSUE

1. The guidance within this issue paper introduces substantive revisions to SSAP No. 32—Preferred Stock pursuant to the Statutory Accounting Principles (E) Working Group’s (Working Group) Investment Classification Project. The Investment Classification Project reflects a comprehensive review to address a variety of issues pertaining to definitions, measurement and overall scope of the investment statements of statutory accounting principles (SSAPs).

2. The substantive revisions to SSAP No. 32 (illustrated in Exhibit A) under the Investment Classification Project, detailed within this issue paper, reflect the following key elements:

   a. Improves preferred stock definitions, with inclusion of information from U.S. generally accepted accounting principles (GAAP) for classifying preferred stock as redeemable or perpetual. The revisions also incorporate a new exhibit to capture various terms prevalent in preferred stock.

   b. Revises the measurement guidance to ensure appropriate, consistent measurement based on the type of preferred stock held and the terms of the preferred stock. The revisions also incorporate guidance for mandatory convertible preferred stock.

   c. Incorporates revisions to clarify impairment guidance as well as guidance for dividend recognition and redemption of preferred stock with the issuer.

DISCUSSION

3. This issue paper intends to provide information on discussions that occurred when considering revisions to SSAP No. 32 under the Investment Classification Project, as well as the adopted revisions.

Preferred Stock Definitions

4. The historical definition of preferred stock within SSAP No. 32 is “any class or shares of the holders which have any preference, either as to the payment of dividends or distribution of assets on liquidation, over the holder of common stock issued by an entity.” This definition has been identified as generally consistent with market terms, including the following NASDAQ and Financial Accounting Standards Board (FASB) definitions for common stock:

   a. NASDAQ Definition: A security that shows ownership in a corporation and gives the holder a claim, prior to the claim of common shareholders, on earnings and also generally on assets in the event of liquidation. Most preferred stock pays a fixed dividend that is paid prior to the common

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stock dividend, stated in a dollar amount or as a percentage of par value. The stock does not usually carry voting rights. Preferred stock has characteristics of both equity and debt.

b. FASB Codification: A security that has preferential rights compared to common stock.

5. Comments received from interested parties in October 2019 indicated that the term “security” is not interchangeable as it pertains to preferred stock and requested all references be changed to “interest” or directly reference the type of stock under consideration. In review of the use of the term “security” in the issue paper, most instances represent existing references carried over from SSAP No. 32. NAIC staff recognizes that preferred stock is a “security,” as demonstrated by the definitions from both the NASDAQ and FASB, but NAIC staff has proposed some revisions to limit the generic use of the term. The use of the term “security” in paragraph 8, paragraphs 10-13 and in Exhibit A (as it pertains to defining specific types of preferred stock) has been revised to “preferred stock.” The use of the term “security” in paragraph 3 has been retained as this usage mirrors the FASB definition for preferred stock.

6. NAIC staff’s original intent was to align various investment definitions with common industry definitions or those specified by U.S. GAAP. As a part of the investment reclassification project, this practice began with unaffiliated common stock (SSAP No. 30R) and now has expanded into preferred stock (SSAP No. 32). The definition proposed by NAIC staff was made with the understanding that preferred stock is either redeemable or perpetual. While the issue paper does mention some stock labeled as “redeemable perpetual preferred stock,” distinctions are made in the prospectus as to its true underlying characteristics (thus being redeemable or perpetual). In general, NAIC staff continue to believe that for a majority of preferred stock issuances, a share which is redeemable at the option of the holder is by definition redeemable outside (or not solely within) the control of the issuer – thus the actions are mutually exclusive. However, interested parties cited guidance for additional circumstances in which, through legal technicalities, could cause shares to be reclassified to redeemable which were originally categorized as perpetual (reported at fair value). ASC 480-10 provides a few of these examples as: change in state law, the issuer fails to achieve certain project milestones, the issuer fails to pay specified dividends, the issuer experiences a change in credit rating, etc. As such, NAIC staff are supportive of the changes suggested by interested parties as they align with the original objective of preferred stock classification and reflect the expected economics of the investment.

7. Although the historical definition of preferred stock in SSAP No. 32 is comparable to current market terms, this issue paper recommends revisions to incorporate the NASDAQ definition as it is more encompassing of the characteristics of preferred stocks.

Definitions and Classification as Redeemable or Perpetual Preferred Stock

8. The accounting guidance of SSAP No. 32 varies based on whether preferred stock is considered to be “redeemable” or “perpetual.” The historical definitions of redeemable and perpetual within SSAP No. 32R reflected the following:

a. Redeemable preferred stock is defined as preferred stock that must be redeemed by the issuing enterprise or is redeemable at the option of the reporting entity. It includes mandatory sinking fund preferred stock and payment-in-kind (PIK) preferred stock.

b. Perpetual preferred stock is defined as preferred stock with no redemption or sinking fund features or preferred stock redeemable at the option of the issuer.
9. In comparing these terms to current U.S. GAAP, the guidance in the FASB Accounting Standards Codification (ASC), which is also consistent with Securities Exchange Commission (SEC) guidance, is more detailed in identifying the requirements for classification as redeemable preferred stock:

a. Preferred Stock Subject to Mandatory Redemption Requirements or Whose Redemption is Outside the Control of the Issuer (“Redeemable Preferred Stock”). The term means any stock which (i) the issuer undertakes to redeem at a fixed or determinable price on the fixed or determinable date or dates, whether by operation of a sinking fund or otherwise; (ii) is redeemable at the option of the holders, or (iii) has conditions for redemption which are not solely within the control of the issuer, such as stocks which must be redeemed out of future earnings. Under this definition, preferred stock which meet one or more of the above criteria would be classified as redeemable preferred stock regardless of their other attributes such as voting rights, dividend rights or conversion features. (FASB ASC 480-10-S99)

b. Preferred Stocks Which Are Not Redeemable or Are Redeemable Solely at the Option of the Issuer (“Non-Redeemable Preferred Stock”). The term means any preferred stock which does not meet the criteria for classification as a "redeemable preferred stock." (FASB ASC 480-10-S99)

10. In reviewing these definitions, and preferred stock components that permit payment of dividends in stock instead of cash (known as payment-in-kind (PIK) stock), it was identified that preferred stock that incorporates PIK dividends is not limited to redeemable preferred stock as implied in the prior SSAP No. 32 definition for redeemable preferred stock.

11. To ensure classification of redeemable and perpetual preferred stock consistently with U.S. GAAP, the definitions from the FASB ASC have been incorporated into the revised SSAP No. 32.

Definition of Restricted Stock:

12. The historical accounting guidance in SSAP No. 32 included a definition of restricted stock as “a security for which sale is restricted by governmental or contractual requirement (other than in connection with being pledged as collateral) except where that requirement terminates within one year or if the holder has the power by contract or otherwise to cause the requirement to be met within one year.” This definition identified that “any portion of the security that can be reasonably expected to qualify for sale within one year is not considered restricted.”

13. In researching this restricted stock definition, it was identified that this guidance was included in the original codification of SSAP No. 32, however, there was no identification of the source of this definition from the issue paper. In reviewing current market terms for restricted stock or restricted securities, definitions and information was noted from both NASDAQ and the SEC:

a. Restricted Stock (NASDAQ): Stock that must be traded in compliance with special SEC regulations concerning its purchase and resale. These restrictions generally result from affiliate ownership, merger and acquisition (M&A) activity, and underwriting activity.

b. Restricted Securities (SEC): Securities acquired in an unregistered, private sale from the issuing company or from an affiliate of the issuer. They typically bear a “restrictive” legend clearly stating that you may not resell them in the public marketplace unless the sale is exempt from the SEC’s registration requirements. Rule 144 under the Securities Act of 1933 provides the most commonly used exemption for holders to sell restricted securities. To take advantage of this rule, you must meet several conditions, including a six-month or one-year holding period.
14. Using the information from both NASDAQ and the SEC, a revised definition of restricted stock has been incorporated into the revised SSAP No. 32. Additionally, the revisions clarify that restricted stock is generally an admitted asset but highlights that nonadmittance could occur in accordance with SSAP No. 4—Assets and Nonadmitted Assets. Under SSAP No. 4, the restrictions limiting use of an asset can be determined to preclude the ability to consider the asset as available for policyholder claims. In such situations, the restricted asset would be considered nonadmitted.

Definitions or Preferred Stock Components / Characteristics

15. The historical guidance in SSAP No. 32 included definitions for a couple of preferred stock terms, including “mandatory sinking fund” and “step-up preferred stock,” but did not include definitions of other common preferred stock components or terms. Furthermore, in reviewing the previously included terms, it was identified that they were no longer current and should be revised or removed from SSAP No. 32. For example, the definition of “mandatory sinking fund” included references to preferred stock outstanding in 1978, and the definition of “step-up preferred stock” referred to the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and there is no current accounting or valuation guidance for step-up preferred stock in that Manual.

16. Rather that include a variety of terms in the body of the SSAP, particularly as components may not impact overall accounting and reporting of the preferred stock, a new exhibit has been included to include a glossary of key preferred stock terms. The definitions intend to capture current market-terms for the noted components.

Accounting and Reporting of Preferred Stock

17. The historical guidance in SSAP No. 32 captured different accounting and reporting provisions based on whether the preferred stock was classified as redeemable or perpetual, and whether the reporting entity maintained an Asset Valuation Reserve (AVR). Although these classifications are still considered appropriate, it has been noted that additional guidance is needed for mandatory convertible preferred stock, and that a review of the various measurement methods permitted (by classification) should occur to ensure appropriate measurement in the financial statements. Specifically, the prior guidance in SSAP No. 32 explicitly permitted “cost” as an applicable measurement method, even for perpetual preferred stock. Consistent with prior conclusions from U.S. GAAP, as well as the Statutory Accounting Principles (E) Working Group, “historical cost” is generally not an acceptable measurement method. Particularly, this measurement method is not acceptable when liquidation of an asset would generally occur at market prices, such as a non-redeemable (perpetual) preferred stock.

18. The changes reflected in the revised SSAP No. 32 continue to differentiate accounting and reporting guidance by whether a reporting entity maintains an AVR and on the type of preferred stock (redeemable or perpetual). However, revisions have been incorporated to clarify the accounting and reporting of mandatory convertible preferred stock and to update the measurement basis for each type of preferred stock:

a. For redeemable preferred stock, the revisions continue to use NAIC designations in determining the measurement method. There was no change proposed to the measurement basis per designation. However, the revisions clarify that the measurement basis shall be either amortized cost or fair value based on NAIC designation, eliminating reference to “cost” as an measurement method that could be used by a reporting entity. For the amortization of redeemable preferred stock, revisions have also been incorporated to clarify that amortization (or accretion) of any discount or premium is reported through investment income, instead of impacting dividends collected. Recognizing this amortization through investment income is consistent with U.S. GAAP.

b. For perpetual preferred stock, the revisions have eliminated use of NAIC designations in determining measurement method and the guidance requires use of fair value, not to exceed any stated call price from the prospectus of the preferred stock. As there are no requirements for an
issuer to redeem these securities, these securities can continue indefinitely until the issuing entity reacquires the preferred stock at current market rates or elects to buy-back the preferred stock in accordance with rates established in the preferred stock prospectus. In order to prevent overstatement of the securities in the financial statements, the measurement of these preferred stocks reflects fair value, not to exceed any currently effective\(^1\) buy-back rates (call prices) that the issuer can utilize to redeem the stock. This measurement guidance is not impacted by the type of reporting entity (AVR or non-AVR filer) and is not impacted by NAIC designation. Although not impacted by NAIC designation, this guidance does not change the requirement to report the NAIC designation as the NAIC designation impacts the risk-based capital (RBC) charge attributed to the preferred stock.

c. For mandatory convertible preferred stock, guidance has been incorporated to require measurement at fair value, not to exceed any stated call price, in the periods prior to conversion. This guidance is applicable regardless if the preferred stock would be classified as redeemable or perpetual and is applicable regardless of NAIC designation. This guidance requires the preferred stock to be measured at the same measurement basis that would be required once converted to common stock. This prevents overstatement in the financial statements at the time of conversion.

d. For exchange traded funds which qualify for preferred stock treatment from the NAIC SVO, the revisions clarify that these investments shall always be treated as perpetual preferred stock. This classification is appropriate as the fund would not qualify as a redeemable preferred stock with a stated term that allows for amortization.

Impairment of Preferred Stock

19. The prior guidance in SSAP No. 32 included different guidance for determining other-than-temporary impairment (OTTI) based on whether the preferred stock was redeemable or perpetual. Although this division has been retained, modifications have been reflected as follows:

a. For redeemable preferred stock, guidance has been captured to require assessment of OTTI whenever mandatory redemption rights or sinking fund requirements do not occur. Although preferred stock may indicate “required” elements, failing to provide dividends, or contribute to a sinking fund, may not be considered an act of default or require liability recognition from the issuer. Not receiving preferred stock provisions does not turn the holder of preferred stock into a creditor, and a redemption right cannot force a company to redeem shares. However, if an issuer fails to comply with “required” components, reporting entities should assess whether the preferred stock is other-than-temporarily impaired.

b. For perpetual preferred stock, the other-than-temporary impairment guidance has been revised to mirror guidance for other equity investments (e.g., common stock). As perpetual preferred stock will be reported at fair value, upon recognition of an OTTI, any unrealized losses will be realized, and the then-current fair value will become the new cost basis. Subsequent variations in fair value are treated as unrealized gains or losses.

c. Comments received from interested parties noted that proposed impairment guidance for perpetual preferred stock could be enhanced if written similar to existing impairment guidance in SSAP No.\(^1\)

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\(^1\) Interested parties noted that call dates may not be effective for a period of time. As such, language regarding that only “currently effective” buy back rates (call prices) was added.
Preferred Stock Income / Redemption

20. The guidance in this issue paper incorporates revisions to clarify the reporting of dividend income from preferred stock. This guidance clarifies that dividends shall be recognized in the form received (cash, preferred stock, common stock), at fair value, with differences between fair value and the dividend receivable recognized as gains or losses. Subsequent to initial recognition, the asset received shall follow the applicable statutory accounting statement. For example, dividends received in the form of common stock shall be captured in SSAP No. 30—Unaffiliated Common Stock.

21. Additionally, this issue paper incorporates new guidance to clarify the reporting when preferred stock is reacquired or redeemed by the issuing entity. Pursuant to this guidance, regardless of how an issuer reacquires the stock (either at market value or pre-set call / redemption price), the reporting entity would recognize any difference between the book/adjusted carrying value and the consideration received as a realized gain or loss.

Disclosures

22. Although this issue paper incorporates various accounting and reporting changes for preferred stock, there have been no revisions incorporated to the existing disclosure requirements.

Effective Date

23. The adoption of this issue paper by the Statutory Accounting Principles (E) Working Group, and the substantively revised statement of statutory accounting principles (SSAP) occurred on July 30, 2020. The substantive revisions to SSAP No. 32R are detailed in Exhibit A of this issue paper and reflected in the substantively-revised SSAP No. 32R—Preferred Stock. The effective date of the guidance will be identified in the SSAP. Users of the Accounting Practices & Procedures Manual should note that issue papers are not represented in the Statutory Hierarchy (see Section IV of the Preamble) and therefore the conclusions reached in this issue paper should not be applied until the corresponding SSAP has been adopted by the Plenary of the NAIC.

RELEVANT STATUTORY ACCOUNTING AND GAAP GUIDANCE

Statutory Accounting

- SSAP No. 32R—Preferred Stock
EXHIBIT A - REVISIONS TO SSAP No. 32—Preferred Stock

Preferred Stock

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for preferred stock.

2. Investments in preferred stock of entities captured in SSAP No. 97—Investments of in subsidiaries, controlled or affiliated entities or SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies, including as well as preferred stock interests of certified capital companies (CAPCO) per INT 06-02: Accounting and Reporting for Investments in a Certified Capital Company (CAPCO) are included within the scope of this statement. The requirement to file investments in preferred stock of certain subsidiaries, controlled or affiliated entities with the NAIC pursuant to SSAP No. 97 does not affect the application of the accounting, valuation or admissibility under this statement. In addition to the provisions of this statement, preferred stock investments in SCAs are also subject to the provisions of SSAP No. 25—Affiliates and Other Related Parties and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

SUMMARY CONCLUSION

3. Preferred stock, which may or may not be publicly traded, is a security that represents ownership of a corporation and gives the holder a claim, prior to the claim of common stockholders on earnings and also generally on assets in the event of liquidation. Most preferred stock pays a fixed dividend that is paid prior to the common stock dividend, stated in a dollar amount or as a percentage of par value. Preferred stock does not usually carry voting rights. Preferred stock has characteristics of both common stock and debt, defined as any class or series of shares the holders of which have any preference, either as to the payment of dividends or distribution of assets on liquidation, over the holder of common stock (as defined in SSAP No. 30R—Unaffiliated Common Stock) issued by an entity. Preferred stock shall include but not be limited to:

a. Redeemable preferred stock, which is preferred stock subject to mandatory redemption requirements or whose redemption is at the option of the holders. Redeemable preferred stock is any stock which 1) the issuer undertakes to redeem at a fixed or determinable price on the fixed or determinable date or dates, whether by operation of a sinking fund or otherwise; or 2) is redeemable at the option of the holders. Preferred stock which meet one or more of these criteria would be classified as redeemable preferred stock regardless of other attributes such as voting rights or dividend rights, including mandatory sinking fund preferred stock and preferred stock redeemable at the option of the holder;

b. Perpetual preferred stock, which is preferred stocks which are not redeemable or for which redemption is not at the option of the holder (non-redeemable preferred stock). Perpetual preferred stock is any preferred stock which does not meet the criteria to be classified as redeemable preferred

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1 Certain legal entities captured in SSAP No. 48, such as LLCs that are corporate-like, do not issue preferred stock in legal form, but instead issue identical instruments labeled preferred units, interests, or shares. These instruments shall be captured in this statement provided they meet the structural characteristics as defined in paragraph 3. Additionally, these instruments shall not be in-substance common stock in which the holder has risk and reward characteristics that are substantially similar to common stock.

2 Preferred stock shall be classified by its characteristics. For example, a preferred stock that is named “redeemable perpetual preferred stock” shall be reported as either “redeemable” or “perpetual” preferred stock based on whether the characteristics of paragraph 3a are met.
Ref #2019-04
Exhibit A

stock pursuant to paragraph 3.a including nonredeemable preferred stock and preferred stock redeemable at the option of the issuer; and

4. The definition of preferred stock, as defined in paragraph 3 does not include fund investments. However, the following types of SVO-identified investments are captured within scope of this statement.

   a. Exchange Traded Funds, which qualify for preferred stock treatment, as identified in Part Six, Section 2, of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and published on the SVO’s web page at www.naic.org. SVO-Identified Preferred Stock ETFs shall follow the accounting provisions for perpetual preferred stock.

5. Redeemable preferred stock is defined as preferred stock that must be redeemed by the issuing enterprise or is redeemable at the option of the reporting entity. It includes mandatory sinking fund preferred stock and payment-in-kind (PIK) preferred stock.

6. Mandatory sinking fund preferred stock is defined as redeemable preferred stock subject to a 100% mandatory sinking fund, annual installments of which will (a) commence not more than 10 years from the date of issue or December 31, 1978, if outstanding on that date; (b) be not less than 2% of the number of shares issued (or outstanding on December 31, 1978, if issued prior to that date); (c) provide for the redemption of the entire issue over a period not longer than 40 years from the date of issue, or December 31, 1978, if outstanding on that date. Redeemable preferred stock which is subject to a 100% mandatory sinking fund, but which does not, at date of issue or December 31, 1978, if outstanding at that time, meet one or more of the other requirements above, shall be considered as mandatory sinking fund preferred stock at the time the deficiency is cured through the passage of time or otherwise.

7. PIK preferred stock is defined as redeemable preferred stock on which, at the option of the issuer, dividends can be paid in additional securities rather than cash.

8. Perpetual preferred stock is defined as preferred stock with no redemption or sinking fund features or preferred stock redeemable at the option of the issuer.

9.5. Restricted preferred stock is defined3 as a security either redeemable or perpetual preferred stock that must be traded in compliance with special Securities Exchange Commission (SEC) regulations concerning its purchase and resale. These restrictions generally result from affiliate ownership, merger and acquisition (M&A) activity and underwriting activity. Pursuant to the SEC, restricted securities are securities acquired in an unregistered, private sale from the issuing company or from an affiliate of the issuer. They typically bear a “restrictive” legend clearly stating that the holding may not resell the stock in the public marketplace unless the sale is exempt from the SEC’s registration requirements. Restricted preferred stock is generally considered an admitted asset; however, admittance may be limited based on the degree of restriction in accordance with SSAP No. 4—Assets and Nonadmitted Assets. Restricted preferred stock shall be coded as restricted in the investment schedule and disclosed pursuant to SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures, for which sale is restricted by governmental or contractual requirement (other than in connection with being pledged as collateral) except where that requirement terminates within one year or if the holder has the power by contract or otherwise to cause the

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3 This definition of restricted stock does not preclude a “restricted asset” classification for any preferred stock that is restricted (e.g., not under the exclusive control of the entity) by actions of the reporting entity or others. For example, if a reporting entity has pledged preferred stock, or used preferred stock in securities lending/repo transactions, the preferred stock shall be coded and disclosed as restricted stock pursuant to SSAP No. 1.

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requirement to be met within one year. Any portion of the security that can be reasonably expected to qualify for sale within one year is not considered restricted.

10.6. Preferred stocks meet the definition of assets as defined in SSAP No. 4—Assets and Nonadmitted Assets and are admitted assets to the extent they conform to the requirements of this statement.

**Acquisitions and Sales**

11.7. At acquisition, preferred stock shall be reported at cost, including brokerage and other related fees. Preferred PIK stock received as dividends shall be initially recorded at fair value. Acquisitions and dispositions shall be recorded on the trade date. Private placement stock transactions shall be recorded on the funding date.

12.8. A reporting entity can subscribe for the purchase of stock, but not be required to make payment until a later time. Transactions of this nature are common in the formation of corporations. Preferred stock acquired under a subscription represents a conditional transaction in which a security—preferred stock is authorized for issuance but not yet actually issued. Such transactions are settled if and when the actual security—preferred stock is issued and the exchange or National Association of Securities Dealers (NASD) rules that the transactions are to be settled. Preferred stock acquired under a subscription shall be recorded as an admitted asset when the reporting entity or its designated custodian or transfer agent takes delivery of the security—preferred stock and the security—preferred stock is recorded in the name of the reporting entity or its nominee, (i.e., the accounting for such preferred stock acquisitions shall be on the settlement date).

**Amortization**

13. Redeemable preferred stock purchased at a premium shall be amortized to reduce the carrying value to the call or redemption value over the period to the call or earliest redemption date, whichever produces the lowest asset value (yield to worst). Redeemable preferred stock purchased at a discount shall be amortized accreted to increase the carrying value to par value the redemption price over the period to maturity or the latest redemption date.

14. PIK preferred stock shall be amortized to the lower of the call price or par value, measured in either case at the end of the stock dividend period and based on all of the shares expected to be held at the end of that period, including those received as dividends.

15.9. Amortization (and accretion) of the premium and discount arising at acquisition shall be calculated using the interest method and shall be reported as increases or decreases in dividends collected during the year through investment income.

**Balance Sheet Amount**

16. The NAIC Securities Valuation Office assigns preferred stocks NAIC designations (NAIC designation 1 through 6) in accordance with the Purposes and Procedures Manual of the NAIC Investment Analysis Office, and that NAIC designation is published in accordance with the SVO compilation instructions in the Purposes and Procedures Manual.

10. Preferred stock shall be valued based on (a) the underlying characteristics of the security (redeemable, or perpetual or mandatory convertible), (b) the quality rating of the security expressed as an NAIC designation pursuant to paragraph 15, and (c) whether an asset valuation reserve (AVR) is maintained by the reporting entity:

   a. For reporting entities that do not maintain an AVR:
b. Step-up preferred stock (a security with the structure of a preferred stock, that has the cash flow characteristics of a debt instrument) is considered a security with characteristics of both debt and equity, and the accounting and valuation of such securities shall be consistent with SVO guidelines as stipulated in the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

17. For reporting entities required to maintain an AVR, the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve (SSAP No. 7). For reporting entities not required to maintain an AVR, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus).

a. Reporting Entities That Do Not Maintain An AVR

i. Highest-quality or high-quality redeemable preferred stocks (NAIC designations 1 and 2), which have characteristics of debt securities, shall be valued at cost or amortized cost. All other redeemable preferred stocks (NAIC designations 3 to 6) shall be reported at the lower of cost, amortized cost, or fair value.

ii. Highest-quality or high-quality perpetual preferred stocks (NAIC designations 1 and 2), which have characteristics of equity securities, shall be reported at fair value, not to exceed any currently effective call price. All other perpetual preferred stocks (NAIC designations 3 to 6) shall be reported at the lower of cost or fair value.

iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.

iv. For preferred stocks reported at fair value, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus).

b. For reporting entities that maintain an AVR:

Reporting Entities That Do Maintain An AVR

i. Highest-quality, high-quality or medium quality redeemable preferred stocks (NAIC designations 1 to 3), which have characteristics of debt securities, shall be valued at cost or amortized cost. All other redeemable preferred stocks (NAIC designations 4 to 6) shall be reported at the lower of cost, amortized cost, or fair value.

ii. Highest-quality, high-quality or medium quality perpetual preferred stocks (NAIC designations 1 to 3), which have characteristics of equity securities, shall be valued at fair value, not to exceed any currently effective call price, cost. All other perpetual preferred stocks (NAIC designations 4 to 6) shall be reported at the lower of cost or fair value.

iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.
For preferred stocks reported at fair value, the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve.

Impairment of Redeemable Preferred Stock

For any decline in the fair value of perpetual preferred stock which is determined to be other-than-temporary (INT 06-07), an impairment loss shall be recognized as a realized loss equal to the entire difference between the perpetual preferred stock’s carrying value and its fair value at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR, realized losses shall be accounted for in accordance with SSAP No. 7.
had been purchased on the measurement date of the other than temporary impairment, and in accordance with paragraph 20 or paragraph 22, as applicable. The fair value of the perpetual preferred stock on the measurement date shall become the new cost basis of the perpetual preferred stock and the new cost basis shall not be adjusted for subsequent recoveries in fair value. Future declines in fair value which are determined to be other-than-temporary, shall be recorded as realized losses.

Income

14. Dividends on preferred stock (whether cumulative or noncumulative), other than mandatorily redeemable preferred stock, shall be recorded as investment income for dividend eligible preferred stock on the ex-dividend date with a corresponding receivable to be extinguished upon receipt of cash dividend settlement (i.e., dividend income shall be recorded on preferred stock declared to be ex-dividend on or prior to the statement date). Dividends received shall be recognized in the form received (e.g., cash, preferred stock, common stock) at fair value with differences between fair value and the dividend receivable recognized as gains or losses. Subsequent treatment shall follow the statement that addresses the type of asset received. For example, dividends received in the form of common stock shall be accounted for and reported in accordance with SSAP No. 30R—Unaffiliated Common Stock.

Redemption of Preferred Stock

15. A reporting entity that sells or redeems preferred stock back to the issuer shall recognize consideration received in excess of the book/adjusted carrying value as a realized gain or loss. This recognition shall occur regardless of whether the issuer repurchases the preferred shares at market value, or if the shares are redeemed by the issuer at a predetermined set call price.

22. Dividends on mandatorily redeemable preferred stock shall be accrued to the redemption price, even if not declared, using the interest method over the period ending on the redemption date.

23. Cash dividends paid on PIK stock during the stock dividend period shall be accounted for as a reduction in the investment.

Exchanges and Conversions

24-16. If preferred stock is exchanged or converted into other securities, the fair value of the preferred stock surrendered at the date of the exchange or conversion shall become the cost basis for the new securities with any gain or loss realized at the time of the exchange or conversion. However, if the fair value of the securities received in an exchange or conversion is more clearly evident than the fair value of the preferred stock surrendered, then it shall become the cost basis for the new securities.

Disclosures

25-17. The following disclosures regarding preferred stocks shall be made in the financial statements:

a. Fair values in accordance with SSAP No. 100R—Fair Value (SSAP No. 100R);

b. Concentrations of credit risk in accordance with SSAP No. 27;

c. Basis at which the preferred stocks are stated; and

d. A description, as well as the amount, of preferred stock that is restricted and the nature of the restriction.
For each balance sheet presented, all preferred stocks in an unrealized loss position for which other-than-temporary declines in value have not been recognized

i. The aggregate amount of unrealized losses (that is, the amount by which cost or amortized cost exceeds fair value) and

ii. The aggregate related fair value of preferred stocks with unrealized losses.

The disclosures in (i) and (ii) above should be segregated by those preferred stocks that have been in a continuous unrealized loss position for less than 12 months and those that have been in a continuous unrealized loss position for 12 months or longer using fair values determined in accordance with SSAP No. 100R.

As of the date of the most recent balance sheet presented, additional information should be included describing the general categories of information that the investor considered in reaching the conclusion that the impairments are not other-than-temporary.

When it is not practicable to estimate fair value, the investor should disclose the following additional information, if applicable, as of each date for which a statement of financial position is presented in its annual financial statements:

iii. The aggregate carrying value of the investments not evaluated for impairment, and

iv. The circumstances that may have a significant adverse effect on the fair value.

Refer to the Preamble for further discussion regarding disclosure requirements. The disclosure requirements of paragraphs 3117.b., 3117.e., 3117.f., 3117.g. and 3117.h. shall be included in the annual audited statutory financial reports only.


This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The guidance in paragraphs 23-26 was previously included within SSAP No. 99—Accounting for Securities Subsequent to an Other-Than-Temporary Impairment and was effective for reporting periods beginning on January 1, 2009, and thereafter, with early adoption permitted. In 2010, the guidance from SSAP No. 99 was incorporated within the impacted standards, with SSAP No. 99 superseded. The original impairment guidance included in this standard, and the substantive revisions reflected in SSAP No. 99 are retained for historical purposes within Issue Paper No. 131. The guidance in paragraphs 2 and 3 to SSAP No. 32 was originally superseded January 1, 2005, by guidance included in SSAP No. 88—Investments in Subsidiaries, Controlled and Affiliated Entities, A replacement of SSAP No. 46, and then subsequently reflected in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities. In 2011, the guidance related to preferred stock of
SCAs from SSAP No. 97 was incorporated into this statement and revised to reflect a definition of preferred stock. The original guidance included in this statement, and the substantive revisions reflected in SSAP No. 88 and SSAP No. 97 (including the title change already reflected in SSAP No. 32) are retained for historical purposes within Issue Paper Nos. 32 and 118. Guidance in paragraph 17 was originally contained in INT 99-29: Classification of Step-Up Preferred Stock and was effective December 6, 1999.

28.21. On July 30, 2020, substantive revisions, as detailed in Issue Paper No. 164—Preferred Stock were adopted. These revisions, effective January 1, 2021, update definitions of preferred stock and reporting values based on characteristics of the preferred stock.

REFERENCES

Other

- Purposes and Procedures Manual of the NAIC Investment Analysis Office
- NAIC Valuation of Securities product prepared by the Securities Valuation Office

Relevant Issue Papers

- Issue Paper No. 32—Investments in Preferred Stock (excluding investments in preferred stock of subsidiary, controlled, or affiliated companies)
- Issue Paper No. 131—Accounting for Certain Securities Subsequent to an Other-Than-Temporary Impairment
- Issue Paper No. 164—Preferred Stock
EXHIBIT A – GLOSSARY

Callable Preferred Stock – A preferred stock in which the issuer has the right to call or redeem the stock at a preset price after a defined date. Callable preferred stock can be either redeemable preferred stock or perpetual preferred stock depending on other characteristics of the preferred stock. For example, callable preferred stock with a maturity or a specific buyback date would be redeemable preferred stock, whereas callable preferred stock electable at the discretion of the issuer is perpetual preferred stock.

Convertible Preferred Stock – A preferred stock that is convertible into another security based on a conversion rate. For example, convertible preferred stock that is convertible into common stock on a two-for-one basis (two shares of common for each share of preferred).

Cumulative Preferred Stock – A preferred stock with a provision that missed dividend payments must be paid to cumulative preferred shareholders before other classes of preferred stock shareholders and common shareholders can receive dividend payments. Cumulative preferred stock may have different levels, with a “first” or “senior” cumulative preferred, “regular” cumulative preferred and “subordinate” cumulative preferred that determines the priority in which accumulated unpaid dividends or asset liquidation occurs. (Under SSAP No. 32R, holders of cumulative preferred stock are not permitted to recognize a receivable for unpaid cumulative dividends until declared and the reporting entity is entitled to the divided.)

Dividend Declaration Date – The date a corporation declares a dividend payment to its shareholders.

Dividend Record Date – The date that identifies the shareholders that are entitled to a declared dividend.

Dividend Payment Date – The date the declared dividend will be paid.

Ex-Dividend Date – The cut-off date of holding stock to be captured as a shareholder on record entitled to the dividend. (A shareholder that sells their stock on the ex-dividend date would continue to be identified as a shareholder on record entitled to a declared dividend. Anyone who acquires a stock on the ex-dividend date would not be a shareholder on record entitled to a declared dividend.)

Mandatory Redeemable Preferred Stock – A preferred stock that embodies an unconditional obligation requiring the issuer to redeem the instrument by transferring its assets at a specified or determinable date (or dates) or upon an event that is certain to occur. (The existence of a mandatory redemption right does not convert the holder of a preferred stock into a creditor, and an issuer may be prohibited from redeeming shares when redemption would cause an impairment of capital.)

Noncumulative Preferred Stock – A preferred stock that does not entitle the stockholder to accumulated unpaid dividends. After missing dividend payments, a corporation only has to be make current dividend payments to preferred stock holders before providing dividends to common stock holders.

Participating Preferred Stock – A preferred stock that gives the holder participation in the additional earnings of a business or liquidation rights in addition to the normal preferred stock dividend. Pursuant to the terms of the preferred stock, the participation rights may only be activated when income or operations of the issuer exceeds a certain threshold level.

Payment-in-kind (PIK) – A term of the preferred stock prospectus that identifies that dividends may take the form of securities (e.g., common stock) rather than cash.
Perpetual Preferred Stock - Preferred stocks which are not redeemable or are redeemable solely at the option of the issuer. Perpetual preferred stock is any preferred stock which does not meet the criteria to be classified as redeemable preferred stock.

Preferred stock - A security, which may or may not be publicly traded, that shows ownership of a corporation and gives the holder a claim, prior to the claim of common stockholders on earnings and also generally on assets in the event of liquidation.

Redeemable Preferred Stock - Preferred stock subject to mandatory redemption requirements or whose redemption is outside the control of the issuer. Redeemable preferred stock is any stock which 1) the issuer undertakes to redeem at a fixed or determinable price on the fixed or determinable date or dates, whether by operation of a sinking fund or otherwise; 2) is redeemable at the option of the holders; or 3) has conditions for redemption which are not solely within the control of the issuer, such as stock which must be redeemed out of future earnings. Preferred stock which meet one or more of these three criteria is redeemable preferred stock regardless of other attributes such as voting rights or dividend rights.

Restricted Preferred Stock - Redeemable or perpetual preferred stock that must be traded in compliance with special SEC regulations concerning its purchase and resale. These restrictions generally result from affiliate ownership, M&A activity and underwriting activity. Pursuant to the SEC, restricted securities are securities acquired in an unregistered, private sale from the issuing company or from an affiliate of the issuer. They typically bear a “restrictive” legend clearly stating that the holding may not resell the stock in the public marketplace unless the sale is exempt from the SEC’s registration requirements.

Sinking Fund – A potential component of a preferred stock charter that requires the issuer to regularly set funds aside in a separate custodial account for the exclusive purpose of redeeming preferred stock shares. Failure of an issuer to provide to the sinking fund does not create an act of default. Rather, the stock charter may implement provisions for failing to provide to the sinking fund, which could include penalties, restrictions of providing common stock dividends or the repurchase of the preferred stock.

Step-Up Preferred Stock – A potential component of a preferred stock charter that identifies whether specific terms will increase over time or with stated provisions. For example, a “step-up dividend” is a feature that increases the dividend rate. A “step-up call” is a feature that increases the call price. A “step-up conversion” increases the conversion price.

Term Preferred Stock – Preferred stock with a mandatory redemption requirement (maturity date) captured in the definition of redeemable preferred stock.
Issue: Accounting for Bond Tender Offers

Check (applicable entity):

- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

P/C: ☒
Life: ☒
Health: ☒

Description of Issue: Questions have arisen regarding the accounting treatment for when a held bond is retired early through the acceptance of a “bond tender offer.” A bond tender offer occurs when the bond issuer repurchases some, or all, of a particular bond issuance prior to its scheduled maturity date. These offers are generally an attempt to retire a substantial amount of outstanding debt by making a one-time, special offer to bond holders. Generally, the purpose of a tender offer is to retire bonds that were originally issued at higher interest rates; however, some tender offers have occurred as a mechanism for capital restructuring. As expected, these activities are most common in a decreasing or depressed interest rate environment.

Tender offers typically share similar characteristics in that the offer is: 1) for a predetermined (finite) number of bonds, 2) a specified, nonnegotiable price, 3) available to the market as a whole – generally advertised through a press release, 4) only available for a limited period of time, and 5) contingent upon acceptance by a substantial percentage of debt holders – generally accepted by at least 25% of those eligible for early buyout.

From a bond holder’s perspective, the only material difference between a called and tendered bond is that with the tender offer, the bond holder must elect to accept the repurchase offer. If the tender offer is not accepted, the bond’s terms (including scheduled maturity date) remain unchanged. Bond tender offers are generally offered at rates slightly above market value, as an economic enticement for the holder to “sell” the bond. This increased compensation is reflective of prepayment penalties and/or acceleration fees noted in called bonds. The reinvestment risk assumed by holding a bond with a call option is generally compensation through a higher yield or a known prepayment penalty. Similarly, through a bond tender offer, increased compensation comes in the form of additional termination payout as compared to current market value.

Specific guidance for the reporting and allocation of investment income and/or capital gain/loss associated with callable bonds (where the issuer, at its sole discretion, can redeem a bond before it scheduled maturity date) is noted in SSAP No. 26R—Bonds; however guidance is not reflected for when a bond is retired early through a tender offer. As previously discussed, called bonds and bond tender offers are similar in the fact that the issuer can retire a bond early, however with a bond tender offer, the holder must elect to accept the offer. If the offer is not accepted, the original terms of the bond are not modified.

Existing Authoritative Literature:

The reporting of prepayment penalties or acceleration fees in the event a bond is liquidated prior to its scheduled termination date are detailed in SSAP No. 26R—Bonds.

Income

15. Interest income for any period consists of interest collected during the period, the change in the due and accrued interest between the beginning and end of the period as well as reductions for premium
amortization and interest paid on acquisition of bonds, and the addition of discount accrual. In accordance with SSAP No. 34—Investment Income Due and Accrued, investment income shall be reduced for amounts which have been determined to be uncollectible. Contingent interest may be accrued if the applicable provisions of the underlying contract and the prerequisite conditions have been met.

16. A bond may provide for a prepayment penalty or acceleration fee in the event the bond is liquidated prior to its scheduled termination date. Such fees shall be reported as investment income when received.

17. The amount of prepayment penalty and/or acceleration fees to be reported as investment income or loss shall be calculated as follows:

a. For called bonds in which the total proceeds (consideration) received exceeds par:
   
i. The amount of investment income reported is equal to the consideration received less the par value of the investment; and
   
ii. Any difference between the book adjusted carrying value (BACV) and the par value at the time of disposal shall be reported as realized capital gains and losses, subject to the authoritative literature in SSAP No. 7.

b. For called bonds in which the consideration received is less than par:
   
i. To the extent an entity has in place a process to identify explicit prepayment penalty or acceleration fees, these should be reported as investment income. (An entity shall consistently apply their process. Once a process is in place, an entity is required to maintain a process to identify prepayment penalties for called bonds in which consideration received is less than par.)
   
ii. After determining any explicit prepayment penalty or acceleration fees, the reporting entity shall calculate the resulting realized gain as the difference between the remaining consideration and the BACV, which shall be reported as realized capital gain, subject to the authoritative literature in SSAP No. 7.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group:
While bond tenders were not specifically discussed, the accounting and reporting of revenues as a result of early termination, was addressed in agenda item 2018-32: SSAP No. 26R—Prepayment Penalties. In this agenda item, authoritative guidance was adopted detailing the breakout of revenues between investment income and capital gains when the called bond consideration was less than par.

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation: NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 26R—Bonds to clarify that the accounting and reporting of investment income and capital gain/loss, due to the early liquidation either through a call

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1 This guidance applies to situations in which consideration received is less than par but greater than the book adjusted carrying value (BACV). Pursuant to the yield-to-worst concept, bonds shall be amortized to the call or maturity date that produces the lowest asset value. In the event a bond has not been amortized to the lowest value prior to the call (BACV is greater than the consideration received), the entire difference between consideration received and the BACV shall be reported to investment income.
or a tender offer, shall be similarly applied. NAIC staff believes this is in line with original intent as the initial SSAP No. 26 codification guidance (still reflected in paragraph 16 of SSAP No. 26R) is not specific to called bonds. Rather, the guidance refers to “prepayment penalties or acceleration fees in the event the bond is liquidated prior to its scheduled termination date.” This guidance would seemingly include all dynamics in which an issuer provides a penalty / fee to the holder to terminate the bond.

A bond retired early through either a call or tender offer are functionally equivalent to a bond holder. The only potential additional consideration for the bond holder is that the yield-to-worst concept was likely not applied in relation to the bond tender offer (as the tender offer amount and date were not known/expected at the time of acquisition). However, this concern is negated as bond tender offers are generally at or above market value and the holder must elect to participate. If a bond tender offer is not economically beneficial to the holder, the holder would simply not participate.

SSAP No. 26R – Proposed Updates

16. A bond may provide for a prepayment penalty or acceleration fee in the event the bond is liquidated prior to its scheduled termination date. Such fees shall be reported as investment income when received.

17. The amount of prepayment penalty and/or acceleration fees to be reported as investment income or loss shall be calculated as follows:

   a. For called or tendered bonds in which the total proceeds (consideration) received exceeds par:
      i. The amount of investment income reported is equal to the consideration received less the par value of the investment; and
      ii. Any difference between the book adjusted carrying value (BACV) and the par value at the time of disposal shall be reported as realized capital gains and losses, subject to the authoritative literature in SSAP No. 7.

   b. For called or tendered bonds in which the consideration received is less than par:
      iii. To the extent an entity has in place a process to identify explicit prepayment penalty or acceleration fees, these should be reported as investment income. (An entity shall consistently apply their process. Once a process is in place, an entity is required to maintain a process to identify prepayment penalties for called bonds in which consideration received is less than par.)
      iv. After determining any explicit prepayment penalty or acceleration fees, the reporting entity shall calculate the resulting realized gain as the difference between the remaining consideration and the BACV, which shall be reported as realized capital gain, subject to the authoritative literature in SSAP No. 7.

Staff Review Completed by: Jim Pinegar, NAIC Staff – January 2020

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2 This guidance applies to situations in which consideration received is less than par but greater than the book adjusted carrying value (BACV). Pursuant to the yield-to-worst concept, bonds shall be amortized to the call or maturity date that produces the lowest asset value. In the event a bond has not been amortized to the lowest value prior to the call, or in cases of an accepted tender bond offer (BACV is greater than the consideration received), the entire difference between consideration received and the BACV shall be reported to investment income.
Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 26R—Bonds, to clarify that the accounting and reporting of investment income and capital gain/loss, due to the early liquidation either through a call or a tender offer, shall be similarly applied. The current guidance refers to “prepayment penalties or acceleration fees in the event the bond is liquidated prior to its schedule termination date,” and includes all dynamics in which an issuer provides a penalty/fee to the holder to terminate the bond. This item has a comment period deadline ending May 29, 2020.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 26R—Bonds, as illustrated below, to clarify that the accounting and reporting of investment income and capital gain/loss, due to early liquidation either through a call or a tender offer, shall be similarly applied. Additionally, an effective date of Jan 1, 2021 was permitted, however is only applicable to reporting entities in which had historically applied differing accounting methodology and require systems changes in order to capture tendered bonds in scope of this guidance.

SSAP No. 26R – Adopted Updates

16. A bond may provide for a prepayment penalty or acceleration fee in the event the bond is liquidated prior to its scheduled termination date. Such fees shall be reported as investment income when received.

17. The amount of prepayment penalty and/or acceleration fees to be reported as investment income or loss shall be calculated as follows:

a. For called or tendered bonds in which the total proceeds (consideration) received exceeds par:

   i. The amount of investment income reported is equal to the consideration received less the par value of the investment; and

   ii. Any difference between the book adjusted carrying value (BACV) and the par value at the time of disposal shall be reported as realized capital gains and losses, subject to the authoritative literature in SSAP No. 7.

b. For called or tendered bonds in which the consideration received is less than par:

   v. To the extent an entity has in place a process to identify explicit prepayment penalty or acceleration fees, these should be reported as investment income. (An entity shall consistently apply their process. Once a process is in place, an entity is required to maintain a process to identify prepayment penalties for called bonds in which consideration received is less than par.)

   vi. After determining any explicit prepayment penalty or acceleration fees, the reporting entity shall calculate the resulting realized gain as the difference between the remaining consideration and the BACV, which shall be reported as realized capital gain, subject to the authoritative literature in SSAP No. 7.

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3 This guidance applies to situations in which consideration received is less than par but greater than the book adjusted carrying value (BACV). Pursuant to the yield-to-worst concept, bonds shall be amortized to the call or maturity date that produces the lowest asset value. In the event a bond has not been amortized to the lowest value prior to the call, or in cases of an accepted tender bond offer (BACV is greater than the consideration received), the entire difference between consideration received and the BACV shall be reported to investment income.
Effective Date and Transition (New Paragraph)

37. On July 30, 2020, nonsubstantive revisions were adopted to clarify existing guidance that all prepayment penalty and acceleration fees for when a bond is liquidated prior to its scheduled maturity date, including those from tendered bonds, shall follow the guidance in SSAP No. 26R. Reporting entities that have historically applied this guidance shall not change historical practices, but an effective date of January 1, 2021, with early application permitted, is allowed for reporting entities to make systems changes to capture tendered bonds in scope of this guidance.
**Statutory Accounting Principles (E) Working Group**  
**Maintenance Agenda Submission Form**  
**Form A**

**Issue:** Enhanced Goodwill Disclosures

**Check (applicable entity):**

<table>
<thead>
<tr>
<th>Modification of Existing SSAP</th>
<th>Life</th>
<th>Health</th>
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<tbody>
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<tr>
<td>New Issue or SSAP</td>
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<td>Interpretation</td>
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**Description of Issue:** This agenda item was drafted to request additional goodwill information and to clarify reporting on Schedule D, Part 6, Section 1 – Valuation of Shares of Subsidiary, Controlled and Affiliated Companies.

1) With the adoption of agenda item 2017-18: Goodwill Limitations in SSAP No. 68—*Business Combinations and Goodwill* and SSAP No. 97—*Investments in Subsidiary, Controlled and Affiliated Entities*, the information reported regarding goodwill, as provided in Annual Statement Footnote 3 – Business Combinations and Goodwill, has improved. This agenda item proposes additional disclosures to enhance the reporting of an SCA’s book adjusted carrying value (BACV). As goodwill is a significant component of many SCAs’ BACV, this agenda item will assist in facilitating review and disclosure of each balance.

2) During a review of SCA Sub 2 filings, it is noted that many companies do not calculate the amortization of goodwill correctly, which sometimes overstates the value of the SCA. Many companies also do not provide additional information to verify beginning goodwill and purchase price; as such NAIC staff rely on a review of Footnote 3 for these details. If the goodwill amount is not verifiable, it is not be allowed to be admitted as part of the SCA’s value.

3) The goodwill limitation of 10% of the insurance reporting entity’s goodwill—capital and surplus is a calculation that all reporting entities who have goodwill must perform. While the admitted result is in the Annual Statement, the details of the calculation are not easily identifiable This agenda item proposes the addition of a disclosure to capture the admissibility information, to ensure transparency in the admission of goodwill.

Additionally, feedback is requested in terms of the proposed edits to Schedule D – Part 6 – Sections 1 and 2. As detailed in the proposal below, two column headings and related Blanks instruction refer to “Intangible Assets,” however NAIC staff believe the original intent of these disclosures were to capture goodwill. FASB defines intangible assets as assets (not including financial assets) that lack physical substance and refer to assets other than goodwill. Feedback is requested from regulators and interested parties regarding what has historically been included in this disclosure and if changing the definition to articulate goodwill is warranted. Upon a sampled review by NAIC staff, it appears as though goodwill is the sole number currently being reported in these applicable columns.

**Existing Authoritative Literature:**

Goodwill calculation and admittance limitations are detailed in *SSAP No. 68—Business Combinations and Goodwill*. Relevant areas in relation to this agenda item have been bolded for emphasis.
Statutory Purchases of SCA Investments

3. The statutory purchase method of accounting is defined as accounting for a business combination as the acquisition of one entity by another. It shall be used for all purchases of SCA entities including partnerships, joint ventures, and limited liability companies. The acquiring reporting entity shall record its investment at cost. Cost is defined as the sum of: (a) any cash payment, (b) the fair value of other assets distributed, (c) the fair value of any liabilities assumed, and (d) any direct costs of the acquisition. Contingent consideration issued in a purchase business combination that is embedded in a security or that is in the form of a separate financial instrument shall be recorded by the issuer at fair value at the acquisition date.

4. For those acquired SCA entities accounted for in accordance with paragraphs 8.b.i., 8.b.ii., 8.b.iii. or 8.b.iv. of SSAP No. 97, and joint venture, partnership or limited liability company entities accounted for in accordance with paragraph 8 of SSAP No. 48, goodwill is defined as the difference between the cost of acquiring the entity and the reporting entity’s share of the book value of the acquired entity. When the cost of the acquired entity is greater than the reporting entity’s share of the book value, positive goodwill exists. When the cost of the acquired entity is less than the reporting entity’s share of the book value, negative goodwill exists. Goodwill resulting from assumption reinsurance shall be recorded as a separate write-in for other-than-invested assets. All other goodwill shall be reported in the carrying value of the investment.

5. A business combination accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with paragraphs 8.b.ii., 8.b.iii. or, 8.b.iv. of SSAP No. 97 shall determine the amount of positive goodwill or negative goodwill created by the combination using the reporting entity’s share of the GAAP net book value of the acquired entity, adjusted to a statutory basis of accounting in accordance with paragraph 9 of SSAP No. 97 in the case of acquired entities valued in accordance paragraphs 8.b.ii. or 8.b.iv. of SSAP No. 97. Business combinations accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with, paragraph 8.b.i. of SSAP No. 97 shall determine the amount of positive or negative goodwill created by the business combination using the insurer’s share of the statutory book value of the acquired entity.

6. For those acquired SCA entities accounted for in accordance with paragraph 8.b.i. of SSAP No. 97 under the statutory purchase method, the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements. Therefore, pushdown accounting is not permitted.

7. Positive goodwill recorded under the statutory purchase method of accounting shall be admitted subject to the following limitation: Positive goodwill from all sources, including life, accident and health, and deposit-type assumption reinsurance and goodwill resulting from the acquisition of an SCA by the insurance reporting entity that is reported on the SCA’s financial statements (resulting from the application of pushdown accounting), is limited in the aggregate to 10% of the acquiring entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Additionally, all positive goodwill shall be nonadmitted when the underlying investment in the SCA or partnership, joint venture and limited liability company is nonadmitted. When negative goodwill exists, it shall be recorded as a contra-asset.

8. Positive or negative goodwill resulting from the purchase of an SCA, joint venture, partnership or limited liability company shall be amortized to unrealized capital gains and losses on investments over the period in which the acquiring entity benefits economically, not to exceed 10 years. Positive or negative goodwill resulting from life,

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1 The “acquiring” entity is intended to reflect the insurance reporting entity that reports the investment resulting in goodwill. The goodwill limitation test shall be completed at the individual reporting company level.

2 This includes, but is not limited to, situations in which the investment is nonadmitted as the audited financial statements for the SCA, joint venture, partnership or limited liability company includes substantial doubt on the entity’s ability to continue as a going concern, or on the basis/contents of the audit opinion pursuant to paragraph 21 of SSAP No. 97.
accident and health, and deposit-type assumption reinsurance shall be amortized to operations as a component of general insurance expenses over the period in which the assuming entity benefits economically, not to exceed 10 years. Goodwill shall be evaluated separately for each transaction.\(^\text{INT 01-18}\)

**Disclosures:**

15. For business combinations accounted for under the statutory purchase method, the financial statements shall disclose the following for as long as unamortized goodwill is reported as a component of the investment:

   a. The name and brief description of the acquired entity;
   
   b. Method of accounting, that is the statutory purchase method;
   
   c. Acquisition date, cost of the acquired entity and the original amount of admitted goodwill; and
   
   d. The amount of amortization of goodwill recorded for the period; the admitted goodwill as of the reporting date, and admitted goodwill as a percentage of the SCA’s book adjusted carrying value (gross of admitted goodwill).

16. For business combinations taking the form of a statutory merger, the financial statements shall disclose:

   a. The names and brief description of the combined entities;
   
   b. Method of accounting, that is the statutory merger method;
   
   c. Description of the shares of stock issued or cancelled in the transaction;
   
   d. Details of the results of operations of the previously separate entities for the period before the combination is consummated that are included in the current combined net income, including revenue, net income, and other changes in surplus; and
   
   e. A description of any adjustments recorded directly to surplus for any entity that previously did not prepare statutory statements.

17. The financial statements shall disclose the following information regarding goodwill resulting from assumption reinsurance:

   a. The name of the ceding entity;
   
   b. The type of business assumed;
   
   c. The cost of the acquired business and the amount of goodwill; and
   
   d. The amount of amortization of goodwill recorded for the period.

18. A reporting entity that recognizes an impairment loss shall disclose the following in the financial statements that include the period of the impairment write-down:

   a. A description of the impaired assets and the facts and circumstances leading to the impairment; and
   
   b. The amount of the impairment charged to realized capital gains and losses and how fair value was determined.
Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):

In March 2018, the Working Group adopted agenda item 2017-18: Goodwill Limitations in SSAP Nos. 68 and 97, requiring additional goodwill disclosures in Footnote 3 – Business Combinations and Goodwill (shown below).

Additional goodwill items under consideration by the Working Group relate to the currently exposed, agenda items:

1) Agenda item 2019-14: Attribution of Goodwill. This agenda item proposes the expansion of statutory guidance regarding the attribution of purchase price and goodwill from an acquisition and to add explicit language regarding the accounting treatment for situations in which an insurance company acquires a holding company that owns multiple companies.

2) Agenda item 2019-17: Pushdown Accounting. This agenda item reviewed the guidance in ASU 2014-17, Business Combinations – Pushdown Accounting and its applicability for statutory accounting. Three options were suggested for consideration which included complete rejection, allowance of pushdown for non-insurance entities, or allowance of pushdown only if previously elected (for SEC Registrants).

Also, in December 2019, the Working Group adopted an edit to SSAP No. 68—Business Combinations and Goodwill to clarify that all goodwill from an insurance entity’s acquisition of SCAs, regardless of whether pushdown accounting is applied, is subject to the existing 10% admittance limitation.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose this agenda item with nonsubstantive revisions to SSAP No. 68—Business Combinations and Goodwill, as detailed below, to add additional goodwill disclosures. The proposed disclosures will improve the validity and accuracy of numbers currently being reported and will assist with the regulators’ review of reported assets not readily available for the payment of policyholder claims.

Proposed additional disclosures in SSAP No. 68—Business Combinations and Goodwill:

Disclosures
19. For business combinations accounted for under the statutory purchase method, the financial statements shall disclose the following for as long as unamortized goodwill is reported as a component of the investment:

   a. The name and brief description of the acquired entity;

   b. Method of accounting, that is the statutory purchase method;

   c. Acquisition date, cost of the acquired entity, the original amount of goodwill and the original amount of admitted goodwill; and

   d. Each SCA’s book value, the amount of amortization of goodwill recorded for the period; the SCA’s admitted goodwill as of the reporting date;

   e. Total admitted goodwill as of the reporting date; and
Ref #2020-03

Admitted goodwill as a percentage of the SCA’s book adjusted carrying value (gross of admitted goodwill).

20. For business combinations taking the form of a statutory merger, the financial statements shall disclose:
   a. The names and brief description of the combined entities;
   b. Method of accounting, that is the statutory merger method;
   c. Description of the shares of stock issued or cancelled in the transaction;
   d. Details of the results of operations of the previously separate entities for the period before the combination is consummated that are included in the current combined net income, including revenue, net income, and other changes in surplus; and
   e. A description of any adjustments recorded directly to surplus for any entity that previously did not prepare statutory statements.

21. The financial statements shall disclose the following information regarding goodwill resulting from assumption reinsurance:
   a. The name of the ceding entity;
   b. The type of business assumed;
   c. The cost of the acquired business and the amount of goodwill; and
   d. The amount of amortization of goodwill recorded for the period.

22. A reporting entity that recognizes an impairment loss shall disclose the following in the financial statements that include the period of the impairment write-down:
   a. A description of the impaired assets and the facts and circumstances leading to the impairment; and
   b. The amount of the impairment charged to realized capital gains and losses and how fair value was determined.

23. A reporting shall disclose the subcomponents and calculation of adjusted surplus and total admitted goodwill as a percentage of adjusted surplus:

**Proposed Blank updates related to SSAP No. 68 include the following:**

**Footnote 3 (A) Illustration:**

<table>
<thead>
<tr>
<th>Purchased Entity</th>
<th>Acquisition Date</th>
<th>Cost of Acquired Entity</th>
<th>Original Amount of Goodwill</th>
<th>Original Amount of Admitted Goodwill</th>
<th>Admitted Goodwill as of the Reporting Date</th>
<th>Amount of Goodwill Amortized During the Reporting Period</th>
<th>Book Value of SCA</th>
<th>Admitted Goodwill as a % of SCA BACV, Gross of Admitted Goodwill</th>
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New Footnote, proposed to be numbered 3(E):

<table>
<thead>
<tr>
<th>Calculation of Limitation using Prior Quarter Numbers</th>
<th>Current reporting period</th>
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<tr>
<td>Capital &amp; Surplus</td>
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<td>Less Admitted Positive Goodwill</td>
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</tr>
<tr>
<td>Less Admitted EDP Equipment &amp; Operating System Software</td>
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</tr>
<tr>
<td>Less Admitted Net Deferred Taxes</td>
<td>&lt;XXX&gt;</td>
</tr>
<tr>
<td>Adjusted Capital and Surplus</td>
<td>XXX.</td>
</tr>
</tbody>
</table>

Limitation on amount of goodwill (adjusted capital and surplus times 10%)

| Current period reported Admitted Goodwill             | XXX.                     |
| Current Period Admitted Goodwill as a % of prior period Adjusted Capital and Surplus | % |

In addition to the above, changes are proposed for the following schedules which detail the Valuation of Shares of Subsidiary, Controlled of Affiliated Companies. As previously addressed, column clarifications regarding the reporting of Goodwill as opposed to Intangible Assets (as currently indicated).

Schedule D – Part 6 – Section 1 (Original) – Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

<table>
<thead>
<tr>
<th>1 CUSIP Identification</th>
<th>2 Description Name Of Subsidiary, Controlled or Affiliated Company</th>
<th>3 Foreign</th>
<th>4 NAIC Company Code</th>
<th>5 ID Number</th>
<th>6 NAIC Valuation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Do Insurer's Assets Include Intangible Assets Connected with Holding of Such Company's Stock?</td>
<td>8 Total Amount of Such Intangible Assets</td>
<td>9 Book / Adjusted Carrying Value</td>
<td>10 Nonadmitted Amount</td>
<td>Stock of Such Company Owned by Insurer on Statement Date</td>
<td>11 Number of Shares</td>
</tr>
</tbody>
</table>

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Schedule D – Part 6 – Section 1 (Proposed Tracked Changes) – Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUSIP Identification</td>
<td>Description Name Of Subsidiary, Controlled or Affiliated Company</td>
<td>Foreign</td>
<td>NAIC Company Code</td>
<td>ID Number</td>
<td>NAIC Valuation Method</td>
<td>Book / Adjusted Carrying Value</td>
</tr>
</tbody>
</table>

Note 1 in Schedule D-Part 6-Section 1 (below), is proposed for removal due to the addition of footnote 3 (D). It is anticipated that if adopted as exposed, both changed would occur simultaneously.

1. Amount of insurer’s capital and surplus from the prior period’s statutory statement reduced by any admitted EDP, goodwill and net deferred tax assets included therein: $....................................

12. Total amount of intangible assets goodwill nonadmitted $ ...................................................................................

For brevity, only instructions for affected columns have been included. Remaining paragraph numbers will be renumbered accordingly.

Column 7——Do Insurer’s Assets Include Intangible Assets Connected with Holding of Such Company’s Stock?

State whether the assets shown by the reporting entity in this statement include, through the carrying value of stock of the SCA company valued under the SSAP No. 97—Subsidiary, Controlled and Affiliated Entities, intangible assets arising out of the purchase of such stock by the reporting entity or the purchase by the SCA Company of the stock of a lower-tier company controlled by the SCA Company. For purposes of this question, intangible assets at purchase shall be defined as the excess of the purchase price over the tangible net worth (total assets less intangible assets and total liabilities) represented by such shares as recorded, immediately prior to the date of purchase, on the books of the company whose stock was purchased.

Column 8——Total Amount of Such Intangible Assets Goodwill

If the answer in Column 7 is “Yes,” give Report the total amount of intangible goodwill assets involved whether admitted or nonadmitted. The intangible assets shown for the SCA Company should include any intangible assets that are included in the SCA Company’s carrying value of the stock of one or more lower-tier companies controlled by the SCA Company. In all cases, the goodwill current intangible assets equals the goodwill calculated intangible assets at purchase, as defined above in SSAP No. 68—Business Combinations and Goodwill, minus any
impairments/write-off thereof between the date of purchase and the statement date. If any portion of the total amount of intangible assets/goodwill is required to be nonadmitted for all SCA companies combined in accordance with SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities and SSAP No. 68—Business Combinations and Goodwill state the total amount nonadmitted in the footnote at the bottom of the this section of the schedule.

Schedule D – Part 6 – Section 2 – Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

<table>
<thead>
<tr>
<th></th>
<th>CUSIP Identification</th>
<th>Name of Lower-Tier Company</th>
<th>Name of Company Listed in Section 1 Which Controls Lower-Tier Company</th>
<th>Total Amount of Intangible Assets/Goodwill Included in Amount Shown in Column 8, Section 1</th>
<th>Stock in Lower-Tier Company Owned Indirectly by Insurer on Statement Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>4</td>
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<td>5</td>
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<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For brevity, only instructions for affected columns have been included.

Column 4 – Total Amount of Intangible Assets/Goodwill Included in Amount Shown in Column 8, Section 1

As explained in the instructions for Section 1, this amount is based on the intangible assets at goodwill purchase of the stock of the lower-tier company, reduced by any subsequent impairment/write-off. The reporting entity also bases the amount shown on the proportionate ownership of the lower-tier company.

Staff Review Completed by: Jim Pinegar & Fatima Sediqzad, NAIC Staff – January 2020

Status:
On March 18, 2020, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 68—Business Combinations and Goodwill, as illustrated above, to add additional goodwill disclosures. The proposed disclosures will improve the validity and accuracy of numbers currently being reported and will assist with the regulators’ review of reported assets not readily available for the payment of policyholder claims. Revisions to Schedule D, Part 6, Section 1 - Valuation of Shares of Subsidiary, Controlled and Affiliated Companies and Schedule D, Part 6, Section 2 - Valuation of Shares of Subsidiary, Controlled and Affiliated Companies primarily focus on the current reference to intangible assets. This item has a comment period deadline ending May 29, 2020.

On July 30, 2020, the Statutory Accounting Principles (E) Working Group adopted, as final, revisions to SSAP No. 68—Business Combinations and Goodwill, as illustrated below, adding goodwill disclosures that will improve the validity and accuracy of intangible assets currently being reported in the financial statements. This disclosure will be effective for the year-end 2021 financial statements.
Adopted disclosures in SSAP No. 68—Business Combinations and Goodwill:

Disclosures

15. For business combinations accounted for under the statutory purchase method, the financial statements shall disclose the following for as long as unamortized goodwill is reported as a component of the investment:

   a. The name and brief description of the acquired entity;
   b. Method of accounting, that is the statutory purchase method;
   c. Acquisition date, cost of the acquired entity, the original amount of goodwill and the original amount of admitted goodwill; and
   d. Each The SCA’s book value, the amount of amortization of goodwill recorded for the period; the SCA’s admitted goodwill as of the reporting date;
   e. Total admitted goodwill as of the reporting date; and
   d. Admitted goodwill as a percentage of the SCA’s book adjusted carrying value (gross of admitted goodwill).

16. For business combinations taking the form of a statutory merger, the financial statements shall disclose:

   f. The names and brief description of the combined entities;
   g. Method of accounting, that is the statutory merger method;
   h. Description of the shares of stock issued or cancelled in the transaction;
   i. Details of the results of operations of the previously separate entities for the period before the combination is consummated that are included in the current combined net income, including revenue, net income, and other changes in surplus; and
   j. A description of any adjustments recorded directly to surplus for any entity that previously did not prepare statutory statements.

17. The financial statements shall disclose the following information regarding goodwill resulting from assumption reinsurance:

   e. The name of the ceding entity;
   f. The type of business assumed;
   g. The cost of the acquired business and the amount of goodwill; and
   h. The amount of amortization of goodwill recorded for the period.

18. A reporting entity that recognizes an impairment loss shall disclose the following in the financial statements that include the period of the impairment write-down:

   a. A description of the impaired assets and the facts and circumstances leading to the impairment; and
   b. The amount of the impairment charged to realized capital gains and losses and how fair value was determined.
19. A reporting shall disclose the subcomponents and calculation of adjusted surplus and total admitted goodwill as a percentage of adjusted surplus:

Effective Date and Transition

22. This statement is effective for years beginning January 1, 2001. The provisions of this statement shall be applied to all business combinations entered into on or after January 1, 2001. Goodwill that had been written off prior to the effective date of this statement is prohibited from being restored for purposes of applying the provisions of this statement. The guidance in paragraphs 4-6 was previously included within SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities and was effective for reporting periods ending on and after December 31, 2007. In 2011, the guidance related to goodwill included in SSAP No. 97 was incorporated into this statement. The original guidance included in this standard, and the substantive revisions reflected in SSAP No. 97 are retained for historical purposes within Issue Paper No. 118. Guidance reflected in paragraph 1, incorporated from INT 03-16: Contribution of Stock, was effective December 7, 2003. Guidance reflected in paragraph 3 incorporated from INT 99-10: EITF No. 97-8: Accounting for Contingent Consideration Issued in a Purchase Business Combination was effective June 7, 1999. Disclosure modifications adopted in July 2020, reflected in agenda item 2020-03, are effective for the year-end 2021 financial statements.

Proposed Blank updates related to SSAP No. 68 include the following:

Footnote 3 (A) Illustration:

<table>
<thead>
<tr>
<th>Purchased Entity</th>
<th>Acquisition Date</th>
<th>Cost of Acquired Entity</th>
<th>Original Amount of Goodwill</th>
<th>Original Amount of Admitted Goodwill</th>
<th>Admitted Goodwill as of the Reporting Date</th>
<th>Amount of Goodwill Amortized During the Reporting Period</th>
<th>Book Value of SCA</th>
<th>Admitted Goodwill as a % of SCA BACV, Gross of Admitted Goodwill</th>
</tr>
</thead>
<tbody>
<tr>
<td>XYZ Insurance Company</td>
<td>6/30/___</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

New Footnote, proposed to be numbered 3(E):

<table>
<thead>
<tr>
<th>Capital &amp; Surplus</th>
<th>Calculation of Limitation using Prior Quarter Numbers</th>
<th>Current reporting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Admitted Positive Goodwill</td>
<td>&lt;XXX&gt;</td>
<td></td>
</tr>
<tr>
<td>Less Admitted EDP Equipment &amp; Operating System Software</td>
<td>&lt;XXX&gt;</td>
<td></td>
</tr>
<tr>
<td>Less Admitted Net Deferred Taxes</td>
<td>&lt;XXX&gt;</td>
<td></td>
</tr>
<tr>
<td>Adjusted Capital and Surplus</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>Limitation on amount of goodwill (adjusted capital and surplus times 10%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Current period reported
Admitted Goodwill

Current Period Admitted
Goodwill as a % of prior
period Adjusted Capital and
Surplus

XXX

In addition to the above, changes are proposed for the following schedules which detail the Valuation of Shares of Subsidiary, Controlled of Affiliated Companies. As previously addressed, column clarifications regarding the reporting of Goodwill as opposed to Intangible Assets (as currently indicated).

Schedule D – Part 6 – Section 1 (Original) – Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

<table>
<thead>
<tr>
<th>CUSIP Identification</th>
<th>Description Name Of Subsidiary, Controlled or Affiliated Company</th>
<th>Foreign</th>
<th>NAIC Company Code</th>
<th>ID Number</th>
<th>NAIC Valuation Method</th>
</tr>
</thead>
</table>

| 7 | Do Insurer’s Assets Include Intangible Assets Connected with Holding of Such Company’s Stock? |
| 8 | Total Amount of Such Intangible Assets |
| 9 | Book / Adjusted Carrying Value |
| 10 | Nonadmitted Amount |

<table>
<thead>
<tr>
<th>Stock of Such Company Owned by Insurer on Statement Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
</tr>
<tr>
<td>12</td>
</tr>
</tbody>
</table>

Schedule D – Part 6 – Section 1 (Proposed Tracked Changes) – Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

<table>
<thead>
<tr>
<th>CUSIP Identification</th>
<th>Description Name Of Subsidiary, Controlled or Affiliated Company</th>
<th>Foreign</th>
<th>NAIC Company Code</th>
<th>ID Number</th>
<th>NAIC Valuation Method</th>
</tr>
</thead>
</table>

| 7 | Do Insurer’s Assets Include Intangible Assets Connected with Holding of Such Company’s Stock? |
| 8 | Total Amount of Goodwill included in Book / Adjusted Carrying Value |
| 9 | Book / Adjusted Carrying Value |
| 10 | Nonadmitted Amount |

<table>
<thead>
<tr>
<th>Stock of Such Company Owned by Insurer on Statement Date</th>
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</thead>
<tbody>
<tr>
<td>11</td>
</tr>
<tr>
<td>12</td>
</tr>
</tbody>
</table>
Note 1 in Schedule D-Part 6-Section 1 (below), is proposed for removal due to the addition of footnote 3 (D). It is anticipated that if adopted as exposed, both changes would occur simultaneously.

1. Amount of insurer’s capital and surplus from the prior period’s statutory statement reduced by any admitted EDP, goodwill and net deferred tax assets included therein: $....................................
12. Total amount of tangible assets, goodwill nonadmitted $ .............................................................

For brevity, only instructions for affected columns have been included. Remaining paragraph numbers will be renumbered accordingly.

Column 7 – Do Insurer’s Assets Include Intangible Assets Connected with Holding of Such Company’s Stock?

State whether the assets shown by the reporting entity in this statement include, through the carrying value of stock of the SCA company valued under the SSAP No. 97—Subsidiary, Controlled and Affiliated Entities, intangible assets arising out of the purchase of such stock by the reporting entity or the purchase by the SCA Company of the stock of a lower-tier company controlled by the SCA Company. For purposes of this question, intangible assets at purchase shall be defined as the excess of the purchase price over the tangible net worth (total assets less intangible assets and total liabilities) represented by such shares as recorded, immediately prior to the date of purchase, on the books of the company whose stock was purchased.

Column 8 – Total Amount of Such Intangible Assets Goodwill

If the answer in Column 7 is “Yes,” give Report the total amount of intangible goodwill assets involved whether admitted or nonadmitted. The intangible assets shown for the SCA Company should include any intangible assets that are included in the SCA Company’s carrying value of the stock of one or more lower-tier companies controlled by the SCA Company. In all cases, the goodwill current intangible assets equals the goodwill calculated intangible assets at purchase, as defined above in SSAP No. 68—Business Combinations and Goodwill, minus any impairments/write-off thereof between the date of purchase and the statement date. If any portion of the total amount of intangible assets goodwill is required to be nonadmitted for all SCA companies combined in accordance with SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities and SSAP No. 68—Business Combinations and Goodwill state the total amount nonadmitted in the footnote at the bottom of the this section of the schedule.

Schedule D – Part 6 – Section 2 – Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

<table>
<thead>
<tr>
<th>1</th>
<th>CUSIP Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Name of Lower-Tier Company</td>
</tr>
<tr>
<td>3</td>
<td>Name of Company Listed in Section 1 Which Controls Lower-Tier Company</td>
</tr>
<tr>
<td>4</td>
<td>Total Amount of Intangible Assets Goodwill Included in Amounts Shown in Column 8, Section 1</td>
</tr>
<tr>
<td>5</td>
<td>Number of Shares</td>
</tr>
<tr>
<td>6</td>
<td>% of Outstanding</td>
</tr>
</tbody>
</table>

Stock in Lower-Tier Company Owned Indirectly by Insurer on Statement Date
For brevity, only instructions for affected columns have been included.

Column 4  —  Total Amount of Intangible Assets Goodwill Included in Amount Shown in Column 8, Section 1

As explained in the instructions for Section 1, this amount is based on the intangible assets at goodwill purchase of the stock of the lower-tier company, reduced by any subsequent impairment/write-off. The reporting entity also bases the amount shown on the proportionate ownership of the lower-tier company.
Interpretation of the Statutory Accounting Principles (E) Working Group

INT 20-09: Basis Swaps as a Result of the LIBOR Transition

INT 20-09 Dates Discussed

Email Vote to Expose July 15, 2020; July 30, 2020

INT 20-09 References

Current:
SSAP No. 86—Derivatives

INT 20-09 Issue

1. This interpretation is to provide statutory accounting and reporting guidance for “basis swaps.” Basis swaps within the scope of this interpretation are defined as compulsory derivatives issued by Central Clearing Parties (CCP), for certain cleared derivatives, issued solely in response to the market-wide transition away from the London Interbank Offered Rate (LIBOR) and toward the Secured Overnight Financing Rate (SOFR).

2. SOFR is a broad measure of the cost of borrowing cash overnight, generally collateralized by Treasury Securities. It represents nearly a risk-free rate that is correlated with other money market rates and is fully transaction based (thus ensuring full transparency), by reflecting a broad measure of overnight U.S. Treasury repurchase transactions. In conjunction with the transition from LIBOR, many alternative reference rates, such as the Effective Federal Funds Rate (EFFR), an interest rate typically utilized by banks representing a charge for overnight loans, used to meet regulatory reserve requirements, are also being transitioned to SOFR. Accordingly, under the general topic referred to as “Reference Rate Reform,” contracts which reference or utilize LIBOR or EFFR, are anticipated to be modified to reference SOFR.

3. The Working Group previously adopted INT 20-01: Reference Rate Reform, which substantially adopted ASU 2020-04 – Reference Rate Reform and applies to all SSAPs with contracts within scope of ASU 2020-04. INT 20-01 allows for contract modifications, due to reference rate reform, to be accounted for as a continuation of the existing contract and thus not requiring remeasurement. Among other things, INT 20-01 allows for 1) certain hedging relationships to continue without requiring redesignation upon a change in certain critical terms (i.e. changing reference rates), and 2) changes in the designated benchmark interest rate to a different eligible benchmark interest rate in a fair value hedging relationship. INT 20-01 recognized that many of these contracts, as part of the discontinuance of LIBOR, will transition to SOFR, an industry recognized preferred benchmark rate.

4. CCPs will make a similar transition, converting open derivative end-of-day valuation calculations from EFFR to SOFR. This transition will occur in two steps, both of which are anticipated to occur on October 16. First, the CCPs will conduct a standard end-of day valuation cycle based on EFFR. Then, the CCP will conduct a special valuation cycle on those same positions, however utilizing SOFR as the new, ongoing discounting rate. Based on the differences between EFFR and SOFR, the CCP will issue cash adjustments to each account to offset the value adjustments arising from the change in discount rates and additionally will issue mandatory EFFR/SOFR basis swaps, thus restoring the account holder’s original risk profile.

5. SSAP No. 86—Derivatives addresses the recognition and measurement of derivatives used for hedging, income generation, and replication transactions. Additionally, guidance is provided for derivatives not utilized for one of these broad categories (known as “other derivatives”). Derivatives that are classified as “other derivatives” are nonadmitted under SSAP No. 86, whereas derivatives in the other categories are admitted provided they conform to the requirements of the statement.
6. The accounting issues are:

   a. Issue 1: How should EFFR/SOFR basis swaps be classified and reported in the statutory financial statements?

   b. Issue 2: How should EFFR/SOFR basis swaps be valued in the statutory financial statements?

**INT 20-09 Discussion**

7. For Issue 1, the Working Group reached a consensus that mandatory basis swaps issued by CCPs, in response to reference rate reform, shall be classified as a derivative used for “hedging.” In collaboration with industry representatives, Working Group support staff has confirmed that a significant majority of the derivatives transacted through a CCP meet the definition of a hedging transaction. By using this “used for hedging” classification, instead of an “other derivative” classification, the basis swap derivative received will be admitted under SSAP No. 86.

8. For Issue 2, the Working Group reached a consensus that although the instrument shall be considered a hedging derivative, the instrument shall not be considered or reported as an “effective” hedging derivative (using the “hedge accounting” measurement approach permitted in SSAP No. 86), unless the instrument qualifies, with the required documentation, as a highly effective hedge under SSAP No. 86. Unless the effective hedge requirements are met, the instruments shall be reported on Schedule DB, utilizing the category of “Hedging Other.” Pursuant to the guidance in SSAP No. 86, if the basis swap derivative is not an effective hedge, the derivative shall be accounted for at fair value and the changes in fair value shall be recorded as unrealized gains or unrealized losses (referred to as fair value accounting.)

**INT 20-09 Status**

8. No further discussion is planned.
MEMORANDUM

TO: Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group

FROM: Kevin Fry, Chair, Valuation of Securities (E) Task Force

Cc: Charles Therriault, Director, NAIC Securities Valuation Office
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)
Julie Gann, Assistant Director, NAIC Financial Regulatory Services
James Pinegar, Manager II, NAIC Financial Regulatory Services

DATE: May 29, 2020

RE: Referral to the Statutory Accounting Principles (E) Working Group Requesting Affirmation that Non-conforming Credit Tenant Loan (CTL) Transactions that Relied Upon Credit Ratings are included in SSAP No. 43R – Loan-Backed and Structured Securities and Have the Characteristics of a Bond if Assigned an NAIC Designation by the SVO Staff.

1. Summary – Early in 2019 the SVO became aware that certain insurance company filers were submitting through the Filing Exempt (FE) process credit tenant loan (CTL) transactions that contained variants or deviations from the Bond Lease Based and Credit Lease Based CTL legal and structural characteristics not otherwise contemplated or defined in the P&P Manual (Non-conforming CTLs) and transactions which were subsequently defined in the P&P Manuel as ground lease financing (GLF) transactions. For example, several CTLs were submitted to the SVO which contained balloon payments of greater than 5% without residual value insurance or another acceptable mitigant. In another instance, a security was submitted for which the Credit Rating Provider (CRP) analysis explained that its rating relied on the “dark value” of the property to cover payment of principal on the notes. The P&P Manual requires all CTL structures to be submitted to the SVO for review so it can determine if they reflect bond characteristics and, if so, assign an NAIC Designation. The SVO considers GLF transactions, which were previously referred to the Working Group, to be distinct from CTL transactions and their related guidance in the P&P Manual. The SVO studied GLF transactions in detail and ultimately recommended new guidance for them to the Valuation of Securities (E) Task Force (the Task Force) which was adopted on Dec. 8, 2019. The SVO is now making a recommendation to the Task Force on addressing what they are calling Non-conforming CTL transactions that were submitted through the Filing Exempt (FE) process in reliance on CRP ratings instead of being submitted to the SVO for review, and to prevent future incorrect filing procedures. To effect such changes, the SVO proposed P&P Manual amendments to the policy in Part One, “The Use of Credit Ratings of NRSROS In NAIC Processes,” and in Part Three, “Credit Tenant Loans.”

2. The Referral - The SVO staff recommendation to the Task Force includes additional guidance in the policy on the “The Use of Credit Ratings of NRSROS In NAIC Processes” clarifying that there should be no presumption of permanent eligibility to receive an NAIC Designation based upon an NAIC CRP rating. The policy currently states, “The sole NAIC objective in obtaining and using publicly available credit ratings is to conserve limited regulatory resources; e.g., the resources of the SVO.” Additionally, the policy clarifies that in its use of CRP ratings the NAIC is not, “endorsing the credit rating or analytical product of any CRP.” Therefore, nothing about the use of CRP ratings should be interpreted, as was seemingly the case with Non-conforming CTLs and certain other investments, that the Task Force has approved the use of CRP ratings for the determination of NAIC Designations or for any other purpose, other than conserving SVO staff resources. The new policy guidance further affirms the Task Force’s role in making all decisions on the use of CRP ratings.
and provides additional guidance to insurance company filers on what to do if they are uncertain about the filing procedure for a particular security or class of securities.

The SVO further recommends a "grandfathering" provision to permit an insurance company filer to file Non-conforming CTLs, which it owned prior to January 1, 2020 and which have CRP ratings, with the SVO for assessment and to authorize the SVO to use its own judgement in assessing eligibility for an NAIC Designation and, if appropriate, to assign an NAIC Designation which need not correspond to the CRP rating.

The Task Force is referring this memo and proposed amendment to the Statutory Accounting Principles (E) Working Group and requesting the Working Group affirm that they would consider these Non-conforming CTLs to have the characteristics of a bond if assigned an NAIC Designation by the SVO staff. Like the referral from earlier this year on GLFs, these Non-conforming Credit Tenant Loan (CTL) Transactions have historically been reported under the Accounting Practices & Procedures Manual’s SSAP No. 43R – Loan-Backed and Structured Securities under Paragraph 27, b as a type of CTL. The SVO staff recommends affirming that treatment only if the SVO staff can assign an NAIC Designation.

Attached is the memorandum and the exposed amendment prepared by the staff for this request. Please direct any questions to Charles Therriault of the SVO.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force  
    Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
        Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) with Updated Instructions for Non-conforming Credit Tenant Loan (CTL) Transactions that Relied Upon Credit Ratings

DATE: April 30, 2020

1. Summary – Early in 2019 the SVO became aware that certain insurance company filers were submitting through the Filing Exempt (FE) process credit tenant loan (CTL) transactions that contained variants or deviations from the Bond Lease Based and Credit Lease Based CTL legal and structural characteristics not otherwise contemplated or defined in the P&P Manual (Non-conforming CTLs) and transactions which were subsequently defined in the P&P Manual as ground lease financing (GLF) transactions. For example, several CTLs were submitted to the SVO which contained balloon payments of greater than 5% without residual value insurance or another acceptable mitigant. In another instance, a security was submitted for which the Credit Rating Provider (CRP) analysis explained that its rating relied on the “dark value” of the property to cover payment of principal on the notes. The P&P Manual requires all CTL structures to be submitted to the SVO for review so it can determine if they reflect bond characteristics and, if so, assign an NAIC Designation. The SVO considered the GLF transactions to be distinct from CTL transactions and their related guidance in the P&P Manual. The SVO studied GLF transactions in detail and ultimately recommended new guidance for them to the Valuation of Securities (E) Task Force (the Task Force) which was adopted on December 8, 2019. Now we recommend addressing those Non-conforming CTL transactions that have been submitted through the Filing Exempt (FE) process in reliance on CRP ratings instead of being submitted to the SVO for review, and to prevent future incorrect filing procedures. To effect such changes, the SVO proposes P&P Manual amendments to the policy in Part One, “The Use of Credit Ratings of NRSROS In NAIC Processes,” and in Part Three, “Credit Tenant Loans.”

2. Recommendation – The SVO staff recommends that the Task Force include additional guidance in the policy on the “The Use of Credit Ratings of NRSROS In NAIC Processes” clarifying that there should be no presumption of permanent eligibility to receive an NAIC Designation based upon an NAIC CRP rating. The policy currently states, “The sole NAIC objective in obtaining and using publicly available credit ratings is to conserve limited regulatory resources; e.g., the resources of the SVO.” Additionally, the policy clarifies that in its use of CRP ratings the NAIC is not, “endorsing the credit rating or analytical product of any CRP.” Therefore, nothing about the use of CRP ratings should be interpreted, as was seemingly the case with Non-conforming CTLs and certain other investments, that the Task Force has approved the use of CRP ratings for the determination of NAIC Designations or for any other purpose, other than conserving SVO staff resources. The new policy guidance further affirms the Task Force’s role in making all decisions on the use of CRP ratings and provides additional guidance to
insurance company filers on what to do if they are uncertain about the filing procedure for a particular security or class of securities.

The SVO further recommends a “grandfathering” provision to permit an insurance company filer to file Non-conforming CTLs, which it owned prior to January 1, 2020 and which have CRP ratings, with the SVO for assessment and to authorize the SVO to use its own judgement in assessing eligibility for an NAIC Designation and, if appropriate, to assign an NAIC Designation which need not correspond to the CRP rating. The SVO also recommends referring this memo and proposed amendment to the Statutory Accounting Principles (E) Working Group and requesting the Working Group affirm that they would consider these Non-conforming CTLs to have the characteristics of a bond if assigned an NAIC Designation by the SVO staff.

3. Proposed Amendment – The following text in red shows the proposed revisions in Part One and Part Three.

PART ONE

POLICIES OF THE NAIC
VALUATION OF SECURITIES (E) TASK FORCE

THE USE OF CREDIT RATINGS OF NRSROs IN NAIC PROCESSES

NOTE: See “Policies Applicable to the Filing Exemption (FE) Process” below; “NAIC Policy on the Use of Credit Ratings of NRSROs” (especially “Definition – Credit Ratings Eligible for Translation to NAIC Designations”) in Part Two (the definition of “Eligible NAIC CRP Credit Ratings” excludes the use of any credit rating assigned to a security type where the NAIC has determined that the security type is not eligible to be reported on Schedule D or that it is not appropriate for NRSRO credit ratings to be used to determine the regulatory treatment of the security or asset); and “Procedure Applicable to Filing Exempt (FE) Securities and Private Letter (PL) Rating Securities” in Part Three.

Providing Credit Rating Services to the NAIC

57. The NAIC uses credit ratings for a number of regulatory purposes, including, to administer the filing exempt rule. Any rating organization that has been designated a Nationally Recognized Statistical Rating Organization (NRSRO) by the U.S. Securities and Exchange Commission (SEC) and which continues to be subject to federal regulation, may apply to provide Credit Rating Services to the NAIC.

1 Credit Rating Services is defined as: (a) electronic data feed transmissions of credit ratings assigned by the NRSRO with their corresponding CUSIP number and other pertinent security specific information in English, updated as frequently as provided to other customers; (b) other analytical services or products, in English, provided to other customers; and (c) access to the NRSRO’s rating analysts by SVO staff.
Policy and Legal Disclosure Pertaining to the NAIC Credit Rating Provider (CRP) List

58. The NAIC uses publicly available credit ratings, when available, as one component of the services it provides to state insurance regulators concerned with financial solvency monitoring of insurance company investments.

59. In adopting or in implementing the procedure described in this section, the NAIC acts solely as a private consumer of publicly available credit ratings. The sole NAIC objective in obtaining and using publicly available credit ratings is to conserve limited regulatory resources; e.g., the resources of the SVO. The VOS/TF has established the procedure specified in this section solely to ensure that the NAIC can avail itself of publicly available credit rating opinions.

60. The NAIC is not selecting, approving or certifying NRSROs or other rating organizations or distinguishing among them for any public or policy purpose whatsoever. Nor is the NAIC endorsing the credit rating or analytical product of any CRP or rating organization or distinguishing between CRPs or rating organizations for any specific public purpose. The NAIC disclaims any authority to regulate CRPs or rating organizations.

No Waiver/Express Reservation of Authority

61. Nothing in this section should be interpreted or construed as a waiver of the authority of the VOS/TF, in its sole and absolute discretion, to modify or change, in any manner whatsoever, the NAIC Policy on the Use of Credit Ratings of NRSROs, including but not limited to:

- Directing the removal of one or more NRSROs from the NAIC Credit Rating Provider List (subject only to the adjustment of any existing contractual obligations);
- Directing the SVO to study any issue related to NRSRO operations in furtherance of state insurance regulatory policy;
- eliminating the NAIC Credit Rating Provider List; or
- Directing any other action or activity the VOS/TF may deem to be useful or necessary to the creation, maintenance or discharge of state-based regulatory policy.

No Presumption of Permanent Eligibility Based Upon a NAIC CRP Rating

62. Nothing in this Manual should be interpreted or construed as affirming that a security has been explicitly approved by the VOS/TF as being permanently eligible to receive an NAIC Designation solely because it was rated by an NAIC CRP. Investment Securities that have received NAIC Designations based on an Eligible NAIC CRP rating through the filing exempt process could, upon direction from the VOS/TF, become subject to SVO or SSG review or declared ineligible to be assigned an NAIC Designation.
63. Securities that meet the general legal and structural characteristics of any type of Investment Security described in this Manual should be presumed to be governed by the policies specific to that type of Investment Security, including Filing Exemption eligibility, or lack thereof. It is incumbent upon the insurer to seek clarification from the SVO when a classification or regulatory treatment of a security is in doubt. Additionally, the insurer or SVO Director may, together or independently, propose amendments to this Manual as they deem appropriate to further clarify the classification or regulatory treatment of Investment Securities identified in this Manual consistent with the Procedures to Amend This Manual.

64. Insurers or other parties wishing to know the probable regulatory treatment and eligibility of a security are encouraged to utilize the Regulatory Treatment Analysis Service – Emerging Investment Vehicle process in this Manual to initiate such a regulatory review and interpretation by the SVO or SSG.
PART THREE

SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS

CREDIT TENANT LOANS

FILING INSTRUCTIONS

NOTE: See “Policies Applicable to Specific Asset Classes” in Part One for policies governing this activity, as well as “Specific Populations of Securities Not Eligible for Filing Exemption” in “Procedure Applicable to Filing Exempt (FE) Securities and Private Letter (PL) Rating Securities” above.

Non-conforming Transactions

70. An insurer that acquired a CTL that contains a variant or deviation from the Bond Lease Based and Credit Lease Based CTL legal and structural characteristics not otherwise contemplated or defined herein (a “Non-conforming CTL”) prior to January 1, 2020, may file it with the SVO. Along with each Non-conforming CTL, the insurer shall submit for review an Audited Financial Statement of the lessee, Credit Lease Based CTL Evaluation Form (including the documents described in the Evaluation Form), a separate memorandum identifying and describing the variants or deviations which make the investment a Non-conforming CTL and all Eligible NAIC CRP Rating analyses of the transaction. Subsequent filings shall require the most recent Eligible NAIC CRP Rating analyses of the transaction, if available from the CRP, and the Audited Financial Statement of the lessee. Upon review of the submission, the SVO may assign an NAIC Designation if the risks posed by the Non-conforming CTL’s variants are, in the opinion of the SVO, adequately mitigated and the Non-conforming CTL would be consistent with an investment security that has characteristics of a bond.

The SVO has complete discretion to make the determination of whether the CTL has characteristics of a bond and the NAIC Designation, including rejecting the transaction as not reflecting bond characteristics, adjusting the NAIC Designation for the transaction downward and away from the Eligible NAIC CRP Rating as the SVO deems analytically appropriate, or requesting additional information the SVO deems necessary for its analysis. If the Non-conforming CTL transaction does not maintain an Eligible NAIC CRP Rating for subsequent filings, the SVO has complete discretion to determine if an NAIC Designation can continue to be assigned. Non-conforming CTL transactions acquired by the insurer after December 31, 2019, shall not be reported as a bond.
71. As directed by the No Presumption of Permanent Eligibility Based Upon a NAIC CRP Rating section of this Manual, the VOS/TF considers securities that generally meet the legal and structural characteristics of Bond Lease Based or Credit Lease Based CTLs, but which do not meet all the specified characteristics, to be CTLs, and therefore not eligible for Filing Exemption and otherwise ineligible for reporting as a bond on Schedule D, except as explained in the paragraph above.
MEMORANDUM

TO: Dale Bruggeman (OH)
Chair of the Statutory Accounting Principles (E) Working Group

FROM: Commissioner Scott A. White (VA)
Chair of the Financial Condition (E) Committee

DATE: June 12, 2020

RE: Referral Regarding Reporting of “Basis” Swaps

The Financial Condition (E) Committee recently received a request from the American Council of Life Insurers relative to the treatment of certain “basis swaps” under state law as a result of the transition away from the London Interbank Offered Rate (LIBOR)(See attached presentation which includes the request). The request recognized that insurance companies are required to abide by investment guidelines and legal and regulatory constraints established by the state insurance law where most state laws limit insurers’ derivative use to the explicit activities of hedging, replication, and income-generation activities. As discussed in the presentation, as part of a market-wide transition away from LIBOR and toward the Secured Overnight Financing Rate (SOFR), U.S. central clearing counterparties (CCPs) will shift their discounting rate from the Effective Federal Funds Rate (EFFR) to the SOFR using a one-time special valuation cycle. This is expected to occur later this year on Oct. 16. As part of this unique market event, the CCPs will revalue existing cleared swaps and issue basis swaps on a mandatory basis to all parties that clear swaps on the CCPs to restore a counterparty’s original risk profile. The issue is that these swaps may not fit into one of these categories of permissible derivatives under state insurance law and therefore may not be allowed.

On June 12, the Committee issued a memorandum to all commissioners, directors and superintendents to make them aware of the issue and more specifically to indicate the Committee’s support to issue state bulletins allowing insurers to hold such swaps as “permissible derivative investments” for up to one year. The Committee made this determination on the basis that insurers have no control over the distribution of such basis swaps to them, and recognizing that insurers may be disadvantaged if required to dispose of such basis swaps upon receipt.

The original request was that these swaps be treated specifically as effective hedges. However, the Committee did not make a determination on the type of permissible investment and while the Committee did not believe that such a determination was needed for most state laws, a determination will be needed for reporting in the statutory financial statements. The Committee requests the Working Group address that specific reporting issue. If you have any questions, please contact Dan Daveline (ddaveline@naic.org).
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.

B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.

C. Coordinate with the Life Actuarial (A) Task Force on changes to the Accounting Practices and Procedures Manual (AP&P Manual) related to the Valuation Manual VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other Valuation Manual requirements. This process will include the receipt of periodic reports on changes to the Valuation Manual on items that require coordination.

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

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

NAIC Support Staff: Robin Marcotte
Accounting Practices and Procedures (E) Task Force
Conference Call
July 22, 2020

The Accounting Practices and Procedures (E) Task Force met via conference call July 22, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Jamie Walker (TX); Trinidad Navarro, Vice Chair, represented by Rylynn Brown (DE); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Sheila Travis (AL); Alan McClain represented by Mel Heaps (AR); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima M. Woods represented by N. Kevin Brown (DC); David Altmaier represented by Virginia Christy (FL); Doug Ommen represented by Kevin Clark (IA); Dean L. Cameron represented by Nathan Faragher and Amber Re (ID); Stephen W. Robertson and Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); James J. Donelon represented by Caroline Fletcher (LA); Gary Anderson represented by John Turchi (MA); Eric A. Cioppa represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Steve Kelley represented by Barbara Carey (MN); Chlorla Lindley-Myers represented by Debbie Doggett (MO); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride (NJ); Russell Toal (NM); Linda A. Lacewell represented by Robert Kasinow (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Jessica K. Altman represented by Joe DiMemno (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Larry D. Deiter represented by Johanna Nickelson (SD); Hodgen Mainda represented by Trey Hancock (TN); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte and David Smith (VA); Michael S. Pieciak represented by Karen Ducharme (VT); Mike Kreidler represented by Steve Drutz (WA); Mark Afable represented by Amy Malm (WI); James A. Dodrill represented by Jamie Taylor (WV); and Jeff Rude represented by Linda Johnson (WY).

1. Adopted Revisions to INT 20-08

Ms. Walker stated that on the July 1 conference call, the Financial Condition (E) Committee received and adopted the Accounting Practices and Procedures (E) Task Force report of interim adoptions of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group, except for Interpretation (INT) 20-08: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends. She noted that INT 20-08 was returned to the Task Force with direction to revise the Interpretation in a way that is still supported by two-thirds of the Task Force members and with the request that the Task Force consider incorporating flexibility in reporting. She stated that during the July 1 call, the American Property Casualty Insurance Association (APCIA) and a few other reporting entities were seeking alternative treatment to allow underwriting expense treatment for reporting entities, which made either manual rate filing or policy endorsements that allow for voluntary payments to policyholders, in response to decreased activity for COVID-19. Ms. Walker said while the reporting entities seeking this treatment are in the minority, they wanted to be permitted to follow this reporting approach without having to seek a permitted practice in multiple states.

Robin Marcotte (NAIC) provided a summary of the prior votes regarding INT 20-08. She stated that on June 15, INT 20-08 was adopted by the Statutory Accounting Principles (E) Working Group with a two-thirds majority vote as required by the NAIC Policy Statement on Maintenance of Statutory Accounting Principles (Policy Statement) for interpretations that provide new guidance or provide temporary overrides to existing guidance. She noted that the Policy Statement requires a minimum number of Working Group members to be present and voting (67%) and a super-majority supporting adoption for these interpretations to be adopted. She stated the voting requirements are in place to permit immediate adoption and application of statutory accounting guidance, most often in response to catastrophes or other situations that require a quick response. She noted that on June 22, INT 20-08 was adopted by a two-thirds majority of the Task Force with 28 members voting in favor, nine members dissenting, and one member abstaining. She stated that per the Policy Statement, these interpretations can be adopted, overturned, amended or deferred only by a two-thirds majority of the Task Force membership (e.g., 28 out of 42 members).

Ms. Marcotte stated that NAIC staff has drafted tracked updates to the proposed INT 20-08 for Task Force review based on input from Task Force members from California, Connecticut, Texas and Virginia. She stated that these representatives are also members of the Statutory Accounting Principles (E) Working Group. She noted that the proposed NAIC redraft included the following key revisions:
• Updated title as follows: INT 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends.
• Voluntary premium payments are an adjustment to premium unless the reporting entity is applying the limited-time exception described in the INT 20-08 or they have a different prescribed or permitted practice issued by their state of domicile.
• Limited-time exception to allow underwriting expense reporting is applicable only for property and casualty policies, which prior to June 15 filed manual rate filings or endorsements to allow for discretionary payments to policyholders due to COVID-19 related issues and disclosed the intent to apply expense treatment. This treatment does not require additional domestic regulator approval; however, if a domestic jurisdiction disapproved of this treatment, then the limited-time exception would not be permitted.
• Requires disclosure of all COVID-19 related payments in Note 21A as unusual or infrequent items by category (e.g., refunds, rate reductions, policyholder dividends, etc.).
• Requires disclosure of the application of the limited-time exception in the similar manner as a prescribed practice. This disclosure shall include the impact on operating ratios caused by use of the limited-time exception in Note 1.
• Strengthens the previously noted guidance that premium taxation is determined in accordance with the laws and administrative rules of the applicable jurisdiction. INT 20-08 defers to each jurisdiction’s premium tax requirements for the purposes of determining taxable amounts.
• INT 20-08 maintains the expiration date of Jan. 1, 2021.

Ms. Marcotte noted that there is a proposed edit to paragraph 24 for disclosures to ensure it includes all payments. She stated that the edit is to add the phrase “limited-time exception payments” in two places in the list of types of payments and to add quotes around the term “payments” in paragraph 24.b, as the disclosure includes payments and other methods, such as a lowered billing amount.

Ms. Belfi stated that the state insurance regulators who provided input to address the Financial Condition (E) Committee recommendations believe that the draft addresses the Committee’s direction to provide flexibility and preserves the statutory accounting standards. She noted that it addresses the perceived concern voiced by industry on prior calls that insurance groups with multiple domestic regulators may not all grant the same permitted practice for all members of the group. Ms. Belfi stated that while some of the state insurance regulators thought that the concern was unlikely, the limited-time exception addresses this possible issue. She stated that they continue to believe that the best disclosure of the limited-time exception is in annual statement footnote 1 as if it were a prescribed or permitted practice for a few different reasons. She stated that having premium reporting as the default and the limited-time exception disclosed fully allows state insurance regulators to demonstrate to federal and international regulators that we remain consistent in our core statutory accounting principles (SAPs). She noted that it also enables analysts to have information fully disclosed to identify the impacts on key ratios. She summarized that the redraft in the materials addresses the Financial Condition (E) Committee referral. Mr. Hudson stated that California supports the comments of Ms. Belfi and believes the redraft is a fair compromise.

Ms. Marcotte provided an overview of the comments received (Attachment Three-A). She noted that that prior to the public posting of the NAIC redraft of INT 20-08, the APCIA provided proposed draft revisions. She stated that the draft is very similar to a prior version discussed by the Working Group on May 20. She stated that instead of noting that underwriting expense treatment is an exception, the APCIA draft proposed to add a policyholder benefit issue as if underwriting expense treatment


Requires disclosure of all COVID-19 related payments in Note 21A as unusual or infrequent items by category (e.g., refunds, rate reductions, policyholder dividends, etc.).

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Ms. Marcotte stated that America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) provided comments after the posting of the NAIC redraft of INT 20-08 expressing support for the NAIC redraft, including that the limited-time exception for underwriting expense reporting should only be applicable to property and casualty lines because such reporting is problematic for health products.

Phillip L. Carson (APCIA) stated agreement and support for the NAIC redraft of INT 20-08. He stated that default reporting in INT 20-08 as an adjustment to premium was the position that the APCIA originally supported. He stated that the APCIA also later asked for an exception that allows underwriting expense reporting and the redraft to provide the limited-time exception. He said the APCIA encourages the Task Force to adopt the revisions to provide certainty for second quarter financial reporting.

Joseph E. Zolecki (BCBSA), representing the BCBSA and AHIP, stated support for the collaborative and expeditious revisions that provide reporting consistency and limited-time flexibility. He noted that as summarized by NAIC staff, their letter supports premium adjustment as the default treatment, and the limited-time exception applies only to property and casualty lines of business. He noted that limiting to the property and casualty lines of business will prevent any misapplication of the guidance for health carriers in the determination of federal or state MLR calculations.

Jim Braue (UHC) stated that the UHC and Anthem Inc. comment letter was submitted before the redraft was available. He noted support for the redraft, as it addresses the issues raised in their letter, and premium treatment is the appropriate accounting. He stated that scoping the limited-time exception to property and casualty lines helps to avoid any potentially serious issues related to the MLR rebate for health carriers and income taxes for policyholders. He stated that they believe the redraft addresses the issues noted in their letter, and he stated support for the redraft.

Mr. Bruggeman stated support for the work of the state insurance regulators that came together to draft a unique approach to the very unique circumstance. He stated that the use of the permitted and prescribed practice disclosure, which are already in place for exceptions, allows data capture for users of the financial statements. He noted that the strengthening of language regarding premium taxes was also beneficial. He encouraged industry members to be consistent in naming the COVID-19 relief payments for ease of identification in the financial statements and the notes.

Mr. Kasinow asked a question regarding the limited-time exception language that requires the reporting entities to have communicated to state insurance regulators their intention to report their payments to policyholders as expenses. He asked if such a disclosure is required to be with the rate filings and policy endorsements or if it could be a disclosure at some point in the process. Ms. Marcotte replied that because of the variety of ways this was accomplished, the format and timing of the discussion was not specified because different entities accomplished this in different ways; therefore, this is left to the judgement of the state of domicile.

Ms. Belfi made a motion, seconded by Mr. Hudson, to adopt the revised consensus in INT 20-08: COVID-19 Premium Refunds, Limited-Time Exception, Rate Reductions and Policyholder Dividends, as redrafted with the minor edit to the disclosure described by NAIC staff (see NAIC Proceedings – Summer 2020, Financial Condition (E) Committee, Attachment Seven). The motion passed with Michigan dissenting. The motion met the two-thirds membership required by the NAIC Policy Statement on Maintenance of Statutory Accounting Principles. The revised INT 20-08 is effective for second quarter 2020 reporting.

Ms. Marcotte noted that the revised INT 20-08 will be posted on the Statutory Accounting Principles (E) Working Group web page. She stated the next call of the Task Force will be Aug. 3, and the revised INT 20-08 will be included in the minutes reviewed by the Task Force as part of the virtual NAIC Summer National Meeting. She stated that the revised INT 20-08 will be reported to the Financial Condition (E) Committee on Aug. 11.

Ms. Walker noted the next call of the Task Force is Aug. 3, and attendees need to register for the virtual NAIC Summer National Meeting in order to attend.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.
## Accounting Practices and Procedures (E) Task Force
### July 22 Conference Call
#### Comment Letters

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Interpretation of the Statutory Accounting Principles Working Group

INT 20-08: COVID-19 Premium Refunds, Rate Reductions, Policyholder Benefit Payments and Policyholder Dividends

INT 20-08 Dates Discussed

Email Vote to Expose May 5, 2020; May 20, 2020; June 15, 2020

INT 20-08 References

SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets
SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items SSAP No. 53—Property Casualty Contracts—Premiums
SSAP No. 54R—Individual and Group Accident and Health Contracts SSAP No. 65—Property and Casualty Contracts
SSAP No. 66—Retrospectively Rated Contracts
SSAP No. 70—Allocation of Expenses

INT 20-08

Issue

COVID-19

1. A previously unknown virus began transmitting between October 2019 and March 2020, with the first deaths in the U.S. reported in early March 2020. The disease caused by the virus is known as Coronavirus Disease 2019 (COVID-19). Several states and cities issued “stay home” orders and forced all non-essential businesses to temporarily close. This led to a significant increase in unemployment and the potential permanent closure of many businesses. Total economic damage is still being assessed however the total impact is likely to exceed $1 trillion in the U.S. alone.

Premium Refunds, Rate Reductions, Policyholder Benefits and Policyholder Dividends

2. The federal, state or local government orders requiring non-essential workers to “stay home” caused a significant reduction in commercial and non-commercial activity, including automotive usage. Some consumer groups wrote letters and issued press releases calling for insurance premium refunds or pricing decreases, which included specific comments directed toward consumer automotive lines. The comments presumed that the decrease in activity would result in fewer losses.

3. Recognizing the extraordinary economic hardship experienced by their policyholders, the reduction in auto accident frequency, and the resulting decline in economic activity, many insurers designed various programs to provide a portion of the favorable experience realized from reduced accident frequency to policyholders. The underlying objective of the programs were to provide temporary relief to customers during the period that various government-imposed “stay home” orders remained in effect. Those government orders resulted in a significant decline in general economic activity and a significant reduction in accident frequency below historic levels. The methods utilized to deliver temporary relief to policyholders include voluntary premium refunds, future rate reductions, policyholder benefit payments (in certain instances, based on manual rule filings or policy endorsements) or policyholder dividends. Most of the relief programs relate to automotive lines of business.
Insurers have provided the policyholder relief in a variety of ways, including direct relief payments for in-force policies, as well as relief programs designed as rate reductions to be applied to future policy renewals.

Voluntary

4. The majority of the relief programs are being offered voluntarily and are not amounts required under existing policy terms. The aggregate monetary amount of the relief programs is considered materially significant.

Jurisdiction Directed

5. In addition, a few jurisdictions have issued bulletins directing refunds and rate reductions on accident and health insurance and varying lines of property and casualty insurance, including but not limited to: private passenger automobile, commercial automobile, workers’ compensation, commercial multiple peril, commercial liability and medical professional liability. In addition, some jurisdictions have indicated support for refunds or rate reductions, but also directed that payment of such amounts require either premium rate filings or policy form amendments.

Accounting Issues

6. The intent of this interpretation is to address the accounting and reporting for premium refunds, rate reductions, policyholder benefit payments and policyholder dividends attributable to COVID-19 impact on the private passenger and commercial auto insurance business. Due to the severity of the pandemic and the speed at which it emerged, different insurers designed and implemented policyholder relief programs that are fundamentally different, even if designed to achieve a similar objective. The intent of this guidance is to ensure that for accounting purposes, the programs are accounted for in accordance with their design and execution, and, separately, to provide policyholders and other stakeholders with information about the size and scope of the programs and the disclosures that should be required. This interpretation provides guidance on the following issues:

- Issue 1: How to account for refunds not required under the existing policy terms.
- Issue 2: How to account for refunds required under the existing policy terms.
- Issue 3: How to account for rate reductions on in-force and renewal business.
- Issue 4: How to account for policyholder benefit payments under modified policy terms.
- Issue 5: How to account for policyholder dividends.
- Issue 6: Where to disclose premium refunds, rate reductions, policyholder benefit payments and policyholder dividends related to COVID-19 decreases in activity.

INT 20-08 Discussion

7. As an overall guiding principle, the accounting shall follow existing statutory accounting principles and annual statement reporting where feasible, consistent with the design and execution of the programs. Insurers that filed policy endorsements or manual rule filings and disclosed with the relevant states their intention to report their payments to policyholders as expenses, before adoption of the INT, should treat those payments in accordance with Issue 4 below, while disclosing those payments as required in Issue 6 of the INT.

Issue 1: How to Account for Refunds Not Required Under the Policy Terms
8. The Working Group reached a consensus that voluntary premium refunds because of decreased activity related to COVID-19 and jurisdiction-directed premium refunds that are not required by the policy terms shall be accounted for as immediate adjustments to premium. The premium refunds shall be recognized as a reduction to written or earned premium and the unearned premium reserve adjusted accordingly.

9. Premium refunds shall be recognized as a liability when the definition of a liability in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets is met. For example, the declaration of a voluntary dividend by the board of directors will trigger liability recognition. In cases where the refunds are directed by a jurisdiction, the SSAP No. 5R definition of a liability shall be used to determine timing of liability recognition.

10. Immediate adjustment to premium is consistent with the existing guidance in SSAP No. 53—Property Casualty Contracts—Premiums. SSAP No. 53 guidance requires adjustments to the premium charged for changes in the level of exposure to insurance risk. It is also consistent with the treatment of loss sensitive premium adjustments in SSAP No. 66—Retrospectively Rated Contracts. While some of the voluntary or jurisdiction-directed refunds may not be required by the explicit policy terms, the principle of reversing premium in the same way that the premium was originally recognized continues to apply.

11. Immediate adjustments to premium for voluntary accident and health premium refunds is also consistent with the guidance in SSAP No. 54R—Individual and Group Accident and Health Contracts on contracts subject to redetermination. While some of the voluntary or jurisdiction-directed refunds may not be required by the explicit policy terms, the principle of reversing premium in the same way that the premium was originally recognized continues to apply. The liability for voluntary health premium refunds attributable to COVID-19 and which are not required under the policy terms shall be recognized in aggregate write-ins for other liabilities.

**Issue 2: How to Account for Refunds Required Under the Policy Terms**

12. While most of the premium refunds are voluntary or jurisdiction-directed and not required under the policy terms, some policies have terms that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses. If the policy terms change the amount charged, existing guidance in SSAP No. 53, SSAP No. 54R or SSAP No. 66 continues to apply:

   a. SSAP No. 53 provides guidance for policies in which the premium amount is adjusted for changes in the level of exposure to insurance risk. This is often seen in commercial lines of business such as workers’ compensation. The guidance notes that audits often occur after the policy term or mid-term in the policy. SSAP No. 53 refers to the adjustment to premium (either due to the customer or to the insurer) as earned but unbilled (EBUB) premium. SSAP No. 53 requires such adjustment to premium to be made immediately either through written premium or earned premium. SSAP No. 53 also requires recognition of the related liabilities and expenses such as commissions and premium taxes based on when the premium is earned.

   b. SSAP No. 54R provides guidance for policies subject to redetermination in which the premium is subject to adjustments by contract terms. This is commonly seen in federal and state groups. The guidance notes that estimates are based on experience to date and premium adjustments are estimated for the portion of the policy that has expired. Accrued return premiums are recorded as a liability with a corresponding entry to written premium. Refunds required under the policy terms would continue to be reported as retrospective or redetermination premium liabilities if applicable.

   c. SSAP No. 66 provides guidance for policies whose terms or legal formulas determine premium
based on losses. SSAP No. 66 references other applicable statements based on contract type for the initial accrual of premium. Estimates of premium adjustments are accrued based on activity to date and result in immediate adjustments to premium. SSAP No. 66 guidance specifies the corresponding annual statement reporting lines for different entity types.

Issue 3: How to Account for Rate Reductions

13. Some reporting entities are offering rate reductions instead of premium refunds. Some of these rate reductions provide one-time price decreases to future payments on in-force policies. Other reporting entities have provided offers of rate reductions on future renewals. Some of the offers for future rate reductions are only applicable to in-force policyholders as of a specified date. Some reporting entities have offered one-time rate reductions for future renewals for both existing and new policyholders for 2020.

   a. Rate reductions on in-force business shall be recognized as immediate adjustments to premium.

   b. Rate reductions on future renewals shall be reflected in the premium rate charged on renewal. The renewal is outside of the policy boundary and cannot require accrual before contract inception. While the amount of a future rate reduction can be estimated, it is not a change to existing policy terms and policyholders are not obligated to renew at the reduced rate; therefore, payment of the amount is avoidable. Such amounts shall be disclosed as discussed in Issue No. 5.

Issue 4: How to Account for Policyholder Benefit Payments Under Modified Policy Terms (e.g., Manual Rule Filings or Policy Endorsements)

15. In an effort to expedite relief to policyholders, certain insurers filed manual rule filings or policy endorsements to modify the terms of their insurance contracts to allow for the payment of discretionary policy benefits. In these instances, policy endorsements or manual rule filings were determined to be the most efficient method to provide relief to policyholders.

16. The manual rule filings or policy endorsements in paragraph 14 allowed for discretionary benefit payments to policyholders that were not otherwise provided under the contract (e.g., the payment did not result from an indemnifiable loss or a premium adjustment based on changes in insurance risk attributable to a policy change or cancellation) and were stated to be in response to circumstances surrounding COVID-19. The manual rule filings or policy endorsement was utilized to expedite relief to policyholders. These insurers represented in their filings that they would treat these payments as expenses. The manual rule filings or policy endorsements would not impact written premium and, therefore, would not result in adjustments to agent commissions. In determining the appropriate accounting and presentation of discretionary policy benefit payments provided through the manual rule filings or policy endorsements, the following factors should be considered:

   a. Accounting for discretionary policy benefits paid in accordance with contract terms modified through a manual rule filing or endorsement authorizing payment to policyholders that are not directly related to a change in the level of insurance risk is not specifically addressed in existing statutory accounting literature.

   b. SSAP 70, Allocation of Expenses, does, however, state that allocable expenses for property and casualty insurance companies shall be classified into one of three categories in the Underwriting and Investment Exhibit, as follows: loss adjustment expenses, investment expenses, other underwriting expenses. Other underwriting expense is defined as allocable expenses other than loss adjustment expenses and investment relate expenses.
Given the absence of existing definitive guidance, the need for insurers to expedite relief to policyholders, insurer representations in their state filings as to how these payments would be reported, and the fact that those filings were not disapproved by those states, it would be appropriate to allow those insurers to follow their conveyed relief programs and related accounting.

d. In those circumstances when an insurer modifies the terms of its insurance contracts to allow for discretionary payments that are not directly related to the level of insurance risk under the contract, the payments are not designed as a premium refund, and the insurer has represented in those manual rule filings or policy endorsements that the payment would be reported as an expense, the payment shall be accounted for as an “other underwriting expense”.

17. Policyholder payments shall be recognized as a liability when the definition of a liability in SSAP No. 5R – Liabilities, Contingencies and Impairments of Assets is met.

Issue 5: How to Account for Policyholder Dividends

18. SSAP No. 65—Property and Casualty Contracts, paragraph 46 requires that dividends to policyholders immediately become liabilities of the reporting entity when they are declared by the board of directors and shall be recorded as a liability.

19. The Working Group noted that policyholder dividends are typically only provided on participating policies or policies issued by non-stock companies, such as mutual entities and other corporate entity types in which profits are shared with policyholders.

20. Research during the development of this item identified that a small number of jurisdictions have legal restrictions which only allow policyholder dividends to be provided after the expiration of the policy period for which the dividend was earned. This interpretation only addresses policyholder dividends which are permitted by the applicable jurisdiction.

21. The property and casualty annual statement blank provides specific reporting lines for policyholder dividends including, but not limited to, a liability line and a line in the income statement and statement of cash flow. For those entities whose policies are participating or whose corporate shell type and/or membership structure allow for policyholder dividends, the accounting for policyholder dividends is unchanged by this interpretation.

22. This interpretation does not change the policyholder dividend disclosure or reporting, but provides additional guidance that such policyholder dividends issued in response to COVID-19 decreases in activity shall also be disclosed as discussed in Issue 6.

Issue 6: Where to Disclose Premium Refunds, Rate Reductions, Policyholder Benefit Payments and Policyholder Dividends Related to COVID-19 Decreases in Activity

23. There are various places in the notes to the statutory annual statement where disclosures of various aspects of premium refunds, premium reductions or policyholder dividends are required. This interpretation does not recommend changes to those existing disclosures. This interpretation does, however, recommend a consistent annual statement disclosure for all such amounts to allow for comparable disclosures.

24. SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items requires disclosure of the nature and financial effects of each unusual or infrequent event or transaction. Gains or losses of a similar nature that are not individually material shall be aggregated. This disclosure shall include the line items which have been affected by the event or transaction considered to be unusual and/or infrequent. This disclosure is currently required to be reported in annual statement Note 21A. (Reporting entities shall maintain jurisdiction-specific
To allow for aggregate, consistent assessment, the Working Group came to a tentative consensus that all COVID-19 inspired premium refunds, rate reductions, policyholder benefit payments and policyholder dividends shall be disclosed as unusual or infrequent items in annual statement Note 21A. This disclosure is in addition to other existing disclosures on various items related to the policyholder payments. For clarification, refunds required under the policy terms as discussed in paragraph 12, (i.e., policies that require an adjustment to premium based on either the level of exposure to insurance risk or the level of losses) are not required to be aggregated in disclosures of COVID-19 inspired premium refunds, rate reductions, policyholder benefit payments and policyholder dividends. Policies, whose terms were modified after the declaration of emergency in response to COVID-19, are required to disclose the COVID-19 inspired premium refunds, rate reductions, policyholder benefit payments and policyholder dividends.

INT 20-08 Consensus

The Working Group reached a consensus to prescribe statutory accounting guidance for insurance reporting entities providing refunds in response to COVID-19. Pursuant to this consensus:

a. Reporting entities that provide voluntary or jurisdiction-directed premium refunds that are not required under the policy terms shall follow the guidance in paragraphs 8-11 of this interpretation. This guidance stipulates that such premium refunds shall be recognized as a reduction of premium.

b. Reporting entities that provide premium refunds in accordance with insurance policy terms shall follow paragraph 13 of this interpretation. This guidance indicates that existing statutory accounting principles in SSAP No. 53, SSAP No. 54R or SSAP No. 66 shall be followed as applicable.

c. Reporting entities that provide rate reductions shall follow paragraph 14 of this interpretation. This guidance provides direction based on whether the rate reduction is for in-force or future policies.

d. Reporting entities that provide for the payment of discretionary policy benefits through a manual rule filing or policy endorsement that authorizes payments to policyholders not otherwise provided under the contract (e.g., not a payment resulting from an indemnifiable loss or a return of premium based on changes in insurance risk related to the policy or not related to a policy change or cancellation) and that disclosed in those filings that they intended to report those payments as expense shall account for the payments in accordance with the guidance in paragraphs 15 – 17. This INT addresses and is limited to the accounting for the particular circumstances when policyholder payments, as specified in modified policy terms, are related to conditions resulting from COVID-19 for manual rule filings or policy endorsements filed in response to COVID-19 activity.

e. Reporting entities that provide policyholder dividend shall follow the existing guidance for policyholder dividends, which is summarized in paragraphs 18-22 and in addition, shall complete the disclosures described in paragraphs 23-25.

f. Paragraphs 23-25 of this interpretation indicate that reporting entities shall continue to comply with all statutory accounting disclosure requirements, and also require that all premium refunds, rate
reductions, policyholder benefit payments and/or policyholder dividends provided because of the decreased activity due to COVID-19 shall be aggregated and reported in Note 21A as unusual or infrequent items.

g. Any related transactions that do not follow the fact patterns described in paragraph 26a through 26e should be considered a permitted or prescribed practice pursuant to SSAP No. 1.

27. The Working Group noted that premium taxation requirements vary by jurisdiction. Taxation is determined by the jurisdiction where the premium is written/returned to the policyholder according to the laws of that jurisdiction.

28. This interpretation will be automatically nullified on January 1, 2021 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “as of March 2021” Accounting Practices and Procedures Manual.

INT 20-08 Status

29. Further discussion is planned.
July 7, 2020

Commissioner Kent Sullivan, Chair
Accounting Practices and Procedures (E) Task Force
National Association of Insurance Commissioners

Via electronic mail to Robin Marcotte

Dear Commissioner Sullivan:

We submit these comments on behalf of the undersigned companies, who together provide insurance and health care coverage for millions of Americans, regarding the accounting treatment for refunds of premium to policyholders that are made in response to the COVID-19 pandemic.

Over the last several months, the emergence of the COVID-19 virus has caused well-documented challenges to people, businesses and institutions across national and global health care systems. Among them is the disruption to traditional patterns of delivering health care causing related economic disruption and imbalances to the nation’s health care coverage systems. In response to this challenge, the undersigned companies have taken a variety of actions to provide financial relief to our members. Once such action is the issuance of premium refunds, including voluntary refunds not outlined in the policy terms. It is the accounting for such programs of refunds or credits that is the subject of this letter.

As you are aware, we supported the accounting treatment proposed in INT 20-08T, as adopted by the Statutory Accounting Principles Working Group on June 15 and by the Accounting Practices and Procedures Task Force on June 22. The Financial Condition Committee has now asked you to reconsider that accounting guidance, in particular to allow more flexibility with regard to non-premium treatment. We strongly urge that any such “flexibility” be limited to the exception proposed in the June 25, 2020 letter from the APCIA, namely:

Companies that filed policy endorsements or manual rate filings and disclosed with the relevant states their intention to report their payments to policyholders as expenses before adoption of the INT should treat those payments as other underwriting expenses, while disclosing those payments as required in Issue 5 of the INT. This treatment would apply to all payments made through the end of 2020.

We urge furthermore that the revised interpretation make clear that this exception is being made as an accommodation, to address concerns raised by regulators and members of the property and casualty industry. We are concerned that any ambiguity on this point could create confusion, and resultant adverse consequences, for both insurers and policyholders.

We believe that treating such refunds and credits to policyholders as a reduction in premium is clearly the proper answer from the standpoint of accounting principles. The payments are not being made as the result of an insured loss, and therefore are not claim payments. They are not being made to purchase goods or services, or to pay for the services of the insurer’s own employees, and therefore are not general expenses. They are not being made pursuant to some statutory authority on the part of policyholders to tax or assess insurers; therefore, they are not taxes, regulatory fees, or assessments. Neither should they be relegated to an undefined, write-in expense category. We are crediting these amounts to policyholders solely because those same policyholders paid premium to us in the first place, and therefore the payments should be related to premium. We recount this at length because we are troubled by the suggestions that appropriate accounting treatment for purposes of solvency regulation should somehow be overridden by concerns such as maximizing premium tax revenue or facilitating the payment of agents’ commissions. We believe...
that it is imperative first to determine the conceptually appropriate accounting treatment, and then to carve out only such limited exceptions as are deemed necessary to address other regulatory goals.

We wish to point out two issues that could arise from creating ambiguity about whether these payments to policyholders are genuinely returns of premium: one from the insurer’s point of view, the other from the policyholder’s. Insofar as the insurer is concerned, it must be clear for purposes of the Affordable Care Act’s Medical Loss Ratio (MLR) rebate provisions that these payments are a reduction of premium. Otherwise, an insurer may be forced to refund the same premium dollar twice, once through these discretionary refunds and again as an MLR rebate. Clearly, it would be an undesirable outcome from the standpoint of solvency regulation that an insurer should be forced to pay out twice a dollar that it had only received once. If the discretionary refund is accounted for as an administrative expense or miscellaneous write-in item rather than a reduction of premium, it would not be given the correct treatment in the MLR rebate calculation, and the undesirable double-payment could result. Even if the refund is initially accounted for as a reduction of premium, if that treatment is viewed as being at the discretion of the insurer, it could be challenged when the MLR calculation is audited by either state insurance regulators or the Centers for Medicare and Medicaid Services.

Even more of a concern may be the potential impact on policyholders, as regards their income taxation. It is well established that a return of premium is generally not taxable to the policyholder; at most, if the premium payment was a deductible expense for that policyholder, the policyholder would lose that deduction. If the NAIC takes the position that these refunds are not a return of premium, that could add confusion to the policyholders’ tax positions. In particular for individual policyholders, for whom the premium payments would typically not be a deductible expense in the first place, this would raise the issue of whether they now have taxable income for federal and/or state income tax purposes. Policyholders would be forced to seek tax advice, or to make a decision on their own as to whether and how to report income from the refund. It is also worth considering whether the payment would be considered income for other purposes; e.g., if an individual policyholder is eligible for some form of government financial assistance, could this payment be deemed income that would reduce or eliminate that eligibility? While we hope that the respective governmental authorities would in each case reach an appropriate conclusion on these issues, we feel that raising the issues in the first place by an ambiguous accounting treatment would create unnecessary uncertainty and burdens for policyholders.

Accordingly, we reiterate our recommendation: that the revised INT make clear that these refunds generally are a return of premium; and that the only exception to that treatment is for the circumstances described in the APCIA’s letter, as cited above.

We would be happy to discuss this matter with you further.

Sincerely,

Anthem, Inc.

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July 17, 2020

Commissioner Kent Sullivan, Chair
Accounting Practices and Procedures (E) Task Force
c/o National Association of Insurance Commissioners

Via electronic mail to Robin Marcotte, NAIC Staff


Dear Commissioner Sullivan,

On behalf of America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA), we thank you for the opportunity to provide comments regarding the accounting treatment for refunds of premium to policyholders that are made in response to the COVID-19 pandemic. In these difficult times, providing financial relief in the form of voluntary premium refunds is among the variety of proactive measures for the hundreds of millions of members that AHIP and BCBSA members serve.

We laud the NAIC’s expeditious efforts through recent collaborative discussions at the Statutory Accounting Principles Working Group (SAPWG), this Task Force and Financial Condition (E) Committee to craft guidance that is flexible for the various ways that insurers report premium refunds, rate reductions and policyholder dividends.

We are writing to express our support of the proposed NAIC staff modifications made to INT 20-08T that are included in the materials for this Task Force’s consideration during its upcoming conference call meeting on July 22. We particularly agree with the bifurcated accounting optionality approach for refunds not required under the existing policy terms and the limited time exception for expense reporting as applicable to P&C lines only since underwriting expense treatment is problematic for health products.

We thank the entire Task Force for its consideration of our comments. If you have any questions, please do not hesitate to contact Joe Zolecki at joseph.zolecki@bcbsa.com or Bob Ridgeway at Bridgeway@AHIP.org.

Respectfully yours,

Joe Zolecki
Director, Financial Regulatory Services
Blue Cross Blue Shield Association

Bob Ridgeway
Senior Counsel, Government Affairs
America’s Health Insurance Plans
The Accounting Practices and Procedures (E) Task Force met via conference call June 22, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by Jamie Walker (TX); Trinidad Navarro, Vice Chair, represented by Rylynn Brown (DE); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Sheila Travis (AL); Alan McClain represented by Tony Gilbert (AR); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima M. Woods represented by N. Kevin Brown (DC); David Altmaier represented by Virginia Christy (FL); Doug Omnen represented by Kevin Clark (IA); Stephen W. Robertson and Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Bill Clark (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by John Turchi (MA); Eric A. Cioppa represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Steve Kelley represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by Diana Sherman (NJ); Russell Toal represented by Leatrice Geckler (NM); Linda A. Lacewell represented by Robert Kasinow (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger, Diane Carter and Andrew Schallhorn (OK); Jessica K. Altman represented by Joe DiMmem (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Larry D. Deiter represented by Johanna Nickelson (SD); Hodgen Mainda represented by Trey Hancock (TN); Todd E. Kiser represented by Jake Garm (UT); Scott A. White represented by Doug Stolte and David Smith (VA); Michael S. Pieciak represented by Karen Ducharme (VT); Mike Kreidler represented by Steve Drutz (WA); Mark Afable represented by Amy Malm (WI); James A. Dodrill represented by Tonya Gillespie (WV); and Jeff Rude represented by Linda Johnson (WY). Also participating was: Eric Moser (IL).


Mr. Bruggeman provided the report of the Statutory Accounting Principles (E) Working Group, which met June 15, May 20, April 15 and March 18. During these meetings, the Working Group took the following action:

   a. Adopted its Jan. 8 minutes, which included the following action:

      1. Adopted an editorial item (Ref #2019-44).

      2. Adopted its 2019 Fall National Meeting minutes.

   b. Adopted the following substantive revisions to statutory accounting guidance:


   c. Adopted the following nonsubstantive revisions to statutory accounting guidance:

      1. **SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments and SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities**: Revisions incorporate principle concepts that will restrict the classification of “rolling” related party or affiliated investments as cash equivalents or short-term investments. The investment schedule will identify investments (or substantially similar investments) that remain on the short-term schedule for more than one consecutive year. (Ref #2019-20)

      2. **SSAP No. 2R**: Revisions reflect that certain cash pools meeting defined criteria shall be reported as cash equivalents. (Ref #2019-42)
3. **SSAP No. 3—Accounting Changes and Corrections of Errors and SSAP No. 51R—Life Contracts**: Revisions specify that changes as a result of VM-21, Requirements for Principle-Based Reserves for Variable Annuities, optional phase-in requirements shall be disclosed as a change in valuation basis, with additional disclosures regarding the phase-in period beginning Jan. 1, 2020. (Ref #2019-47)

4. **SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities**: Revisions expand guidance regarding financial guarantees and the use of the equity method for when losses exceed the subsidiary, controlled and affiliated entity's (SCA’s) equity value. The reported equity losses of an SCA would not go negative (thus stopping at zero); however, the guaranteed liabilities would be reported to the extent that there is a financial guarantee or commitment. (Ref #2018-26)

5. **SSAP No. 5R, SSAP No. 72—Surplus and Quasi-Reorganizations, and SSAP No. 86—Derivatives**: Revisions reject Accounting Standards Update (ASU) 2017-11, Accounting for Certain Financial Instruments with Down Round Features; Replacement of the Indefinite Deferral for Mandatorily Redeemable Financial Instruments of Certain Nonpublic Entities and Certain Mandatorily Redeemable Noncontrolling Interests with a Scope Exception in SSAP No. 86 and incorporate guidance into SSAP No. 5R and SSAP No. 72, requiring issued, free-standing financial instruments with characteristics of both liability and equity to be reported as a liability to the extent that the instrument embodies an unconditional obligation of the issuer. (Ref #2019-43)

6. **SSAP No. 25—Affiliates and Other Related Parties**: Revisions data-capture existing disclosures, which are currently completed in a narrative format. A blanks proposal to data-capture the template was proposed to be concurrently exposed. (Ref #2019-33)

7. **SSAP No. 26R—Bonds**: Revisions clarify that the assessment of an other-than-temporary impairment (OTTI) shall be based on modified contract terms. The revisions provide consistency with guidance in **SSAP No. 36R—Troubled Debt Restructuring** and SSAP No. 103R. (Ref #2020-14)

8. **SSAP No. 41R—Surplus Notes**: Revisions require disclosures of surplus notes that are structured in a manner in which cash-flow exchanges have been reduced or eliminated. (Ref #2019-37)

9. **SSAP No. 47—Uninsured Plans**:
   i. Revisions reject ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers in SSAP No. 47. (Ref #2020-08)
   
   ii. Revisions reject ASU 2018-18, Collaborative Arrangements (Topic 808) in SSAP No. 47. (Ref #2020-09)

10. **SSAP No. 51R, SSAP No. 56—Separate Accounts, and SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance**: Revisions: 1) ensure that separate account guaranteed products are referenced in all applicable paragraphs of the withdrawal characteristics disclosures; 2) correct an identified inconsistency in one of the new disclosures regarding products that will move from the reporting line of having surrender charges at 5% or more to the reporting line of surrender charges at less than 5%; and 3) add a cross reference from SSAP No. 56 to the existing disclosures by withdrawal characteristics in SSAP No. 51R and SSAP No. 61R, as the disclosures include separate account products. (Ref #2019-35)

11. **SSAP No. 51R and SSAP No. 52—Deposit-Type Contracts**: Revisions add a footnote to aggregate deposit-type contracts, which are captured in annual statement Exhibit 5 – Life Contracts. This item did not result in statutory revisions, but instead it resulted in a blanks proposal. (Ref #2019-08)

12. **SSAP No. 53—Property and Casualty Contracts—Premiums**: Revisions clarify that the installment fee guidance should be narrowly applied. If warranted, a separate agenda item would be prepared to discuss any installment expense comments received from the Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk-Based Capital (E) Working Group, as they both were notified of the prior exposure. (Ref #2019-40)
13. **SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses**: Revisions emphasize existing guidance that loss and loss adjusting expense liabilities are established regardless of payments to third parties (except for capitated health claim payments). (Ref #2018-38)

14. **SSAP No. 62R—Property and Casualty Reinsurance**: Revisions incorporate disclosure updates for reinsurers from reciprocal jurisdictions. (Ref #2019-48)

15. SSAP No. 97: Revisions clarify that a more-than-one holding company structure is permitted for look-through if each of the holding companies within the structure complies with the look-through requirements in SSAP No. 97. (Ref #2019-32)


17. **Appendix A—Excerpts of NAIC Model Laws: Appendix A-001, Investments of Reporting Entities**: Revisions add a line for “Total Valuation Allowance” to Appendix A-001, Section 3, Summary Investment Schedule. (Ref #2020-07)

18. **Appendix B—Interpretations of Statutory Accounting Principles**:  
   
i. **Interpretation (INT) 20-01: Reference Rate Reform**: This interpretation provides optional guidance, allowing for the continuation of certain contracts that are modified in response to ASU 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting*. Additionally, it provides waivers from derecognizing hedging transactions and exceptions for assessing hedge effectiveness as a result of transitioning away from certain interbank offering rates. (Ref #2020-12 and INT 20-01)

   ii. **INT 20-02: Extension of Ninety-Day Rule for the Impact of COVID-19**: This interpretation provides an optional extension of the 90-day rule before nonadmitting premium receivables and receivables from non-government uninsured plans in response to COVID-19. (INT 20-02)

   iii. **INT 20-03: Troubled Debt Restructuring Due to COVID-19**: This interpretation clarifies that a modification of mortgage loan or bank loan terms in response to COVID-19, shall follow the provisions detailed in the April 7, 2020, “Interagency Statement on Loan Modifications and Reporting for Financial Institutions Working with Customers Affected by the Coronavirus,” and the provisions of the federal Coronavirus Aid, Relief and Economic Security (CARES) Act in determining whether the modification shall be reported as a troubled debt restructuring. (INT 20-03)

   iv. **INT 20-04: Mortgage Loan Impairment Assessment Due to COVID-19**: This interpretation provides limited time exceptions to defer the assessment of impairment for certain bank loans, mortgage loans and investments that predominantly hold underlying mortgage loans, which are affected by forbearance or modifications in response to COVID-19. (INT 20-04)

   v. **INT 20-05: Investment Income Due and Accrued**: This interpretation provides temporary exceptions for the assessment of collectability for specific investments, as well as exceptions on the nonadmittance of investment income due and accrued that becomes more than 90 days past due in response to COVID-19. (INT 20-05)

   vi. **INT 20-06: Participation in the 2020 TALF Program**: This interpretation provides guidance for reporting entities that participate as a direct borrower or material investor in the 2020 Term Asset-Backed Securities Loan Facility (TALF). This interpretation permits direct borrowers to admit securities pledged to the TALF program; although, the TALF program does not permit substitution of pledged assets if other admittance criteria is met. (INT 20-06)
vii. **INT 20-07: Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19**: This interpretation provides temporary practical expedients in assessing whether modifications in response to COVID-19 are insignificant under SSAP No. 36R and in assessing whether a modification shall be considered an exchange under SSAP No. 103R. (INT 20-07)

19. **Appendix D—Nonapplicable GAAP Pronouncements:**

i. Revisions reject **ASU 2016-14, Presentation of Financial Statements of Not-for-Profit Entities** as not applicable to statutory accounting. (Ref #2019-46)

ii. Revisions reject **ASU 2017-14, Amendments to SEC Paragraphs in Topic 220, Topic 605 and Topic 606** for statutory accounting. (Ref #2020-10)

iii. Revisions reject **ASU 2017-14, Amendments to SEC Paragraphs in Credit Losses (Topic 326) and Leases (Topic 842)** for statutory accounting. (Ref #2020-11)

d. **Adopted the following editorial revisions to statutory accounting:**

1. **SSAP No. 21R—Other Admitted Assets**: Removes the excerpts from SSAP No. 4—Assets and Nonadmitted Assets regarding the definition and accounting treatment for admitted assets. (Ref #2020-06EP)

2. **SSAP No. 51R**: Updates various paragraph references, requiring that changes in valuation basis be consistent with the originally adopted language in **Issue Paper No. 154—Implementation of Principle-Based Reserving, Exhibit A.** (Ref #2020-06EP)

3. **SSAP No. 62R**: Revisions update references in Exhibit A – Implementation Questions and Answers and paragraph 85 to match the current format of property/casualty (P/C) annual statement Schedule F – Reinsurance. (Ref #2019-44EP)

4. Various other SSAPs: Revisions revise all references to the annual statement instructions for consistency and combine life and fraternal statement references. (Ref #2019-44EP)

e. **Disposed the following without revisions to statutory accounting guidance:**

1. **Agenda item 2019-39**: Acceptable Collateral for Derivatives was disposed without statutory revisions as third-party derivative exposure through centrally cleared exchanges is appropriately captured in the existing financial statement disclosure requirements and blanks. (Ref #2019-39)

2. **Agenda Item 2019-41**: Eliminating Financial Modeling Process: This item proposed revisions to **SSAP No. 43R—Loan-Backed and Structured Securities** to remove the financial modeling process. This item was proposed in response to initial action by the Valuation of Securities (E) Task Force. As the Task Force has taken a different approach, this agenda item was disposed without statutory revisions. (Ref #2019-41)

f. **The effective dates for the following INTs are as follows:**

1. **INT 20-02, INT 20-04 and INT 20-05** are effective for the March 31, 2020, and June 30, 2020, financial statements only, but consideration of an extension will occur in August 2020.

2. **INT 20-03 and INT 20-07** have an effective date that mirrors the CARES Act and will only be applicable for the period beginning on March 1, 2020, and ending on the earlier of Dec. 31, 2020, or the date that is 60 days after the date on which the national emergency concerning the COVID-19 outbreak terminates.

Mr. Bruggeman made a motion, seconded by Mr. Hudson, to adopt the report of the Statutory Accounting Principles (E) Working Group (see **NAIC Proceedings – Summer 2020, Accounting Practices and Procedures (E) Task Force, Attachment One**). The motion passed unanimously.

Mr. Garn provided the report of the Blanks (E) Working Group, which met via conference call May 28 and took the following action:

a. Adopted its Dec. 17, 2019, minutes.

b. Adopted 24 proposals:

1. 2019-25BWG – Modify the instruction for Column 10 (Schedule F, Part 3 – Property and Schedule F, Part 2 – Life/Fraternal Workers’ Compensation Carve-out supplement) to remove instruction to exclude adjusting and other reserves from the column and add instruction to include those reserves with the defense and cost containment reserves. Add a new instruction for Column 12 for the same schedules. Add crosschecks to Schedule P, Part 1.

2. 2019-28BWG – Modify the instruction for Supplemental Investment Risk Interrogatories Lines 13.02 through 13.11 clarifying when to identify the actual equity interests within a fund and aggregate those equity interests for determination of the 10 largest equity interests.


4. 2019-30BWG – Add a category and instructions for Reciprocal Jurisdiction Companies in Schedule S for the Life/Fraternal and Health blanks and to Schedule F for the Property and Title blanks. Add a list of identification numbers in instruction to Schedule Y, Part 1A; Schedule Y, Part 2; and Schedule D, Part 6, Section 1 for Reciprocal Jurisdiction Companies. Add a reference to Reciprocal Jurisdiction Companies in the Trusteed Surplus Statement instructions for Life/Fraternal, Health and Property statements.

5. 2020-01BWG – Add crosschecks to Lines 13 and 14 of the Exhibit of Premiums, Enrollment and Utilization (State Page) to Lines 10 and 11 of the Underwriting and Investment Exhibit, Part 1. Add crosschecks to Lines 9, 10 and 11 of the Underwriting and Investment Exhibit, Part 1 and Schedule T, Line 61.

6. 2020-03BWG – Modify the instruction and illustration for 13(11) to the Notes to Financial Statement. Change the numbering from 1 through 13 to A through M to reflect the disclosure addition for SSAP No. 41R being adopted by the Statutory Accounting Principles (E) Working Group and correct the instruction.

7. 2020-04BWG – Modify the instruction and illustration for Note 23A – Unsecured Reinsurance Recoverables to reflect the disclosure addition for SSAP No. 62R being adopted by the Statutory Accounting Principles (E) Working Group.

8. 2020-05BWG – Modify the instruction and illustration for Note 2 – Accounting Changes and Correction of Errors to reflect the disclosure addition for SSAP No. 3 and SSAP No. 51R being adopted by the Statutory Accounting Principles (E) Working Group.


10. 2020-08BWG – Add a disclosure instruction for 10C to the Notes to Financial Statement for related party transactions not captured on Schedule Y to reflect the disclosure addition for SSAP No. 25 being adopted by the Statutory Accounting Principles (E) Working Group. Combine existing 10C into 1B instructions and illustration narrative.

11. 2020-09BWG – Modify the Annual Statement Instructions for Schedule F, Part 3 to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified and reciprocal reinsurance.
12. 2020-10BWG – Revise the column 10 header in the Variables Annuities Supplement Blank to be Contract Level Reserves Less Cash Surrender Value. Revise the line descriptions in Lines 1 through 3 in the footer and add a line for the Reserve Credit from Other Reinsurance and for Post-Reinsurance Ceded Aggregate Reserve. Adjust the instructions to correspond with changes made to the blanks, as well as changes in the 2020 Valuation Manual for the new Variable Annuities (VA) Framework.

13. 2020-11BWG – For the VM-20 Reserves Supplement Blank, split Part 1 into Part 1A and Part 1B.
   
   i. For Part 1A, change the description header for column 3 to Due and Deferred Premium Asset to match the instructions. Add “XXX” in the two places needed to indicate that a due and deferred premium asset does not need to be reported in the lines shown for Total Reserves. Change the reporting units for all columns to be in dollars rather than in thousands. Expand all columns to allow room for a number as large as 999,999,999,999. Change the product labels for clarity.

   ii. For Part 1B, change the reporting units for the reserve columns to be in dollars rather than in thousands. Expand the reserve columns to allow room for a number as large as 999,999,999,999. Expand the face amount columns to allow room for a number as large as 9,999,999,999. Change the product labels for clarity. Remove Part 2 and renumber the remaining parts. Adjust the instructions according to the changes made to the blanks. Clarify instructions and add examples for Parts 1A and 1B.

14. 2020-12BWG – The proposal will require appointed actuaries to attest to meeting continuing education (CE) requirements and participate in the Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) CE review procedures, if requested.

15. 2020-13BWG – Remove Line 24.04 from the General Interrogatories, Part 1 and renumber remaining lines for Interrogatory Question 24. Modify Lines 24.05 and 24.06 to require reporting amounts for conforming and non-conforming collateral programs.

16. 2020-14BWG – Modify the columns and rows on the blank pages for the Long-Term Care Experience Reporting Forms 1 through 5 and make appropriate changes to the instructions for those forms.

17. 2020-15BWG – Contains a new Private Flood Insurance Supplement collecting residential and commercial private flood insurance data and revisions to the Credit Insurance Experience Exhibit (CIEE) to collect lender-placed flood coverages.

18. 2020-16BWG – Modify Questions 3.1 and 3.2 of General Interrogatories Part 2 and provide instructions.

19. 2020-17BWG – Adjust the asset valuation reserve (AVR) presentation to include separate lines for each of the expanded bond designation categories.

20. 2020-18BWG Modified – Clarify the instructions to indicate which funds reported on Schedule D, Part 2, Section 2 (annual filing) and Schedules D, Part 3 and Part 4 (quarterly filing) must have an NAIC designation, NAIC designation modifier, and Securities Valuation Office (SVO) administrative symbol. Modify the reference to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) found in the following investment instructions.

21. 2020-19BWG – Add a code of “%” to the code column for all investments which have been reported on Schedule DA, Part 1 and Schedule E, Part 2 for more than one consecutive year. Add certification to the General Interrogatories, Part 1 inclusion of these investments on Schedule DA, Part 1 and Schedule E, Part 2 (SAPWG 2019-20).

22. 2020-20BWG – For Schedule D, Part 1, add code “10” to Column 26 – Collateral Type for ground lease financing. Renumber “Other” code to “11.”

23. 2020-21BWG – Add a new line 4.05 for valuation allowance for mortgage loans to the Summary Investment Schedule and renumber existing line 4.05 to 4.06. Modify the instructions to include a crosscheck for new line 4.05 back to Schedule B – Verification Between Years. Clarify the instructions for 4.01–4.04 to explicitly show crosschecking to Column 8 of Schedule B, Part 1.
24. 2020-23BWG – Add footnote to Exhibit 5 (life/fraternal & health – life supplement) and Exhibit 3 separate
counts to disclose cases when a mortality risk is no longer present or a significant factor; i.e., due to a
policyholder electing a payout benefit (SAPWG 2019-08).

c. Adopted its editorial listing.

Mr. Garn made a motion, seconded by Mr. Eft, to adopt the report of the Blanks (E) Working Group (Attachment Four-A). The
motion passed unanimously.

3. Adopted INT 20-08

The Task Force took a separate vote on INT 20-08: COVID-19 Premium Refunds, Rate Reductions and Policyholder Dividends,
which was adopted by the Statutory Accounting Principles (E) Working Group with a two-thirds majority vote. This separate
vote was to allow the discussion of additional industry comments. INT 20-08 provides guidance on how to account for premium
refunds, rate reductions and policyholder dividends in response to decreased insured activity related to COVID-19. With
regards to premium refunds that are outside of policy terms, INT 20-08 identifies that these shall be reported as a reduction of
premium and not as an expense. INT 20-08 provides that reporting in expenses would require a prescribed or permitted practice.
INT 20-08 also provides guidance on premium reductions and policyholder dividends. INT 20-08 directs an aggregate
disclosure to allow for the identification of the full impact from COVID-19 in the financial statements. INT 20-08 notes that
premium taxation is determined by the respective jurisdiction and not the interpretation. (INT 20-08)

Ms. Marcotte stated that per the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, interpretations
that provide new guidance or provide temporary overrides to existing guidance are required to be adopted by a two-thirds
majority of the Working Group. In addition, there is a requirement for at least two-thirds of the Working Group to be present
to vote. These vote requirements are in place to permit immediate adoption and application of statutory accounting guidance,
most often in response to catastrophes or other situations that need a quick response. Prior examples include hurricanes; the
California wildfires; and most recently, the COVID-19 pandemic. Additionally, per the policy statement, interpretations can
be adopted, overturned, amended or deferred by a two-thirds majority of the Task Force membership; however, this has not
previously occurred. Ms. Marcotte stated that INT 20-08 was originally exposed by email vote on May 5 and initially discussed
on May 20. After the May 20 discussion, which included consideration of comments received, the Working Group retained the
original concepts within the proposed interpretation but re-exposed the item to include additional provisions for health insurers
and disclosure refinements. On June 15, after discussion and consideration of the recent and previous comments received, the
Working Group adopted the interpretation with 13 members voting and two opposed, noting that the chair also did not vote, as
his vote would not have changed the outcome. The 13 members voting in the affirmative exceeded the two-thirds requirements
for adoption.

Ms. Marcotte stated that several comment letters were received noting that most commenters focused on Issue 1: How to
account for refunds not required under policy terms.

Ms. Marcotte stated there seems to be general support for:

- Issue 2: How to account for refunds required under policy terms.
- Issue 3: How to account for rate reductions on in-force and renewal business.
- Issue 4: Requires policyholder dividends to follow existing guidance and complete the disclosures per Issue 5.
- Issue 5: Requires reporting entities to comply with statutory accounting disclosure requirements, and requires that all
  premium refunds, rate reductions or policyholder dividends provided because of the decreased activity due to COVID-
  19, be aggregated and reported in Note 21A as unusual and infrequent items. She noted that the property and casualty
  actuaries who perform rate reviews and analysis noted that transparency will assist them in evaluating 2020 activity.

Regarding Issue 1, Ms. Marcotte stated that the refund will be an adjustment to written or earned premium with corresponding
adjustments to unearned premium, as applicable. Liability recognition is required in accordance with SSAP No. 5R. It also
states that refunds that are recognized in a different manner (e.g., as an expense), shall be considered a permitted or prescribed
practice pursuant to SSAP No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures. She stated Issue 2
specified that refunds required under policy terms shall be recognized as an adjustment to premium; however, discounts on
future business shall be recognized during the future policy period. Issue 3 addresses rate reductions on in-force and renewal
business, and it requires rate reductions on in-force business to be recognized as immediate adjustments to income.
Additionally, rate reductions on future business shall be reflected in premium upon renewal. Issue 4 requires policyholder dividends to continue following existing guidance and to complete the disclosures described in Issue 5. Ms. Marcotte stated that the interpretation notes that premium taxation requirements vary by jurisdiction, and it is determined by each jurisdiction as to whether premium taxation occurs on premium written or returned to the policyholder. Additionally, due to the short-term nature of the items included, this interpretation will be automatically nullified on Jan. 1, 2021. Ms. Marcotte stated the guidance provided in this interpretation would ensure continued financial statement comparability, with variations approved by state insurance regulators as permitted or prescribed practices to then be reported in a data-captured disclosure. Additionally, the guidance is consistent with existing guidance and historical precedent in which amounts returned to policyholders are recognized in the same manner in which they were originally recognized.

Ms. Marcotte stated industry support regarding Issue 1 remains divided. The industry representatives in support of premium reduction also noted historical precedent, comparability, as well as concern that changing policy forms to permit non-indemnity-based payments at the discretion of the company raises several additional issues for accounting and reporting. However, other industry representatives opposed the premium reduction proposal and supported reporting the refund as an underwriting expense, especially in cases where the insurer filed a policy endorsement or amended rate filing with their domestic regulator.

Phillip L. Carson (American Property Casualty Insurance Association—APCIA) stated that the APCIA offered a compromised reporting proposal to the Statutory Accounting Principles (E) Working Group; however, as the compromise was not adopted, the APCIA is requesting consideration at the Task Force level. The reporting compromise would only affect insurers that have filed an endorsement or an amended rate filing with the state. He noted that in these filings, the insurers communicated their intent to report the relief payments as a policyholder expense and desire to be allowed to do so while disclosing those payments per the requirements of this interpretation. This treatment would allow insurers who have taken such actions to continue to report the COVID-19 relief payments as an other underwriting expense. This treatment would apply to all applicable payments made during the remainder of 2020. Mr. Carson noted that the APCIA supports all other aspects of the interpretation; however, it is supportive of allowing a reporting exception for these insurers, who in good faith, developed COVID-19 relief programs and worked with state insurance regulators throughout the crisis. He stated that compromise would not jeopardize consistent reporting, as the disclosure requirements in the interpretation provide adequate financial information and would not negatively affect non-policyholder stakeholders, such as agent commissions or state premium taxes. Additionally, without a compromise, insurers will incur the burden of having to pursue numerous permitted practices in many jurisdictions.

Jeff Beck (Selective Insurance Company of America) stated their organization is comprised of multiple entities in numerous jurisdictions, and it will incur significant logistical challenges in attempting to obtain one consistent accounting treatment among the states in which it operates. He stated that it would be most efficient to allow reporting flexibility and thus not require the administrative process of pursuing a permitted practice, as is directed in the interpretation.

Jeffrey Shank (Progressive Insurance) stated that Progressive supports flexibility in the reporting of COVID-19 relief payments. Progressive operates in a dozen domiciliary states, which if the interpretation is adopted in its current form, will require the insurer to obtain multiple permitted practices. Mr. Shank noted that this process creates uncertainty, and it will likely result in greater inconsistency in reporting.

Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC) stated great respect for statutory accounting and analysis, but he noted that this event is unprecedented and that there is great diversity of actions and preferences among its members. Insurers acted in good faith and in the best interest of their policyholders, and NAMIC is requesting reporting flexibility due to the unprecedented nature of the return of funds to policyholders. Mr. Rodgers noted that without reporting flexibility, state insurance regulators will see an unprecedented volume of permitted practice requests. He stated that the process of obtaining a permitted practice will create an unnecessary hurdle, as flexibility could be granted, thus not requiring the exercise, cost and uncertainty in being granted permitted practice. He stated that in response to COVID-19, insurers have responded to hundreds of special requests or additional regulations—i.e., suspending cancellations for non-payments, waiving late fees, and waiving co-pays—and they view the relief payments, especially those made through a policy endorsement, all in the same category as insurers appropriately responded to the crisis. He stated that characterizing the return of funds to policyholders as a return of premium does not work for everyone. Due to the unprecedented nature of the return of funds to policyholders, the payments were done in a sense of urgency and generally with ongoing communication with domestic regulators. Mr. Rodgers noted that some members desired to treat the payments as a dividend, but they did not have the ability to do so. He stated that rather than pursuing permitted practices, the preferred method to clarify the accounting should be through an interpretation, however flexibility should be allowed so that the accounting through the INT process for such relief...
payments. He noted NAMIC’s support for allowing the method that was previously communicated with domestic regulators. He stated that if flexibility is not permitted, many companies will seek a permitted practice, which also further erodes the comparability of financial statements. Additionally, by not allowing flexibility to treat the relief payments as a reduction in revenues, the impact will be felt by agents through reduced commissions and by states through reduced premium taxes. Mr. Rodgers stated that NAMIC was supportive of the reporting compromise proposed by the APCIA.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that the CEJ began calling for premium relief payments at the early onset of COVID-19. He stated the relief was in correlation with the reduction in risk exposure of affected policies, i.e., a significant reduction in automobile usage, which occurred in early March 2020. The aggregate risk exposures for current policies reflect an overnight reduction in risk, and the return of funds reflect the return of premium associated with the reduced insured risk. Without these premium relief payments, insurers would have experienced windfall profits due to the significantly lower claim counts. Mr. Birnbaum stated that the premium relief was to reflect the new (reduced) expected risk exposure, and it was calculated as a percentage of premium for a certain number of affected months. He stated that to account for these relief payments as an expense would not be appropriate because they do not typically reflect an expense activity. In terms of consistent reporting, the permitted practice process allows for the possibility of inconsistent reporting, while if flexibility is granted in the interpretation, inconsistent reporting is almost assured. Mr. Birnbaum stated support for the accounting treatment as a return of premium, which would assist in both the comparability of financial statements and the ease in analysis by state insurance regulators.

Kevin Spataro (Allstate) stated support of the interpretation as it relates to premium refunds, rate reductions and policyholder dividends, but he stated that the interpretation should be expanded to allow flexibility in the accounting and reporting guidance for discretionary payments provided to policyholders. He stated that the disclosure proposed in the interpretation would provide adequate detail and transparency of the relief payments, and he is supportive of the compromised reporting as proposed by the APCIA and the comments of NAMIC, at least through the end of 2020. He stated that the calculation of the relief payment amounts was significantly more complex than simply reviewing miles driven, and thus a rate filing was not elected. At the time the funds were disbursed to policyholders, actuarial information, such as differences in crash severity, distracted driving, or other vehicle uses, was not available, thus an amended rate filing was not a viable option. Mr. Spataro stated that Allstate believes the nature of its payments to policyholders would qualify as an other underwriting expense, and it supports expanded comprehensive disclosures to detail the policyholder COVID-19 relief payments.

Keith Bell (Travelers) stated that Travelers arrived at the conclusion that these relief payments are in fact a reduction in premium because they reflected a reduction in risk exposures. He noted support for premium reduction for reasons similar to those listed by Mr. Birnbaum. Additionally, by not accounting for the relief payments as a reduction in premium, it would have been improperly reflected in the [pure] loss ratio. Mr. Bell noted that when Travelers heard that some industry members were advocating for expense reporting, it evaluated the definition of an expense and believed these payments did not fulfill the requirements for expense reporting in the guidance or SSAP No. 70—Allocation of Expenses. He said Travelers ultimately reviewed level five guidance in the statutory hierarchy, which includes Financial Accounting Standards Board (FASB) Concept Statement Number 6. He noted that the review concluded that the payments are a reduction of premium revenue. He stated that additionally, Travelers contacted several of its domestic regulators, and they also concurred with the treatments of such payments as a reduction to premium. He also noted that insurers all acted in the best interests of policyholders in returning funds quickly.

Rachel Underwood (The Cincinnati Insurance Companies) stated support for modifying the interpretation to allow for COVID-19 relief payments to be recognized as an expense. She stated that the Cincinnati Insurance Companies believe that reporting relief payments as an expense is the most conservative approach in that it would reflect the true nature of the cash outflows. She stated that if consistent reporting is the primary reason for not allowing flexibility in reporting, the interpretation already allows for some variation through the reporting of either a reduction in premium or a policyholder dividend. She stated that a specific expense line does not currently exist in the financial statements, so the use of an aggregate write-in expense is recommended. Additionally, underwriting or loss data was not evaluated when considering the calculation of the relief payments, thus it is not strictly a reduction to premium. If reported as a reduction to premium, analysis ratios, which rely heavily on premium, could be adversely affected. Ms. Underwood also noted a concern with potentially receiving different treatment from different states of domicile.

Ms. Belfi stated that during the financial crisis, multiple permitted practices were given to multiple companies covering a wide range of issues; however, despite this, there were not any issues with comparability due to the details that are required to be provided in footnote 1. Despite the multiple granted permitted practices, inconsistencies were not noted as a problem among
state insurance regulators, as they work well together and should not cause any undue process in granting permitted practices across multiple jurisdictions.

Ms. Underwood stated the financial crisis was significantly different than the COVID-19 pandemic currently being experienced. During the financial crisis, most permitted practices were related to investments and relief regarding other-than-temporary impairment analysis requirements. Ms. Underwood stated that this situation is different in that COVID-19 is broader and has a greater impact than just on an insurer’s investments. She stated that the nature of the relief payments does not reflect a reduction in premium nor a policyholder dividend, and she supports a one-time aggregate write-in as an expense. She stated that not allowing reporting as an expense feels like a disadvantage, as it creates a burden for insurers who will wish to seek a permitted practice close to the end of the quarter, when the end results will have the same net impact to the income statement.

Mr. Stolte inquired to previous commenters if a policy endorsement has historically allowed a separation from statutory accounting guidance regarding consistency, i.e., allowing a company to determine how financial items are reported.

Mr. Spataro responded that the endorsements are not in the statutory hierarchy. He noted that in his view the nature and intent of the policy endorsement reflects the true nature of the relief payments, that as a policyholder benefit. He said that is why Allstate concluded that expense treatment is appropriate.

Mr. Stolte stated he remained concerned with the lack of consistency if flexibility is granted in the interpretation. He stated that state analysts are experienced in reviewing footnote 1 in terms of permitted or prescribed practices, which note any impact on income or surplus and risk-based capital (RBC). Mr. Stolte stated that he believes not reporting the relief payments as a reduction to revenue does not reflect the economic reality of the transaction and that premium is an important metric. He also noted a concern regarding the comparability of treating some of the payments as a reduction of revenue and others as an underwriting expense.

Mr. Spataro noted support for adequate disclosure.

Mr. Birnbaum stated that if a reporting compromise is allowed, a new disclosure will be required to articulate and detail the financial impact of the relief payments. He noted that the proposed compromise would create diversity in reporting. This new disclosure causes concern, as it will need to be developed and interpreted, all while the existing disclosures required for a permitted practice have been in place for a number of years. Utilizing existing disclosures will ensure consistent reporting. Mr. Birnbaum stated that in response to reporting relief payments as an expense, many insurers called the payments “premium relief,” so by their own definition, this should reflect a reduction in premium.

Commissioner Robertson stated that while consistent reporting is important, we are in unprecedented times and every state has lost tremendous revenue due to the impacts of COVID-19. By requiring companies to record this as a return of premium, the states will be negatively affected through the reduction of premium tax paid to the states. The magnitude of the loss of tax revenue is significant, and Indiana will not support adoption of this interpretation. Commissioner Robertson prefers to account for all relief payments as an expense, with exceptions granted in certain circumstances regarding reductions to premium.

Ms. Brown stated that Delaware agrees with the comments stated by Commissioner Robertson, and it does not support the adoption of requiring relief payments to be accounted for a reduction in premium. She said Delaware would support allowing an aggregate write in as an other underwriting expense. She noted that the focus should be on the temporary issues caused by the pandemic.

Ms. Walker asked for a clarification regarding the position of Commissioner Robertson and Ms. Brown. She asked if their preference was in support of allowing flexibility in reporting or if the preference was to require all the payments be reported as an expense.

Commissioner Robertson noted a preference to have all of the payments be reported as an expense; however, he noted that he appreciates the need for flexibility to allow some of the amounts to be reported as a reduction of premium. He noted concerns about the possibility of state revenue reduction.

Ms. Brown noted support for Commissioner Robertson’s position.
Mr. Bruggeman stated he is open to flexibility in reporting, noting that these payments are akin to a policyholder dividend. He stated that the policy endorsements allowing optional payments are different than negative premium. He supports considering an alternative approach, such as an aggregate write-in, used solely for the purpose of the COVID-19 relief payments. He stated that he understands that the relief provided was not necessarily specific to underwriting, was provided to all applicable policyholders, and was performed at an enterprise level, rather than at an individual policy level. Additionally, if reported as a reduction to revenue, premium taxes, agent commission and reinsurance would be adversely affected.

Mr. Bruggeman noted that reporting as a reduction of premium would affect other schedules that premium is reported on. However, if allowed to be reported as an expense, the relief payments would be segregated so that they do not affect rate filings in upcoming years.

Mr. Bruggeman stated when reviewing on a U.S. generally accepted accounting principles (GAAP) vs. a statutory accounting basis, statutory accounting is more balance sheet focus and rigid in its reporting structure. However, U.S. GAAP filers would typically be allowed to create a supplemental reporting line related to relief payments. Accordingly, an aggregate write-in line, either as an underwriting expense or a negative write-in for miscellaneous income, should be considered for statutory accounting. Mr. Bruggeman stated that in terms of a permitted practice, they only apply to domestic regulated companies, not to all companies that write premium in their state (foreign insurers). He stated that diversity will be very prevalent amongst different filers throughout many states, all of which will have an impact on premium tax revenue. He stated Ohio is supportive of the APCIA proposed compromise.

Mr. Rehagen noted support for flexibility as described by Mr. Bruggeman.

Ms. Belfi stated that throughout the pandemic, state insurance regulators and industry have worked well together to ensure continued financial strength and solvency, all in the interest of policyholders. However, the fundamental building block of reporting consistency remains a cornerstone for statutory accounting. In terms of the flexibility requested by industry, the permitted practice process remains a viable, time tested process, which remains an option for state insurance regulators.

Ms. Belfi stated that the use of a consistent reporting process is important, as the accounting will affect critical ratios that are used for regulatory analysis, especially during COVID-19. She stated that footnote 1 is used to describe any differences in accounting. What is determined will set a precedent for future accounting policy during the next crisis.

Ms. Belfi stated Connecticut is supportive of the interpretation as written, requiring relief payments to be accounted for as a reduction in premium. She noted further that it is what was also communicated to their companies.

Mr. Stolte expressed agreement with the comments expressed by Ms. Belfi, stating consistent reporting is a critical aspect of statutory accounting. He noted that the prescribed or permitted practice is an option for those desiring flexibility in reporting. He noted that as a long-term original member of the Working Group.

Mr. Garn stated he understands the economic concerns noted by Commissioner Robertson. He noted that he serves on other councils dealing with the loss of revenue; however, the discussion today revolves around a technicality in accounting, thus purporting the reduction of revenue. He stated using a technicality to maintain the level of premiums solely to maintain state revenues might not be the best way to address the revenue issues.

Mr. Hudson stated that the discussion presented fair arguments for both perspectives; however, California remains supportive of accounting for COVID-19 relief payments as a reduction to premiums.

Mr. Moser stated that Illinois is a significant marketplace as many property and casualty insurers are domiciled within the state. He stated that Illinois believes that if an insurer has filed an endorsement with the state, then they should be allowed the option to report these relief payments as an expense. Additionally, with all the discussion on this topic, there will likely be great diversity in reporting, however Illinois is supportive of expense treatment in this circumstance.

Mr. Schallhorn expressed support for the position of Illinois.

Mr. Clark stated Iowa is in favor of the interpretation as written, noting that it provides clarity in reporting guidance, and it will ensure consistent reporting among insurers, all while providing flexibility in reporting through the permitted practice process.
Ms. Belfi made a motion, seconded by Mr. Stolte, to adopt the consensus in INT 20-08, as previously adopted by the Statutory Accounting Principles (E) Working Group (see NAIC Proceedings – Summer 2020, Financial Condition (E) Committee, Attachment Seven). The motion passed, with 28 members voting in favor and the following nine members dissenting: Delaware; Indiana; Louisiana; Massachusetts; Missouri; North Carolina; Ohio; Oklahoma; and Rhode Island. New Jersey abstained. The motion met the two-thirds membership requirement required by the NAIC Policy Statement on Maintenance of Statutory Accounting Principles. INT 20-08 is effective on its June 15, 2020, adoption and is effective for 2020 reporting.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met via conference call May 28, 2020. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair and Perry Kupferman (CA); Jeffery Bethel (AK); William Arfanis (CT); N. Kevin Brown (DC); Tom Hudson (DE); Carolyn Morgan (FL); Daniel Mathis and Carrie Mears (IA); Roy Eft (IN); Dan Schaefer (MI); Debbie Doggett (MO); Lindsay Crawford (NE); Doug Bartlett and Patricia Gosselin (NH); John Sirovetz (NJ); Tom Botsko, Dale Bruggeman and Tracy Snow (OH); Diane Carter (OK); Brian Fordham and James Borrowman OR); Joe DiMemmo (PA); Trey Hancock and Hui Wattanaskolpant (TN); Shawn Frederick (TX); Steve Drutz (WA); Randy Milquett (WI); and Jamie Taylor (WV). Also participating was: David Browning (MS).

1. **Adopted its Dec. 17, 2019, Minutes**

The Working Group met Dec. 17, 2019. During this meeting, the Working Group: 1) adopted its Oct. 22, 2019, minutes; 2) adopted two items previously exposed—a proposal that adds clarifying instructions to address questions that have been received regarding the new Analysis of Operations by Lines of Business on the life and health blank and a proposal that requests the removal of the alphabetic index from inclusion at the back of the annual statement blank, instructions and the Blanks (E) Working Group web page; 3) exposed its procedures; 4) exposed four proposals; and 5) adopted the editorial listing.

Mr. Eft made a motion, seconded by Mr. Sirovetz, to adopt the Working Group’s Dec. 17, 2019, minutes (Attachment Four-A1). The motion passed unanimously.

2. **Considered Adoption of Items Previously Exposed**


   Mr. Snow stated that this proposal modifies the instructions for column 10, Schedule F, Part 3 – Property and Schedule F, Part 2 – Life/Fraternal Workers’ Compensation Carve-Out Supplement, removing instructions to exclude adjusting and other reserves from the column. The proposal adds instructions to include those reserves with the defense and cost containment reserves. It adds a new instruction for column 12, incurred but not reported (IBNR) loss adjustment expense (LAE) reserves for the same schedules. It adds crosschecks to Schedule P, Part 1. He stated that there was a modification made to clarify that the crosscheck for column 10 does not apply to those companies participating in inter-company pooling participation arrangements where the participation percentage in Schedule P, Part 1, column 34 is not equal to zero.

   Mr. Snow made a motion, seconded by Mr. Hudson, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Sirovetz made a motion, seconded by Mr. Hudson, to adopt the modified proposal (Attachment Four-A2). The motion passed unanimously.

   b. **Modify the Instructions for the Supplemental Investment Risk Interrogatories Lines 13.02 Through 13.11 Clarifying When to Identify the Actual Equity Interests Within a Fund and Aggregate Those Equity Interests for Determination of the 10 Largest Equity Interests (2019-28BWG) Effective Dec. 31, 2020.**

   Mr. Bruggeman stated that the purpose of this proposal is to clarify when reporting entities are required to identify actual equity interests within a fund and aggregate those equity interests to determine their 10 largest equity interests. The Statutory Accounting Principles (E) Working Group adopted this item in December 2019. This proposal modifies those instructions for Supplemental Investment Risk Interrogatories lines 13.02 through 13.11.

   Mr. Bruggeman made a motion, seconded by Ms. Gosselin, to adopt the proposal (Attachment Four-A3). The motion passed unanimously.
c. **Modify the Instructions and Blank for Supplemental Investment Risk Interrogatories Question 14.01 (2019-29BWG)**


Mr. Bruggeman stated that the purpose of this proposal is to clarify that interrogatories 14.06 through 14.15 are to be completed regardless of the answer to Supplemental Investment Risk Interrogatories, question 14.01. This item is in response to questions received on a prior adoption change to specify what is captured in line 2 for total equity exposures. Essentially, the new disclosure for fund managers was captured after a threshold question. The clarification simply indicates that the fund manager disclosure should be completed regardless of that threshold provision. This proposal adds a note to lines 14.06 through 14.15 stating that these lines should be completed, even if the answer to question 14.01 is “yes.”

Mr. Bruggeman made a motion, seconded by Mr. Drutz, to adopt the proposal (Attachment Four-A4). The motion passed unanimously.


Jake Stultz (NAIC) stated that the intent of this proposal is to set up the annual reporting blanks for companies to report reinsurance with reciprocal jurisdiction reinsurers as soon as the states begin enactment of the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786). These minor revisions are similar to those that were made to incorporate the certified reinsurer provisions in 2011. The proposal adds the ability to report the new type of reinsurer and adds some descriptions of this new category of reinsurer.

Mr. Stultz stated that as a result of the interested party comments, there were several minor revisions highlighted in the proposal. He noted that an instruction was added for the annual 2020 reporting, which clarifies the details for proper reporting where the reporting entity’s software may not yet be able to capture reinsurance from reciprocal jurisdiction reinsurers. Additionally, NAIC staff have made a correction to the original exposed document. The reference to “Alien Insurer Identification Number” was stricken when “Certified Reinsurer Identification Number” should have been removed. This correction has been included in the document presented for adoption.

Ms. Doggett made a motion, seconded by Mr. Sirovetz, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Arfanis made a motion, seconded by Ms. Gosselin, to adopt the modified proposal (Attachment Four-A5). The motion passed unanimously.

e. **Add Crosschecks to Lines 13 and 14 of the Exhibit of Premiums, Enrollment and Utilization (State Page) to Lines 10 and 11 of the Underwriting and Investment Exhibit, Part 1. Add Crosschecks to Lines 9, 10 and 11 of the Underwriting and Investment Exhibit, Part 1 and Schedule T, Line 61 (2020-01BWG) Dec. 31, 2020.**

Ms. Gosselin stated that this proposal affects the health blank and adds crosschecks to line 13 and line 14 of the Exhibit of Premiums, Enrollment and Utilization (State Page) to line 10 and line 11 of the Underwriting and Investment Exhibit, Part 1 for the life and property premiums written. It adds crosschecks to line 9, line 10 and line 11 of the Underwriting and Investment Exhibit, Part 1 for the health, life and property premiums to tie to the respective columns within Schedule T for line 61.

Ms. Gosselin made a motion, seconded by Mr. Schaefer, to adopt the proposal (Attachment Four-A6). The motion passed unanimously.

f. **Modify the Instructions and Illustration for Note 10L to Reflect the Disclosure Changes for Statement of Statutory Accounting Principles (SSAP) No. 97—Investments in Subsidiary, Controlled, and Affiliated Entities Being Considered for Adoption by the Statutory Accounting Principles (E) Working Group (2020-02BWG).**

Mr. Bruggeman stated that this proposal was originally intended to modify the instructions and illustration for Note 10L—Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties to reflect SSAP No. 97—Investments in Subsidiary, Controlled, and Affiliated Entities disclosure changes planned for discussion by the Statutory Accounting Principles
Mr. Bruggeman stated that the purpose of this proposal is to reflect the disclosure addition for SSAP No. 41R—Surplus Notes adopted by the Statutory Accounting Principles (E) Working Group on May 20 and correct the instructions. This proposal modifies the instructions and illustration for 13(11) for the Notes to Financial Statement. It changes the numbering of 1 through 13 to A through M to be more consistent with numbering sequences. Interested parties also requested additional disclosure instructions to reference information about any guarantees, support agreements or related party transactions associated with the surplus note issuance, and whether payments have been made under such agreements. He stated that this corresponds to number 18.O of the Statutory Accounting Principles (E) Working Group exposure. It aligns the order of the disclosures between the Statutory Accounting Principles (E) Working Group and the Blanks (E) Working Group exposures. There were some editorial modifications made to the proposal as requested by interested parties.

Mr. Bruggeman made a motion, seconded by Ms. Crawford, to adopt the proposal (Attachment Four-A8). The motion passed unanimously.


Mr. Bruggeman stated that this proposal modifies the instructions and illustration for Note 2 – Accounting Changes and Correction of Errors to reflect the disclosure addition for SSAP No. 3—Accounting Changes and Corrections of Errors and SSAP No. 51R—Life Contracts adopted by the Statutory Accounting Principles (E) Working Group. He stated that interested parties proposed clarifying language defining the amounts to be disclosed, to use language consistent with VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and to recognize the role of VM-21 to define the reserve requirement.

Mr. Bruggeman made a motion, seconded by Mr. Milquet, to adopt the modified proposal (Attachment Four-A9). The motion passed unanimously.

j. Modify the Instructions and Illustration for Note 19 on Managing General Agents (MGAs) and Third-Party Agents (TPAs) to Reflect the Disclosure Addition for SSAP No. 51R—Life Contracts, SSAP No. 53—Property Casualty Contracts—Premiums, SSAP No. 54R—Individual and Group Accident and Health Contracts and SSAP No. 59—
Mr. Bruggeman stated that this item is still being considered by the Statutory Accounting Principles (E) Working Group. Due to the extent of expected future discussions, it is recommended that the Blanks (E) Working Group withdraw this proposal. A subsequent proposal will be submitted once the Statutory Accounting Principles (E) Working Group has further discussions and determines the appropriate revisions.


Mr. Bruggeman stated that the purpose of this proposal is to reflect the disclosure additions for SSAP No. 61R—Life, Deposit-Type Contracts and Accident and Health Contracts Reinsurance adopted by the Statutory Accounting Principles (E) Working Group. This proposal adds a new disclosure to Note 23 – Reinsurance for Reinsurance Credit (23H – Life/Fraternal, 23E Health and 23K Property). Interested parties had a previous comment regarding capturing the disclosure on a prospective basis. Mr. Bruggeman stated that the comment was rejected as part of statutory accounting.

Mr. Bruggeman made a motion, seconded by Mr. Hudson, to adopt the proposal (Attachment Four-A10). The motion passed unanimously.


Mr. Bruggeman stated that the purpose of this proposal is to reflect the disclosure addition for SSAP No. 25—Affiliates and Other Related Parties adopted by the Statutory Accounting Principles (E) Working Group in March 2020. This proposal adds a disclosure instruction for 10C to the Notes to Financial Statement for related party transactions not captured on Schedule Y. It combines the existing 10C into 1B instructions and illustration narrative. The interested parties made a few editorial revisions, which have been reflected in the proposal. Interested parties requested a few editorial changes, which were incorporated into the proposal as modifications. Interested parties also suggested that if this disclosure is to be data captured, then the normal instruction about using the exact format(s) needs to be added. That modification has also been made.

Mr. Bruggeman made a motion, seconded by Mr. Drutz, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Mr. Sirovetz, to adopt the modified proposal (Attachment Four-A11). The motion passed unanimously.

m. Modify the Annual Statement Instructions for Schedule F, Part 3 to Reflect the Factors for All Uncollateralized Reinsurance Recoverable from Unrated Reinsurers be the Same for Authorized, Unauthorized, Certified, and Reciprocal Reinsurance (2020-09BWG) Effective Dec. 31, 2020.

Mr. Botsko stated that this proposal modifies the annual statement instructions for Schedule F, Part 3 to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified, and reciprocal reinsurance. The factors for reinsurance recoverables from uncollateralized, unrated reinsurers is being updated by the Property and Casualty Risk-Based Capital (E) Working Group to move towards a charge that is more aligned with the risk-indicated factors used by the rating agencies. He stated that with respect to the broader implementation of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), the Working Group identified the need to eliminate the different treatment of uncollateralized reinsurance recoverables from the authorized versus unauthorized, unrated reinsurers.

Mr. Botsko made a motion, seconded by Mr. Milquet, to adopt the proposal (Attachment Four-A12). The motion passed unanimously.

n. Revise the Column 10 Header in the Variables Annuities Supplement Blank to be Contract Level Reserves Less Cash Surrender Value. Revise the Line Descriptions in Line 1 Through 3 in the Footer and Add a Line for the Reserve

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Jennifer Frasier (NAIC) stated that this proposal suggests changes to the Variable Annuities Supplement for the 2020 annual filing. The new framework for the variable annuities reserves was incorporated into the 2020 Valuation Manual. The proposal reflects those changes to include revising the column 10 header in blank to “Contract Level Reserves Less Cash Surrender Value.” It revises the line descriptions in the footer and adds a line for the reserve credit from other reinsurance and for post-reinsurance ceded aggregate reserve to be consistent with the framework changes in the 2020 Valuation Manual.

Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the proposal (Attachment Four-A13). The motion passed unanimously.

Ms. Frasier stated that this proposal makes changes to the VM-20, Requirements for Principle-Based Reserves for Life Products, Reserves Supplement blank and instructions for the 2020 filing. There are no new requirements, but there are two main changes to the supplement. For Part 1, the proposal requests changing the reserves to be reported in whole dollars rather than in thousands. She stated that in order to create enough space to allow for this, Part 1 has been split into Part 1A and Part 1B. The intent is to create more consistency with other blanks and reduce reporting errors. Ms. Frasier stated that the proposal also removes Part 2 as it is no longer applicable and re-numbers the remaining parts. She stated that there was an interested party comment regarding the reporting in whole dollars versus thousands. After discussions with interested parties, it was agreed to proceed without any modifications.

Mr. Sirovetz made a motion, seconded by Mr. Eft, to adopt the proposal (Attachment Four-A14). The motion passed unanimously.

Kris DeFrain (NAIC) stated that this proposal requests changes to the Property and Casualty Statement of Actuarial Opinion instructions to require appointed actuaries to meet the education requirements. Some interested party comments were received. Phil Vigliaturo, Casualty Actuarial and Statistical (C) Task Force chair, provided a statement to address the comments. Ms. DeFrain read the statement: “The annual statement instructions in this proposal is in response to the Casualty Actuarial and Statistical (C) Task Force’s continued competence charge, which originated from the Executive (EX) Committee and was adopted by the Property and Casualty Insurance (C) Committee in 2017. It was decided at a higher level than the Casualty Actuarial and Statistical (C) Task Force that this project be performed. The annual statement instructions merely lay the framework for the continuing education (CE) log.

The Casualty Actuarial and Statistical (C) Task Force asked for all of the professional organizations in the United States to participate in the discussion. The Casualty Actuarial Society (CAS) and the Society of Actuaries (SOA) agreed to participate. Most of the remaining comments address the actual CE log, which is not addressed in detail in the annual statement instructions, but instead is being discussed by the Task Force. That discussion does not belong to the Blanks (E) Working Group given the annual statement instructions are meant only to lay the framework for the CE log. The annual statement instructions do not include the detail about the CE log to be required by the CAS and SOA. Therefore, Mr. Vigliaturo asked the Blanks (E) Working Group to adopt the proposal without modification.
Shawna Ackerman (American Academy of Actuaries—Academy) stated that she respects the comments read and is limiting her comments to the framework. As was stated in its May 5 comment letter, the Academy believes it is not necessary as part of the framework because the certification is redundant to the instruction that the NAIC already provides, which requires the appointed actuary to state that he or she is qualified. Ms. Ackerman stated that this would cover all aspects of CE. She stated that secondly, with regards to the framework, the Academy is very concerned with qualifications as is the NAIC. She indicated that the Academy has existing tools that both attest to the qualifications of actuaries and track annual CE, and that it offers those tools again, as well as its help with the certification process, to meet the NAIC’s goals without developing something in addition to what is currently in existence. Mr. Garn stated that he appreciates the Academy’s comments. However, he said this is an issue that should be more appropriately addressed by the Casualty Actuarial and Statistical (C) Task Force and not the Blanks (E) Working Group.

Mr. Hudson made a motion, seconded by Mr. Drutz, to adopt the proposal (Attachment Four-A15). The motion passed unanimously.


Mr. Botsko stated that this proposal removes line 24.04 from the General Interrogatories, Part 1, and modifies line 24.05 and line 24.06 to require reporting amounts for conforming and nonconforming collateral programs. This affects all statement types. He stated that interrogatory question 24.05 and question 24.06 are completely dependent on the answer to question 24.04, which works for companies that have either all conforming or all nonconforming collateral programs. When a company has both, only the collateral amount of the conforming programs is captured. This proposal allows the capture of the amount of collateral for both conforming and nonconforming collateral programs when a company has both.

Mr. Botsko made a motion, seconded by Mr. Drutz, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Botsko made a motion, seconded by Mr. Milquet, to adopt the modified proposal (Attachment Four-A16). The motion passed unanimously.

r. Modify the Columns and Rows on the Blank Pages for the Long-Term Care Experience Reporting Forms 1 Through 5 and Make Appropriate Changes to the Instructions for Those Forms (2020-14BWG) Effective Dec. 31, 2020.

Mr. Kupferman, Long-Term Care Actuarial (B) Working Group chair, stated that about 15 years ago, the long-term care (LTC) reporting forms were developed, put into effect and have been reported every year. He stated that the Working Group was surveyed and found that there was very limited use of the current data. Around the same time, Mr. Kupferman received a request from one of the LTC executive committees asking for more meaningful data. Over a three-year period, the Working Group worked to develop changes to the forms that provided more information about stand-alone LTC and the newest version of the hybrid riders to be better able to respond to state insurance commissioners or media requests. Within this proposal, four of the five forms have been revised to accommodate those changes. The changes include separate reporting for individual, for group and for stand-alone policies by state. The Working Group believes this is a vast improvement over the current forms. The changes have been vetted by the Working Group, as well as the Health Actuarial (B) Task Force, and discussed with the America’s Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI).

Mr. Kupferman made a motion, seconded by Mr. Sirovetz, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Hudson made a motion, seconded by Schaefer, to adopt the modified proposal (Attachment Four-A17). The motion passed unanimously.


Mr. Browning stated that this proposal adds a new supplement to collect private flood insurance data for residential and commercial private flood insurance and revises the Credit Insurance Experience Exhibit (CIEE) to collect lender-placed flood coverages. He stated that throughout 2019, the Property and Casualty Insurance (C) Committee discussed the need for more granular private flood insurance data. Currently, the only private flood data that exists on the Exhibit of Premiums and Losses (state page) does not distinguish between commercial and residential policies and, therefore, has limited utility. The NAIC reports on this data every year, but state insurance regulators and interested parties cannot get a true picture of the growth of
the private residential flood market from the state page. For several years, state insurance regulators have worked on building the private flood market in their states so citizens can be better protected from flood risk. The Federal Emergency Management Agency (FEMA) has had a goal of doubling flood insurance, whether through the National Flood Insurance Program (NFIP) or private policies, and have asked the NAIC to collect more detailed private flood data. Mr. Browning stated that the Property and Casualty Insurance (C) Committee adopted this proposal in an attempt to help state insurance regulators better understand the true growth of the private flood market and the type of polices being written.

Mr. Browning stated that this proposal will separate residential from commercial, as well as capture stand-alone/endorsement and first-dollar/excess policy information. The revisions to the CIEE will allow for the collection of lender-placed flood coverages in order to get a more complete picture of the private flood insurance market. Interested parties have expressed concern with reporting IBNR reserves. Therefore, some modifications have been made to the proposal that would split direct losses into losses paid and paid plus case reserves and case reserves. Similar changes were made to the defense and cost containment expense columns. Interested parties agreed with these changes.

Mr. Hudson made a motion, seconded by Ms. Doggett, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Hudson made a motion, seconded by Ms. Doggett, to adopt the modified proposal (Attachment Four-A18). The motion passed unanimously.


Mr. Borrowman stated that the purpose of this proposal is to clarify capturing whether reporting entities have written participating policies in the current calendar year and reporting amount of premium written for both participating and non-participating policies. It modifies question 3.1 and question 3.2 of General Interrogatories Part 2 and provides instructions for the questions to clarify the intended reporting. Question 3.1 currently asks if participating policies are going to be disclosed if both participating and non-participating policies are written. This created a situation where a company that writes participating polices only did not need to answer the subsequent question, which was for the amount. He stated that this proposal removes the word “both” from the question so the amounts would have to be disclosed as well in question 3.2 any time participating policies are being written.

Mr. Borrowman made a motion, seconded by Mr. Sirovetz, to adopt the proposal, including the friendly amendment (Attachment Four-A19). The motion passed unanimously.


Mr. Botsko stated that this proposal adjusts the asset valuation reserve (AVR) presentation to include separate lines for each of the expanded bond designation categories. He stated that the Blanks (E) Working Group and the NAIC Security Valuation Office (SVO) have adopted the 20 bond designations for 2020 reporting in the investment schedules and in the AVR. The reported designations will flow into the risk-based capital (RBC) formula but will not include factors. The current factor for designations 1–6 will remain in the RBC until an impact analysis can be done to confirm the new factors for the 20 designations. This proposal applies the same expanded presentation to the AVR as it is used to populate the life RBC formula.

Mr. Botsko made a motion, seconded by Milquet, to adopt the proposal (Attachment Four-A20). The motion passed unanimously.


Charles Therriault (NAIC) stated that this proposal clarifies the instructions for reporting the NAIC designations, NAIC designation modifiers and SVO administrative symbols for fund investments reported on the common stock schedule. The symbols should only be used for securities reported in the line numbers specified in the proposal for mutual funds, unit investment trusts and closed-end trusts. Otherwise, these NAIC designation fields should not be reported. He stated that additional information was also added to reference where a list of these funds can be found on the SVO web page and how to
receive the NAIC designations published in AVS+ per the instructions in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) on the compilation and publication of the SVO List of Investment Securities.

Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the proposal including the editorial correction (Attachment Four-A21). The motion passed unanimously.

**w. Add a Code of “%” to the Code Column for All Investments Which have been Reported Schedule DA, Part 1 and Schedule E, Part 2 for More Than One Consecutive Year. Add Certification to the General Interrogatories, Part 1 Inclusion of These Investments on Schedule DA, Part 1 and Schedule E, Part 2 (2020-19BWG) Effective Dec. 31, 2020.**

Mr. Bruggeman stated that the purpose of this proposal is to identify instances where cash equivalents and/or short-term investments, or substantially similar investments, remain on the applicable investment schedule for more than one reporting period (i.e., reported as a short-term investment for more than one consecutive year due to the investment being re-underwritten and renewed). This proposal adds a code of “%” to the code column for all investments that have been reported on Schedule DA, Part 1, and Schedule E, Part 2, for more than one consecutive year. It adds a certification to the General Interrogatories, Part 1, questioning the inclusion of these investments on Schedule DA, Part 1, and Schedule E, Part 2.

This item was adopted by the Statutory Accounting Principles (E) Working Group on May 20, and it was noted that the disclosure reference in SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments only included short-term investments. The Statutory Accounting Principles (E) Working Group is planning a subsequent agenda item to specifically include cash equivalents. Mr. Bruggeman stated that he agrees with proceeding with the current proposal with the adoption as planned, pending the adoption of the Schedule E, Part 2, reference by the Statutory Accounting Principles (E) Working Group. If the Statutory Accounting Principles (E) Working Group does not subsequently include the cash equivalents reference, then that will be noted as an editorial change and removed from the financial reporting instructions.

Interested parties suggested modifying this exposure to be consistent with the corresponding Statutory Accounting Principles (E) Working Group exposure by adding clarifying language to the instructions. For Schedule DA – Part 1, Column 2, on page 2 of the proposal, revise the % definition as follows: “Enter “%” in this column for all investments, except cash pooling structures and money market mutual funds, which have been reported on this schedule for more than one consecutive year.” Mr. Bruggeman indicated that this change is not being done because money market mutual funds not reported on the schedule and qualifying cash pools are to be reported on Schedule E, Part 2 as other cash equivalents. The suggestion for Schedule E – Part 2, column 3 on page 3 and page 5 of the portable document format (PDF) being revised to reference the “%” in this column for all investments, except cash pooling structures and money market mutual funds, which have been reported on this schedule for more than one consecutive quarter, but also to include the SSAP No. 2R reference.

Mr. Bruggeman made a motion, seconded by Mr. Hudson, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Mr. DiMemmo, to adopt the modified proposal pending the Statutory Accounting Principles (E) Working Group adoption for the Schedule E, Part 2, reporting (Attachment Four-A22). The motion passed unanimously.

**x. For Schedule D, Part 1, Add Code “9” to Column 23 – Collateral Type for Ground Lease Financing. Renumber Other” Code to 10 (2020-20BWG) Effective Dec. 31, 2020.**

Mr. Bruggeman stated that during the 2019 Fall National Meeting, the Valuation of Securities (E) Task Force adopted an amendment to add ground lease financing transactions as a newly-defined asset class to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), effective Jan. 1, 2020, and referred such action to the Statutory Accounting Principles (E) Working Group for consideration. While an update was not required in the *Accounting Practices and Procedures Manual* (AP&P Manual), specific identification of such activities is warranted for analysis and reporting purposes. This proposal adds the following for Schedule D, Part 1, add code “10” to column 26 – Collateral Type for ground lease financing. Renumber “Other” code to 11. Mr. Bruggeman stated that interested parties suggested an editorial change correcting the description references of the exposure for Schedule D, Part 1, to be code “10” rather than “9”; the column reference to be “26” rather than “23”; and the “Other” code to be “11” rather than “10”. These changes have been reflected in the proposal.

Mr. Bruggeman made a motion, seconded by Mr. Milquet, to adopt the proposal including the editorial correction (Attachment Four-A23). The motion passed unanimously.
y. Add New Line 4.05 for Valuation Allowance for Mortgage Loans to the Summary Investment Schedule and Renumber Existing Line 4.05 to 4.06. Modify the Instructions to Include a Crosscheck for New Line 4.05 Back to Schedule B – Verification Between Years. Clarify the Instructions for 4.01-4.04 to Explicitly Show Crosschecking to Column 8 of Schedule B, Part 1 (2020-21BWG) Effective Dec. 31, 2020.

Mr. Bruggeman stated that the purpose of this schedule revision is to address that the amount reported on Schedule B, Part 1, column 8 excludes the valuation allowance, but the total reported for mortgage loans in the Summary Investment Schedule must tie to the asset page, which includes the valuation allowance. This change was adopted by the Statutory Accounting Principles (E) Working Group on May 20. This proposal adds a new line 4.05 for valuation allowance for mortgage loans to the Summary Investment Schedule and renumbers the existing line 4.05 to 4.06. It modifies the instructions to include a crosscheck back to Schedule B – Verification Between Years for the new line 4.05. He stated that the proposal clarifies the instructions for lines 4.01 through 4.04 to explicitly show crosschecking to column 8 of Schedule B, Part 1. Interested parties recommend changing the instructions on page 3 for “line 4.0506” to add the appropriate lines: “Sum of Lines 4.01 to 4.0405.” This has been reflected in the proposal.

Mr. Bruggeman made a motion, seconded by Mr. Sirovetz, to adopt the proposal with the editorial correction (Attachment Four-A24). The motion passed unanimously.

z. Modify the Instructions and Illustration for Note 3A and a New Note 3E with Instructions and Illustrations to be Data Captured. Modify the Blank and Instructions for Schedule D, Part 6, Sections 1 and 2 (2020-22BWG).

Mr. Bruggeman stated that this item is still exposed by the Statutory Accounting Principles (E) Working Group, with comments due May 29. It is recommended that the Blanks (E) Working Group defer this item until the Statutory Accounting Principles (E) Working Group reviews comments and takes an action.

Mr. Bruggeman made a motion, seconded by Mr. Hudson, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Mr. Hudson, to defer the modified proposal. The motion passed unanimously.

aa. Add a Footnote to Exhibit 5 (Life/Fraternal & Health – Life Supplement) and Exhibit 3 Separate Accounts to Disclose Cases When a Mortality Risk is No Longer Present or a Significant Factor – i.e. Due to a Policyholder Electing a Payout Benefit (2020-23BWG) Effective Dec. 31, 2020.

Mr. Bruggeman stated that while this update did not result in a statutory accounting change, this footnote will disclose cases when a mortality risk is no longer present or a significant factor, i.e., due to a policyholder electing a payout benefit. This proposal adds a footnote to Exhibit 5 (life/fraternal & health – life supplement) and Exhibit 3 separate accounts. Interested parties recommend changes to the Exhibit 5 footnote. These revisions were reflected in the proposal.

Mr. Bruggeman made a motion, seconded by Mr. Sirovetz, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Ms. Carter, to adopt the modified proposal (Attachment Four-A25). The motion passed unanimously.

3. Exposed Proposals


Ms. Frasier stated that this proposal makes changes to the Supplemental Exhibits and Schedules Interrogatories for the 2021 annual filing. There are four certifications related to business subject to Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43) being provided in the Principles-Based Reserve Actuarial Report as required by VM-31. The proposal removes questions 29, 30, 31 and 32 referencing these separate certifications.

Hearing no objection, the proposal was exposed for a 60-day public comment period ending July 28.
b. **Add a New Column 5 to the Blank for Schedule T with Instructions to Specifically Capture the CHIP Premium. Existing Columns After the New Column 5 will be Renumbered (2020-25BWG).**

Mr. Garn stated that this proposal is intended to assist in identifying the Children’s Health Insurance Program (CHIP) premiums as it relates to guaranty fund assessments. This proposal adds a new column to Schedule T with instructions to specifically capture the CHIP premium.

Hearing no objection, the proposal was exposed for a 60-day public comment period ending July 28.

c. **Add a New Column 5 to Schedule DB, Part D, Section 1 and Renumber the Remaining Columns. Add Instruction for the New Column 5, Add the Column Reference to Column 7 and Adjust Other Column References in Crosschecks. Correct Column References for this Schedule on the Liability Page, Asset Page and Schedule DB Verification. Modify Instruction Language for the Disclosure Note 8A(8) (2020-26BWG).**

Mr. Bruggeman stated that the purpose of this proposal is to reflect on Schedule DB, Part D, Section 1, and the Notes to Financial Statement disclosure changes to SSAP No. 97—*Investments in Subsidiary, Controlled and Affiliated Entities* being considered by the Statutory Accounting Principles (E) Working Group. This issue pertains to financing derivatives and would reflect premium due/owed for these derivative transactions to be factored into the “counterparty risk” for RBC purposes.

Hearing no objection, the proposal was exposed for a 60-day public comment period ending July 28.

4. **Adopted the Editorial Listing**

Mr. Hudson made a motion, seconded by Mr. Snow, to adopt the editorial listing (Attachment Four-A26). The motion passed unanimously.

5. **Electronic Blanks and Instructions Publications**

Mr. Garn stated that in order to continue to provide the blanks and instructions to customers during the current remote work situation, the 2019 annual and 2020 quarterly blanks and instructions have been produced in electronic format using the same Bookshelf product being used for the electronic AP&P Manual. He stated that the NAIC products web page notes that: “New in April 2020 – the Annual Statement Instructions for Data Year 2019 and the Quarterly Statement Instructions for Data Year 2020 will now be offered as individual PDFs via an online subscription service (OSS). This new subscription service provides access to the published version of the publications. Subscriptions are specific to an individual user and access to the platform requires a redemption code, which will be provided via email following verification of the purchase.” Mr. Garn stated that customers will need to contact the NAIC publications department for a subscription.

Having no further business, the Blanks (E) Working Group adjourned.
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met via conference call Dec. 17, 2019. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair (CA); William Arfanis (CT); N. Kevin Brown (DC); Adrienne Lupo (DE); Virginia Christy, Carolyn Morgan and Jason Reynolds (FL); Carrie Mears and Daniel Mathis (IA); Roy Eft (IN); Dan Schaefer (MI); Debbie Doggett (MO); Justin Schrader (NE); Patricia Gosselin (NH); John Sirovetz (NJ); Dale Bruggeman and Tracy Snow (OH); Eli Snowbarger and Joel Sander (OK); Joe DiMemmo (PA); Trey Hancock and Hui Wattanaskolpant (TN); Shawn Frederick (TX); Steve Drutz (WA); Randy Milquet (WI); and Jamie Taylor (WV).

1. **Adopted its Oct. 22 Minutes**

Mr. Eft made a motion, seconded by Mr. Sander, to adopt the Working Group’s Oct. 22 minutes (see NAIC Proceedings – Fall 2019, Accounting Practices and Procedures (E) Task Force, Attachment Two). The motion passed unanimously.

2. **Adopted Items Previously Exposed**


   Mr. Schrader stated that this proposal adds clarifying instructions to address questions that have been received regarding the new Analysis of Operations by Lines of Business on the life and health blank. The proposal adds instructions and crosschecks for line 34 on the Analysis of Operations by Lines of Business – Summary. It adds instructions for column 5 for indexed life on the Analysis of Operations by Lines of Business for individual life. It adds clarifying instructions to the Analysis of Operations by Lines of Business for individual life and group life, indicating that the reporting should be consistent with policy type language in the contract and the reporting of policies issued with secondary guarantees that have expired. Mr. Schrader stated that interested parties have some concerns with crosscheck references which have been addressed and highlighted as modifications within the proposal.

   Mr. Schrader made a motion, seconded by Mr. Eft, to adopt the modifications to the proposal. The motion passed unanimously. Connnie Jasper Woodroof (Sapiens) requested that the adopted proposal language be posted on the Blanks (E) Working Group web page as guidance to assist the life, accident & health/fraternal blank filers with the 2019 annual statement reporting of the Analysis of Operations by Lines of Business. The Working Group members agreed to posting the guidance document.


   Mr. Hudson stated that this proposal requests the removal of the alphabetic index from inclusion at the back of the annual statement blank, instructions, and the Blanks (E) Working Group web page. Interested parties indicated that the alphabetic index reference should be deleted from the vendor electronic filing submission directive. Staff will make those changes when updating the directive for the 2019 filing period. The Working Group does not need to take an action on that change.

   Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the proposal (Attachment Four-A1b). The motion passed unanimously.
3. Exposed its Procedures

Mr. Garn stated that there have been changes incorporated into the procedures document and even more recent changes related to dates and timing. For example, moving the final adoption date to June 1 rather than “June” or what may have been presumed to be June 30. The proposed procedures include a deadline of April 15 for exposure of proposals with an annual statement effective date. Mary Caswell (NAIC) stated that one recent suggested change was to change the word “may” to “can be technically” in the “subsequent requests” paragraph. The sentence would read, “[a]ny proposal which includes data capture elements will be evaluated individually as to whether the data capture can be technically accommodated in that year.” Mr. Bruggeman stated that he agreed with designating specific dates for exposures and adoptions. He also said allowing for exceptions if technically possible makes it easier to understand the timing. John Bauer (Prudential Financial) agrees with the change of “can be technically” language to be incorporated as indicated.

Mr. Hudson made a motion, seconded by Mr. DiMemmo, to adopt the procedures with the minor word modifications as indicated. The motion passed unanimously.

Mr. Garn stated that interested parties had requested one in-person meeting to be held. Since the procedures reference “meetings,” there is no need to specifically reference “in-person” or a specific time period for that meeting in the procedures document. The 2020 Spring National Meeting has been suggested for an in-person meeting. The Meetings Department will perform the scheduling and avoid conflicts with any Financial Condition (E) Committee, Financial Regulation Standards and Accreditation (F) Committee, or International Insurance Relations (G) Committee groups.

4. Exposed Proposals


Mr. Snow stated that this proposal modifies the instructions for Column 10, Schedule F, Part 3 – Property and the Schedule F, Part 2 – Life/Fraternal Workers’ Compensation Carve-out supplement, removing instructions to exclude adjusting and other reserves from the column. It adds instructions to include those with the defense and cost containment reserves. It adds a new instruction for Column 12 for the same schedules. It adds crosschecks to Schedule P, Part 1. Mr. Snow stated that interested parties had a minor modification to add the word “and” that was missing from the reference to “adjusting and other.”

Mr. Snow stated that interested parties also ask for a wording clarification to address companies that might fail crosschecks because of pooling arrangements. Since the proposal is not effective until the annual 2020 filing, there is time to clarify the language and re-expose the proposal. Mr. Snow made a motion, seconded by Mr. Drutz, to re-expose the proposal with the minor modification adding the word “and,” as well as adding clarifying crosscheck language to address companies involved in pooling. The motion passed unanimously.

Mr. Bauer expressed support for re-exposing the proposal with the clarifying language to address the application of crosschecks for companies involved in pooling. Ms. Caswell stated that, with the approval of the Working Group, staff could add language to the crosscheck reference to indicate that it “does not apply to companies with inter-company pooling participation arrangements having amounts reported in Sch P, Part 1, Column 34.” Staff would set up the crosscheck to test any crosscheck failures to see if amounts are recorded in the pooling column of Schedule P, Part 1, Column 34 and pass the crosscheck. It would be set up like an “if-then” statement test.

b. Modify the Instruction for SIRI Lines 13.02 Through 13.11 Clarifying When to Identify the Actual Equity Interests Within a Fund and Aggregate Those Equity Interests for Determination of the Ten Largest Equity Interests (2019-28BWG)

Mr. Bruggeman stated that the purpose of this proposal is to clarify when to identify the actual equity interests within a fund like an exchange-traded fund (ETF) or a mutual fund and aggregate those equity interests for determination of the 10 largest equity interests. The proposal modifies the instruction for Supplemental Investment Risk Interrogatories (SIRI) lines 13.02 through 13.11. The Statutory Accounting Principles (E) Working Group adopted this application at the 2019 Fall National Meeting. This proposal has an annual 2020 effective date. The clarification indicates that the company must look through a non-diversified fund to aggregate exposures in the top 10 equity interest, but a look through is not required with diversified...
funds. Hearing no state insurance regulator objection, the proposal was exposed for a public comment period ending Feb. 21, 2020.

c. **Modify the Instruction and Blank for Supplemental Investment Risk Interrogatories Question 14.01 (2019-29BWG)**

Mr. Bruggeman stated that this proposal is to clarify that interrogatories 14.06 through 14.15 in the blank are to be completed regardless of the answer to SIRI question 14.01. This item was adopted by the Statutory Accounting Principles (E) Working Group at the 2019 Spring National Meeting and adopted by the Blanks (E) Working Group. This proposal is a clarification of that previous proposal. Hearing no objection, the proposal was exposed for a public comment period ending Feb. 21, 2020.

d. **Add a Category and Instructions for Reciprocal Jurisdiction Companies in Schedule S for the Life/Fraternal and Health Blanks and Schedule F for the Property and Title Blanks. Add a List of Identification Numbers in Instruction to Schedule Y, Part 1A; Schedule Y, Part 2; and Schedule D, Part 6, Section 1 for Reciprocal Jurisdiction Companies. Add a Reference to Reciprocal Jurisdiction Companies in the Trusteed Surplus Statement Instructions for Life/Fraternal, Health and Property Statements (2019-30BWG)**

Jake Stultz (NAIC) stated that this proposal relates to work of the Reinsurance (E) Task Force with regards to the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement) and the creation of a reciprocal jurisdiction. The intent of this proposal is to set up annual reporting blanks to allow companies to report reinsurance with reciprocal jurisdiction reinsurers as soon as the states enact the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786). This is similar to the process used to implement the certified reinsurer provision in 2011. The Reinsurance (E) Task Force exposed this change during the 2019 Fall National Meeting for a concurrent exposure with the Blanks (E) Working Group. Hearing no objection, the proposal was exposed for a public comment period ending Feb. 21, 2020.

5. **Adopted the Editorial Listing**

Mr. Hudson made a motion, seconded by Mr. Snow, to adopt the editorial listing (Attachment Four-A1c). The motion passed unanimously.

Having no further business, the Blanks (E) Working Group adjourned.
**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

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<th>FOR NAIC USE ONLY</th>
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**Anticipated Effective Date:** Annual 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**


**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Add clarifying instructions to address questions that have come up regarding reporting on the new Analysis of Operations by Lines of Business pages.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________

Other Comments:

** This section must be completed on all forms.  

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1
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – SUMMARY

Detail Eliminated to Conserve Space

Column 9 – YRT Mortality Risk Only


Line 34 – Policies/Certificates in Force End of Year

The number provided should be count of direct written policies/certificates in force at the end of the year.

The sum of Columns 2, and 3, 4 and 5 should equal Line 23, Column 9 of Life Insurance (state page).

The sum of Columns 4 and 5 should equal the Exhibit of Number of Policies, Contracts, Certificates, Income Payable and Account Values in Force for Supplementary Contracts, Annuities, Accident and Health and Other Policies Line 9 (Column 1 plus Column 3 for the Supplementary Contracts section) plus Line 9 (sum of Columns 1 through 4 for the Annuities section).

Column 6 should equal sum of Column 1, Column 3 and Column 5, Line 10 – Line 3 + Line 8 of the Exhibit of Number of Policies, Contracts, Certificates, Income Payable and Account Values in Force for Supplementary Contracts, Annuities, Accident and Health and Other Policies in the Accident and Health Insurance section.
**ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – INDIVIDUAL LIFE INSURANCE**

This exhibit shows Lines 1 through 33 of the Summary of Operations by Line of Business, in part.

**Reporting for the columns of this schedule should be consistent with the policy type language per the product contract.**

Policies where the product was issued with secondary guarantees, but those secondary guarantees have since expired should be reported consistent with how the policy was issued (i.e., still report product as one with secondary guarantees).

For definitions of lines of business, see the appendix of these instructions.

A company shall not omit the columns for any lines of business in which it is not engaged.

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**Detail Eliminated to Conserve Space**

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<td>Total</td>
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<tr>
<td></td>
<td>The lines in this column are to agree with Page 4, Column 1, in part.</td>
</tr>
<tr>
<td>5</td>
<td>Indexed Life</td>
</tr>
<tr>
<td></td>
<td>Include: Indexed universal life with secondary guarantees.</td>
</tr>
<tr>
<td>10</td>
<td>Credit Life</td>
</tr>
<tr>
<td></td>
<td>Include: Business not exceeding 120 months.</td>
</tr>
<tr>
<td></td>
<td><strong>This column are not applicable to Fraternal Benefit Societies.</strong></td>
</tr>
<tr>
<td>11</td>
<td>Other Individual Life</td>
</tr>
<tr>
<td></td>
<td>Include: All individual life insurance not included in columns 2 through 10.</td>
</tr>
<tr>
<td>12</td>
<td>YRT Mortality Risk Only</td>
</tr>
<tr>
<td></td>
<td>This column should only be completed for assumed and retained (net) yearly-renewable-term reinsurance business where the only risk included is mortality.</td>
</tr>
<tr>
<td></td>
<td>If a company reports YRT assumed business in Columns 2 through 11, then that business should not be reported in column 12.</td>
</tr>
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**Detail Eliminated to Conserve Space**
**ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – GROUP LIFE INSURANCE**

This exhibit shows Lines 1 through 33 of the Summary of Operations by Line of Business, in part.

Reporting for the columns of this schedule should be consistent with the policy type language per the product contract.

Policies where the product was issued with secondary guarantees, but those secondary guarantees have since expired should be reported consistent with how the policy was issued (i.e., still report product as one with secondary guarantees).

For definitions of lines of business, see the appendix of these instructions.

A company shall not omit the columns for any lines of business in which it is not engaged.

---

Detail Eliminated to Conserve Space

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W:\National Meetings\2020\Summer\TF\App\BlanksWG\minutes\Att Four-A1a 2019-26BWG_Modified.doc
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| CONTACT PERSON: | ______________________ |
| TELEPHONE: | ______________________ |
| EMAIL ADDRESS: | ______________________ |
| ON BEHALF OF: | ______________________ |
| NAME: | Kim Hudson |
| TITLE: | ______________________ |
| AFFILIATION: | California Department of Insurance |
| ADDRESS: | 300 South Spring St. |
| Anticipated Effective Date: | Annual 2020 |

BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ ] QUARTERLY STATEMENT
- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ X ] Health
- [ X ] Separate Accounts
- [ X ] Protected Cell
- [ X ] Health (Life Supplement)
- [ X ] Title
- [ ] Other ______________________

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

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<td>[ ] Deferred Date ______________________</td>
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<tr>
<td>[ ] Other (Specify) ______________________</td>
</tr>
</tbody>
</table>

Identification of Item(s) to Change

Remove the alphabetic index from inclusion at the back of the annual statement blank, instructions and Blanks Working Group Web page.

Reason, Justification for and/or Benefit of Change**

When the index was added back to being included in the hard copy of the annual statement states were still primarily using hard copies of the statement and the index make finding pages in the statement easier. Now the PDF copies of the statement are primarily used and are book marked, inclusion of the index in the statement is no longer needed.

NAIC Staff Comments

Comment on Effective Reporting Date: ______________________

Other Comments: ______________________

** This section must be completed on all forms.  
Revised 6/13/2009
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

INSTRUCTIONS

Detail Eliminated to Conserve Space

INDEX

The annual statement shall contain an alphabetized index on the last page of the hard copy statement which references the title and page number of all of the pages that are required to be included in that filing. The NAIC shall maintain, and place on its Website at www.naic.org/cmte_e_app_blanks.htm, the alphabetized index for all statement types that is required to be included in the hard copy of the statement. The above is only required on the March 1 filing, and specifically excludes any supplements.

GENERAL

Detail Eliminated to Conserve Space

ANNUAL STATEMENT INSTRUCTIONS – SEPARATE ACCOUNTS

INSTRUCTIONS

FOR COMPLETING SEPARATE ACCOUNTS ANNUAL STATEMENT BLANK

INDEX

The annual statement shall contain an alphabetized index on the last page of the hard copy statement which references the title and page number of all of the pages that are required to be included in that filing. The NAIC shall maintain, and place on its Website at www.naic.org/cmte_e_app_blanks.htm, the alphabetized index for all statement types that is required to be included in the hard copy of the statement. The above is only required on the March 1 filing, and specifically excludes any supplements.

GENERAL

Detail Eliminated to Conserve Space

ANNUAL STATEMENT INSTRUCTIONS – PROTECTED CELL

INSTRUCTIONS

For Completing Protected Cell Annual Statement Blank

INDEX

The annual statement shall contain an alphabetized index on the last page of the hard copy statement which references the title and page number of all of the pages that are required to be included in that filing. The NAIC shall maintain, and place on its Website at www.naic.org/cmte_e_app_blanks.htm, the alphabetized index for all statement types that is required to be included in the hard copy of the statement. The above is only required on the March 1 filing, and specifically excludes any supplements.

Detail Eliminated to Conserve Space
**Blanks (E) Working Group**  
*Editorial Revisions to the Blanks and Instructions*  
*(presented at the December 17, 2019, Meeting)*

Statement Type:  
- **H** = Health;  
- **L/F** = Life/Fraternal Combined;  
- **P/C** = Property/Casualty;  
- **SA** = Separate Accounts;  
- **T** = Title

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<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
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</table>
| 2020      | Exhibit 6           | **CHANGE TO INSTRUCTION**  
Modify the instructions as shown below to clarify loss/claims adjusting expenses are not to be included on the exhibit.  
Reserves or other amounts relating to uninsured accident and health plans and the uninsured portion of partially insured accident and health plans should be excluded from this exhibit.  
Do not include amounts for loss/claims adjusting expenses.  
Column 10 – Credit Accident and Health (Group and Individual)  
Include: Business not exceeding 120 months.  
Refer to SSAP No. 59—Credit Life and Accident and Health Insurance Contracts for accounting guidance.  
This column is not applicable to Fraternal Benefit Societies. | L/F            | Annual        |
| 2020      | Exhibit 8           | **CHANGE TO INSTRUCTION**  
Modify the instructions as shown below to clarify loss/claims adjusting expenses are not to be included on the exhibit.  
Amounts relating to uninsured accident and health plans and the uninsured portion of partially insured accident and health plans should be excluded from this exhibit.  
Do not include amounts for loss/claims adjusting expenses. | L/F            | Annual        |
| 2019      | Schedule DB, Part E | **CHANGE TO BLANK**  
Null column 9, Total line as it is a percentage.                                                                                      | All            | Annual       |
<table>
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<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
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</table>
| 2019      | Analysis of Reserves – Accident and Health | **CHANGE TO BLANK**  
Change name of table from Analysis of Increase in Reserves During the Year – Accident and Health to Analysis of Reserves During the Year – Accident and Health as the table does not calculate an increase (Similar to Exhibit 6 in Life Statement.) | SA             | Annual      |
| 2020      | Schedule D, Parts 3 and 4 Footnote   | **CHANGE TO BLANK**  
Delete footnote for market indicator to coincide with removal of market indicator and make consistent with annual.                                                                                       | All            | Quarterly    |
| 2020      | Schedule DB, Part E                  | **CHANGE TO BLANK**  
Header originally was for annual referring to December 31. Change to quarterly terminology: Derivatives Hedging Variable Annuity Guarantees as of *Current Statement Date*  | All            | Quarterly    |
| 2020      | General Interrogatories Part 1       | **CHANGE TO BLANK**  
Add N/A as a choice on Line 15.2 to mimic annual statement. This will allow entities that answer NO on line 15.1 (do not enter into hedging transactions) to answer N/A.                        | All            | Quarterly    |
**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

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<td>Chief, Captive Insurance</td>
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<td>Ohio Department of Insurance</td>
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<tr>
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**DATE:** 09/24/2019

**FOR NAIC USE ONLY**

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<td>New Reporting Requirement</td>
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**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

| [ ] Rejected For Public Comment |
| [ ] Referred To Another NAIC Group |
| [ ] Received For Public Comment |
| [ X ] Adopted Date 05/28/2020 |
| [ ] Rejected Date |
| [ ] Deferred Date |
| [ ] Other (Specify) |

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ X ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ ] BLANK
- [ X ] Life, Accident & Health/Fraternals
- [ X ] Property/Casualty
- [ ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ ] Title
- [ ] Other ________________

Anticipated Effective Date: Annual 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Modify the instruction for Column 10 (Schedule F, Part 3 — Property and Schedule F, Part 2 — Life/Fraternal Workers’ Compensation Carve-out supplement) to remove instruction to exclude adjusting and other reserves from the column and add instruction include along with the defense and cost containment reserves. Add a new instruction for Column 12 for the same schedules. Add crosschecks to Schedule P, Part 1.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is ensure adjusting other and defense and cost containment reserves are reported properly as Known Case LAE Reserves or IBNR LAE Reserves.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:______________

Other Comments:______________________________

**This section must be completed on all forms.**

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ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

SCHEDULE F – PART 3

CEDED REINSURANCE
AS OF DECEMBER 31, CURRENT YEAR

Detail Eliminated to Conserve Space

Column 9  –  Known Case Loss Reserves

Total multiplied by 1000 should agree with Underwriting and Investment Exhibit, Part 2A, Line 35, Column 3.

Column 10  –  Known Case LAE Reserves

Include: Defense and Cost Containment from Schedule P, Part 1, Columns 18 and Adjusting and Other from Schedule P, Part 1, Column 22, in part

The sum of Schedule F, Part 3, Columns 10 and 12 should equal the sum of Schedule P, Part 1, Columns 18, 20 and 22. (Note: This crosscheck doesn’t apply to those companies participating in inter-company pooling participation arrangements where the participation percentage in Schedule P, Part 1, Column 34 is not equal to zero.)

Exclude: Adjusting & Other Expense Reserves.

Column 11  –  IBNR Loss Reserves

Total multiplied by 1000 should agree with Underwriting and Investment Exhibit, Part 2A, Line 35, Column 7.

Column 12  –  IBNR LAE Reserves

Include: Defense and Cost Containment from Schedule P, Part 1, Columns 20 and Adjusting and Other from Schedule P, Part 1, Column 22, in part

Column 13  –  Unearned Premiums

Total multiplied by 1000 should equal Page 3, Line 9 parenthetical amount.

Detail Eliminated to Conserve Space
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

WORKERS’ COMPENSATION CARVE-OUT SUPPLEMENT

SCHEDULE F – PART 2

CEDED REINSURANCE

Column 9 – Known Case Loss Reserves
Total multiplied by 1000 should agree with Underwriting and Investment Exhibit, Part 4, Column 2.

Column 10 – Known Case LAE Reserves
Include: Defense and Cost Containment from Schedule P, Part 1, Columns 18
Adjusting and Other from Schedule P, Part 1, Column 22, in part

The sum of Schedule F, Part 2, Columns 10 and 12 should equal the sum of Schedule P, Part 1, Columns 18, 20 and 22. (Note: This crosscheck doesn’t apply to those companies participating in inter-company pooling participation arrangements where participation the percentage in Schedule P, Part 1, Column 34 is not equal to zero.)

Exclude: Adjusting and other Expense reserves.

Column 11 – IBNR Loss Reserves
Total multiplied by 1000 should agree with Underwriting and Investment Exhibit, Part 4, Column 5.

Column 12 – IBNR LAE Reserves
Include: Defense and Cost Containment from Schedule P, Part 1, Columns 20
Adjusting and Other from Schedule P, Part 1, Column 22, in part

Column 14 – Contingent Commissions
Include: Contingent commissions receivable from a reinsurer. Regular commissions should be netted with ceded balances payable in Column 16.

W:\National Meetings\2020\Summer\TF\App\BlanksWG\minutes\Att Four-A2 2019-25BWG_Modified.doc
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<td>ON BEHALF OF:</td>
</tr>
<tr>
<td>NAME: Dale Bruggeman</td>
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<tr>
<td>TITLE: Chair SAPWG</td>
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<tr>
<td>AFFILIATION: Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS: 50W. Town St., 3rd Fl., Ste. 300</td>
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<tr>
<td>Columbus, OH 43215</td>
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<td>Modifies Required Disclosure [ ]</td>
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IDENTIFICATION OF ITEM(S) TO CHANGE

Modify the instruction for Supplemental Investment Risk Interrogatories Lines 13.02 through 13.11 clarifying when to identify the actual equity interests within a fund and aggregate those equity interests for determination of the ten largest equity interests.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to clarify when reporting entities are required to identify actual equity interests within a fund and aggregate those equity interests to determine their ten largest equity interests.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: 

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

Detail Eliminated to Conserve Space

Line 13.02 through 13.11 – Report the amounts and percentages of admitted assets held in the ten largest equity interests including equity funds that qualify individually as one of the largest equity interests and a look-through of investments in the shares of non-diversified mutual funds and ETFs, preferred stocks, publicly traded equity securities, and other equity securities (including Schedule BA equity interests), and excluding money market and bond mutual funds listed in Part Six, Sections 2(f) and (g) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office as exempt or NAIC 1). Equity interests in all funds that are diversified in accordance with the Investment Company Act of 1940 do not need to be individually assessed and aggregated to determine the ten largest equity interests. For funds that are not diversified within the meaning of the Investment Company Act of 1940, insurance reporting entities are required to identify actual equity interests within the fund and aggregate those equity interests to determine their ten largest equity interests.

Determine the ten largest equity interests by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000 and common stock of the XYZ Company of $300,000 and $50,000 of XYZ identified through a look-through of a non-diversified stock closed-end fund reported on Schedule D-2-2. The total is $950,000 ($600,000+$300,000+$50,000). The reporting entity also owns bonds issued by the XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. The reporting entity may also have exposure to equity interests in XYZ through mutual funds that are excluded from this calculation as the funds are diversified within the meaning of the Investment Company Act of 1940. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA classified as equity.

The following funds shall also be excluded from aggregation as equity interests: SVO-Identified U.S. Direct Obligations / Full Faith And Credit Exempt List of Money Market Mutual Funds, SVO-Identified Bond ETFs, SVO-Identified Bond Mutual Funds and SVO Identified fund investments with underlying characteristics of fixed-income instruments, which do not contain underlying equities and that are outlined within the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

W:\National Meetings\2020\Summer\TF\App\BlanksWG\minutes\Att Four-A3 2019-28BWG.doc
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| CONTACT PERSON: | Dale Bruggeman |
| TELEPHONE: | |
| EMAIL ADDRESS: | |
| ON BEHALF OF: | Ohio Department of Insurance |
| ADDRESS: | 50W. Town St., 3rd Fl., Ste. 300 |

FOR NAIC USE ONLY

| Agenda Item # 2019-29BWG |
| Year 2020 |
| Changes to Existing Reporting [X] |
| New Reporting Requirement [ ] |

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact [X] |
| Modifies Required Disclosure [ ] |

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[X] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

- [X] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [X] INSTRUCTIONS
- [X] CROSSCHECKS
- [X] Life, Accident & Health/Fratal
d- [X] Property/Casualty
- [X] Health
- [X] Separate Accounts
- [ ] Protected Cell
- [X] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Modify the instruction and blank for Supplemental Investment Risk Interrogatories Question 14.01.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to clarify that Interrogatories 14.06 through 14.15 are to be completed regardless of the answer to Supplemental Investment Risk Interrogatories Question 14.01.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:__________________________

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

Line 14.06 through 14.15 – These lines should be completed even if the answer to Question 14.01 is “YES.”

Report the investments held in the ten largest fund managers, with allocation between funds that are diversified or non-diversified in accordance with the meaning of the Investment Company Act of 1940. This should include all “funds” regardless of the type of fund (private placement, mutual fund, exchange-traded fund, closed-end fund, money market mutual fund, etc), reporting schedule or underlying investments captured in a fund.

ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2019
(To Be Filed by April 1)

14. Amounts and percentages of the reporting entity’s total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity’s total admitted assets? Yes [ ] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05 the remainder of Interrogatory 14.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| CONTACT PERSON: | Jake Stultz |
| TELEPHONE: | 816-783-8481 |
| EMAIL ADDRESS: | jstultz@naic.org |
| ON BEHALF OF: | Chlora Lindley-Myers |
| TITLE: | Chair, Reinsurance (E) Task Force |
| AFFILIATION: |  |
| ADDRESS: |  |

FOR NAIC USE ONLY

| Agenda Item # | 2019-30BWG MOD |
| Year | 2020 |
| Changes to Existing Reporting | [ X ] |
| New Reporting Requirement | [ ] |

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ X ] Health
- [ ] Instructions
- [ X ] BLANK
- [ ] Separate Accounts
- [ ] Protected Cell
- [ X ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

See next page for details.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

See next page for details

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: 

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018

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REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE

On June 25, 2019, NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) to incorporate the relevant provisions from the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement). Under the revisions, credit for reinsurance is allowed for domestic ceding insurers for reinsurance that has been ceded to reinsurers from Reciprocal Jurisdictions, and that those reinsurers are not required to post collateral. As a result, it is necessary to consider revisions to the appropriate reinsurance schedules and instructions in order to collect the relevant information with respect to these reinsurance transactions.

IDENTIFICATION OF ITEM(S) TO CHANGE

<table>
<thead>
<tr>
<th>Annual Statement Instructions</th>
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**Life/Fraternal and Health**

**Schedule S General Instructions**
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.
- Modify note on applying Reciprocal Jurisdiction.
- Add Reciprocal Jurisdiction to the instruction for determining status.
- Reference in certified reinsurer number paragraph.

**Schedule S, Part 1, Section 1**
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

**Schedule S, Part 1, Section 2**
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

**Schedule S, Part 2**
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

**Schedule S, Part 3, Section 1**
- Add category lines for Reciprocal Jurisdiction Companies.
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

**Schedule S, Part 3, Section 2**
- Add category lines for Reciprocal Jurisdiction Companies.
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

**Schedule S, Part 4**
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

**Schedule S, Part 5**
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.

**Life/Fraternal**

**Workers’ Compensation Cave-out Supplement**
- **Schedule F General Instructions**
  - Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.
  - Modify note on applying Reciprocal Jurisdiction.
  - Add Reciprocal Jurisdiction to the instruction for determining status.
  - Reference in certified reinsurer number paragraph.
Schedule F, Part 1
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 2
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Supplemental term and Universal Life Insurance Reinsurance Exhibit
   Part 1
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 2.
   Part 2A
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 3.
   Part 2B
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 3.

Trusteed Surplus Statement
- Add instructions for Line 4.4 Reciprocal Jurisdiction Companies

Property

Schedule F General Instructions
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.
- Modify note on applying Reciprocal Jurisdiction.
- Add Reciprocal Jurisdiction to the instruction for determining status.
- Reference in certified reinsurer number paragraph.

Schedule F, Part 1
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 2
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 3
- Add category lines for Reciprocal Jurisdiction Companies.
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.
- Modify category lines references for the list of lines for Reciprocal Jurisdiction Companies for Columns 28 through 36.
- Modify category lines references for the list of lines for Reciprocal Jurisdiction Companies for Columns 71 and 72.
- Modify category lines references for the list of lines for Reciprocal Jurisdiction Companies for Columns 73 and 74.

Supplemental Schedule for Reinsurance Counterparty Reporting Acceptations – Asbestos and Pollution Contracts
- Add category lines for Reciprocal Jurisdiction Companies.
- Add Reciprocal Jurisdiction to list of type of reinsurers for Columns 1 and 5.

Notes to Financial Statement 23F(1)f
- Add section to illustration for Reciprocal Jurisdiction Companies

Trusteed Surplus Statement
- Add instructions for Line 7.4 Reciprocal Jurisdiction Companies
Title

Schedule F General Instructions
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.
- Modify note on applying Reciprocal Jurisdiction.
- Add Reciprocal Jurisdiction to the instruction for determining status.
- Reference in certified reinsurer number paragraph.

Schedule F, Part 1
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 2
- Add category lines for Reciprocal Jurisdiction Companies.
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 3
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Schedule F, Part 4
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 1.

Operations and Investments Exhibit – Part 2B
- For Line 2 remove the references to authorized, unauthorized and certified. Line is for all types of reinsurers so specifying is not needed.

Notes to Financial Statement 23F(1)f
- Add section to illustration for Reciprocal Jurisdiction Companies

Life/Fraternals, Health, Property, Title

Schedule Y, Part 1A
- Add Reciprocal Jurisdiction to the list of ID numbers provided in Column 4

Schedule Y, Part 2
- Add Reciprocal Jurisdiction to the list of ID numbers provided in Column 2

Schedule D, Part 6, Section 1
- Add Reciprocal Jurisdiction to the list of ID numbers provided in Column 5

Quarterly Statement Instructions

Life/Fraternity and Health

Trusted Surplus Statement
- Add instructions for Line 4.4 Reciprocal Jurisdiction Companies

Property

Trusted Surplus Statement
- Add instructions for Line 7.4 Reciprocal Jurisdiction Companies
Life/Fraternal and Health

Schedule S
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 7.
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.

Property and Title

Schedule F
- Add Reciprocal Jurisdiction to list of type of reinsurers for Column 5.
- Modify instructions to include section on numbers for Reciprocal Jurisdiction Companies.

Life/Fraternal, Health, Property, Title

Schedule Y, Part 1A
- Add Reciprocal Jurisdiction to the list of ID numbers provided in Column 4.

Annual Statement Blank

Property

Schedule F, Part 3
- Add the word Reciprocal Jurisdiction to the column descriptions for Columns 73, 74, and 75.

Title

Operations and Investments Exhibit – Part 2B
- For Line 2 remove the references to authorized, unauthorized and certified. Line is for all types of reinsurers so specifying is not needed.

Life/Fraternal and Property

Trusted Surplus Statement
- Add Line 7.4 for Reciprocal Jurisdiction Companies

Quarterly Statement Blank

Life/Fraternal and Property

Trusted Surplus Statement
- Add Line 7.4 for Reciprocal Jurisdiction Companies
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL AND HEALTH (INCLUDES HEALTH LIFE SUPPLEMENT)

SCHEDULE S – REINSURANCE

These parts (except Part 1, which shows reinsurance assumed) provide an analysis by reinsurance carrier of reinsurance ceded data shown in total in various parts of the statement. Information is included on all reinsurance ceded to other entities authorized as well as unauthorized or certified in the state of domicile of the reporting entity. Additional data for unauthorized companies is displayed in Part 4; additional data for certified reinsurers is displayed in Part 5.

NOTE: Certified reinsurer status applies on a prospective basis and is determined by the state of domicile of the ceding insurer. Reciprocal jurisdiction reinsurer status applies on a prospective basis and is for reinsurance agreements entered into, amended, or renewed on or after the effective date of the domiciliary state of the ceding entity enacting the 2019 revisions to the Credit for Reinsurance Models, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. As such, it is possible that a ceding insurer will report reinsurance balances applicable to a single assuming insurer under multiple classifications within Schedule S. For example, with respect to a certified reinsurer that was considered unauthorized prior to certification, balances attributable to contracts entered into prior to the assuming insurer’s certification would be reported in the unauthorized classification, while balances attributable to contracts entered into or renewed on or after the assuming insurer’s certification would be reported in the certified classification. This will also be the case for reciprocal jurisdiction reinsurance, which may have been classified as certified reinsurance prior to the enactment of the 2019 revisions to the Credit for Reinsurance Models by the domiciliary state of the ceding entity. Proper classification of such balances is essential to ensure accurate reporting of collateral requirements applicable to specific balances and the corresponding calculation of the liability for unauthorized and/or certified reinsurance.

Effective date as used in this schedule is the date the contract originally went into effect.

Index to Schedule S

| Part 1, Section 1  | Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits |
| Part 1, Section 2  | Reinsurance Assumed Accident and Health Insurance |
| Part 2            | Reinsurance Recoverable on Paid and Unpaid Losses |
| Part 3, Section 1 | Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits |
| Part 3, Section 2 | Reinsurance Ceded Accident and Health Insurance |
| Part 4            | Reinsurance Ceded to Unauthorized Companies |
| Part 5            | Reinsurance Ceded to Certified Reinsurers |
| Part 6            | Five-Year Exhibit of Reinsurance Ceded Business |
| Part 7            | Restatement of Balance Sheet to Identify Net Credit for Ceded Reinsurance |

ID Number

Most parts of Schedule S require that the “ID Number” be reported for assuming or ceding entities.

Reinsurance intermediaries should not to be listed, because Schedule S is intended to identify the risk-bearing entities.

A ceding insurer can have unauthorized reinsurance, certified reinsurance and reciprocal jurisdiction reinsurance with the same reinsurer, based on when the contract became effective. It is important that the ceding insurer report
all types correctly. The same reinsurer may be listed on the same Schedule S by the ceding insurer with an AIIN for unauthorized reinsurance, a CRIN for certified reinsurance, and a RJIN for reciprocal jurisdiction reinsurance.

**Use of Federal Employer Identification Number**

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers even if the federal government has issued such a number.

**Alien Insurer Identification Number (AIIN)**

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule S instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Pool and Association Numbers**

In order to report transactions involving non-risk bearing pools or associations consisting of nonaffiliated companies correctly, the company must include on Schedule S the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Certified Reinsurer Identification Number (CRIN)**

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule S instead of the FEIN, AIIN or CRIN. The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)**

In order to report transactions involving reciprocal jurisdiction reinsurers correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule S instead of the FEIN, AIIN or CRIN. The RJIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.
Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

For 2020 Reporting Only

Reinsurers that have met the requirements for reciprocal jurisdiction reinsurer status in your state of domicile should be reported in the appropriate reciprocal jurisdiction reinsurer category if the reporting entity has implemented the necessary system and reporting changes for 2020 annual reporting to identify and report those reinsurance transactions in the appropriate reciprocal jurisdiction reinsurer category.

If the reporting entity has not been able to make the necessary system and reporting changes for 2020 annual reporting, the reporting entity may report those reinsurance transactions using the authorized reinsurer lines. Any crosschecks the reporting entity fails as a result of reporting reciprocal jurisdiction reinsurers on the authorized reinsurer lines should be explained.

NAIC Company Code

Company codes are assigned by the NAIC and are listed in the NAIC *Listing of Companies*. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the “Pool and Association Numbers” section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC *Listing of Companies*, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Determination of Authorized Status

The determination of the authorized, reciprocal jurisdiction, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule S shall be based on the status of that insurer or reinsurer in the reporting entity’s state of domicile.
### SCHEDULE S – PART 1 – SECTION 1

**REINSURANCE ASSUMED LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURED COMPANY AS OF DECEMBER 31, CURRENT YEAR**

This section should include data on all reinsurance assumed for life insurance, annuities, deposit fund and other liabilities without life or disability contingencies, and related benefits by reinsured company as of December 31, current year.

<table>
<thead>
<tr>
<th>Column 2 – ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.</td>
</tr>
<tr>
<td>Federal Employer Identification Number (FEIN)</td>
</tr>
<tr>
<td>Alien Insurer Identification Number (AIIN)</td>
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<td>Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)</td>
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<tr>
<td>Certified Reinsurer Identification Number (CRIN)</td>
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<tr>
<td>Pool/Association Identification Number</td>
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</table>

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### SCHEDULE S – PART 1 – SECTION 2

**REINSURANCE ASSUMED ACCIDENT AND HEALTH INSURANCE LISTED BY REINSURED COMPANY AS OF DECEMBER 31, CURRENT YEAR**

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

<table>
<thead>
<tr>
<th>Column 2 – ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.</td>
</tr>
<tr>
<td>Federal Employer Identification Number (FEIN)</td>
</tr>
<tr>
<td>Alien Insurer Identification Number (AIIN)</td>
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<td>Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)</td>
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<td>Certified Reinsurer Identification Number (CRIN)</td>
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<tr>
<td>Pool/Association Identification Number</td>
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SCHEDULE S – PART 2

REINSURANCE RECOVERABLE ON PAID AND UNPAID LOSSES LISTED BY REINSURING COMPANY AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

SCHEDULE S – PART 3 – SECTION 1

REINSURANCE Ceded LIFE INSURANCE, ANNUITIES, DEPOSIT FUNDS AND OTHER LIABILITIES WITHOUT LIFE OR DISABILITY CONTINGENCIES, AND RELATED BENEFITS LISTED BY REINSURING COMPANY AS OF DECEMBER 31, CURRENT YEAR

NOTE: This schedule is to include Exhibit 7 cessions. Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

General Account
- Authorized Affiliates
  - U.S.
    - Captive: 0199999
    - Other: 0299999
    - Total: 0399999
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© 2020 National Association of Insurance Commissioners
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## Total Separate Accounts Authorized, Reciprocal Jurisdiction, Unauthorized and Certified

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## Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number
SCHEDULE S – PART 3 – SECTION 2

REINSURANCE CEDED ACCIDENT AND HEALTH INSURANCE LISTED BY REINSURING COMPANY
AS OF DECEMBER 31, CURRENT YEAR

Include actual reinsurance ceded on group cases but exclude jointly underwritten group contracts.

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number:

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### Non-Affiliates

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<tbody>
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### Non-Affiliates

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### Non-Affiliates

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<thead>
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</table>
Non-Affiliates

U.S. Non-Affiliates ............................................................................................................ 8699999
Non-U.S. Non-Affiliates .................................................................................................... 8799999
Total Reciprocal Jurisdiction Non-Affiliates ..................................................................... 8899999

Total Separate Accounts Reciprocal Jurisdiction ......................................................................... 8999999
Total Separate Accounts Authorized, Reciprocal Jurisdiction, Unauthorized and Certified ............ 69999999099999

Total Separate Accounts Authorized, Reciprocal Jurisdiction, Unauthorized and Certified............ 69999999099999

Total U.S. (Sum of 0399999, 0899999, 1499999, 1999999, 2599999, 3099999, 3799999, 4299999, 4899999, 5399999, 5999999, 6499999, 7099999, 7599999, 8199999 and 65999998699999)

Total Separate Accounts Authorized, Reciprocal Jurisdiction, Unauthorized and Certified............ 69999999099999

Total Non-U.S. (Sum of 0699999, 0999999, 1799999, 2099999, 2899999, 3199999, 3999999, 4399999, 5199999, 5499999, 6299999, 6599999, 7399999, 7699999, 8499999 and 65999998799999)

Total (Sum of 1499999, 4599999 and 68999999099999) ............................................................................................ 9999999

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

Federal Employer Identification Number (FEIN)
Alien Insurer Identification Number (AIIN)
Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
Certified Reinsurer Identification Number (CRIN)
Pool/Association Identification Number

Detail Eliminated to Conserve Space

SCHEDULE S – PART 4

REINSURANCE CEDED TO UNAUTHORIZED COMPANIES

Contains data on life and accident and health insurance in force that is reinsured with companies not authorized in the state of domicile of the reporting insurance company. The purpose of this schedule is to display reinsurance ceded data used in the development of the liability for reinsurance in unauthorized companies. This liability serves to offset those assets and liability reductions that reflect the result of reinsurance ceded with unauthorized companies.

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

Federal Employer Identification Number (FEIN)
Alien Insurer Identification Number (AIIN)
Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
Certified Reinsurer Identification Number (CRIN)
Pool/Association Identification Number

Detail Eliminated to Conserve Space
SCHEDULE S – PART 5
REINSURANCE CEDED TO CERTIFIED REINSURERS

NOTE: This schedule is to be completed by those reporting entities whose domiciliary state has enacted the Credit for Reinsurance Model Law (#785) and/or Credit for Reinsurance Model Regulation (#786) with the defined certified reinsurer provisions.

<table>
<thead>
<tr>
<th>Column 2 – ID Number</th>
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<tbody>
<tr>
<td>Federal Employer Identification Number (FEIN)</td>
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<tr>
<td>Alien Insurer Identification Number (AIIN)</td>
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<tr>
<td>Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)</td>
</tr>
<tr>
<td>Certified Reinsurer Identification Number (CRIN)</td>
</tr>
<tr>
<td>Pool/Association Identification Number</td>
</tr>
</tbody>
</table>

Enter one of the following as appropriate CRIN for the entity being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

SCHEDULE F – REINSURANCE

Index to Schedule F

Part 1 – Assumed Reinsurance
Part 2 – Portfolio Reinsurance
Part 3 – Ceded Reinsurance
Part 4 – Issuing or Confirming Banks for Letters of Credit from Schedule F, Part 3
Part 5 – Interrogatories for Schedule F, Part 3
Part 6 – Restatement of Balance Sheet to Identify Net Credit for Ceded Reinsurance

NOTE: Certified reinsurer status applies on a prospective basis and is determined by the state of domicile of the ceding insurer. Reciprocal jurisdiction reinsurer status applies on a prospective basis and is for reinsurance agreements entered into, amended, or renewed on or after the effective date of the domiciliary state of the ceding entity enacting the 2019 revisions to the Credit for Reinsurance Models, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. As such, it is possible that a ceding insurer will report reinsurance balances applicable to a single assuming insurer under multiple classifications within Schedule F. For example, with respect to a certified reinsurer that was considered unauthorized prior to certification, balances attributable to contracts entered into prior to the assuming insurer’s certification would be reported in the unauthorized classification, while balances attributable to contracts entered into or renewed on or after the assuming insurer’s certification would be reported in the certified classification. This will also be the case for reciprocal jurisdiction reinsurance, which may have been classified as certified reinsurance prior to the enactment of the 2019 revisions to the Credit for Reinsurance Models by the domiciliary state of the ceding entity. Proper classification of such balances is essential to ensure accurate reporting of collateral requirements applicable to specific balances and the corresponding calculation of the liability for unauthorized and/or certified reinsurance.

Due Date

All parts of Schedule F are to be filed with the annual statement.

Please note that Parts 1, 3, 4 and 5 of this schedule are reported with thousands omitted. Parts 2 and 6 are reported in whole dollars.

ID Number

Most parts of Schedule F require that the “ID Number” be reported for assuming or ceding entities.

Reinsurance intermediaries should not be listed, because Schedule F is intended to identify only risk-bearing entities.

A ceding insurer can have unauthorized reinsurance, certified reinsurance and reciprocal jurisdiction reinsurance with the same reinsurer, based on when the contract became effective. It is important that the ceding insurer report all types correctly. The same reinsurer may be listed on the same Schedule F by the ceding insurer with an AIIN for unauthorized reinsurance, a CRIN for certified reinsurance, and a RJIN for reciprocal jurisdiction reinsurance.

Use of Federal Employer Identification Number

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers, even if the federal government has issued such a number.
**Alien Insurer Identification Number (AIIN)**

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule F instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If an alien company does not appear in that publication, contact with the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Pool and Association Numbers**

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule F the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC *Listing of Companies*. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Alien pools and associations should be reported on Schedule F under the category “Other Non-U.S. Insurers” rather than under “Pools, Associations and Similar Facilities.” Pools and associations consisting of affiliated companies should be listed by individual company names rather than by pool or association identification.

**Certified Reinsurer Identification Number (CRIN)**

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule F instead of the FEIN, Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)**

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule F instead of the FEIN, Alien Insurer Identification Number (AIIN) or Certified Reinsurer Identification Number (CRIN). The RJIN number is assigned by the NAIC and is listed in the NAIC *Listing of Companies*. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC *Listing of Companies*, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.
For 2020 Reporting Only

Reinsurers that have met the requirements for reciprocal jurisdiction reinsurer status in your state of domicile should be reported in the appropriate reciprocal jurisdiction reinsurer category if the reporting entity has implemented the necessary system and reporting changes for 2020 annual reporting to identify and report those reinsurance transactions in the appropriate reciprocal jurisdiction reinsurer category.

If the reporting entity has not been able to make the necessary system and reporting changes for 2020 annual reporting, the reporting entity may report those reinsurance transactions using the authorized reinsurer lines. Any crosschecks the reporting entity fails as a result of reporting reciprocal jurisdiction reinsurers on the authorized reinsurer lines should be explained.

NAIC Company Code

Company codes are assigned by the NAIC and are listed in the NAIC Listing of Companies. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the “Pool and Association Numbers” section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC Listing of Companies, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Determination of Authorized Status

The determination of the authorized, reciprocal jurisdiction, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule F shall be based on the status of that insurer or reinsurer in the reporting entity’s state of domicile.
SCHEDULE F – PART 1

ASSUMED REINSURANCE
AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal of the corresponding group, category, or subcategory, with the specified subtotal line appearing in the same manner and location as the pre-printed total or grand total line and number:

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<thead>
<tr>
<th>Column 1</th>
<th>ID Number</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Detail Eliminated to Conserve Space**

Column 1 = ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

SCHEDULE F – PART 2

PREMIUM PORTFOLIO REINSURANCE EFFECTED OR (CANCELED) DURING CURRENT YEAR

This schedule should list by portfolio any original premiums and reinsurance premiums for portfolio reinsurance transactions affected or canceled during the year. Portfolio reinsurance is the transfer of the entire liability of a reporting entity for in force policies as respects a described segment of the reporting entity’s business.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**Detail Eliminated to Conserve Space**

Column 1 = ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number
SCHEDULE F – PART 3

CEDED REINSURANCE
AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has amounts reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

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<td>U.S. Non-Pool Captive</td>
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<td><strong>Total Unauthorized</strong></td>
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<td>Affiliates</td>
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<td>Pools</td>
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<td>Mandatory Pools**@</td>
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<tr>
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<tr>
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<tr>
<td>Other U.S. Unaffiliated Insurers</td>
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</tbody>
</table>

| Pools                                          | Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells (Sum of | Total Protected Cells (Sum of | Totals (Sum of |
| Mandatory Pools*                              | 4299999 and 5499999)                                  | 4399999 and 5499999)                            | 4999999 |
| Voluntary Pools%                              | 5299999        |                                  |       |       |
| Other Non-U.S. Insurers#                      | 5399999        |                                  |       |       |
| Protected Cells                                | 5499999        |                                  |       |       |
| Total Reciprocal Jurisdiction – Affiliates    | 5099999        |                                  |       |       |
| Other U.S. Unaffiliated Insurers               | 5199999        |                                  |       |       |

| U.S. Non-Pool                                  | 4599999        |                                  |       |       |
| Captive                                       | 4699999        |                                  |       |       |
| Other                                          | 4799999        |                                  |       |       |
| Total                                          | 4999999        |                                  |       |       |

- Pools and Associations consisting of affiliated companies should be listed by individual company names.
- Include in Mandatory Pools all U.S. Government programs (e.g., National Flood Insurance, National Crop Insurance Corporation), all state residual market mechanisms, the Workers Compensation Reinsurance Pool, and the National Council on Compensation Insurance.
- Include in Voluntary Pools all pool participation that is voluntary on the part of the reporting entity. Include participation in any state program for which participation is not mandatory.
- Alien Pools and Associations should be reported on Schedule F under the category “Other Non-U.S. Insurers.”
Column 1 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

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<table>
<thead>
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<td>Affiliates</td>
<td></td>
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<td>Other (Non-U.S.)</td>
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<td>Affiliates</td>
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</tr>
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<td>Other (Non-U.S.)</td>
<td></td>
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<td>Captive</td>
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<td>Other</td>
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<tr>
<td>Voluntary Pools*%</td>
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<td>Other Non-U.S. Insurers#</td>
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<tr>
<td><strong>Total Unauthorized Excluding Protected Cells (Sum of 2299999, 2399999, 2499999, 2599999 and 2699999)</strong></td>
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</tr>
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### Total Certified

<table>
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<th>Line Number</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Captive</td>
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<tr>
<td>Other</td>
<td>3499999</td>
</tr>
<tr>
<td>Total</td>
<td>3599999</td>
</tr>
<tr>
<td>Total Certified – Affiliates</td>
<td>3699999</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
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<tr>
<td><strong>Pools</strong></td>
<td></td>
</tr>
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<td>Voluntary Pools*%</td>
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<tr>
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### Total Reciprocal Jurisdiction

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<th>Line Number</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Captive</td>
<td>4799999</td>
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<tr>
<td>Total Reciprocal Jurisdiction – Affiliates</td>
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<tr>
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<tr>
<td><strong>Pools</strong></td>
<td></td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
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<td>Other Non-U.S. Insurers#</td>
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<tr>
<td>Totals (Sum of 4399999, 5799999 and 5899999)</td>
<td>9999999</td>
</tr>
</tbody>
</table>

---

### Provision for Certified Reinsurance – Columns 54 Through 69

**Note:** Columns 54 through 69 are to be completed by those reporting entities whose domiciliary state has enacted the *Credit for Reinsurance Model Law* (#785) and/or *Credit for Reinsurance Model Regulation* (#786) with the defined certified reinsurer provisions.

**Only complete columns 54 through 69 for the following required groups, categories, or subcategories (Line Numbers); otherwise leave blank.**

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
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<tr>
<td>U.S. Intercompany Pooling</td>
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<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
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</tr>
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<td>Other</td>
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<tr>
<td>Group or Category</td>
<td>Line Number</td>
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<tr>
<td>-------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Other (Non-U.S.)</strong></td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Total Certified – Affiliates</td>
<td></td>
</tr>
<tr>
<td><strong>Other U.S. Unaffiliated Insurers</strong></td>
<td></td>
</tr>
<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Mandatory Pools*@</td>
<td></td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
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<tr>
<td>Other Non-U.S. Insurers#</td>
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<tr>
<td>Protected Cells</td>
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<tr>
<td>Total Certified Excluding Protected Cells (Sum of 3699999, 3799999, 3899999, 3999999 and 4099999)</td>
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<tr>
<td>Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells (Sum of 1499999, 2899999, 42999995699999)</td>
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</table>

**Detail Eliminated to Conserve Space**

Provision for Unauthorized Reinsurance – Columns 71 and 72

Only complete columns 71 and 72 for the following required groups, categories or subcategories (Line Numbers); otherwise enter zero.
Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells (Sum of 1499999, 2899999, 4299999 and 4299999) ........................... 4399999
Total Protected Cells (Sum of 1399999, 2799999, and 4199999) ............................................. 4499999
Totals (Sum of 4399999 and 4499999) ........................................................................................... 9999999

Provision for Overdue Authorized and Reciprocal Jurisdiction Reinsurance – Columns 73 and 74

Only complete columns 73 and 74 for the following required groups, categories or subcategories (Line Numbers); otherwise enter zero.

Group or Category Line Number

Total Authorized
Affiliates
U.S. Intercompany Pooling ................................................................. 0199999
U.S. Non-Pool
Captive .......................................................................................... 0299999
Other ............................................................................................ 0399999
Total ................................................................. 0499999
Other (Non-U.S.)
Captive .......................................................................................... 0599999
Other ............................................................................................ 0699999
Total ................................................................. 0799999
Total Authorized – Affiliates .............................................................. 0899999
Other U.S. Unaffiliated Insurers ............................................................ 0999999
Pools
Mandatory Pools*@ ........................................................................ 1099999
Voluntary Pools**% ........................................................................ 1199999
Other Non-U.S. Insurers# .................................................................. 1299999
Protected Cells ................................................................................. 1399999
Total Authorized Excluding Protected Cells (Sum of 0899999, 0999999, 1099999, 1199999 and 1299999) .............................................................. 1499999

Total Reciprocal Jurisdiction
Affiliates
U.S. Intercompany Pooling ................................................................. 4399999
U.S. Non-Pool
Captive .......................................................................................... 4499999
Other ............................................................................................ 4599999
Total ................................................................. 4699999
Other (Non-U.S.)
Captive .......................................................................................... 4799999
Other ............................................................................................ 4899999
Total ................................................................. 4999999
Total Reciprocal Jurisdiction – Affiliates .............................................................. 5099999
Other U.S. Unaffiliated Insurers ............................................................ 5199999
Pools
Mandatory Pools*@ ........................................................................ 5299999
Voluntary Pools**% ........................................................................ 5399999
Other Non-U.S. Insurers# .................................................................. 5499999
Protected Cells ................................................................................. 5599999
Total Reciprocal Jurisdiction Excluding Protected Cells (Sum of 5099999, 5199999, 5299999, 5399999 and 5499999) .............................................................. 5699999
Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells (Sum of 14,999,999, 28,999,999, 42,999,999 and 42,999,999) ................................................................. 43,999,999,579,9999
Total Protected Cells (Sum of 13,999,999, 27,999,999, 41,999,999 and 41,999,999,559,9999) ................................................................. 44,999,999,589,9999
Totals (Sum of 43,999,999,579,9999 and 44,999,999,589,9999) ......................................................................................................................... 99,999,999

Columns 73 & 74 – Provisions for Overdue Authorized Reinsurance

Amounts reported in the detail lines cannot be less than 0. If the calculated amounts are less than 0, then enter 0.

Columns 75 through 78 – Total Provisions for Reinsurance

Amounts reported in the detail lines cannot be less than 0. If the calculated amounts are less than 0, then enter 0.
## SUPPLEMENTAL SCHEDULE FOR REINSURANCE COUNTERPARTY REPORTING EXCEPTION – ASBESTOS AND POLLUTION CONTRACTS

### DETAIL OF ORIGINAL REINSURERS AGGREGATED ON SCHEDULE F

**AS OF DECEMBER 31, CURRENT YEAR**

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<tr>
<td>Other U.S. Unaffiliated Insurers</td>
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<tr>
<td>Mandatory Pools*@</td>
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<tr>
<td>Voluntary Pools*%</td>
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<tr>
<td>Other Non-U.S. Insurers#</td>
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<tr>
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<tr>
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<td>Affiliates</td>
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<tr>
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© 2020 National Association of Insurance Commissioners
### Pools

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<th>Value</th>
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</thead>
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<tr>
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<tr>
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<tr>
<td>Other Non-U.S. Insurers#</td>
<td>5499999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>5499999</td>
</tr>
</tbody>
</table>

**Total Reciprocal Jurisdiction Excluding Protected Cells** (Sum of 5099999, 5199999, 5299999, 5399999 and 5499999) = 5599999

**Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells** (Sum of 1499999, 2899999, 4299999 and 4299999) = 5699999

**Total Protected Cells** (Sum of 1399999, 2799999, 4199999 and 4199999) = 5799999

**Totals** (Sum of 4399999, 5799999 and 4499999) = 9999999

* – Pools and Associations consisting of affiliated companies should be listed by individual company names.

@ – Include in Mandatory Pools all U.S. Government programs (e.g., National Flood Insurance, National Crop Insurance Corporation), all state residual market mechanisms, the Workers Compensation Reinsurance Pool, and the National Council on Compensation Insurance.

% – Include in Voluntary Pools all pool participation that is voluntary on the part of the reporting entity. Include participation in any state program for which participation is not mandatory.

# – Alien Pools and Associations should be reported on Schedule F under the category “Other Non-U.S. Insurers.”

---

**Column 1 – ID Number (Original Reinsurer)**

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

---

**Column 5 – ID Number (Retroactive Reinsurer)**

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

---

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ANNUAL STATEMENT INSTRUCTIONS – TITLE

SCHEDULE F – REINSURANCE

Index to Schedule F

Part 1 – Assumed Reinsurance  
Part 2 – Ceded Reinsurance  
Part 3 – Provision for Unauthorized Reinsurance  
Part 4 – Provision for Reinsurance Ceded to Certified Reinsurers

NOTE: Certified reinsurer status applies on a prospective basis and is determined by the state of domicile of the ceding insurer. Reciprocal jurisdiction reinsurer status applies on a prospective basis and is for reinsurance agreements entered into, amended, or renewed on or after the effective date of the domiciliary state of the ceding entity enacting the 2019 revisions to the Credit for Reinsurance Models, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. As such, it is possible that a ceding insurer will report reinsurance balances attributable to a single assuming insurer under multiple classifications within Schedule F. For example, with respect to a certified reinsurer that was considered unauthorized prior to certification, balances attributable to contracts entered into prior to the assuming insurer’s certification would be reported in the unauthorized classification, while balances attributable to contracts entered into or renewed on or after the assuming insurer’s certification would be reported in the certified classification. This will also be the case for reciprocal jurisdiction reinsurance, which may have been classified as certified reinsurance prior to the enactment of the 2019 revisions to the Credit for Reinsurance Models by the domiciliary state of the ceding entity. Proper classification of such balances is essential to ensure accurate reporting of collateral requirements applicable to specific balances and the corresponding calculation of the liability for unauthorized and/or certified reinsurance.

Due Date

All parts of Schedule F are to be filed with the annual statement.

Please note that Parts 1, 2, 3 and 4 of this schedule are reported with thousands omitted.

ID Number

Schedule F require that the “ID Number” be reported for assuming or ceding entities.

Reinsurance intermediaries should not be listed, because Schedule F is intended to identify only risk-bearing entities.

A ceding insurer can have unauthorized reinsurance, certified reinsurance and reciprocal jurisdiction reinsurance with the same reinsurer, based on when the contract became effective. It is important that the ceding insurer report all types correctly. The same reinsurer may be listed on the same Schedule S by the ceding insurer with an AIIN for unauthorized reinsurance, a CRIN for certified reinsurance, and a RJIN for reciprocal jurisdiction reinsurance.

Use of Federal Employer Identification Number

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers even if the federal government has issued such a number.
**Alien Insurer Identification Number (AIIN)**

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule F instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information for on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Pool and Association Numbers**

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule F the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Alien pools and associations should be reported on Schedule F under the category “Other Non-U.S. Insurers” rather than under “Pools, Associations and Similar Facilities.” Pools and associations consisting of affiliated companies should be listed by individual company names rather than by pool or association identification.

**Certified Reinsurer Identification Number (CRIN)**

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule F instead of the FEIN, Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

**Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)**

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule F instead of the FEIN, Alien Insurer Identification Number (AIIN) or Certified Reinsurer Identification Number (CRIN). The RJIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.
For 2020 Reporting Only

Reinsurers that have met the requirements for reciprocal jurisdiction reinsurer status in your state of domicile should be reported in the appropriate reciprocal jurisdiction reinsurer category if the reporting entity has implemented the necessary system and reporting changes for 2020 annual reporting to identify and report those reinsurance transactions in the appropriate reciprocal jurisdiction reinsurer category.

If the reporting entity has not been able to make the necessary system and reporting changes for 2020 annual reporting, the reporting entity may report those reinsurance transactions using the authorized reinsurer lines. Any crosschecks the reporting entity fails as a result of reporting reciprocal jurisdiction reinsurers on the authorized reinsurer lines should be explained.

NAIC Company Code

Company codes are assigned by the NAIC and are listed in the NAIC Listing of Companies. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the “Pool and Association Numbers” section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC Listing of Companies, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Determination of Authorized Status

The determination of the authorized, reciprocal jurisdiction, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule F shall be based on the status of that insurer or reinsurer in the reporting entity’s state of domicile.
SCHEDULE F – PART 1

ASSUMED REINSURANCE AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal of the corresponding group, category, or subcategory, with the specified subtotal line appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Detail Eliminated to Conserve Space</strong></td>
<td></td>
</tr>
</tbody>
</table>

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

SCHEDULE F – PART 2

CEDED REINSURANCE AS OF DECEMBER 31, CURRENT YEAR

If a reporting entity has amounts reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Detail Eliminated to Conserve Space</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Authorized</th>
<th>Affiliates</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>0199999</td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>0299999</td>
</tr>
<tr>
<td>Other</td>
<td>0399999</td>
</tr>
<tr>
<td>Total</td>
<td>0499999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other (Non-U.S.)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Captive</td>
<td>0599999</td>
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<tr>
<td>Other</td>
<td>0699999</td>
</tr>
<tr>
<td>Total</td>
<td>0799999</td>
</tr>
</tbody>
</table>

<p>| Total Authorized – Affiliates | 0899999 |</p>
<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
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<tr>
<td>Pools</td>
<td></td>
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<tr>
<td>Mandatory Pools*</td>
<td>1099999</td>
</tr>
<tr>
<td>Voluntary Pools*</td>
<td>1199999</td>
</tr>
<tr>
<td>Total Authorized</td>
<td>1299999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td></td>
</tr>
<tr>
<td>Total Unauthorized</td>
<td>1399999</td>
</tr>
<tr>
<td>Total Unauthorized – Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>1499999</td>
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<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>1599999</td>
</tr>
<tr>
<td>Other</td>
<td>1699999</td>
</tr>
<tr>
<td>Total</td>
<td>1799999</td>
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<tr>
<td>Other (Non-U.S.)</td>
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<tr>
<td>Captive</td>
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<tr>
<td>Other</td>
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<td>Total</td>
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<tr>
<td>Total Unauthorized – Affiliates</td>
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<tr>
<td>Pools</td>
<td></td>
</tr>
<tr>
<td>Mandatory Pools*</td>
<td>2399999</td>
</tr>
<tr>
<td>Voluntary Pools*</td>
<td>2499999</td>
</tr>
<tr>
<td>Total Unauthorized – Other Non-U.S. Insurers#</td>
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<tr>
<td>Total Unauthorized</td>
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<tr>
<td>Total Unauthorized – Affiliates</td>
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<td>U.S. Intercompany Pooling</td>
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<td>U.S. Non-Pool</td>
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<td>Other</td>
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<td>Total</td>
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<tr>
<td>Total Certified – Affiliates</td>
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<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>3599999</td>
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<td>Pools</td>
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<td>Mandatory Pools*</td>
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<tr>
<td>Mandatory Pools*</td>
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<tr>
<td>Voluntary Pools*</td>
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</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td></td>
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<tr>
<td>Total Certified</td>
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</tr>
</tbody>
</table>
### Total Reciprocal Jurisdiction

#### Affiliates

<table>
<thead>
<tr>
<th>Category</th>
<th>ID Number</th>
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<tbody>
<tr>
<td>U.S. Intercompany Pooling</td>
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<td>U.S. Non-Pool</td>
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<td>Captive</td>
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<tr>
<td>Other</td>
<td>4299999</td>
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<tr>
<td>Total</td>
<td>4399999</td>
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<tr>
<td>Other (Non-U.S.)</td>
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<td>Captive</td>
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#### Total Reciprocal Jurisdiction – Affiliates

<table>
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<tr>
<th>ID Number</th>
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<td>4799999</td>
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</tbody>
</table>

#### Other U.S. Unaffiliated Insurers

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>4899999</td>
</tr>
</tbody>
</table>

#### Pools

<table>
<thead>
<tr>
<th>Category</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Pools*@</td>
<td>4999999</td>
</tr>
<tr>
<td>Voluntary Pools**%</td>
<td>5099999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>5199999</td>
</tr>
</tbody>
</table>

#### Total Reciprocal Jurisdiction

<table>
<thead>
<tr>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>5299999</td>
</tr>
</tbody>
</table>

#### Totals

<table>
<thead>
<tr>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>9999999</td>
</tr>
</tbody>
</table>

---

* Pools and Associations consisting of affiliated companies should be listed by individual company names.

# Alien Pools and Associations should be reported on Schedule F under the category “Other Non-U.S. Insurers.”

**NOTE:** Disclosure of the five largest provisional commission rates should exclude mandatory pools and joint underwriting associations.

**Column 1 – ID Number**

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number
**SCHEDULE F – PART 3**

**PROVISION FOR UNAUTHORIZED REINSURANCE AS OF DECEMBER 31, CURRENT YEAR**

If a reporting entity has amounts reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, category, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.</td>
<td></td>
</tr>
<tr>
<td>Federal Employer Identification Number (FEIN)</td>
<td></td>
</tr>
<tr>
<td>Alien Insurer Identification Number (AIIN)</td>
<td></td>
</tr>
<tr>
<td>Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)</td>
<td></td>
</tr>
<tr>
<td>Certified Reinsurer Identification Number (CRIN)</td>
<td></td>
</tr>
<tr>
<td>Pool/Association Identification Number</td>
<td></td>
</tr>
</tbody>
</table>

**SCHEDULE F – PART 4**

**PROVISION FOR REINSURANCE CEDED TO CERTIFIED REINSURERS AS OF DECEMBER 31, CURRENT YEAR**

NOTE: This schedule is to be completed by those reporting entities whose domiciliary state has enacted the Credit for Reinsurance Model Law (#785) and/or Credit for Reinsurance Model Regulation (#786) with the defined certified reinsurer provisions.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter one of the following as appropriate CRIN for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.</td>
<td></td>
</tr>
<tr>
<td>Federal Employer Identification Number (FEIN)</td>
<td></td>
</tr>
<tr>
<td>Alien Insurer Identification Number (AIIN)</td>
<td></td>
</tr>
<tr>
<td>Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)</td>
<td></td>
</tr>
<tr>
<td>Certified Reinsurer Identification Number (CRIN)</td>
<td></td>
</tr>
<tr>
<td>Pool/Association Identification Number</td>
<td></td>
</tr>
</tbody>
</table>
This schedule reports unpaid loss and loss adjustment expenses on direct and agency operations. Affiliated agencies are those that meet the affiliation standards defined by SSAP No. 25—Affiliates and Other Related Parties. Refer to SSAP No. 57—Title Insurance, paragraphs 8–13, for accounting guidance.

Line 2 — Reinsurance Recoverable from Authorized, Unauthorized and Certified Companies

The amounts shown on this line represent reinsurance ceded recoverables (from authorized, unauthorized and certified companies) on unpaid losses of which notice has been received. This can be done through reinsurance ceded treaties, facultative reinsurance assumed agreements, or under transfer and assumption agreements.

The amounts shown on this line should reconcile to amounts reported in Schedule F, Part 2, Column 9, Total.

The amount shown in Column 1 should agree to Schedule P, Part 1A, Column 19, Line 12.

The amount shown in Column 2 plus the amount shown in Column 3 should agree to Schedule P, Part 1B, Column 19, Line 12.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

WORKERS’ COMPENSATION CARVE-OUT SUPPLEMENT

The Workers’ Compensation Carve-out Supplement shall be completed by those reporting entities that assume or cede workers’ compensation carve-out business.

Workers’ compensation carve-out business is defined as reinsurance (including retrocessional reinsurance) assumed by life and health insurers of medical, wage loss and death benefits of the occupational illness and accident exposures, but not the employer’s liability exposures, of business originally written as workers compensation insurance.

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NOTE: Certified reinsurer status applies on a prospective basis and is determined by the state of domicile of the ceding insurer. Reciprocal jurisdiction reinsurer status applies on a prospective basis and is for reinsurance agreements entered into, amended, or renewed on or after the effective date of the domiciliary state of the ceding entity enacting the 2019 revisions to the Credit for Reinsurance Models, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal. As such, it is possible that a ceding insurer will report reinsurance balances applicable to a single assuming insurer under multiple classifications within Schedule F. For example, with respect to a certified reinsurer that was considered unauthorized prior to certification, balances attributable to contracts entered into prior to the assuming insurer’s certification would be reported in the unauthorized classification, while balances attributable to contracts entered into or renewed on or after the assuming insurer’s certification would be reported in the certified classification. Proper classification of such balances is essential to ensure accurate reporting of collateral requirements applicable to specific balances and the corresponding calculation of the liability for unauthorized and/or certified reinsurance.

**SCHEDULE F – REINSURANCE**

**Index to Schedule F**

<table>
<thead>
<tr>
<th>Part</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assumed Reinsurance</td>
</tr>
<tr>
<td>2</td>
<td>Ceded Reinsurance</td>
</tr>
</tbody>
</table>

**ID Number**

Schedule F requires that the “ID Number” be reported for assuming or ceding entities.

Reinsurance intermediaries should not be listed, because Schedule F is intended to identify only risk-bearing entities.

A ceding insurer can have unauthorized reinsurance, certified reinsurance and reciprocal jurisdiction reinsurance with the same reinsurer, based on when the contract became effective. It is important that the ceding insurer report all types correctly. The same reinsurer may be listed on the same Schedule S by the ceding insurer with an AIIN for unauthorized reinsurance, a CRIN for certified reinsurance, and a RJIN for reciprocal jurisdiction reinsurance.

**Use of Federal Employer Identification Number**

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers even if the federal government has issued such a number.
Alien Insurer Identification Number (AIIN)

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule F instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Pools and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule F the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The NAIC Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Alien pools and associations should be reported on Schedule F under the category “Other Non-U.S. Insurers” rather than under “Pools, Associations and Similar Facilities.” Pools and associations consisting of affiliated companies should be listed by individual company names rather than by pool or association identification.

Certified Reinsurer Identification Number (CRIN)

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule F instead of the FEIN, or Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.

Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule F instead of the FEIN. The RJIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC also provides this information to annual statement software vendors for incorporation into the software.
For 2020 Reporting Only

Reinsurers that have met the requirements for reciprocal jurisdiction reinsurer status in your state of domicile should be reported in the appropriate reciprocal jurisdiction reinsurer category if the reporting entity has implemented the necessary system and reporting changes for 2020 annual reporting to identify and report those reinsurance transactions in the appropriate reciprocal jurisdiction reinsurer category.

If the reporting entity has not been able to make the necessary system and reporting changes for 2020 annual reporting, the reporting entity may report those reinsurance transactions using the authorized reinsurer lines. Any crosschecks the reporting entity fails as a result of reporting reciprocal jurisdiction reinsurers on the authorized reinsurer lines should be explained.

NAIC Company Code

Company codes are assigned by the NAIC and are listed in the NAIC Listing of Companies. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the “Pool and Association Numbers” section above for details on assignment of Pool/Association Identification Numbers. Risk-bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk-bearing entity (e.g., risk-bearing pools or associations) does not appear in the NAIC Listing of Companies, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Determination of Authorized Status

The determination of the authorized, reciprocal jurisdiction, unauthorized or certified status of an insurer or reinsurer listed in any part of Schedule F shall be based on the status of that insurer or reinsurer in the reporting company’s state of domicile.
SCHEDULE F – PART 1

ASSUMED REINSURANCE

If a reporting entity has any detail lines reported for any of the following required groups, categories, or subcategories, it shall report the subtotal of the corresponding group, category, or subcategory, with the specified subtotal line appearing in the same manner and location as the pre-printed total or grand total line and number.

Detail Eliminated to Conserve Space

Column 1 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

Detail Eliminated to Conserve Space

SCHEDULE F – PART 2

CEDED REINSURANCE

If a reporting entity has amounts reported for any of the following required groups, categories, or subcategories, it shall report the subtotal amount of the corresponding group, categories, or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total line and number.

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Authorized</td>
<td></td>
</tr>
<tr>
<td>Affiliates</td>
<td></td>
</tr>
<tr>
<td>U.S. Non-Pool</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>0299999</td>
</tr>
<tr>
<td>Other</td>
<td>0399999</td>
</tr>
<tr>
<td>Total</td>
<td>0499999</td>
</tr>
<tr>
<td>Other (Non-U.S.)</td>
<td></td>
</tr>
<tr>
<td>Captive</td>
<td>0599999</td>
</tr>
<tr>
<td>Other</td>
<td>0699999</td>
</tr>
<tr>
<td>Total</td>
<td>0799999</td>
</tr>
<tr>
<td>Total Authorized – Affiliates</td>
<td>0899999</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>0999999</td>
</tr>
<tr>
<td>Pools</td>
<td>Mandatory Pools*</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Total Unauthorized Affiliates</td>
<td>U.S. Intercompany Pooling</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>Voluntary Pools*</td>
</tr>
<tr>
<td>Total Certified Affiliates</td>
<td>U.S. Intercompany Pooling</td>
</tr>
<tr>
<td>Other U.S. Unaffiliated Insurers</td>
<td>Voluntary Pools*</td>
</tr>
</tbody>
</table>
### Total Reciprocal Jurisdiction

#### Affiliates

<table>
<thead>
<tr>
<th>Description</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Intercompany Pooling</td>
<td>4399999</td>
</tr>
<tr>
<td>U.S. Non-Pool Captive</td>
<td>4499999</td>
</tr>
<tr>
<td>U.S. Non-Pool Other</td>
<td>4599999</td>
</tr>
<tr>
<td>Total</td>
<td>4699999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Captive</td>
<td>4799999</td>
</tr>
<tr>
<td>Other (Non-U.S.) Other</td>
<td>4899999</td>
</tr>
<tr>
<td>Total</td>
<td>4999999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction – Affiliates</td>
<td>5099999</td>
</tr>
</tbody>
</table>

#### Other U.S. Unaffiliated Insurers

<table>
<thead>
<tr>
<th>Description</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>5199999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>5299999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction Excluding Protected Cells</td>
<td>5399999 and 5499999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Authorized, Reciprocal Jurisdiction, Unauthorized and Certified Excluding Protected Cells</td>
<td>5599999</td>
</tr>
<tr>
<td>Total Protected Cells</td>
<td>5699999</td>
</tr>
</tbody>
</table>

#### Pools

<table>
<thead>
<tr>
<th>Description</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Pools*@</td>
<td>5299999</td>
</tr>
<tr>
<td>Voluntary Pools*%</td>
<td>5399999</td>
</tr>
<tr>
<td>Other Non-U.S. Insurers#</td>
<td>5499999</td>
</tr>
<tr>
<td>Protected Cells</td>
<td>5599999</td>
</tr>
<tr>
<td>Total Reciprocal Jurisdiction Excluding Protected Cells</td>
<td>5699999</td>
</tr>
</tbody>
</table>

#### Column 1 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

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SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 1 – ALL CESSIONS OF TERM AND UNIVERSAL LIFE INSURANCE WITH SECONDARY GUARANTEES

Column 2 — ID Number

Enter one of the following as appropriate for the assuming insurer reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)

SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT

PART 2A – TRANSACTIONS SUBJECT TO PART 2 DISCLOSURE (GRANDFATHERED OR SPECIAL EXEMPTION)

Column 1 — Cession ID

Enter a unique Cession ID for each line (01 – 99).

Column 2 — NAIC Company Code

Provide the NAIC code of the assuming insurer.

Column 3 — ID Number

Enter one of the following as appropriate for the assuming insurer being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)

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**SUPPLEMENTAL TERM AND UNIVERSAL LIFE INSURANCE REINSURANCE EXHIBIT**

**PART 2B – TRANSACTIONS SUBJECT TO PART 2 DISCLOSURE**
*(NON-GRANDFATHERED)*

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Cession ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter a unique Cession ID for each line (01 – 99).</td>
<td></td>
</tr>
<tr>
<td>To differentiate between cessions that contain risks subject to the provisions of AG48 and those that contain risks subject to the provisions of a state regulation equivalent to Model #787, append an A or B after the cession ID.</td>
<td></td>
</tr>
<tr>
<td>In the event that a cession contains risks subject to both the provisions of AG48 and the provisions of a state regulation equivalent to Model #787, the reporting of the cession shall be bi-furcated accordingly and listed on two distinct lines.</td>
<td></td>
</tr>
<tr>
<td>Use “A” for cessions that contain risks subject to the provisions of AG48.</td>
<td></td>
</tr>
<tr>
<td>Use “B” for cessions that contain risks subject to the provisions of a state regulation.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 2</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide the NAIC code of the assuming insurer.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 3</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter one of the following as appropriate for the assuming insurer being reported on the schedule. See the Schedule S General Instructions for more information on these identification numbers.</td>
<td></td>
</tr>
<tr>
<td>Federal Employer Identification Number</td>
<td>(FEIN)</td>
</tr>
<tr>
<td>Alien Insurer Identification Number</td>
<td>(AIIN)</td>
</tr>
<tr>
<td>Reciprocal Jurisdiction Reinsurer Identification Number</td>
<td>(RJIN)</td>
</tr>
<tr>
<td>Certified Reinsurer Identification Number</td>
<td>(CRIN)</td>
</tr>
</tbody>
</table>

---

**Detail Eliminated to Conserve Space**
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY AND TITLE

NOTES TO FINANCIAL STATEMENTS

Notes to the Annual Statement are to be filed on March 1.

---

Detail Eliminated to Conserve Space

23. Reinsurance

Instruction:

A. Unsecured Reinsurance Recoverables

If the company has with any individual reinsurers (authorized, reciprocal jurisdiction, unauthorized or certified), an unsecured aggregate recoverable for losses, paid and unpaid including IBNR, loss adjustment expenses, and unearned premium that exceeds 3% of the company’s policyholder surplus, list each individual reinsurer and the unsecured aggregate recoverable pertaining to that reinsurer. If the individual reinsurer is part of a group, list the individual reinsurers, each of its related group members having reinsurance with the reporting company, and the total unsecured aggregate recoverables for the entire group.

Include: The NAIC group code number, where appropriate, and the Federal Employer Identification Number for each individual company.

---

Detail Eliminated to Conserve Space

F. Retroactive Reinsurance

(1) Provide the following information for all retroactive reinsurance agreements that transfer liabilities for losses that have already occurred and that will generate special surplus transactions:

---

Detail Eliminated to Conserve Space

f. List the total Paid Loss/LAE amounts recoverable (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers), any amounts more than 90 days overdue (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers) and for amounts recoverable the collateral held (for unauthorized and certified reinsurers).

The insurer (assuming or ceding) shall assign a unique number to each retroactive reinsurance agreement and shall utilize this number for as long as the agreement exists. Do not report transactions utilizing deposit accounting in this note.

---

Detail Eliminated to Conserve Space
A. Unsecured Reinsurance Recoverables

The Company does not have an unsecured aggregate recoverable for losses, paid and unpaid including IBNR, loss adjustment expenses and unearned premium with any individual reinsurers, authorized or unauthorized, that exceeds 3% of the Company’s policyholder surplus.

---

F. Retroactive Reinsurance

(1) Total Paid Loss/LAE amounts recoverable (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers), any amounts more than 90 days overdue (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers), and for amounts recoverable the collateral held (for authorized, reciprocal jurisdiction, unauthorized and certified reinsurers) as respects amounts recoverable from authorized, reciprocal jurisdiction, unauthorized and certified reinsurers:

1. Authorized Reinsurers

<table>
<thead>
<tr>
<th>Company</th>
<th>Total Paid/Loss/LAE Recoverable</th>
<th>Amounts Over 90 Days Overdue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$_____________________________</td>
<td>$_________________________</td>
</tr>
<tr>
<td></td>
<td>$_____________________________</td>
<td>$_________________________</td>
</tr>
<tr>
<td></td>
<td>$_____________________________</td>
<td>$_________________________</td>
</tr>
<tr>
<td>Total</td>
<td>$_____________________________</td>
<td>$_________________________</td>
</tr>
</tbody>
</table>

2. Unauthorized Reinsurers

<table>
<thead>
<tr>
<th>Company</th>
<th>Total Paid/Loss/LAE Recoverable</th>
<th>Amounts Over 90 Days Overdue</th>
<th>Collateral Held</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$_____________________________</td>
<td>$_________________________</td>
<td>$________________</td>
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<td></td>
<td>$_____________________________</td>
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<tr>
<td></td>
<td>$_____________________________</td>
<td>$_________________________</td>
<td>$________________</td>
</tr>
<tr>
<td>Total</td>
<td>$_____________________________</td>
<td>$_________________________</td>
<td>$________________</td>
</tr>
</tbody>
</table>
### 3. Certified Reinsurers

<table>
<thead>
<tr>
<th>Company</th>
<th>Total Paid/Loss/LAE Recoverable</th>
<th>Amounts Over 90 Days Overdue</th>
<th>Collateral Held</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
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<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

### 4. Reciprocal Jurisdiction Reinsurers

<table>
<thead>
<tr>
<th>Company</th>
<th>Total Paid/Loss/LAE Recoverable</th>
<th>Amounts Over 90 Days Overdue</th>
<th>Collateral Held</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
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<td>$</td>
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<tr>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space
ANNUAL & QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY & TITLE

SCHEDULE Y

PART 1A – DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

All insurer and reporting entity members of the holding company system shall prepare a schedule for inclusion in each of the individual annual statements that is common for the group with the exception of Column 10, Relationship to Reporting Entity.

<table>
<thead>
<tr>
<th>Column 4</th>
<th>ID Number</th>
</tr>
</thead>
</table>

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)*
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)*
- Certified Reinsurer Identification Number (CRIN)*

* RJIN, AIINs or CRINs are only reported if the entity in Column 8 is a reinsurer that has had an RJIN, AIIN or CRIN number assigned or should have one assigned due to transactions being reported on Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) of another entity regardless of whether the entity in Column 8 is part of reporting entity’s group.

If not applicable for the entity in Column 8, leave blank.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE Y

PART 2 – SUMMARY OF INSURER’S TRANSACTIONS WITH ANY AFFILIATES

This schedule was designed to provide an overview of transactions among insurance holding company system members. It is intended to demonstrate the scope and direction of major fund and/or surplus flows throughout the system. This schedule should be prepared on an accrual basis.

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN) *
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) *
- Certified Reinsurer Identification Number (CRIN) *

* RJIN, AIIN or CRIN numbers are only reported if the entity in Column 3 is a reinsurer that has had an RJIN, AIIN or CRIN number assigned or should have one assigned due to transactions being reported on Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) of another entity regardless of whether the entity in Column 3 is part of reporting entity’s group or not.

If not applicable for the entity in Column 3, leave blank.
VALUATION OF SHARES OF SUBSIDIARY, CONTROLLED OR AFFILIATED COMPANIES

If a reporting entity has any common stock or preferred stock reported for any of the following required categories or subcategories, it shall report the subtotal amount of the corresponding category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

Column 5 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) General Instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN) *
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) *
- Certified Reinsurer Identification Number (CRIN) *

* RJIN, AIINs or CRINs are only reported if the entity is a reinsurer that has had an RJIN, AIIN or CRIN number assigned or should have one assigned due to transactions being reported on Schedule F (Property and Title) or Schedule S (Life, Health and Fraternal) of another reporting entity.

If not applicable for the entity, leave blank.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

TRUSTEED SURPLUS STATEMENT

Page 3

Line 1 – Total Liabilities

Should agree with the amount reported on Page 3, Line 28 of the annual statement.

Line 4 – Amounts Recoverable From Reinsurers

Line 4.1 – Authorized Companies

Include: Any reinsurance recoverable on paid losses from authorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 4.2 – Unauthorized Companies

Include: Any reinsurance recoverables on paid losses from unauthorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 4.3 – Certified Companies

Include: Any reinsurance recoverable on paid losses from certified companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 4.4 – Reciprocal Jurisdiction Companies

Include: Any reinsurance recoverable on paid losses from reciprocal jurisdiction companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

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ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

TRUSTEED SURPLUS STATEMENT

Detail Eliminated to Conserve Space

Page 3

Line 1 – Total Liabilities

Should agree with the amount reported on Page 3, Line 28 of the annual statement.

Detail Eliminated to Conserve Space

Line 7 – Reinsurance Recoverable on Paid Losses and Loss Adjustment Expenses

Line 7.1 – Authorized Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from authorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 7.2 – Unauthorized Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from unauthorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 7.3 – Certified Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from certified companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 7.4 – Reciprocal Jurisdiction Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from reciprocal jurisdiction companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Detail Eliminated to Conserve Space
ANNUAL AND QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

TRUSTEED SURPLUS STATEMENT

Page 3

Line 1 – Total Liabilities
Should agree with the amount reported on Page 3, Line 28 of the quarterly statement.

Line 4 – Amounts Recoverable From Reinsurers

Line 4.1 – Authorized Companies
Include: Any reinsurance recoverable on paid losses from authorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 4.2 – Unauthorized Companies
Include: Any reinsurance recoverables on paid losses from unauthorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 4.3 – Certified Companies
Include: Any reinsurance recoverable on paid losses from certified companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 4.4 – Reciprocal Jurisdiction Companies
Include: Any reinsurance recoverable on paid losses from reciprocal jurisdiction companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.
ANNUAL AND QUARTERLY STATEMENT INSTRUCTIONS – PROPERTY

TRUSTEED SURPLUS STATEMENT

Page 3

Line 1 – Total Liabilities

Should agree with the amount reported on Page 3, Line 28 of the quarterly statement.

Line 7 – Reinsurance Recoverable on Paid Losses and Loss Adjustment Expenses

Line 7.1 – Authorized Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from authorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 7.2 – Unauthorized Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from unauthorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 7.3 – Certified Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from certified companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

Line 7.4 – Reciprocal Jurisdiction Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from reciprocal jurisdiction companies that are included in the asset on Page 2, Line 16.1, Column 3 of the quarterly statement.

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Billable Text

QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL AND HEALTH

SCHEDULE S – CEDED REINSURANCE

SHOWING ALL NEW REINSURANCE TREATIES – CURRENT YEAR TO DATE

Detail Eliminated to Conserve Space

Column 1 – NAIC Company Code

Company codes are assigned by the NAIC and are listed in the NAIC Listing of Companies. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the instruction for Column 2 for details on assignment of Pool/Association Identification Numbers. Risk bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk bearing entity (e.g., risk bearing pools or associations) does not appear in the NAIC Listing of Companies, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Column 2 – ID Number

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule S General Instructions in the annual statement instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN)
- Alien Insurer Identification Number (AIIN)
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)
- Certified Reinsurer Identification Number (CRIN)
- Pool/Association Identification Number

Federal ID Number (FEIN)

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “Federal ID Number” for other alien insurers even if the federal government has issued such a number.

Alien Insurer Identification Number (AIIN)

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule S instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semiannually. The NAIC provides this information to annual statement software vendors for incorporation into the software.
Pool and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule S the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

Newly assigned numbers are incorporated in revised editions of the NAIC Listing of Companies, which are available semiannually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

Certified Reinsurer Identification Number (CRIN)

In order to report transactions involving certified reinsurers correctly, the appropriate Certified Reinsurer Identification Number (CRIN) must be included on Schedule S instead of the FEIN or Alien Insurer Identification Number (AIIN) or Reciprocal Jurisdiction Reinsurer Identification Number (RJIN). The CRIN is assigned by the NAIC and is listed in the NAIC Listing of Companies. If a certified reinsurer does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

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Reciprocal Jurisdiction Reinsurer Identification Number (RJIN)

In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule S instead of the FEIN. The RJIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

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QUARTERLY STATEMENT INSTRUCTIONS – PROPERTY AND TITLE

SCHEDULE F – CEDED REINSURANCE

SHOWING ALL NEW REINSURERS – CURRENT YEAR TO DATE

<table>
<thead>
<tr>
<th>Column 1</th>
<th>NAIC Company Code</th>
</tr>
</thead>
</table>

Company codes are assigned by the NAIC and are listed in the NAIC Listing of Companies. The NAIC does not assign a company code to insurers domiciled outside of the U.S. or to non-risk bearing pools or associations. The “NAIC Company Code” field should be zero-filled for those organizations. Non-risk bearing pools or associations are assigned a Pool/Association Identification Number. See the instruction for Column 2 for details on assignment of Pool/Association Identification Numbers. Risk bearing pools or associations are assigned a company code. If a reinsurer or reinsured has merged with another entity, report the company code of the surviving entity.

If a risk bearing entity (e.g., risk bearing pools or associations) does not appear in the NAIC Listing of Companies, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned. Newly assigned company codes are incorporated in revised editions of the NAIC Listing of Companies, which are available semi-annually. The NAIC provides this information to annual statement software vendors for incorporation into the software.

<table>
<thead>
<tr>
<th>Column 2</th>
<th>ID Number</th>
</tr>
</thead>
</table>

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions in the annual statement instructions for more information on these identification numbers.

- Federal Employer Identification Number (FEIN).
- Alien Insurer Identification Number (AIIN).
- Reciprocal Jurisdiction Reinsurer Identification Number (RJIN).
- Certified Reinsurer Identification Number (CRIN).
- Pool/Association Identification Number.

Federal ID Number (FEIN)

The Federal Employer Identification Number (FEIN) must be reported for each U.S.-domiciled insurer and U.S. branch of an alien insurer. The FEIN should not be reported as the “ID Number” for other alien insurers even if the federal government has issued such a number.

Alien Insurer Identification Number (AIIN)

In order to report transactions involving alien companies correctly, the appropriate Alien Insurer Identification Number (AIIN) must be included on Schedule F instead of the FEIN. The AIIN number is assigned by the NAIC and is listed in the Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

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Pool and Association Numbers

In order to report transactions involving non-risk bearing pools or associations consisting of non-affiliated companies correctly, the company must include on Schedule F the appropriate Pool/Association Identification Number. These numbers are listed in the NAIC Listing of Companies. The Pool/Association Identification Number should be used instead of any FEIN that may have been assigned. If a pool or association does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or information on having a number assigned.

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In order to report transactions involving alien companies correctly, the appropriate Reciprocal Jurisdiction Reinsurer Identification Number (RJIN) must be included on Schedule S instead of the FEIN. The RJIN number is assigned by the NAIC and is listed in the NAIC Listing of Companies. If an alien company does not appear in that publication, contact the NAIC Financial Systems and Services Department, Company Demographics Analyst at FDRCCREQ@NAIC.ORG for numbers assigned since the last publication or for information on having a number assigned.

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Column 5 – Type of Reinsurer

The determination of the authorized, certified or unauthorized status of an insurer or reinsurer shall be based on the status of that insurer or reinsurer in the reporting company’s state of domicile.

Enter “Authorized” “Reciprocal Jurisdiction” “Certified” or “Unauthorized” to indicate the type of reinsurer.
### SCHEDULE F – PART 3 (Continued)

Ceded Reinsurance as of December 31, Current Year ($000 Omitted)

(Total Provision for Reinsurance)

<table>
<thead>
<tr>
<th>ID Number</th>
<th>Name of Reinsurer</th>
<th>Provision for Unauthorized Reinsurance</th>
<th>Provision for Overdue Authority and Reciprocal Jurisdiction</th>
<th>Total Provision for Reinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>70</td>
<td>71 (Cols. 52 = &quot;Yes&quot;; Otherwise Enter 0)</td>
<td>75 (Cols. 64 + 69)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>72 (Greater of 20% of Net on Paid Losses &amp; LAE Over 90 Days Past Due Amounts in Dispute (Cols. 47 * 20%) + Recoverable Net of LAE Over 90 Days)</td>
<td>76 (Cols. 75 + 76 + 77)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>77 (Cols. 64 + 69)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>78 (Cols. 64 + 69)</td>
</tr>
</tbody>
</table>

Note: For the purpose of calculation, please refer to the column headings and formulas provided in the schedule.

**Provision for Unauthorized Reinsurance**
- 70% of Recoverable on Paid Losses & LAE Over 90 Days Past Due Amounts Not in Dispute (Cols. 47 * 20%)
- 20% of Recoverable on Paid Losses & LAE Over 90 Days Past Due Amounts Not in Dispute + 20% of Amounts in Dispute (Cols. 47 * 20%)
- Greater of 20% of Net Recoverable Net of Funds Held & Collateral or 20% of Recoverable on Paid Losses & LAE Over 90 Days Past Due Amounts Not in Dispute (Cols. 47 * 20%)

**Provision for Overdue Authority and Reciprocal Jurisdiction**
- Complete if Col. 52 = "Yes"; Otherwise Enter 0

**Total Provision for Reinsurance**
- Cols. 71 + 72 Not in Dispute + Recoverable on Paid Losses & LAE Over 90 Days Past Due Amounts Not in Dispute (Cols. 75 + 76 + 77)

**Provision for Amounts Ceded to Certified Reinsurers**
- Cols. 64 + 69

**Provision for Amounts Ceded to Unauthorized Reinsurers**
- Complete if Col. 52 = "Yes"; Otherwise Enter 0

**Provision for Amounts Ceded to Reciprocal Jurisdiction**
- Cols. 73 + 74

**Total Provision for Reinsurance**
- Cols. 75 + 76 + 77

**Notes:**
- Provision for Past Due Amounts: Complete if Col. 52 = "Yes"; Otherwise Enter 0
- Greater of 20% of Net Recoverable Net of Funds Held & Collateral or 20% of Recoverable on Paid Losses & LAE Over 90 Days Past Due Amounts Not in Dispute (Cols. 47 * 20%)

**Form: 1999999**

**Dimensions:**
- 612.0 x 792.0

**Page Number:**
- 63

**Attachment Four-A5**
### ANNUAL STATEMENT BLANK – TITLE

#### OPERATIONS AND INVESTMENT EXHIBIT

**PART 2B – UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES**

<table>
<thead>
<tr>
<th></th>
<th>1. Loss and allocated LAE reserve for title and other losses of which notice has been received:</th>
<th>2. Deduct reinsurance recoverable from authorized, unauthorized and certified companies</th>
<th>3. Known claims reserve net of reinsurance (Line 1.1 plus Line 1.2 minus Line 2)</th>
<th>4. Incurred But Not Reported:</th>
<th>5. Unallocated LAE reserve</th>
<th>6. Less discount for time value of money, if allowed (Schedule P, Part 1, Line 12, Col. 33)</th>
<th>7. Total Schedule P reserves (Lines 3 + 4.4 + 5 - 6)</th>
<th>8. Statutory premium reserve at year end (Part 1B, Line 2.6)</th>
<th>9. Aggregate of other reserves required by law (Page 3, Line 3)</th>
<th>10. Supplemental reserve (a) (Lines 7 - (3 + 8 + 9))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.1 Direct (Schedule P, Part 1, Line 12, Col. 17)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td></td>
<td>1.2 Reinsurance assumed (Schedule P, Part 1, Line 12, Col. 18)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td></td>
<td>2.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td></td>
<td>3.0</td>
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<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td></td>
<td>4.1 Direct (Schedule P, Part 1, Line 12, Col. 20)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td></td>
<td>4.2 Reinsurance assumed (Schedule P, Part 1, Line 12, Col. 21)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td></td>
<td>4.3 Reinsurance ceded (Schedule P, Part 1, Line 12, Col. 22)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td></td>
<td>4.4 Net incurred but not reported (Line 4.1 plus Line 4.2 minus Line 4.3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
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<td>8.0</td>
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<td></td>
<td>XXX</td>
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<td>XXX</td>
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<td>XXX</td>
</tr>
<tr>
<td></td>
<td>9.0</td>
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<td></td>
<td></td>
<td></td>
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<td>XXX</td>
<td>XXX</td>
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</tr>
<tr>
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<td>10.0</td>
<td></td>
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<td></td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

(a) If the sum of Lines 3 + 8 + 9 is greater than Line 7, place a "0" in this Line.
ANNUAL AND QUARTERLY STATEMENT BLANK – LIFE/FRATERNAL

TRUSTEED SURPLUS STATEMENT
LIABILITIES AND TRUSTEED SURPLUS

<table>
<thead>
<tr>
<th></th>
<th>Current Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total Liabilities...........................................................................................................</td>
</tr>
<tr>
<td>2</td>
<td>Aggregate write-ins for additions to liabilities................................................................</td>
</tr>
<tr>
<td>3</td>
<td>Total (Lines 1 + 2)........................................................................................................</td>
</tr>
</tbody>
</table>

DEDUCTIONS FROM LIABILITIES:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Amounts Recoverable From Reinsurers:</td>
</tr>
<tr>
<td>4.1</td>
<td>Authorized Companies........................................................................................................</td>
</tr>
<tr>
<td>4.2</td>
<td>Unauthorized Companies....................................................................................................</td>
</tr>
<tr>
<td>4.3</td>
<td>Reciprocal Jurisdiction Companies................................................................................</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Special State Deposits, not exceeding net liabilities carried:</td>
</tr>
<tr>
<td>5.1</td>
<td>Special State Deposits (submit schedule)........................................................................</td>
</tr>
<tr>
<td>5.2</td>
<td>Accrued interest on special state deposits.......................................................................</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Life insurance premiums and annuity considerations deferred and uncollected................</td>
</tr>
<tr>
<td>7</td>
<td>Accident and health premiums due and unpaid.................................................................</td>
</tr>
<tr>
<td>8</td>
<td>Contract loans and premium notes:</td>
</tr>
<tr>
<td>8.1</td>
<td>Contract loans not exceeding reserves carried on such policies...................................</td>
</tr>
<tr>
<td>8.2</td>
<td>Premium notes....................................................................................................................</td>
</tr>
<tr>
<td>8.3</td>
<td>Interest due and accrued on contract loans and premium notes........................................</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Aggregate write-ins for other deductions from liabilities..............................................</td>
</tr>
<tr>
<td>10</td>
<td>Total Deductions (Lines 4 thru 9)..................................................................................</td>
</tr>
<tr>
<td>11</td>
<td>Total Adjusted Liabilities (Line 3 minus Line 10)..............................................................</td>
</tr>
<tr>
<td>12</td>
<td>Trusteed Surplus................................................................................................................</td>
</tr>
<tr>
<td>13</td>
<td>Total..................................................................................................................................</td>
</tr>
</tbody>
</table>

DETAILS OF WRITE-INS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0201.</td>
<td></td>
</tr>
<tr>
<td>0202.</td>
<td></td>
</tr>
<tr>
<td>0203.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0298.</td>
<td>Summary of remaining write-ins for Line 2 from overflow page.................................</td>
</tr>
<tr>
<td>0299.</td>
<td>Totals (Lines 0201 thru 0203 plus 0298) (Line 2 above)...............................................</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0901.</td>
<td></td>
</tr>
<tr>
<td>0902.</td>
<td></td>
</tr>
<tr>
<td>0903.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0998.</td>
<td>Summary of remaining write-ins for Line 9 from overflow page....................................</td>
</tr>
<tr>
<td>0999.</td>
<td>Totals (Lines 0901 thru 0903 plus 0998) (Line 9 above).............................................</td>
</tr>
</tbody>
</table>

INTERROGATORIES:

1.1 Have there been any changes made to any of the trust indentures during the period? Yes [ ] No [ ]

1.2 If yes, has the domiciliary or entry state approved the change? Yes [ ] No [ ]
## ANNUAL AND QUARTERLY STATEMENT BLANK – PROPERTY

### TRUSTEED SURPLUS STATEMENT

**LIABILITIES AND TRUSTEED SURPLUS**

<table>
<thead>
<tr>
<th></th>
<th>1 Current Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Liabilities</td>
<td></td>
</tr>
<tr>
<td>2. Ceded Reinsurance Balances Payable</td>
<td></td>
</tr>
<tr>
<td>3. Agents’ Credit Balances</td>
<td></td>
</tr>
<tr>
<td>4. Aggregate Write-ins For Other Additions to Liabilities</td>
<td></td>
</tr>
<tr>
<td>5. Total Additions (Lines 2 + 3 + 4)</td>
<td></td>
</tr>
<tr>
<td>6. Total (Lines 1 + 5)</td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONS TO LIABILITIES:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Reinsurance Recoverable on Paid Losses and Loss Adjustment Expenses:</td>
<td></td>
</tr>
<tr>
<td>7.1 Authorized Companies</td>
<td></td>
</tr>
<tr>
<td>7.2 Unauthorized Companies</td>
<td></td>
</tr>
<tr>
<td>7.3 Reciprocal Jurisdiction Companies</td>
<td></td>
</tr>
<tr>
<td>7.4 Total (Lines 7 thru 2)</td>
<td></td>
</tr>
</tbody>
</table>

### DEDUCTIONS FROM LIABILITIES:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Special State Deposits, not exceeding net liabilities carried in this statement on business in each respective state:</td>
<td></td>
</tr>
<tr>
<td>8.1 Special State Deposits (submit schedule)</td>
<td></td>
</tr>
<tr>
<td>8.2 Accrued interest on Special State Deposits</td>
<td></td>
</tr>
<tr>
<td>9. Agents’ balances or uncollected premiums not more than ninety days past due, not exceeding unearned premium reserves carried thereon</td>
<td></td>
</tr>
<tr>
<td>10. Unpaid Reinsurance Premiums Receivable, not exceeding losses and loss adjustment expenses due to reinsured:</td>
<td></td>
</tr>
<tr>
<td>10.1 Authorized Companies</td>
<td></td>
</tr>
<tr>
<td>10.2 Unauthorized Companies</td>
<td></td>
</tr>
<tr>
<td>11. Aggregate write-ins for other deductions from liabilities</td>
<td></td>
</tr>
<tr>
<td>12. Total Deductions (Lines 7 thru 11)</td>
<td></td>
</tr>
<tr>
<td>13. Total Adjusted Liabilities (Line 6 minus Line 12)</td>
<td></td>
</tr>
<tr>
<td>14. Total Liabilities</td>
<td></td>
</tr>
<tr>
<td>15. Total</td>
<td></td>
</tr>
</tbody>
</table>

### DETAILS OF WRITE-INS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1191. Totals (Lines 1101 thru 1103 plus 1198)</td>
<td></td>
</tr>
<tr>
<td>1192. Summary of remaining write-ins for Line 11 from overflow page</td>
<td></td>
</tr>
<tr>
<td>1193. Totals (Lines 1101 thru 1103 plus 1198)</td>
<td></td>
</tr>
<tr>
<td>1194. Summary of remaining write-ins for Line 4 from overflow page</td>
<td></td>
</tr>
<tr>
<td>1199. Totals (Lines 1401 thru 1403 plus 1198)</td>
<td></td>
</tr>
</tbody>
</table>

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>Contact Person:</th>
<th>Patricia Gosselin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Name:</td>
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FOR NAIC USE ONLY

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Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Add crosschecks to Lines 13 and 14 of the State Page to Lines 10 and 11 of the Underwriting and Investment Exhibit, Part 1. Also add crosschecks to Lines 9, 10 and 11 of the Underwriting and Investment Exhibit, Part 1 and Schedule T, Line 61.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to add additional crosschecks between the State Page, Schedule T and Underwriting and Investment Exhibit, Part 1 for the direct written premium for the Health, Life and Property business.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.

© 2020 National Association of Insurance Commissioners 1
ANNUAL STATEMENT INSTRUCTIONS – HEALTH

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

Detail Eliminated to Conserve Space

Line 12 – Health Premiums Written

Include: Direct premiums written.

Amount Column 1 should agree with Underwriting and Investment Exhibit, Part 1, Column 1, Line 9.

Line 13 – Life Premiums Direct

Include: Direct premiums and annuity considerations for life contracts excluding reinsurance assumed and without deduction of reinsurance ceded.

Column 1 should equal Underwriting and Investment Exhibit, Part 1, Column 1, Line 10.

Line 14 – Property/Casualty Premiums Written

Include: Direct premiums for property and casualty lines of business excluding reinsurance assumed and without deduction of reinsurance ceded.

Column 1 should equal Underwriting and Investment Exhibit, Part 1, Column 1, Line 11.

Detail Eliminated to Conserve Space
### UNDERWRITING AND INVESTMENT EXHIBIT

**PART 1 – PREMIUMS**

<table>
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<tr>
<th>Line</th>
<th>Category</th>
<th>Description</th>
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<tr>
<td>8</td>
<td>Other Health</td>
<td>Other health revenues not included in any other column, including stop loss, disability income and long-term care. Policies providing stand alone Medicare Part D Prescription Drug Coverage. ASO (administrative services only) contracts and ASC (administrative service contracts). Refer to SSAP No. 47—Uninsured Plans for accounting guidance. Policies providing Medicare Part D Prescription Drug Coverage through a Medicare Advantage product.</td>
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<td>9</td>
<td>Health Subtotal</td>
<td>Column 1 should equal Schedule T, Line 61 sum of Columns 2, 3, 4 and 5.</td>
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<td>Life</td>
<td>Revenue for life insurance. Column 1 should equal Schedule T, Line 61, Column 6.</td>
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<tr>
<td>11</td>
<td>Property/Casualty</td>
<td>Revenue for property/casualty insurance. Column 1 should equal Schedule T, Line 61, Column 7.</td>
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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<td><strong>ON BEHALF OF:</strong></td>
</tr>
<tr>
<td><strong>NAME:</strong> Dale Bruggeman</td>
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<td><strong>TITLE:</strong> Chair SAPWG</td>
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<tr>
<td><strong>AFFILIATION:</strong> Ohio Department of Insurance</td>
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<tr>
<td><strong>ADDRESS:</strong> 50W. Town St., 3rd Fl., Ste. 300</td>
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<tr>
<td>Columbus, OH 43215</td>
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**ANNUAL STATEMENT**

Modify the instruction and illustration for 13(11) to the Notes to Financial Statement. Change the numbering from 1 through 13 to A through M.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect the disclosure addition for SSAP No. 41R—Surplus Notes being adopted by the Statutory Accounting Principles (E) Working Group and correct the instruction.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:

Other Comments:

Proposal is being exposed concurrently with the changes being considered by the Statutory Accounting Principles (E) Working Group.

---

**This section must be completed on all forms.**

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NOTES TO FINANCIAL STATEMENTS

13. Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations

Instruction:

Disclose the following information related to capital and surplus, shareholder’s dividend restrictions and quasi-reorganizations.

(A) The number of shares of each class of capital stock authorized, issued and outstanding as of the balance sheet date and the par value or stated value of each class.

(B) The dividend rate, liquidation value and redemption schedule (including prices and dates) of any preferred stock issues.

(C) Dividend restrictions, if any, and an indication if the dividends are cumulative.

(D) The dates and amounts of dividends paid. Note for each payment whether the dividend was ordinary or extraordinary.

(E) The portion of the reporting entity’s profits that may be paid as ordinary dividends to stockholders.

(F) A description of any restrictions placed on the unassigned funds (surplus), including for whom the surplus is being held.

(G) For mutual reciprocals, and similarly organized entities, the total amount of advances to surplus not repaid, if any.

(H) The total amount of stock held by the reporting entity, including stock of affiliated entities, for special purposes such as:

   a. Conversion of preferred stock
   b. Employee stock options
   c. Stock purchase warrants

(I) A description of the reasons for changes in the balances of any special surplus funds from the prior period.

(J) The portion of unassigned funds (surplus) represented or reduced by cumulative unrealized gains and losses.

(K) Surplus Notes

For each surplus debenture or similar obligation, except those surplus notes required or those that are a prerequisite for purchasing an insurance policy and are held by the policyholder, furnish the following information:

   a. Date issued
   b. Description and fair value of the assets received
• e.—Holder of the note or, if public, the names of the underwriter and trustee with identification on whether the holder of the surplus note is a related party per SSAP No. 25

  Original issue amount of note
  d. —Par Value (Face Amount of Note)
  e.—Carrying value of note (current year and prior year)
  f.—The rate at which interest accrues
  g.—Maturity dates or repayment schedules, if stated
  h.—Unapproved interest and/or principal
  i.—Interest and/or principal paid in the current year
  j.—Total interest and/or principal paid on surplus notes

  Approved interest recognized and principal paid (current year and life-to-date):
  —Approved interest and/or principal recognized as “paid”
  —Amount of approved interest and/or principal remitted to the holder of the surplus note (actual transfer of cash/ assets) and
  —The amount of approved interest and/or principal not remitted to the holder of the surplus note (no transfer of cash/ assets);

  Life-to-date:
  —Amount of approved interest and/or principal remitted to the holder of the surplus note (actual transfer of cash/ assets)

  Information regarding a 3rd party liquidity source including:
  —Name
  —Identification if a related party
  —Cost of the liquidity guarantee and
  —Maximum amount available should a triggering event occur.

• Percentage of offset interest payments offset through administrative offsetting (not inclusive of amounts paid to a 3rd party liquidity provider). I.E. if $100 in interest was recognized through the year, $10 of which was remitted to a 3rd party liquidity provider and the reminder $90 was offset, the reporting entity shall report 100% as offset.

• Disclosure of whether the surplus note was issued as part of a transaction with any of the following attributes:
  ❖ Do surplus note/associated asset terms negate or reduce cash flow exchanges, and/or are amounts payable under surplus note and amounts receivable under other agreements contractually linked (For example, the asset provides interest payments only when the surplus note provides interest payments).
  ❖ Are any amounts due under surplus notes and associated assets netted or offset (partially or in full) thus eliminating or reducing the exchange of cash or assets that would normally occur throughout the duration, or at maturity, of the agreement (This may be referred to as administrative offsetting.)
  ❖ Were the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note.
If a reporting entity has ceded business to a surplus note issuer that is a related party as part of a reinsurance transaction in which the surplus note meets any of the criteria above, the ceding entity shall provide a description of the transaction, including whether the criteria above were met with respect to the surplus note issuance, as long as the reinsurance agreement remains in force.

The ceding entity should provide a description of the risks reinsured, the related party reinsurer, any guarantees or support agreements and the amount of notes outstanding.

If the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note, the following information shall be disclosed regarding the assets received:

- Identification of asset, including the investment schedule where the asset is reported and reported NAIC designation;
- Book/adjusted carrying value of asset as of the current reporting date;
- A description of terms under which liquidity would be provided should a triggering event occur.

- Principal amount value of assets received upon Surplus Note issuance, if applicable;
- k.—Subordination terms
- l.—Liquidation preference to the reporting entity’s common and preferred shareholders
- m.—The repayment conditions and restrictions
- Information about any guarantees, support agreements, or related party transactions associated with the surplus note issuance, and whether payments have been made under such agreements.

If a reporting entity has ceded business to a surplus note issuer that is a related party as part of a reinsurance transaction in which the surplus note meets any of the criteria above, the ceding entity shall provide a description of the transaction, including whether the criteria above were met with respect to the surplus note issuance, as long as the reinsurance agreement remains in force.

The ceding entity should provide a description of the risks reinsured, the related party reinsurer, any guarantees or support agreements and the amount of notes outstanding.

If the proceeds from the issuance of a surplus note used to purchase an asset directly or indirectly from the holder of the surplus note, the following information shall be disclosed regarding the assets received:

- Identification of asset, including the investment schedule where the asset is reported and reported NAIC designation;
- Book/adjusted carrying value of asset as of the current reporting date;
- A description of terms under which liquidity would be provided should a triggering event occur.
- n.—In addition to the above, a reporting entity shall identify all affiliates that hold any portion of a surplus debenture or similar obligation (including an offering registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933), and any holder of 10% or more of the outstanding amount of any surplus note registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933.

NOTE: For the table illustrated for the disclosures above provide an “Item Number” (4 digits) to identify each surplus note being disclosed and should remain the same between year.

(12)L The impact of the restatement in a quasi-reorganization as long as financial statements for the period of the reorganization are presented.

(13)M The effective date of a quasi-reorganization for a period of ten years following the reorganization.
Illustration:

(44)A The Company has ________ shares authorized, ________ shares issued and ________ shares outstanding. All shares are Class A shares.

(45)B The Company has no preferred stock outstanding.

(46)C Without prior approval of its domiciliary commissioner, dividends to shareholders are limited by the laws of the Company’s state of incorporation, ________, to $_________, an amount that is based on restrictions relating to statutory surplus.

(47)D An ordinary dividend in the amount of $_________ on _________ was paid by the Company.

(48)E Within the limitations of (3) above, there are no restrictions placed on the portion of Company profits that may be paid as ordinary dividends to stockholders.

(49)F There were no restrictions placed on the Company’s surplus, including for whom the surplus is being held.

(50)G The total amount of advances to surplus not repaid is $_________.

(51)H The amounts of stock held by the Company, including stock of affiliated companies, for special purposes are:

   a. For conversion of preferred stock: ________ shares
   b. For employee stock options: __________ shares
   c. For stock purchase warrants: _________ shares

(52)I Changes in balances of special surplus funds from the prior year are due to: ______________________

   ______________________________________________________________________________________

(53)J The portion of unassigned funds (surplus) represented or reduced by cumulative unrealized gains and losses is $ ___________.

This exact format must be used in the preparation of this note for the table below. Reporting entities are not precluded from providing clarifying disclosure before or after this illustration.

(Note: This does not include the ending narrative.)

(44)K The Company issued the following surplus debentures or similar obligations:

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Date Issued</th>
<th>Interest Rate</th>
<th>Original Issue Amount of Note</th>
<th>Is Surplus Note Held by Related Party (Y/N)</th>
<th>Carrying Value of Note Prior Year</th>
<th>Carrying Value of Note Current Year *</th>
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* Total should agree with Page 3, Line 32.

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<th>Life-To-Date Interest Expense Recognized</th>
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* Total should agree with Page 3, Line 32.
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<th>Note Interest Since Acquisition</th>
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#### Notes

- **Date Issued**: [Date]
- **Interest Rate**: [Rate]
- **Par Value (Face Amount of Notes)**: [Value]
- **Carrying Value of Note**: [Value]
- **Interest And/Or Principal Paid Current Year**: [Paid]
- **Total Interest And/Or Principal Paid**: [Paid]
- **Unapproved Interest And/Or Principal**: [Paid]
- **Date of Maturity**: [Date]

* Total should agree with Page 3, Line 32.

The surplus note in the amount of $[Value], listed as item [Number] in the above table, was issued to [Issuer] (parent) in exchange for [Exchanged].

The surplus note, in the amount of $[Value], listed as item [Number] in the above table, was issued pursuant to Rule 144A under the Securities Act of 1933, underwritten by [Underwriter], and is administered by [Trustee] as trustee.

The surplus note has the following repayment conditions and restrictions: (e.g., Each payment of interest on and principal of the surplus notes may be made only with the prior approval of the Commissioner of Insurance of the State and only to the extent the Company has sufficient surplus earnings to make such payment).

The surplus note has the following subordination terms: (e.g., The Notes will rank pari passu with any other future surplus notes of the Parent and with all other similarly subordinated claims).

The liquidation preference to the insurer's common and preferred shareholders are as follows: (e.g., In the event that the Parent is subject to such a proceeding, holders of Indebtedness, Policy Claims and Prior Claims would be afforded a greater priority under the Liquidation Act and the terms of the Notes and, accordingly, would have the right to be paid in full before any payments of interest or principal are made to Note holders).

The surplus debenture in the amount of $[Value], listed as item [Number] in above table, is held by [Holder] (an affiliate).

The surplus debenture in the amount of $[Value], listed as item [Number] in above table, was issued pursuant to Rule 144A under the Securities Act of 1933, and is held by [Holder] in the following ownership percentage [Percentage] (10% or more).

The (an affiliate) holds $[Value] or [Percentage]% of the surplus debenture listed as item [Number] in the above table.

The Company has outstanding $[Value] of [Percentage]% debentures due in 20__ issued on [Date]. The carrying amount of the debt is $[Value] with an effective rate of [Rate]% The debentures are not redeemable prior to 20__. The Company is required to make annual sinking fund payments of $[Value] that will provide sufficient funds for the retirement of debentures at maturity. Interest paid during 20__ was $[Value].
The Company has an outstanding liability for borrowed money in the amount of $_______ due to __________ on __/__/20__. The principal amount is due 20__. At the option of the Company, early repayment may be made. Interest at ___% is required to be paid annually. Interest paid during 20___ was $_______. The Company is required to maintain a collateral security deposit with the lender. Assets in such security deposit are required to be maintained in a fair value amount at least equal to the outstanding principal. At December 31, 20__, assets having an admitted value of $__________ and a fair value of $_______ were on deposit with the lender.

THIS EXACT FORMAT MUST BE USED IN THE PREPARATION OF THIS NOTE FOR THE TABLE BELOW. REPORTING ENTITIES ARE NOT PRECLUDED FROM PROVIDING CLARIFYING DISCLOSURE BEFORE OR AFTER THIS ILLUSTRATION.

<table>
<thead>
<tr>
<th>Year</th>
<th>Change in Gross Paid-in and Contributed Surplus</th>
<th>Change in Change in Surplus and Contributed Surplus</th>
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The effective date(s) of all quasi-reorganizations in the prior 10 years is/are ________.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<tr>
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<th>Dale Bruggeman</th>
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<tr>
<td>ON BEHALF OF:</td>
<td>Ohio Department of Insurance</td>
</tr>
<tr>
<td>NAME:</td>
<td>Dale Bruggeman</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair SAPWG</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
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Agenda Item # 2020-04BWG
Year 2020
Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) __________

BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ ] QUARTERLY STATEMENT
- [ ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ X ] Title
- [ ] Other __________

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Modify the instruction and illustration for Note 23A – Unsecured Reinsurance Recoverables.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect the disclosure addition for SSAP No. 62R—Property and Casualty Reinsurance being adopted by the Statutory Accounting Principles (E) Working Group.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: __________________________

Other Comments:

Proposal is being exposed concurrently with the changes being considered by the Statutory Accounting Principles (E) Working Group.

** This section must be completed on all forms. Revised 7/18/2018
23. Reinsurance

Instruction:

A. Unsecured Reinsurance Recoverables

If the company has with any individual reinsurers (authorized, reciprocal jurisdiction, unauthorized or certified), an unsecured aggregate recoverable for losses, paid and unpaid including IBNR, loss adjustment expenses, and unearned premium that exceeds 3% of the company’s policyholder surplus, list each individual reinsurer and the unsecured aggregate recoverable pertaining to that reinsurer. If the individual reinsurer is part of a group, list the individual reinsurers, each of its related group members having reinsurance with the reporting company, and the total unsecured aggregate recoverables for the entire group.

Include: The NAIC group code number, where appropriate, and the Federal Employer Identification Number for each individual company.

Illustration:

A. Unsecured Reinsurance Recoverables

The Company does not have an unsecured aggregate recoverable for losses, paid and unpaid including IBNR, loss adjustment expenses and unearned premium with any individual reinsurers, authorized or unauthorized, that exceeds 3% of the Company’s policyholder surplus.

DRAFTING NOTE: The tables below will not be data captured

Individual Reinsurers with Unsecured Reinsurance Recoverables Exceeding 3% of Policyholder Surplus

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<thead>
<tr>
<th>FEIN</th>
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<th>Unsecured Amount</th>
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<table>
<thead>
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<th>Group Code</th>
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<th>Reinsurer Name</th>
<th>Unsecured Amount</th>
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</tbody>
</table>

© 2020 National Association of Insurance Commissioners
### All Members of the Groups Shown above with Unsecured Reinsurance Recoverables

<table>
<thead>
<tr>
<th>Group Code</th>
<th>FEIN</th>
<th>Reinsurer Name</th>
<th>Unsecured Amount</th>
</tr>
</thead>
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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| DATE: | 01/14/2020 |
| CONTACT PERSON: | |
| TELEPHONE: | |
| EMAIL ADDRESS: | |
| ON BEHALF OF: | |
| NAME: | Dale Bruggeman |
| TITLE: | Chair SAPWG |
| AFFILIATION: | Ohio Department of Insurance |
| ADDRESS: | 50W. Town St., 3rd Fl., Ste. 300 |
| Columbus, OH 43215 |

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Agenda Item # 2020-05BWG MOD

Year 2020

Changes to Existing Reporting [ X ]

New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]

Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment

[ ] Referred To Another NAIC Group

[ ] Received For Public Comment

[ X ] Adopted Date 05/28/2020

[ ] Rejected Date

[ ] Deferred Date

[ ] Other (Specify) ______

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT

[ ] QUARTERLY STATEMENT

[ X ] INSTRUCTIONS

[ ] CROSSCHECKS

[ X ] Life, Accident & Health/Fraternal

[ ] Property/Casualty

[ ] Separate Accounts

[ ] Protected Cell

[ ] Health

[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Modify the instruction and illustration for Note 2 – Accounting Changes and Correction of Errors.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect the disclosure addition for SSAP No. 3—Accounting Changes and Corrections of Errors and SSAP No. 51R—Life Contracts being adopted by the Statutory Accounting Principles (E) Working Group.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

Proposal is being exposed concurrently with the changes being considered by the Statutory Accounting Principles (E) Working Group

** This section must be completed on all forms. Revised 7/18/2018
2. Accounting Changes and Corrections of Errors

Instruction:

Describe material changes in accounting principles and/or correction of errors. Include:

- A brief description of the change, encompassing a general disclosure of the reason and justification for the change or correction.

- The impact of the change or correction on net income, surplus, total assets and total liabilities for the two years presented in the financial statements (i.e., the balance sheet and statement of income).

- The effect on net income of the current period for a change in estimate that affects several future periods, such as a change in the service lives of depreciable assets or actual assumptions affecting pension costs. Disclosure of the effect on those income statement amounts is not necessary for estimates made each period in the ordinary course of accounts for items such as uncollectible accounts. However, disclosure is recommended if the effect of a change in the estimate is material.

- Changes in accounting that are changes in reserve valuation basis as described in SSAP No. 51R—Life Contracts which have elected gradephase-in provided for in the Valuation Manual section VM-21 or other optional application features, shall also include in the change in accounting disclosures information regarding the application of any phasegrade-in as provided for in SSAP No. 51R.

Reporting entities shall provide disclosure of the following:

- The phasegrade-in period being applied, and the remaining time period of the gradephase-in.

- Any adjustments to the phasegrade-in period.

- Amount of change in valuation basis phasegrade-in, which has been recognized in unassigned funds.

- The remaining amount to be phasedgrade-in (reflected in special surplus if the ungraded-in amount represents an increase in reserving).

- When subsequent financial statements are issued containing comparative restated results as a result of the filing of an amended financial statement, the reporting entity shall disclose that the prior period has been restated and the nature and amount of such restatement.
Illustration:

During the current year’s financial statement preparation, the Company discovered an error in the compiling and reporting of investment income from an affiliate for the prior year. In the prior year, common stocks (Assets Page, Line _____) and investment income earned from affiliates (included in Summary of Operation, Line _____) were understated by $________. Line _____ on the Assets Page and Line ____ on the Gains and Losses section of the Summary of Operations have been adjusted in the current year to correct for this error.

In 2020, the Company elected a phase-in period of three years of a change in reserve valuation basis as described in SSAP No. 51R—Life Contracts for its variable annuity reserves. This change in valuation basis, which impacts annuities reserves written from 1981 to 2019 is permitted under the revisions to the Commissioners Annuity Reserve Valuation Method (CARVM) adopted in Valuation Manual Requirements for Principle-Based Reserves for Variable Annuities (VM-21), and Actuarial Guideline 43 CARVM for variable annuities (AG 43). There have been no adjustments to the phase-in period. The amount of phase-in, which has been recognized in unassigned funds is $________. The remaining amount to be phased-in reflects in special surplus is $________.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| CONTACT PERSON: | Dale Bruggeman |
| TELEPHONE: | |
| EMAIL ADDRESS: | |
| ON BEHALF OF: | Ohio Department of Insurance |
| NAME: | Dale Bruggeman |
| TITLE: | Chair SAPWG |
| AFFILIATION: | Ohio Department of Insurance |
| ADDRESS: | 50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215 |

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DATE: 01/14/2020

Agenda Item # 2020-07BWG
Year 2020

Changes to Existing Reporting [X]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [X]
Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[X] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

- [X] ANNUAL STATEMENT
- [X] INSTRUCTIONS
- [ ] CROSSCHECKS
- [X] Life, Accident & Health/Fraternal
- [X] Property/Casualty
- [X] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Add new disclosure Note 23 – Reinsurance for reinsurance credit (23H – Life/Fraternal, 23E Health and 23K Property).

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect the disclosure additions for SSAP No. 61R—Life, Deposit-Type Contracts and Accident and Health Contracts Reinsurance adopted by the Statutory Accounting Principles (E) Working Group.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.
23. Reinsurance

Instruction:

H. Reinsurance Credit

(1) Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks.

(2) Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk limiting features.

(3) Disclose if any reinsurance contracts contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

- Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period).
- Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.

(4) Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.

- Assumption Reinsurance – new for the reporting period.
- Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured event(s) triggering contract coverage has been recognized.
(5) Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:

- Accounted for that contract as reinsurance under statutory accounting principles (“SAP”) and as a deposit under generally accepted accounting principles (“GAAP”); or
- Accounted for that contract as reinsurance under GAAP and as a deposit under SAP.

(6) If affirmative disclosure is required for Paragraph 23H(5) above, explain why the contract(s) is treated differently for GAAP and SAP.

Illustration:

Detail Eliminated to Conserve Space

ANNUAL STATEMENT INSTRUCTIONS – HEALTH

NOTES TO FINANCIAL STATEMENTS

Detail Eliminated to Conserve Space

23. Reinsurance

Instruction:

Detail Eliminated to Conserve Space

E. Reinsurance Credit

(1) Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks.

(2) Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk limiting features.
(3) Disclose if any reinsurance contracts contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

- Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period).

- Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.

(4) Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts:

- Assumption Reinsurance – new for the reporting period.

- Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured event(s) triggering contract coverage has been recognized.

(5) Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:

- Accounted for that contract as reinsurance under statutory accounting principles (“SAP”) and as a deposit under generally accepted accounting principles (“GAAP”); or

- Accounted for that contract as reinsurance under GAAP and as a deposit under SAP.

(6) If affirmative disclosure is required for Paragraph 23E(5) above, explain why the contract(s) is treated differently for GAAP and SAP.

Illustration:

Detail Eliminated to Conserve Space
23. Reinsurance

Instruction:

K. Reinsurance Credit

The disclosures below apply to reinsurance contracts covering health business.

(1) Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks.

(2) Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk limiting features.

(3) Disclose if any reinsurance contracts contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

- Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period).
- Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.

(4) Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.

- Assumption Reinsurance – new for the reporting period.
- Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured event(s) triggering contract coverage has been recognized.
(5) Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:

- Accounted for that contract as reinsurance under statutory accounting principles ("SAP") and as a deposit under generally accepted accounting principles ("GAAP"); or
- Accounted for that contract as reinsurance under GAAP and as a deposit under SAP.

(6) If affirmative disclosure is required for Paragraph 23K(5) above, explain why the contract(s) is treated differently for GAAP and SAP.

Illustration:

Detail Eliminated to Conserve Space
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 01/14/2020

CONTACT PERSON:

TELEPHONE:

EMAIL ADDRESS:

ON BEHALF OF:

NAME: Dale Bruggeman

TITLE: Chair SAPWG

AFFILIATION: Ohio Department of Insurance

ADDRESS: 50W. Town St., 3rd Fl., Ste. 300

Columbus, OH 43215

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Agenda Item # 2020-08BWG MOD

Year 2020

Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ ] QUARTERLY STATEMENT
[ X ] INSTRUCTIONS
[ ] CROSSCHECKS
[ X ] BLANK

[ X ] Separate Accounts
[ X ] Title
[ ] Protected Cell
[ ] Other (Specify)
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Add a disclosure instruction for 10C to the Notes to Financial Statement for related party transactions not captured on Schedule Y. Combine existing 10C into 1B instructions and illustration narrative.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect the disclosure addition for SSAP No. 25—Affiliates and Other Related Parties being adopted by the Statutory Accounting Principles (E) Working Group.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: 

Other Comments:

Proposal is being exposed concurrently with the changes being considered by the Statutory Accounting Principles (E) Working Group.

** This section must be completed on all forms.

Revised 7/18/2018
NOTES TO FINANCIAL STATEMENTS

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

Instruction:

The financial statements shall include disclosures of all material related party transactions. In some cases, aggregation of similar transactions that on a stand-alone basis are not material may be appropriate. Sometimes, the effect of the relationship between the parties may be so pervasive that disclosure of the relationship alone will be sufficient. If necessary, to the understanding of the relationship, disclose the name of the related party. Transactions shall not be purported to be arm’s-length transactions unless there is demonstrable evidence to support such statement. Note 10 is primarily for SCAs under SSAP No. 97, but the disclosure for 10O should also be completed of SSAP No. 48 entities. The disclosures shall include:

A. The nature of the relationship involved.

B. A description of the transactions for each of the periods for which financial statements are presented, and such other information considered necessary to obtain an understanding of the effects of the transactions on the financial statements. Exclude reinsurance transactions, any non-insurance transactions that are less than ½ of 1% of the total admitted assets of the reporting entity, and cost allocation transactions. The following information shall be provided if applicable:

- (1) Date of transaction;
- (2) Explanation of transaction;
- (3) Name of reporting entity;
- (4) Name of affiliate;
- (5) Description of assets received by reporting entity;
- (6) Statement value of assets received by reporting entity;
- (7) Description of assets transferred by reporting entity; and
- (8) Statement value of assets transferred by reporting entity.

C. The dollar amounts of transactions for each of the periods for which financial statements are presented and the effects of any change in the method of establishing the terms from that used in the preceding period.

C. Transactions with related parties who are not reported on Schedule Y

A reference number should be provided for each transaction with the related party to be used in the tables for the disclosures below. In each disclosure the transaction for each related party should be reported contiguously together and not separated by other transactions with other related parties. (Multiple transactions with the same related party shall not be aggregated into a single row.)

Example: Company A has three separate transactions with Related Party B. All of transactions with Related Party B would be reported together on three consecutive rows of the disclosure table before reporting transaction with the next related party.)
(1) Detail of material related party transactions

- Date of transaction
- Name of related party
- Nature of relationship

**Options for type of transaction:**
- Loan
- Exchange of assets or liabilities (e.g., buys, sells and secured borrowing transactions)
- Management services
- Cost-sharing agreement
- Other transactions involving services
- Guarantee (e.g., guarantees to related parties, on behalf of, and when beneficiary is related party)
- Other

- Type of transaction

**Options for type of transaction:**
- Loan
- Exchange of assets or liabilities (e.g., buys, sells and secured borrowing transactions)
- Management services
- Cost-sharing agreement
- Other transactions involving services
- Guarantee (e.g., guarantees to related parties, on behalf of, and when beneficiary is related party)
- Other

- Written agreement (Yes/No)
- Due date
- Reporting period date amount due from (to)

(2) Detail of material related party transactions involving services

- Name of related party
- Overview description
- Amount charged
- Amount based on allocation of costs or market rates
- Amount charged modified or waived (Yes/No)
(3) Detail of material related party transactions involving exchange of assets and liabilities

- Name of related party
- Overview description
- Description of assets received
- Description of assets transferred
- Statement value of assets received
- Statement value of assets transferred
- Have terms changed from preceding period? (Yes/No)

(4) Detail of amounts owed to/from a related party

- Name of related party
- Aggregate reporting period amount due from
- Aggregate reporting period amount due to
- Amount offset in financial statement (if qualifying)
- Net amount recoverable/(payable) by related party
- Admitted recoverable

D. Amounts due from or to related parties as of the date of each balance sheet presented and, if not otherwise apparent, the terms and manner of settlement.

E. Any guarantees or undertakings, written or otherwise, shall be disclosed in Note 14, Liabilities, Contingencies and Assessments, in accordance with the requirements of SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets. In addition, the nature of the relationship to the beneficiary of the guarantee or undertaking (affiliated or unaffiliated) shall also be disclosed.

F. A description of material management or service contracts and cost-sharing arrangements involving the reporting entity and any related party. This shall include, but is not limited to, sale lease-back arrangements, computer or fixed asset leasing arrangements, and agency contracts that remove assets that may otherwise be recorded (and potentially nonadmitted) on the reporting entity’s financial statements.

F. Any guarantees or undertakings, written or otherwise, shall be disclosed in Note 14, Liabilities, Contingencies and Assessments, in accordance with the requirements of SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets. In addition, the nature of the relationship to the beneficiary of the guarantee or undertaking (affiliated or unaffiliated) shall also be disclosed.

G. The nature of the control relationship whereby the reporting entity and one or more other enterprises are under common ownership or control and the existence of that control could result in operating results or financial position of the reporting entity being significantly different from those that would have been obtained if the enterprises were autonomous. Disclose the relationship even though there are no transactions between the enterprises.
Illustration:


THIS EXACT FORMAT MUST BE USED IN THE PREPARATION OF THIS NOTE FOR THE TABLES BELOW. REPORTING ENTITIES ARE NOT PRECLUDED FROM PROVIDING CLARIFYING DISCLOSURE BEFORE OR AFTER THIS ILLUSTRATION.

C Transactions with related party who are not reported on Schedule Y

(1) Detail of Material Related Party Transactions

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Date of Transaction</th>
<th>Name of Related Party</th>
<th>Nature of Relationship</th>
<th>Type of Transaction</th>
<th>Written Agreement (Yes/No)</th>
<th>Due Date</th>
<th>Reporting Period Date</th>
<th>Amount Due From (To)</th>
</tr>
</thead>
</table>

Options for Type of Transaction:
- Loan
- Exchange of Assets or Liabilities (e.g., buys, sells and secured borrowing transactions)
- Management Services
- Cost-Sharing Agreement
- Other Transactions Involving Services
- Guarantee (e.g., guarantee to related parties, on behalf of, and when beneficiary is related party)
- Other

(2) Detail of Material Related Party Transactions Involving Services

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Name of Related Party</th>
<th>Overview Description</th>
<th>Amount Changed</th>
<th>Amount Based on Allocation of Costs or Market Rates</th>
<th>Amount Charged Modified or Waived (Yes/No)</th>
</tr>
</thead>
</table>

(3) Detail of Material Related Party Transactions Involving Exchange of Assets and Liabilities

a. Description of Transaction

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Name of Related Party</th>
<th>Overview Description</th>
<th>Have Terms Changed from Preceding Period (Yes/No)</th>
</tr>
</thead>
</table>

b. Assets Received

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Name of Related Party</th>
<th>Description of Assets Received</th>
<th>Statement Value of Assets Received</th>
</tr>
</thead>
</table>

Total
c. Assets Transferred

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Name of Related Party</th>
<th>Description of Assets Transferred</th>
<th>Statement Value of Assets Transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(4) Detail of Amounts Owed To/From a Related Party

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Name of Related Party</th>
<th>Aggregate Amount Due From Reporting Period</th>
<th>Aggregate Amount Due To Reporting Period</th>
<th>Amount Offset in Financial Statement (if qualifying)</th>
<th>Net Amount Recoverable / Payable by Related Party</th>
<th>Admitted Recoverable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>XXX</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D. At December 31, 20__, the Company reported $_________ as amounts due to the Parent Company, The ABC Insurance Company. The terms of the settlement require that these amounts be settled within 30 days.

E. The Company has given XYZ Inc., an affiliated company, a standing commitment until January 1, 20__, in the form of guarantees in the event of a default of XYZ on various of its debt issues as disclosed in Note 14.

F.E. The Company has agreed to provide the Parent Company, The ABC Insurance Company, certain actuarial investment services with respect to the administration of certain large group insurance contracts that are subject to group experience rating procedures.

F. The Company has given XYZ Inc., an affiliated company, a standing commitment until January 1, 20__, in the form of guarantees in the event of a default of XYZ on various of its debt issues as disclosed in Note 14.

   The Parent Company has agreed to provide collection services for certain contracts for the Company.

G. All outstanding shares of The Company are owned by the Parent Company, The ABC Insurance Company, an insurance holding company domiciled in the State of ____________.
**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Eva Yeung</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8407</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:eveung@naic.org">eveung@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>P/C RBC WG</td>
</tr>
<tr>
<td>NAME:</td>
<td>Tom Botsko</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>50 W. Town Street, Third Floor – Suite 300 Columbus, OH 43215</td>
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</table>

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
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<th>2020-09BWG</th>
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<tbody>
<tr>
<td>Year</td>
<td>2020</td>
</tr>
<tr>
<td>Changes to Existing Reporting</td>
<td>X</td>
</tr>
<tr>
<td>New Reporting Requirement</td>
<td></td>
</tr>
<tr>
<td>Reviewed For Accounting Practices and Procedures Impact</td>
<td></td>
</tr>
<tr>
<td>No Impact</td>
<td>X</td>
</tr>
<tr>
<td>Modifies Required Disclosure</td>
<td></td>
</tr>
</tbody>
</table>

**DISPOSITION**

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [X] Adopted Date 05/28/2020
- [ ] Rejected Date
- [ ] Deferred Date
- [ ] Other (Specify)

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [X] ANNUAL STATEMENT
- [X] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ ] QUAERTERLY STATEMENT
- [ ] Life, Accident & Health/Fraternal
- [ ] Separate Accounts
- [ ] Title
- [X] Property/Casualty
- [ ] Protected Cell
- [ ] Other
- [ ] Health
- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Modify the Annual Statement Instructions for Schedule F, Part 3 to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified, and reciprocal reinsurance.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

1. The factor for reinsurance recoverable from uncollateralized, unrated reinsurers is being updated by PCRBC WG to move towards a charge that is more aligned with risk-indicated factors used by the ratings agencies.

2. With respect to the broader implementation of the Covered Agreement, the PCRBC WG identified the need to eliminate the different treatment of uncollateralized reinsurance recoverable from authorized versus unauthorized, unrated reinsurers.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:

Other Comments:

**This section must be completed on all forms.**

Revised 7/18/2018
Column 34 – Reinsurer Designation Equivalent

Following is a listing of the valid codes.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
</table>

Utilize the table below and report a reinsurer designation equivalent code of 1 through 6 (where 6 represented vulnerable 6 or unrated) or 7 (for unrated authorized reinsurers). The equivalent designation category assigned will correspond to a current financial strength rating received from an approved rating agency as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. If the reinsurer is unauthorized and does not have at least one financial strength rating, it should be assigned the “Vulnerable 6 or Unrated Unauthorized Reinsurers” equivalent rating. If the reinsurer is authorized and does not have at least one financial strength rating, it should be assigned the “Unrated Authorized Reinsurers” equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the “reinsurer equivalent code of 3.” An authorized association including incorporated and individual unincorporated underwriters or a member thereof may utilize the lowest financial strength group rating received from an approved rating agency.

Reinsurer Designation Equivalent Category

<table>
<thead>
<tr>
<th>Code</th>
<th>Secure 1</th>
<th>Secure 2</th>
<th>Secure 3</th>
<th>Secure 4</th>
<th>Secure 5</th>
<th>Vulnerable 6 or Unrated Unauthorized Reinsurers</th>
<th>Unrated Authorized Reinsurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best</td>
<td>A++</td>
<td>A+</td>
<td>A</td>
<td>A-</td>
<td>B++, B+</td>
<td>B, B-, C++, C+, C-, D, E, F</td>
<td>.................................</td>
</tr>
<tr>
<td>Moody's</td>
<td>Aaa</td>
<td>Aa1, Aa2, Aa3</td>
<td>A1, A2</td>
<td>A3</td>
<td>Baa1, Baa2, Baa3</td>
<td>Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C</td>
<td>.................................</td>
</tr>
</tbody>
</table>
### Column 35 – Credit Risk on Collateralized Recoverables

Following is a table of factors applicable to the respective reinsurer designation equivalent categories in Column 34

<table>
<thead>
<tr>
<th>Code</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

### Column 36 – Credit Risk on Uncollateralized Recoverables

Following is a table of factors applicable to the respective reinsurer designation equivalent categories in Column 34

<table>
<thead>
<tr>
<th>Code</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.3%</td>
<td>7.1%</td>
<td>14.0%</td>
<td>14.0%</td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>DATE:</th>
<th>02/21/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT PERSON:</td>
<td>Pat Allison</td>
</tr>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8528</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:pallison@naic.org">pallison@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>LATF</td>
</tr>
<tr>
<td>NAME:</td>
<td>Mike Boerner, Chair</td>
</tr>
<tr>
<td>TITLE:</td>
<td></td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
</tr>
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</table>

FOR NAIC USE ONLY

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th>2020-10BWG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2020</td>
</tr>
<tr>
<td>Changes to Existing Reporting</td>
<td>[ X ]</td>
</tr>
<tr>
<td>New Reporting Requirement</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) 

BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] INSTRUCTIONS
- [ ] CROSSCHECKS
- [ ] QUARTERLY STATEMENT
- [ ] BLANK
- [ ] Life, Accident & Health/Frathernal
- [ ] Property/Casualty
- [ ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ ] Title
- [ ] Other 

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Variable Annuities Supplement Blank:
- Changing the header for Column 10
- Changing Lines 1-3 and adding Line 4

Variable Annuities Supplement Instructions:
- Adjusting the instructions to correspond with changes made to the blanks as well as changes in the 2020 Valuation Manual for the new VA Framework.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The new VA Framework is effective for 2020.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

VARIABLE ANNUITIES SUPPLEMENT
PARTS 1 AND 2

This supplement is to be filed on or before April 1.

Complete this supplement for contracts and certificates subject to VM-21 or AG 43. A separate chart shall be prepared for individual contracts and for group contracts with individual certificates.

For variable annuities (VAs) with guaranteed benefits, disclose the type(s) of guaranteed benefit(s), the number of contracts or certificates with those benefits, the amount of the benefit base related to each type of benefit, the net amount at risk for death benefits and the guaranteed annual payout for income and withdrawal benefits, the gross amount of the reserve for the guaranteed benefit(s), the portion of the contract/certificate account value related to contract/certificate funds in the General Account or the Separate Account, and the percent of the guaranteed benefit reinsured.

Column 1 & Column 2  –  Type of Guaranteed Benefit

For purposes of this supplement, a Guaranteed Death Benefit is defined in accordance with the term “Guaranteed Minimum Death Benefit” in VM-21, and a Guaranteed Living Benefit (GLB) is defined in accordance with the term “Variable Annuity Guaranteed Living Benefits” in VM-01.

“Type” shall include a summary description of the type of benefit. Examples are provided in the table illustrated below. Descriptions that may apply when identifying “Type” for Column 2 include, “Guaranteed Minimum Accumulation Benefit” (GMAB), “Guaranteed Minimum Income Benefit” (GMIB), “Hybrid GMIB,” “Traditional GMIB,” “Guaranteed Minimum Withdrawal Benefit” (GMWB), “Lifetime GMWB,” “Non-Lifetime GMWB,” and “Guaranteed Payout Annuity Floor” (GPAF). These terms are defined in VM-01. For those guaranteed benefits that include waiting periods before any benefit can be realized, include the length of the original waiting period in the description.

- A separate line shall be created for each combination of Guaranteed Death Benefit and Guaranteed Living Benefit.
  - See the illustration in the table below for an example.
  - For a category with only one guarantee, show “None” in the other column.
  - For a category with no guaranteed benefit, show “None” in both columns.
- Each contract/certificate shall be included in one and only one line.
  - For a contract with multiple living benefits, determine the most appropriate classification.

A separate chart shall be prepared for individual contracts and for group contracts with individual certificates. In each chart, show the amount of any reinsurance reserve credit being taken separately for treaties with affiliated captive reinsurers and for other reinsurers.

For purposes of this supplement, a Guaranteed Living Benefit (GLB) is defined as a contract/certificate, agreement or rider in which the insurance entity guarantees specified payouts during a defined period, which may include the lifetime of the insured(s). For VAs, these guaranteed payouts are typically made regardless of the performance of the contractual account value that is used to determine cash surrender values and/or withdrawal benefits.

Column 3  –  Number of Individual (Part 1) Contracts or Group (Part 2) Certificates
<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 4</td>
<td>Benefit Base For Guaranteed Death Benefit (Col 1)</td>
</tr>
<tr>
<td></td>
<td>Report the Benefit Base (defined in the contract/certificate) as of the valuation date as the basis for the guaranteed value. If no guarantee exists, enter $0.</td>
</tr>
<tr>
<td>Column 5</td>
<td>Benefit Base For Guaranteed Living Benefit (GLB) (Col 2)</td>
</tr>
<tr>
<td></td>
<td>Report the Benefit Base (defined in the contract/certificate) as of the valuation date as the basis for the guaranteed value. If no guarantee exists, enter $0.</td>
</tr>
<tr>
<td>Column 6</td>
<td>Net Amount at Risk For Guaranteed Death Benefit (Col 1)</td>
</tr>
<tr>
<td></td>
<td>Death Benefit Net Amount at Risk (NAR) is defined as the greater of a) zero and b) the difference between the Guaranteed Death Benefit and the Account Value as of the valuation date. Report the sum of the NAR for all contracts/certificates.</td>
</tr>
<tr>
<td>Column 7</td>
<td>Guaranteed Annual Income Amount For Guaranteed Living Benefit (GLB) (Col 2)</td>
</tr>
<tr>
<td></td>
<td>Report the total annual income/withdrawal benefits available if the income/withdrawal guarantees were elected on the valuation date. If no GLB/GMWB is available on the valuation date for a particular contract/certificate (e.g. due to a waiting period), use $0. Note, for GLB and GMWB previously elected, show the guaranteed amount based on the prior elections. For GMAB, use $0 since this is not an income benefit. Disclosures for GMAB shall be provided in the AG 43 Memorandum.</td>
</tr>
<tr>
<td>Column 8</td>
<td>Account Value – General Account</td>
</tr>
<tr>
<td>Column 9</td>
<td>Account Value – Separate Account</td>
</tr>
<tr>
<td>Column 10</td>
<td>Reserve for Guaranteed Benefits (Total Reserve Less Base Adjusted Reserve) Contract-Level Reserves Less Cash Surrender Value</td>
</tr>
<tr>
<td></td>
<td>Total gross reserve for guarantees as defined in AG 43 or VM 21 as applicable in excess of the base contract reserve. Reserves calculated according to AG 43 and VM 21 are allocated to individual contracts or certificates following the guidance of Appendix 6 of AG 43 or Section 8 of VM 21. Report in column 10 the excess of this per policy reserve over the base contract reserve. For base contract reserve, the company may use CSV or Base Adjusted Reserve (defined in Appendix 3, A.3.2D of AG 43 or Section 5, B.4. of VM 21) for that contract or certificate. For each contract/certificate, calculate the excess amount of the pre-reinsurance ceded contract-level reserve, defined in VM-21, over the contract’s cash surrender value. For each “Type” listed under Columns 1 and 2, report the sum of the excess amounts calculated for the associated contracts/certificates. For the Subtotal, report the sum of the excess amounts calculated for all contracts/certificates. The Subtotal should equal the excess of the aggregate reserve over the aggregate cash surrender value.</td>
</tr>
<tr>
<td>Column 11 &amp; Column 12</td>
<td>Percentage of Guaranteed Benefits Reinsured</td>
</tr>
<tr>
<td></td>
<td>Show percentage of the Guaranteed Benefit ceded to all reinsurers.</td>
</tr>
<tr>
<td>Line 1</td>
<td>Aggregate Cash Surrender Value</td>
</tr>
<tr>
<td></td>
<td>Report the sum of the cash surrender values for all contracts/certificates.</td>
</tr>
</tbody>
</table>
**Line 2**  –  Pre-Reinsurance Ceded Aggregate Reserve (Subtotal for Column 10 plus Line 1)

Report the sum of the pre-reinsurance ceded contract-level reserves for all contracts/certificates. This should equal the Subtotal Line for Column 10 plus Line 1.

**Line 3**  –  Reserve Credit from affiliated captive reinsurance

**Line 4**  –  Reserve Credit from other reinsurance

**Line 3-5**  –  Total Net of Reinsurance Post-Reinsurance Ceded Aggregate Reserve

Line 3 Total Net of Reinsurance should equal the Subtotal Line for Column 10 minus the sum of Line 1 Reserve Credit from Affiliated Captive Reinsurance and Line 2 Reserve Credit from Other Reinsurance. Report the sum of the post-reinsurance ceded contract-level reserves for all contracts/certificates.

Illustration:

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefit Base</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Percentage of Guaranteed Benefits Reinsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Guaranteed Death Benefit</td>
<td>Guaranteed Death Benefit (Col 1)</td>
<td>Guaranteed Annual Income For Guaranteed Death Benefit (GLB) (Col 2)</td>
<td>Net Amount at Risk For Guaranteed Death Benefit (Col 1)</td>
<td>General Account</td>
<td>Separate Account</td>
<td>Reserve from Guaranteed Death Benefit Less Base Adjusted Contract-Level Reserve Less Cash Surrender Value</td>
<td></td>
</tr>
<tr>
<td>2 Guaranteed Living Benefit</td>
<td>Guaranteed Living Benefit (GLB) (Col 2)</td>
<td>Net Amount at Risk For Guaranteed Living Benefit (GLB) (Col 2)</td>
<td>General Account</td>
<td>Separate Account</td>
<td>Reserve from Guaranteed Living Benefit Less Base Adjusted Contract-Level Reserve Less Cash Surrender Value</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Max Anniversary Value (MAV)**: GMAB - 110% of premium
- **GMAB prem accum @5% w/10 yr waiting period**: 312 $32.6M $34.6M $1.4M $2.4M $0 $31.2M $1.0M 100% 100%
- **GMIB ROP, 10 yrs**: 482 $40.0M $35.0M $3.0M $0 $0 $37.0M $2.0M 0% 0%

**Subtotal**: 1,751 $174.0M $69.6M $10.1M $2.4M $2.7M $161.2M $4.5M XXX XXX

1. Reserve credit from affiliated captive reinsurance 160.5M
2. Reserve credit from other reinsurance 165.0M
3. Total net of reinsurance 20.0M
4. Reserve credit from other reinsurance 30.0M
5. Post-Reinsurance Ceded Aggregate Reserve 115.0M
### PART 1 – INDIVIDUAL

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guaranteed Death Benefit</strong></td>
<td><strong>Guaranteed Living Benefit</strong></td>
<td>Number of Individual Contracts</td>
<td>Benefit Base For Guaranteed Death Benefit (Col 1)</td>
<td>Benefit Base For Guaranteed Living Benefit (GLB) (Col 2)</td>
<td>Net Amount at Risk For Guaranteed Death Benefit (Col 1)</td>
<td>Guaranteed Annual Income Amount For Guaranteed Living Benefit (GLB) (Col 2)</td>
<td>Account Value General Account</td>
<td>Account Value Separate Account</td>
<td>Reserve for Guaranteed Benefits Base Adjusted Reserves Less Reserve for Life Exposures</td>
<td>Guaranteed Death Benefit</td>
<td>Guaranteed Living Benefit</td>
</tr>
<tr>
<td>Subtotal</td>
<td>Subtotal</td>
<td>Subtotal</td>
<td>Subtotal</td>
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<td>Subtotal</td>
<td>Subtotal</td>
<td>Subtotal</td>
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</tr>
</tbody>
</table>

1. Reserve credit from affiliated captive reinsurance Aggregate Cash Surrender Value
2. Reserve credit from other reinsurance Pre-Reinsurance Ceded Aggregate Reserve (Subtotal for Column 10 plus Line 1)
3. Total net of reinsurance Reserve credit from affiliated captive reinsurance
4. Reserve credit from other reinsurance
5. Post-Reinsurance Ceded Aggregate Reserve

Subtotal XXX XXX
<table>
<thead>
<tr>
<th>Variable Annuities Supplement</th>
<th>Part 2 - Group Contracts With Individual Certificates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
<td><strong>Guaranteed Death Benefit</strong></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
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<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Percentage of Guaranteed Benefits Remaining</td>
</tr>
<tr>
<td>11</td>
<td>Guaranteed Living Benefit</td>
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<td>12</td>
<td>Guaranteed Death Benefit</td>
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<td>Account Value</td>
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<td>Reserve for Separate Account</td>
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<td>15</td>
<td>Reserve for Life Account</td>
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<td>16</td>
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### NAIC BLANKS (E) WORKING GROUP

#### Blanks Agenda Item Submission Form

| CONTACT PERSON: | Pat Allison |
| TELEPHONE: | 816-783-8528 |
| EMAIL ADDRESS: | pallison@naic.org |
| ON BEHALF OF: | LATF |
| NAME: | Mike Boerner, Chair |
| TITLE: | |
| AFFILIATION: | |
| ADDRESS: | |

**FOR NAIC USE ONLY**

| Agenda Item # | 2020-11BWG |
| Year | 2020 |
| Changes to Existing Reporting | [X] |
| New Reporting Requirement | [ ] |

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [X] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [X] Adopted Date 05/28/2020
- [ ] Rejected Date
- [ ] Deferred Date
- [ ] Other (Specify) 

#### BLANK(S) TO WHICH PROPOSAL APPLIES

- [X] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [X] INSTRUCTIONS
- [ ] CROSSCHECKS
- [X] Title
- [ ] Other _______________________

Anticipated Effective Date: Annual 2020

#### IDENTIFICATION OF ITEM(S) TO CHANGE

See next page for details of changes to the VM-20 Reserves Supplement.

#### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Changing the reporting units for reserves to attain consistency with other annual statement blanks. Clarifying the instructions to attain consistency in company reporting. Changes are based on findings from the 2018 review of company filings.

#### NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ____________________________

Other Comments: ____________________________

** This section must be completed on all forms.
IDENTIFICATION OF ITEM(S) TO CHANGE

VM-20 Reserves Supplement Blank:

- Splitting Part 1 into Part 1A and Part 1B.
- For Part 1A:
  - Changing the description header for Column 3 to be “Due and Deferred Premium Asset” so that it matches the instructions.
  - Adding “XXX” in two places to indicate that a Due and Deferred Premium Asset does not need to be reported in the lines shown for Total Reserves.
  - Changing the reporting units for all columns to be in dollars rather than in thousands.
  - Expanding all columns to allow room for a number as large as 999,999,999,999.
  - Changing the product labels for clarity.
- For Part 1B:
  - Changing the reporting units for the Reserve columns to be in dollars rather than in thousands.
  - Expanding the Reserve columns to allow room for a number as large as 999,999,999,999.
  - Expanding the Face Amount columns to allow room for a number as large as 9,999,999,999.
  - Changing the product labels for clarity.
- Removing Part 2 and re-numbering the remaining Parts.

VM-20 Reserves Supplement Instructions:

- Adjusting the instructions according to the changes made to the blanks.
- Clarifying instructions and adding examples for Parts 1A and 1B.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

VM-20 RESERVES SUPPLEMENT—PART 1

Life Insurance Reserves Valued According to VM-20 by Product Type

($000 Omitted Except for Number of Policies)

This Supplement provides information on the reserves required to be calculated by Section VM-20 of the Valuation Manual. This includes the Net Premium Reserve and, as applicable, the Deterministic Reserve and the Stochastic Reserve. This Supplement also provides information regarding business where VM-20 of the Valuation Manual is not required to be applied. Only business issued on or after Jan. 1, 2017, valued by the requirements of VM-20 should be reported in Part 1A and Part 1B. Part 1A and Part 1B are intended to aid regulators in the analysis of reserves as determined under Section VM-20 of the Valuation Manual for both the prior and current year. Companies that elect the three-year transition for some of their policies should not report those policies in this part.

This Supplement also provides information regarding business where VM-20 of the Valuation Manual is not required to be applied. Companies that elect the three-year transition period for all of their business or are otherwise exempted from the requirements of Section VM-20 are not required to complete Part 1A or Part 1B of this Supplement pursuant to the instructions in Part 2 of this Supplement, but must complete Part 2 or Part 3 as applicable.

VM-20 RESERVES SUPPLEMENT – PART 1A

Life Insurance Reserves Valued According to VM-20 by Product Type

Part 1A of this Supplement breaks out, by product type, the prior year and current year reported reserves on a Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded basis as defined in Section 8.D of Section VM-20 of the Valuation Manual. The Due and Deferred Premium Asset for the current year is also shown. In addition, Part 1 of this Supplement shows, by product type for the current year, the Due and Deferred Premium Asset, the Net Premium Reserve (NPR), the Deterministic Reserve (DR) and the Stochastic Reserve (SR), where the NPR, DR and SR are as defined in Section VM-20 of the Valuation Manual. This Supplement is intended to aid regulators in the analysis of reserves as determined under Section VM-20 of the Valuation Manual for both the prior and current year.

Section VM-20 of the Valuation Manual requires that the Post-Reinsurance-Ceded Reserve be determined by three product groups VM-20 Reserving Categories: Term Insurance, Universal Life with Secondary Guarantees (ULSG) and all other. Term Insurance should be reported on line 1.1. ULSG, including Variable Universal Life with a secondary guarantee, Indexed life insurance with a secondary guarantee, regular Universal Life with a secondary guarantee, and ULSG policies with a non-material secondary guarantee as defined in Section VM-01 of the Valuation Manual, should be reported on line 1.2. Each of the other products reported in lines 1.3 – 1.8 should be determined as the sum of the policy reserves using the policy reserves determined following the allocation process of VM-20 Section 2. A similar process should be used for each of the pre-reinsurance-ceded reserves.

Section A: Columns 4 through 8 are to be completed if each of the reserves in Columns 4 through 6 (NPR, DR, SR) is calculated according to the requirements of Section VM-20 of the Valuation Manual.

Section B: Columns 9 through 12 are to be completed only if the reserves in Columns 9 and 10 (NPR, DR) are calculated according to the requirements of Section VM-20 of the Valuation Manual.

Section C: Columns 13 through 15 are to be completed only if the reserve in Column 13 (NPR) is calculated according to the requirements of Section VM-20 of the Valuation Manual.
Column 1 & 2 – Reported Reserve

Provide the reported reserve, in thousands whole dollars, for the prior year and current year for each line item. Post-Reinsurance-Ceded is net of reinsurance ceded, and Pre-Reinsurance-Ceded includes reinsurance assumed and excludes any reinsurance ceded should be prior to any reinsurance ceded and include reinsurance assumed. Sections 2 and 8 in the Valuation Manual further describe the required reserve and treatment of reinsurance. The reported reserve for the current year should reflect all policies in force as of the end of the current year. The reported reserve for the prior year should reflect all policies in force as of the end of the prior year.

Column 3 – Due and Deferred Premium Asset

Provide the due and deferred premium asset amount, in thousands whole dollars, associated with the current year Reported Reserve from Column 2 and calculated in a manner consistent with lines 15.1 and 15.2 of the Annual Statement Assets page.

**Example 1:**
A company reinsures a ULSG product using YRT reinsurance.
- The ceding company reports their reserve on lines 1.2 and 3.2 for ULSG.
- The assuming company reports their reserve on lines 1.1 and 3.1 for Term.

**Example 2:**
A company reinsures a Term product using YRT reinsurance.
- The ceding company reports their reserve on lines 1.1 and 3.1 for Term.
- The assuming company reports their reserve on lines 1.1 and 3.1 for Term.
VM-20 RESERVES SUPPLEMENT – PART 1B

Life Insurance Reserves Valued According to VM-20 by Product Type

($000 Omitted for Face Amount)

Part 1B of this Supplement provides details underlying the amounts shown in Part 1A.

Section A: Columns 4.1 through 8.5 are to be completed if each of the reserves in Columns 4.1 through 6.3 (NPR, DR, SR) is calculated according to the requirements of Section VM-20 of the Valuation Manual.

Section B: Columns 9.6 through 12.9 are to be completed only if the reserves in Columns 9.6 and 10.7 (NPR, DR) are calculated according to the requirements of Section VM-20 of the Valuation Manual.

Section C: Columns 13.10 through 15.12 are to be completed only if the reserve in Column 13.10 (NPR) is calculated according to the requirements of Section VM-20 of the Valuation Manual.

Column 4.1, 9.6 & 13.10 – Net Premium Reserve (NPR)

Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Net Premium Reserve for each product type, in whole dollars. The Net Premium Reserve is defined in Section 3 in VM-20 of the Valuation Manual.

Column 5.2 & 10.7 – Deterministic Reserve

Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Deterministic Reserve for each product type, in thousand whole dollars. Report the amount whether it is positive or negative; do not floor the amount at zero if it is negative. The Deterministic Reserve calculation is defined in Section 4 in VM-20 of the Valuation Manual.

Column 6.3 – Stochastic Reserve

Report the Post-Reinsurance-Ceded and Pre-Reinsurance-Ceded Stochastic Reserve for each product type, in thousand whole dollars. Report the amount whether it is positive or negative; do not floor the amount at zero if it is negative. The Stochastic Reserve calculation is defined in Section 5 in VM-20 of the Valuation Manual.

Column 7.4, 11.8 & 14.11 – Number of Policies

Report the number of individual life insurance policies by product type and by the required VM-20 methodology used as described in Section A, Section B and Section C above. The number of policies should be prior to any reinsurance ceded and include reinsurance assumed.

Column 8.5, 12.9 & 15.12 – Face Amount

Report the face amount, in thousands, of individual life insurance by product type and by the required VM-20 methodology used as described in Section A, Section B and Section C above. The face amount should be prior to any reinsurance ceded and include reinsurance assumed.

Example:
A company has Term business subject to VM-20, and there is no reinsurance. The Stochastic Exclusion Test was passed. The Deterministic Reserve at year-end was negative.

- The company completes Section B.
- The Net Premium Reserve is reported in whole dollars in Column 6.
- The negative Deterministic Reserve is reported in whole dollars in Column 7.
- The Number of Policies is reported in Column 8.
- The Face Amount is reported in thousands in Column 9.
VM-20 RESERVES SUPPLEMENT—PART 2

Three Year-Transition Period

($000 Omitted Except for Number of Policies)

This section of the Supplement should be completed when a reporting entity has elected to apply the three-year transition provided in Section II, Sub-section C under Life Insurance Products of the Valuation Manual to some or all of its business. This Part 2 should include the values requested for the business for which the three-year transition has been elected and should not include values for any policies valued based on VM-20. This Part 2 allows the company to establish minimum reserves according to applicable requirements stated in Appendix A (VM-A) and Appendix C (VM-C), in the Valuation Manual, for business otherwise subject to VM-20 requirements and issued during the first three years following the Operative Date of the Valuation Manual. If a company does not elect this three-year transition, but elects to apply VM-20 to a block of business issued on and after the Operative Date, then such company must continue to apply the requirements of VM-20 to this block of business, as well as future new issues of this type of business.

A company that elects to apply the three-year transition for all of its products within the scope of VM-20 does not have to complete Part 1 of the VM-20 Supplement. If a company applies VM-20 to a product or products, then Part 1 of this VM-20 Supplement will need to be completed.

VM-20 RESERVES SUPPLEMENT – PART 3-2

Life PBR Exemption

This section of the Supplement should be completed by a company that has filed and been granted a Life PBR Exemption from its state of domicile.

If a company has been granted a Life PBR Exemption, the company must indicate the source of the Life PBR Exemption, which could be defined in a state statute, a state regulation or in the NAIC-adopted Valuation Manual. If the source of the granted Life PBR Exemption is not the NAIC-adopted Valuation Manual, the company must disclose the criteria of the state’s Life PBR Exemption that the company has met, and the company must disclose the minimum reserve requirements that are required by the state of domicile. If the minimum reserve requirements of the state of domicile are the same as those specified in the NAIC-adopted Valuation Manual, the company may indicate: “Same as NAIC VM”.

Companies whose individual ordinary life business is exempted from the requirements of VM-20 pursuant to a Life PBR Exemption are not required to complete Part 1 of this VM-20 Supplement.

VM-20 RESERVES SUPPLEMENT – PART 4-3

Other Exclusions from Life PBR

Questions 1 and 2 of this section of the Supplement should be completed by a company that has filed and been granted a Single State Exemption from the reserve requirements of VM-20 by its state of domicile pursuant to requirements similar to the optional Section 15 of the NAIC Standard Valuation Law (#820). The response to question 2 should be “Yes” if the company has any business assumed that relates to issues outside the state of domicile.

Question 3 of this section of the Supplement should be completed by a company if all its life business is excluded from the requirements of VM-20 pursuant to Section II.B of the Valuation Manual.

Companies responding “Yes” to question 1 are not required to complete Part 1 of this VM-20 Supplement if all of their individual ordinary life business was covered under the Single State Exemption. Companies responding “YES” to question 3 are not required to complete Part 1 of this VM-20 Supplement.
## ANNUAL STATEMENT BLANK – LIFE/FRATERNAL

### VM-20 RESERVES SUPPLEMENT – PART 1A

Life Insurance Reserves Valued According to VM-20 by Product Type

For The Year Ended December 31, 20__

(To Be Filed by March 1)

($000 Omitted Except for Number of Policies)

NAIC Group Code __________________  NAIC Company Code ________________

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<td>1.2. Universal Life With Secondary Guarantee</td>
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<td>1.3. Non-Participating Whole Life</td>
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NAIC Proceedings – Summer 2020

Accounting Practices and Procedures (E) Task Force

10-1005

8/3/20
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<td>Aggregate Write-Ins for Other Products</td>
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### Current Year Reserve

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Reported Reserve</th>
<th>Due and Deferred Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.1</td>
<td>Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.1</td>
<td>Non-Participating Whole Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4.1</td>
<td>Participating Whole Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5.1</td>
<td>Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6.1</td>
<td>Variable Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7.1</td>
<td>Variable Life Without Secondary Guarantee</td>
<td></td>
<td></td>
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<tr>
<td>1.8.1</td>
<td>Indexed Life Without Secondary Guarantee</td>
<td></td>
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<tr>
<td>1.9.1</td>
<td>Aggregate Write-Ins for Other Products</td>
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### Total Pre-Reinsurance-Ceded Reserve

<table>
<thead>
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<th>Description</th>
<th>Reported Reserve</th>
<th>Due and Deferred Reserve</th>
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</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Term Life Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Universal Life With Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Non-Participating Whole Life</td>
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</tr>
<tr>
<td>2.4</td>
<td>Participating Whole Life</td>
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<td></td>
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<tr>
<td>2.5</td>
<td>Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td>Variable Universal Life Without Secondary Guarantee</td>
<td></td>
<td></td>
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<tr>
<td>2.7</td>
<td>Variable Life Without Secondary Guarantee</td>
<td></td>
<td></td>
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<td>2.8</td>
<td>Indexed Life Without Secondary Guarantee</td>
<td></td>
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<tr>
<td>2.9</td>
<td>Aggregate Write-Ins for Other Products</td>
<td></td>
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### Total Reserves Ceded (Line 2 minus Line 1)

<table>
<thead>
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<tbody>
<tr>
<td>3.1</td>
<td>Term Life Insurance</td>
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<td>3.2</td>
<td>Universal Life With Secondary Guarantee</td>
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<td>3.3</td>
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<td>3.4</td>
<td>Participating Whole Life</td>
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<td>3.5</td>
<td>Universal Life Without Secondary Guarantee</td>
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<td>3.7</td>
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<td>Indexed Life Without Secondary Guarantee</td>
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</tr>
<tr>
<td>3.9</td>
<td>Aggregate Write-Ins for Other Products</td>
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### DETAILS OF WRITE-INS

<table>
<thead>
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<th>Description</th>
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<th>Due and Deferred Reserve</th>
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<tr>
<td>1.901</td>
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<tr>
<td>1.902</td>
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<td></td>
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<tr>
<td>1.903</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1.908</td>
<td>Summary of remaining write-ins for Line 1.9 from overflow page</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.999</td>
<td>Totals (Lines 1.901 through 1.908) (Line 1.9 above)</td>
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<td></td>
</tr>
<tr>
<td>3.901</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.902</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.903</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.998</td>
<td>Summary of remaining write-ins for Line 3.9 from overflow page</td>
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<tr>
<td>3.999</td>
<td>Totals (Lines 3.901 through 3.903 plus 3.998) (Line 3.9 above)</td>
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</table>
### VM-20 RESERVES SUPPLEMENT – PART 1B

Life Insurance Reserves Valued According to VM-20 by Product Type

For The Year Ended December 31, 20__

(To Be Filed by March 1)

($000 Omitted for Face Amount)

<table>
<thead>
<tr>
<th>Section A</th>
<th>Section B</th>
<th>Section C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Total Post-Reinsurance-Ceded Reserve (Sum of Lines 1.1 through 1.9)</strong></td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

### Additional Notes:

- **Section A**
  - Line 1.1: Term Life Insurance
  - Line 1.2: Un insured Life With Secondary Guarantee
  - Line 1.3: Non-Participating Whole Life
  - Line 1.4: Participating Whole Life
  - Line 1.5: Universal Life Without Secondary Guarantee
  - Line 1.6: Variable Universal Life Without Secondary Guarantee
  - Line 1.7: Immediate Annuity Without Secondary Guarantee
  - Line 1.8: Aggregate Reserves for Other Products
  - Line 1.9: Summary of write-ins for other products

- **Section B**
  - Line 2. Total Post-Reinsurance-Ceded Reserve
  - Line 3. Pre-Reinsurance-Ceded Reserve
    - Line 3.1: Term Life Insurance
    - Line 3.2: Uninsured Life With Secondary Guarantee
    - Line 3.3: Non-Participating Whole Life
    - Line 3.4: Participating Whole Life
    - Line 3.5: Universal Life Without Secondary Guarantee
    - Line 3.6: Variable Universal Life Without Secondary Guarantee
    - Line 3.7: Immediate Annuity Without Secondary Guarantee
    - Line 3.8: Aggregate Reserves for Other Products

- **Section C**
  - Line 4. Summary of write-ins for other products
    - Line 4.1: Term Life Insurance
    - Line 4.2: Uninsured Life With Secondary Guarantee
    - Line 4.3: Non-Participating Whole Life
    - Line 4.4: Participating Whole Life
    - Line 4.5: Universal Life Without Secondary Guarantee
    - Line 4.6: Variable Universal Life Without Secondary Guarantee
    - Line 4.7: Immediate Annuity Without Secondary Guarantee
    - Line 4.8: Aggregate Reserves for Other Products

### Other Information:

- **Declaration of Write-ins**
  - Line 5.1: Summary of write-ins for other products
  - Line 5.2: Summary of write-ins for other products

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

**Attachment Four-A14**
# VM-20 RESERVES SUPPLEMENT – PART 2

## Reserves for Policies Not Based on VM-20 as a Result of the Three-Year Transition Period

**For The Year Ended December 31, 20__**  
*(To Be Filed by March 1)*

($000 Omitted Except for Number of Policies)

### DETAILS OF WRITE-INS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
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<tbody>
<tr>
<td>1. Life Insurance Reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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### VM-20 RESERVES SUPPLEMENT – PART 3-2

**Life PBR Exemption**  
*For The Year Ended December 31, 20__*  
*(To Be Filed by March 1)*

**Life PBR Exemption as defined in the NAIC adopted Valuation Manual (VM)**

1. Has the company filed and been granted a Life PBR Exemption from the reserve requirements of VM-20 of the Valuation Manual by their state of domicile?  
   Yes [   ] No [   ]

2. If the response to Question 1 is "Yes", then check the source of the granted “Life PBR Exemption” definition? (Check either 2.1, 2.2 or 2.3)

   2.1 NAIC Adopted VM  
   2.2 State Statute (SVL)  
   a. Is the criteria in the State Statute (SVL) different from the NAIC adopted VM?  
      Yes [   ] No [   ]
   b. If the answer to "a" above is “Yes”, provide the criteria the state has used to grant the Life PBR Exemption (e.g., Group/Legal Entity criteria) and the minimum reserve requirements that are required by the state of domicile (if the minimum reserve requirements are the same as the Adopted VM, write SAME AS NAIC VM):
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................

   2.3 State Regulation  
   a. Is the criteria in the State Regulation different from the NAIC adopted VM?  
      Yes [   ] No [   ]
   b. If the answer to "a" above is “Yes”, provide the criteria the state has used to grant the Life PBR Exemption (e.g., Group/Legal Entity criteria) and the minimum reserve requirements that are required by the state of domicile (if the minimum reserve requirements are the same as the Adopted VM, write SAME AS NAIC VM):
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................
      .................................................................................................................................

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**VM-20 RESERVES SUPPLEMENT – PART 4-3**

Other Exclusions from Life PBR

For The Year Ended December 31, 20__

(To Be Filed by March 1)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. Has the company filed and been granted a Single State Exemption from the reserve requirements of VM-20 of the Valuation Manual by their state of domicile?</td>
<td>[]</td>
<td>[ ]</td>
</tr>
<tr>
<td>1B. If the answer to question 1A is “Yes” please discuss any business not covered under the Single State Exemption.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A. If the answer to question 1A is “Yes”, does the company have risks for policies issued outside its state of domicile?</td>
<td>Yes</td>
<td>[ ]</td>
</tr>
<tr>
<td>2B. If the answer to question 2A is “Yes” please discuss the risks for policies issued outside the state of domicile, how those risks came to be a responsibility of the company, and why the company would still be considered a Single State Company with such risks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is all of the company’s individual ordinary life insurance business excluded from the requirements of VM-20 pursuant to Section II.B of the Valuation Manual?</td>
<td>Yes</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>DATE: 02/21/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT PERSON: Kris DeFrain</td>
</tr>
<tr>
<td>TELEPHONE: 816-783-8229</td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:kdefrain@naic.org">kdefrain@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF: Phil Vigliaturo, Chair, Casualty Actuarial and Statistical (C) Task Force</td>
</tr>
<tr>
<td>TITLE: Director, Research and Actuarial Dept.</td>
</tr>
<tr>
<td>AFFILIATION: NAIC</td>
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<tr>
<td>ADDRESS: NAIC Central Office</td>
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FOR NAIC USE ONLY

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<tr>
<td>Year 2020</td>
</tr>
<tr>
<td>Changes to Existing Reporting [ X ]</td>
</tr>
<tr>
<td>New Reporting Requirement [ ]</td>
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REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact [ X ] |
| Modifies Required Disclosure [ ] |

DISPOSITION

[ ] Rejected For Public Comment |
[ ] Referred To Another NAIC Group |
[ ] Received For Public Comment |
[ X ] Adopted Date 05/28/2020 |
[ ] Rejected Date |
[ ] Deferred Date |
[ ] Other (Specify) |

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT |
[ ] QUARTERLY STATEMENT |
[ ] Instructions |
[ ] Crosschecks |

Life, Accident & Health/Fraternal |
Property/Casualty |
Health |
Health (Life Supplement) |

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

The proposal will require appointed actuaries to attest to meeting Continuing Education (CE) requirements and participate in the CAS/SOA CE review procedures, if requested. These proposed changes were adopted by the Task Force on Jan. 28, 2020.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

As charged by the Property and Casualty Insurance (C) Committee to ensure continued competence of appointed actuaries, the revisions would implement the CAS and SOA P/C Appointed Actuary Continuing Education Verification Process.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:________________________

Other Comments:________________________

** This section must be completed on all forms. Revised 7/18/2018
ACTUARIAL OPINION

1. There is to be included with or attached to Page 1 of the Annual Statement the statement of the Appointed Actuary, entitled “Statement of Actuarial Opinion” (Actuarial Opinion), setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required Exhibits, shall be in the format of and contain the information required by this section of the Annual Statement Instructions – Property and Casualty.

Upon initial engagement, the Appointed Actuary must be appointed by the Board of Directors by Dec. 31 of the calendar year for which the opinion is rendered. The Company shall notify the domiciliary commissioner within five business days of the initial appointment with the following information:

a. Name and title (and, in the case of a consulting actuary, the name of the firm).

b. Manner of appointment of the Appointed Actuary (e.g., who made the appointment and when).

c. A statement that the person meets the requirements of a Qualified Actuary (or was approved by the domiciliary commissioner) and that documentation was provided to the Board of Directors.

Once this notification is furnished, no further notice is required with respect to this person unless the Board of Directors takes action to no longer appoint or retain the actuary or the actuary no longer meets the requirements of a Qualified Actuary.

If subject to the U.S. Qualification Standards, the Appointed Actuary shall annually attest to having met the continuing education requirements under Section 3 of the U.S. Qualification Standards for issuing Actuarial Opinions. As agreed with the actuarial organizations, the Casualty Actuarial Society (CAS) and Society of Actuaries (SOA) will determine the process for receiving the attestations for their respective members and make available the attestations to the public. An Appointed Actuary subject to the U.S. Qualification Standards and not a member of the CAS or SOA shall select one of the above organizations to submit their attestation.

In accordance with the CAS and SOA’s continuing education review procedures, an Appointed Actuary who is subject to the U.S. Qualification Standards and selected for review shall submit a log of their continuing education in a form determined by the CAS and SOA. The log shall include categorization of continuing education approved for use by the Casualty Actuarial and Statistical Task Force. As agreed with the actuarial organizations, the CAS and SOA will provide an annual consolidated report to the NAIC identifying the types and subject matter of continuing education being obtained by Appointed Actuaries. An Appointed Actuary subject to the U.S. Qualification Standards and not a member of the CAS or SOA shall follow the review procedures for the organization in which they submitted their attestation.

The Appointed Actuary shall provide to the Board of Directors qualification documentation on occasion of their appointment, and on an annual basis thereafter, directly or through company management. The documentation should include brief biographical information and a description of how the definition of “Qualified Actuary” is met or expected to be met (in the case of continuing education) for that year. The documentation should describe the Appointed Actuary’s responsible experience relevant to the subject of the Actuarial Opinion. The Board of Directors shall document the company’s review of those materials and any other information they may deem relevant, including information that may be requested directly from the Appointed Actuary. The qualification documentation shall be considered workpapers and be available for inspection upon regulator request or during a financial examination.

Detail Eliminated to Conserve Space
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Tom Botsko</th>
</tr>
</thead>
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<td>TELEPHONE:</td>
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<tr>
<td>EMAIL ADDRESS:</td>
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<tr>
<td>ON BEHALF OF:</td>
<td>Capital Adequacy (E) Task Force</td>
</tr>
<tr>
<td>NAME:</td>
<td>Tom Botsko</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chief P &amp; C Actuary</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>Ohio Dept. of Insurance</td>
</tr>
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<td>ADDRESS:</td>
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FOR NAIC USE ONLY

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<td>2020</td>
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<tr>
<td>Changes to Existing Reporting</td>
<td>[ X ]</td>
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<tr>
<td>New Reporting Requirement</td>
<td>[    ]</td>
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REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact | [ X ] |
| Modifies Required Disclosure | [    ] |

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) ________________

BLANK(S) TO WHICH PROPOSAL APPLIES

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<td></td>
<td>[ X ] Life, Accident &amp; Health/FRATERNAL</td>
<td>[ ] Separate Accounts</td>
<td>[ X ] Title</td>
<td>[ ] Other ________________</td>
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<td>[ X ] Property/Casualty</td>
<td>[ ] Protected Cell</td>
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<td></td>
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</tr>
<tr>
<td>[ X ] Health</td>
<td>[ ] Health (Life Supplement)</td>
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Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Remove Line 24.04 from the General Interrogatories, Part 1 and renumber remaining lines for Interrogatory Question 24. Modify Lines 24.05 and 24.06 to require reporting amounts for conforming and non-conforming collateral programs.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Interrogatory Questions 24.05 and 24.06 are completed dependent on the answer to Question 24.04 which works for companies that have either all conforming or all non-conforming collateral programs. When a company has both, only the collateral amount of the conforming programs is captured. This proposal allows the capture of the amount of collateral for both conforming and non-conforming collateral programs when a company has both.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ________________________________

Other Comments: ________________________________

** This section must be completed on all forms. Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

GENERAL INTERROGATORIES

PART 1 – COMMON INTERROGATORIES

INVESTMENT

24. For the purposes of this interrogatory, “exclusive control” means that the company has the exclusive right to dispose of the investment at will, without the necessity of making a substitution thereof. For purposes of this interrogatory, securities in transit and awaiting collection, held by a custodian pursuant to a custody arrangement or securities issued subject to a book entry system are considered to be in actual possession of the company.

If bonds, stocks and other securities owned December 31 of the current year, over which the company has exclusive control are: (1) securities purchased for delayed settlement, or (2) loaned to others, the company should respond “NO” to 24.01 and “YES” to 25.1.

24.03 Describe the company’s securities lending program, including value for collateral and amount of loaned securities, and whether the collateral is held on- or off-balance sheet. Note 17 of Notes to Financial Statement provides a full description of the program.

24.04 A company with a conforming securities lending program as defined in the risk-based capital instructions should respond “YES.”

24.045 Report amount of collateral for conforming programs as outlined in the Risk-Based Capital Instructions (24.04 answer is “YES”).

24.056 Report amount of collateral for other programs (24.04 answer is “NO”).

24.1091 The fair value amount reported should equal the grand total of Schedule DL, Part 1, Column 5 plus Schedule DL, Part 2, Column 5.

The fair value amount reported amount should also equal the fair value amount reported in Note 5E(5)a1(m).

24.1092 The book adjusted/carrying value amount reported should equal the grand total of Schedule DL, Part 1, Column 6 plus Schedule DL, Part 2, Column 6.

24.1093 The payable for securities lending amount reported should equal current year column for payable for securities lending line on the liability page.
ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

GENERAL INTERROGATORIES

PART 1 – COMMON INTERROGATORIES

Detail Eliminated to Conserve Space

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03)
Yes [ ] No [ ]

24.02 If no, give full and complete information, relating thereto

24.03 For securities lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)

24.04 Does the company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions?
Yes [ ] No [ ] N/A [ ]

24.05 For the reporting entity’s security lending program, report amount of collateral for conforming programs as outlined in the Risk-Based Capital Instructions.
$ _____________________

24.06 For the reporting entity’s securities lending program, report amount of collateral for other programs.
$ _____________________

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%?
Yes [ ] No [ ] N/A [ ]

24.09 Does the reporting entity or the reporting entity’s securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending?
Yes [ ] No [ ] N/A [ ]

24.10 For the reporting entity’s securities lending program, state the amount of the following as of December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2
$ _____________________

24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2
$ _____________________

24.103 Total payable for securities lending reported on the liability page
$ _____________________

Detail Eliminated to Conserve Space
### NAIC BLANKS (E) WORKING GROUP

#### Blanks Agenda Item Submission Form

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<th>DATE:</th>
<th>02/21/2020</th>
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<tbody>
<tr>
<td>CONTACT PERSON:</td>
<td>Eric King</td>
</tr>
<tr>
<td>TELEPHONE:</td>
<td>816-783-8234</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:eking@naic.org">eking@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>Health Actuarial (B) Task Force</td>
</tr>
<tr>
<td>NAME:</td>
<td>Perry Kupferman</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chief Life Actuary</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>California Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
</tr>
</tbody>
</table>

#### FOR NAIC USE ONLY

<table>
<thead>
<tr>
<th>Agenda Item #:</th>
<th>2020-14BWG MOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year:</td>
<td>2020</td>
</tr>
<tr>
<td>Changes to Existing Reporting:</td>
<td>[ X ]</td>
</tr>
<tr>
<td>New Reporting Requirement:</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact: | [ X ] |
| Modifies Required Disclosure: | [ ] |

#### DISPOSITION

| [ ] Rejected For Public Comment |
| [ ] Referred To Another NAIC Group |
| [ ] Received For Public Comment |
| [ X ] Adopted Date: 05/28/2020 |
| [ ] Rejected Date |
| [ ] Deferred Date |
| [ ] Other (Specify) |

#### BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ X ] QUARTERLY STATEMENT
- [ X ] BLANK
- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ X ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

#### IDENTIFICATION OF ITEM(S) TO CHANGE

Modify the columns and rows on the blank pages for the Long-Term Care Experience Reporting Forms 1 through 5 and make appropriate changes to the instructions for those forms.

#### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Changes are proposed to provide more accurate and useful information to regulators and their customers, and to facilitate greater consistency among and ease of reporting by insurers.

#### NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

---

** This section must be completed on all forms. **

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ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH AND PROPERTY

LONG-TERM CARE INSURANCE EXPERIENCE REPORTING FORMS 1 THROUGH 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are “incidental” regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue). If a policy form has had no policies in force and all claims on the policy form have been settled for more than one year, then the policy form is no longer reported on Forms 1, 2 and 4.

Form 1 gives an overview of the stand-alone LTC business and claims experience for both individual and group policies. Form 2 focuses on the experience of individual policies broken down into three Primary Issue Periods: Prior to 2003, 2003-2010, and 2011 and later. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 focuses on the experience of group business. Form 5 provides a location to report data at the state level and additionally asks for data related to hybrid life or annuity products with LTC extended and/or accelerated benefits.

Form 1 focuses on the critical assumptions of morbidity and persistency while still presenting loss ratio data (without the level of detail in the original forms). As noted in the instructions specific to the form, prior year values will be filled in over time. Only information as of 2009 and subsequent years is required on the forms, unless it was required on the previous Long-Term Care Insurance Experience Reporting Forms. Companies are not required to supply information for spaces on the forms corresponding to any year prior to adoption of the forms, unless that information was previously reported. Form 2 focuses on the developing level of funds from the issue age premium basis and compares this to the active life reserve. As noted in the instructions specific to the form, prior year values will be filled in over time. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred year over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 is to include life and annuity products that are not exempt as outlined in the Long-Term Care Insurance Model Regulation. Form 5, which replaces the LTC experience Form C, requires information at the state level. In addition to the considerable changes in the structure and purpose of the forms, the new forms are based on adding additional calendar years of experience to prior results. To more appropriately compare the actual results with expectations, the expected values are based on the exposure at the beginning of that year, not the original assumed sales distribution used when completing the original forms.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident and health annual statement. The list of the various annual statements is: life/fraternal, accident and health, property/casualty and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.
Experience for LTC insurance should be reported separately by stand-alone LTC policy form or by rider where experience is to be reported by form. Reporting by rider is applicable only to riders having distinct premiums for LTC coverage that are attached to products other than stand-alone LTC policies. Experience under forms that provide substantially similar coverage and provisions, that are issued to substantially similar risk classes and that are issued under similar underwriting standards, may be combined. If this option is utilized, the forms combined should be identified in the column captioned “Policy Form.”

Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse’s benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods:

1. If the assumption is that future premiums (gross or net) will be considered as “paid by waiver,” the reserve will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

2. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve would be the paid-up value and future incurred claims will be only for LTC benefits.

Report using (1) above unless there are system limitations which require data to be entered under assumption (2).

When reporting dollar amounts, report the amount in thousands ($000 omitted). For non-dollar values, do not truncate the amounts.

Definition of Incurred Claims:

The amount of developed claims incurred during the calendar year is equal to the present value of all claim payments during the year and any changes in claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

- Paid claims in the year of incurrar are discounted one-quarter year.
- Paid claims subsequent to the year of incurrar are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 of Form 3 are discounted from the valuation date to the midpoint of the incurred year.

If

\[ iy = \text{Incurred year} \]
\[ T = \text{Report year} – \text{incurred year} \]
\[ v = \text{Discount rate} \]
\[ \text{Paid Claims}_{t}^{iy} = \text{Paid claims during current or prior calendar year } t \text{ from claims incurred in year } iy \]
\[ \text{Case Reserve}_{t}^{iy} = \text{Case reserve at end of calendar year } t \text{ from claims incurred in } iy \]
\[ \text{Transferred Reserve}_{t}^{iy} = \text{Transferred reserve at end of calendar year } t \text{ from claims incurred in } iy \]
t = iy, iy+1, iy+2, ..., iy + T

then the Present Value of Incurred Claims for incurred year iy:

For T=0
\[ \text{iyPaid Claims}_0 \times v^{iy/2} + \text{iyCase Reserve}_0 \times v^{iy/2} + \text{iyIBNR}_0 \times v^{iy/2} + \text{iyTransferred Reserve}_0 \times v^{iy/2} \]

For T>0
\[ \text{iyPaid Claims}_0 \times v^{iy/2} + (\text{iy+1Paid Claims}_0 \times v^{iy+1/2}) + \text{iy+2Paid Claims}_0 \times v^{iy+2/2} + \ldots + (\text{iy+TPaid Claims}_0 \times v^{iy+T/2}) + \text{iy+TCase Reserve}_0 \times v^{iy+T/2} + (\text{iy+TIBNR}_0 \times v^{iy+T/2}) + \text{iy+TTransferred Reserve}_0 \times v^{iy+T/2} \]

If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the total direct liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health & fraternal) attributable to LTC business for life, accident & health and fraternal only.

This amount includes accrued and unaccrued claims liabilities that are incurred but not yet paid, both reported and not reported.
INSTRUCTIONS FOR FORM 1  
Stand-Alone LTC Only ($000 Omitted)

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual premium, claims, persistency, and reserves on a nationwide basis. Yearly and cumulative comparisons for direct, assumed, and ceded business are exhibited.

OVERVIEW

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims and persistency against expected on a nationwide basis. Certain group business is reported separately from individual and some group business. (See Section 4(E) of the Long-Term Care Insurance Model Act.) Policy forms are grouped into three categories: comprehensive, institutional only or non-institutional. Yearly and cumulative comparisons are exhibited. Even though only policy form groupings are displayed, policy form level information should be kept. It may facilitate rating reviews by the regulators. If a policy form has had no policies in force and all claims on the policy form have been settled for more than one year, then the policy form is no longer reported on this form.

DEFINITIONS AND FORMULAS

**Comprehensive**

Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

**Institutional Only**

Policy forms that provide institutional coverage only.

**Non-Institutional Only**

Policy forms that provide only non-institutional coverage.

**Current**

Current calendar year of reporting.

*Example:* For a specific policy form category, the first year of issue was 2001. This Form 1 is required starting for the year 2009 and the reporting year is 2011. The current year would be 2011.

**Prior**

The year immediately prior to the year of reporting.

*Example:* 2010

**2nd Prior**

Two years prior to the year of reporting.

*Example:* 2009

**3rd Prior**

Three years prior to the year of reporting.

*Example:* Blank, because the first year of reporting is 2009.
4th Prior

Four years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

5th Prior

Five years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

Form Inception-to-Date

Aggregate experience data since the adoption of this Form 1.

Example: Data from 2009 through 2011.

Actual and expected in force counts are sums of counts for all years since adoption of Form 1.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Example: Data from 2001 through 2011.

Assumed/Ceded Rows

Does not include YRT reinsurance transactions. For columns that are reported as “Number of” (count) rather than an amount, assumed/ceded business is only recorded here if the business is 100% coinsured.

Column 1 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only

Total earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, Line 10.3 for Individual Business section and Line 12 Group Business section.

Column 2 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

If $iy$ = Incurred year
$T$ = Report year – incurred year
$V$ = Discount rate
$\text{Paid Claims}_{iy, t}$ = Paid claims during claim duration $t$ from claims incurred in year $iy$, $t = 0, 1, 2, 3, \ldots T$
$\text{Case Reserve}_{iy}$ = Case reserve at end of report year from claims incurred in $iy$
**Incurred claims for incurred year iy:**

**For** \( T=0 \)

\[
\text{Paid Claims}_i \times v^{\frac{1}{2}} + \text{Case Reserve}_i \times v^{\frac{1}{2}} + \text{IBNR}_i \times v^{\frac{1}{2}}.
\]

**For** \( T>0 \)

\[
\text{Paid Claims}_i \times v^T + \text{Paid Claims}_i \times v^{T-1} + \text{Paid Claims}_i \times v^{T-2} + \ldots + \text{Paid Claims}_i \times v^1 + \text{Paid Claims}_i \times v^0 + \text{Case Reserve}_i \times v^{T+\frac{1}{2}} + (\text{IBNR}_i \times v^{T+\frac{1}{2}})
\]

This is the developed claim amounts for claims incurred during the specific calendar year. For each claim, the incurred claim equals the present values of all claim payments and the present value of any outstanding case reserve. This will be different from the reported financial incurred claims. The financial incurred claims, including the change in claim reserves that contains gain or loss due to reserve estimation different from actual payments for claims incurred in prior years.

For purposes of the present value calculation, assume all payments are made in the middle of the calendar year and the case reserve is at the end of the calendar year. The discount rate is the statutory valuation interest rate for case reserve. For the current calendar year, an Incurred But Not Reported (IBNR) reserve should be assigned. If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the direct liability attributable to long term care business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities, which are incurred but not yet paid, both reported and not reported.

The incurred claims should be consistent with the claims exhibited on Form 3.

**Column 3** — **Number of Claims Opened**

The number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

**Column 4** — **Number of Claims Closed**

Number of claims that had been opened, which became closed during the year due to recovery, exhaustion of benefits, or death.

**Column 5** — **Number of Claims Remaining Open**

Open claims are all claims that have been opened at any date, but have not been closed as of the end of the year.

**Column 6** — **Number of Terminations**

Total number of policy or certificate holders whose coverage ended during the year for any reason, including death, lapse, or benefit exhaustion.
<table>
<thead>
<tr>
<th>Column 7</th>
<th>Number of Policies/Certificates In-force at Year End</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of policies or certificates in force at the end of the year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 8</th>
<th>Number of Lives In-force at Year End</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 9</th>
<th>Active Life Reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total amount of active life reserves held for policyholders, including those in non-forfeiture status. The amount reported in annual statement Exhibit 6, Line 2 for life, accident &amp; health, and fraternal only. The amount reported in annual statement Underwriting and Investment Exhibit 2D, line 2, less the premium deficiency reserve in footnote (a) of that exhibit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 10</th>
<th>Claim Reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total amount of reserves held for payment of claims that have been incurred but not yet paid, including claims on policies in non-forfeiture status.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 11</th>
<th>Other Reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total amount of any other reserves associated with long-term care policies, including premium deficiency reserves, unearned premium reserves, and additional actuarial reserves. For the additional actuarial reserve, use the lesser of the aggregate additional reserve and a reserve calculated specifically for LTC business. A reserve must be carried for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 3</th>
<th>Valuation Expected Incurred Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The expected claim cost for an individual covered under a policy in force at the beginning of the calendar year based on statutory active life reserve morbidity assumption. This is the interpolation of successive policy year expected claim cost for all coverages in force at the beginning of the year. Simple averaging is acceptable. An acceptable approximation is the expected claim cost multiplied by an exposure adjustment, where expected claim cost is the sum of claim costs during the year based on the valuation morbidity assumption of each life in force at the beginning of the year. The valuation claim cost during the year is an interpolation of successive claim costs by policy year. Other approximations may also be acceptable. Any changes in method should be disclosed on the form. The exposure adjustment is:</td>
</tr>
</tbody>
</table>

\[
\text{Exposure Adjustment} = \frac{\text{Actual Number of Lives In Force at Beginning of Year} - (\text{Expected Deaths} + \text{Expected Lapses})}{2} \div \text{Actual Number of Lives In Force at Beginning of Year},
\]

where Expected Deaths and Expected Lapses are based on valuation assumptions. They can be derived from a single average decrement rate combining deaths and lapses, or specific decrement rates applying to actual exposures. If there is no in force at the beginning of the year, the expected claim cost can be zero. |

---

2 If active life reserves are not held for claimants, then exclude the claimants.

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Column 4 — Actual to Expected Incurred Claims

Actual incurred claims as a percentage of valuation expected incurred claims.

Column 5 — Open Claim Count

Number of claims that have at least one benefit payment made during the year after the elimination period. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. Examples are payments of caregiver training benefits and optional care coordination benefits. For these examples, if the amounts paid are included as benefits under the policy, they should be included in the claim amounts but excluded from the claim counts. A claim should be included in the count, even though it has terminated by the end of the year.

Column 6 — New Claim Count

Number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A new claim should be included in the count even though it has terminated by the end of the year.

Column 7 — Lives In Force End of Year

Actual number of lives in force at the end of the year. Joint policies should be counted by number of lives.

Column 8 — Expected Lives In Force End of Year

Expected number of lives in force at the end of the year:

\[
\text{Actual Number of Lives In Force at Beginning of Year} + \text{New Issue Lives} - \text{Expected Deaths} - \text{Expected Lapses},
\]

where Expected Deaths and Expected Lapses are based on valuation assumptions. They can be derived from a single average decrement rate combining deaths and lapses or specific decrement rates applying to actual exposures. Joint policies should be counted by number of lives.

Column 9 — Actual to Expected Lives In Force

Actual number of lives in force as a percentage of expected number of lives in force at the end of the year.

NOTES

1. Form 1 applies to direct business only.

2. Prior years’ figures, except for incurred claims, should be the same as the figures from prior years’ Form 1.

3. Form Inception-to-Date figures, except for incurred claims, should be the corresponding figures from prior year Form 1 plus the figures for the current year. No interest discounting is required to determine Form Inception-to-Date and Total Inception-to-Date figures.

4. If Incurred But Not Reported reserves must be allocated by policy form, the allocation should be based on paid claims and change in case reserves.
5. Use the valuation assumptions corresponding to the current reserves being held. They are not necessarily the original reserve assumptions if strengthening or release of reserves has been made in the past. The assumptions for each year should be applied to the actual in-force (age, gender, plan distribution), not the distribution originally expected or issued.

6. An insurance company may use more refined methods in determining the required information than those described in the definitions and instructions. Methods must be consistent from report year to report year.
INSTRUCTIONS FOR FORM 2
Direct Individual Experience – Stand-Alone Only ($000 Omitted)

Primary Issue Period Splits

Experience data for each policy should be aggregated in one of the three Primary Issue Year Periods shown on the experience form. It would be permissible for a company to include 100% of a policy form’s experience in just one of the three Primary Issue Year periods (using the issue year period where the majority of the policies were originally issued). It would also be permissible for a company to split a policy form’s experience by issue year into multiple Primary Issue Year periods shown in the form based upon policy issue year.

OVERVIEW

The purpose of Form 2 is to calculate a ratio of an experience reserve to the reported reserve by calendar year on a nationwide basis. Summary data by policy form is to be reported. Data for the current reporting year, as well as that reported in each of the prior two reporting years, is to be shown on Form 2.

The following formulae specify data by calendar duration (t) and calendar year of issue (n). Data at this detail is required for the calculation of the experience reserve, although only totals by policy form are illustrated. Experience data is notated by a superscript E to distinguish from valuation assumptions. The experience reserve reported in column 13 is developed from: 1) the experience reserve at the end of the prior reporting year (t-1); 2) valuation net premiums and interest rates; and 3) experience incurred claims, earned premiums, and actual persistency. The valuation net premiums used are the actual net premiums used for that reporting year. As an example, if a factor file method is used, the valuation net premiums used to calculate the reserve factors would be used for Form 2.

For 2009, the experience reserve (column 13) was calculated using the reported reserve as of the end of 2008 as the prior year’s reserve. Similarly, for acquired business, the experience reserve as of the year-end following acquisition is set equal to the reported reserve as of that date. The experience reserve as of subsequent periods is developed from the first experience reserve reported in this form. If a policy form has had no policies in force and all claims on the policy form have been settled for more than one year, then the policy form is no longer reported on this form.

Experience and valuation data are reported by base policy form. Rider forms will be reported with the base forms to which they are attached.

Only summary data by reporting year is illustrated. The reporting company should have detail by calendar duration available upon request.

DEFINITIONS AND FORMULAS

Current

Current calendar year of reporting.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Comprehensive

Policies that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.
Institutional Only

Policies that provide institutional coverage only.

Non-Institutional Only

Policies that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of policies in the block were sold. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policies that remain in force as of 12/31.

Column 2 – Percent Male Lives Insured

Percentage of males within the block of policyholders. For example, a block consisting of 60% males would be reported as 60. When reporting figures for inception-to-date, include all policies ever sold in the block. For the current year, include only those policyholders that remain insured as of 12/31.

Column 3 – Average Attained Age

Arithmetic mean of the attained ages of all in force policyholders in the block at year end.

Column 4 – Earned Premium

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Total earned premiums should equal Accident and Health Policy Experience Exhibit Column 1, Line 10.3 for Individual Business section and Line 12 Group Business section.

Column 5 – Incurred Claims

Developed claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 – Number of Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 7 – Number of Terminations

Total number of policyholders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.

Column 8 – Number of New Lives Insured

Total number of new lives issued LTC policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.
Column 3 — Last Year Issue

For closed blocks of business, report the last year a policy was issued for the policy form. For open blocks of business, leave blank.

Column 4 — Earned Premiums

\[ \text{EP}_n = \text{The direct earned premium in calendar duration } t \text{ for all business of Calendar Year of Issue (CYI) } n. \]

Include earned premiums only for the reporting year. Total direct earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2 for life, accident & health, fraternal and property/casualty only.

Column 5 — Incurred Claims

\[ \text{IC}^t_n = \text{The experience incurred claims of all business of CYI } n \text{ in calendar duration } t \text{ for the reporting year.} \]

Where:

\[ \text{(Paid Claims)}_n = \text{The paid claims of all business of CYI } n \text{ in calendar duration } t \text{ for the reporting year. Paid claims is the total direct paid claims for LTC business from Exhibit 8, Part 2, Line 1.1 for life, accident & health and fraternal only.} \]

\[ i_n = \text{The valuation interest rate for CYI } n. \]

\[ \text{CLiab}^t_n = \text{The claim liability of all business of CYI } n \text{ in calendar duration } t \text{ for the reporting year. CLiab}^t_n \text{ is the portion of the total direct claim liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities, which are incurred but not yet paid, both reported and not reported.} \]

\[ \text{CLiab}^{t-1}_n = \text{The claim liability of all business of CYI } n \text{ in calendar duration } t-1 \text{ for the prior reporting year. CLiab}^{t-1}_n \text{ is the total direct claim liability for LTC business from Exhibit 8, Part 2, Line 4.1 (life, accident & health and fraternal) of the current year’s annual statement plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business on the prior year’s annual statement for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities that were incurred but not paid at the prior year end, both reported and not reported.} \]

Column 6 — Loss Ratio

\[ \text{LR}_n = \text{The incurred claims loss ratio in calendar duration } t \text{ for all business of CYI } n. \]

\[ \text{LR}_n = \frac{\text{IC}^t_n}{\text{EP}_n} \]

Column 6 = Column 5 / Column 4 x 100
Column 7 — Annual Net Premium/Annual Gross Premium

The ratio of annual net premium to annualized gross premium.

Annual Net Premium = \sum (annual valuation net premiums for policies issued in calendar year \( n \) at the start of calendar duration \( t \)). Companies may report zero (0) for the net premiums during the Preliminary Term period.

Annual Gross Premium = \sum (Annualized Premium In Force, including mode loadings for policies issued in calendar year \( n \) at the start of calendar duration \( t \)). For calendar duration 0, the net premiums and gross premiums at issue should be used.

Column 8 — Current Year Net Premiums

\( tPn = \) The annual valuation net premium for all business of CYI \( n \) in calendar duration \( t \).

\( tPn = EPn \times \sum (annual valuation net premiums for policies issued in calendar year \( n \) at the start of calendar duration \( t \))/\sum (Annualized Premium In Force for policies issued in calendar year \( n \) at the start of calendar duration \( t \)). At the detail level of CYI \( n \) and calendar duration \( t \), Column 8 = Column 4 x Column 7.

Column 9 — In Force Count Beginning of Year

\( t_{-1}IFn = \) The in force count in calendar duration \( t-1 \) for all business of CYI \( n \) at the end of the calendar year preceding the reporting year. In Force Count Beginning of Years should equal in force end of prior year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 1) for LTC business for life, accident & health and fraternal only.

Column 10 — New Issues Current Year

The new issues count during the reporting year. New Issues Current Year should equal issued during year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 2) for LTC business for life, accident & health and fraternal only.

Column 11 — In Force Count End of Year

\( tIFn = \) The in force count in calendar duration \( t \) for all business of CYI \( n \) at the end of the reporting year. In Force Count End of Years should equal in force end of year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 9) for LTC business for life, accident & health and fraternal only.

Column 12 — Persistency Rate

\[
\text{Persistency Rate} = \frac{(Column 11 - .5 \times Column 10)}{(Column 9 + .5 \times Column 10)}
\]
Column 13 — Experience Policy Reserves

\[ V_{n}^{E} = \left( V_{n-1}^{E} + P_{n} \right) \times (1 + i_{n}) - tIC_{n} \times (1 + i_{n})^{1/2} \]

Where:

- \( V_{n}^{E} \) = The experience reserve as of the end of the reporting year for calendar duration \( t \), and CYI \( n \).
- \( V_{n-1}^{E} \) = The experience reserve as of the end of the prior reporting year for calendar duration \( t-1 \), and CYI \( n \). For the first filing of this form, the experience reserve as of the second prior year is set equal to the reported reserve as of that date.
- \( P_{n} \) = The annual valuation net premium for all business of CYI \( n \) in calendar duration \( t \). The total for the reporting year is the amount reported in Column (8).
- \( i_{n} \) = The valuation interest rate for CYI \( n \).
- \( tIC_{n} \) = The experience incurred claims for all business of CYI \( n \) in calendar duration \( t \). The total amount for the reporting year is reported in Column (5).

Column 14 — Reported Policy Reserves

The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health and fraternal only.

Column 15 — Experience: Reported Ratio

\[ \text{Column 15} = \frac{\text{Column 13}}{\text{Column 14}} \times 100 \]

Section C — Summary

Line 1 — Total Current — Individual = Sum of each Section A, Line 1 (all policy forms)
Line 2 — Total Prior — Individual = Sum of each Section A, Line 2 (all policy forms)
Line 3 — Total 2nd Prior — Individual = Sum of each Section A, Line 3 (all policy forms)
Line 4 — Total Current — Group = Sum of each Section B, Line 1 (all policy forms)
Line 5 — Total Prior — Group = Sum of each Section B, Line 2 (all policy forms)
Line 6 — Total 2nd Prior — Group = Sum of each Section B, Line 3 (all policy forms)
Line 7 — Current Year Total = Section C, Line 1 + Section C, Line 4
INSTRUCTIONS FOR FORM 3
LTC Experience Development ($000 Omitted)

The purpose of this form is to test the adequacy of claim reserves held on long-term care policies. This form allows for the
development of a seven-year trend of losses incurred by incurred calendar a specific year group of claimants. This form is to
be prepared on a nationwide basis.

Report all dollar amounts in thousands ($000 omitted).

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance.
Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will
include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These
policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral
year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims
incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y
for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2
should be included in Line 1, Columns 1 through 8.

The “Prior” values in these sections will not be directly comparable to prior statements, as the current year’s statement will
include an additional incurred year’s values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These
policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for transfer claims (acquired or sold) are shown here, by claim incurred year, starting from the year of
transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer
year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.

Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading
to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and
claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year). The discount rate is the
statutory valuation interest rate for case reserves.
• Paid claims in the year of incurral are discounted one-quarter year.

• Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.

• Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 are discounted from the valuation date to the midpoint of the incurred year.

• Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

If $i_y$ = Incurred year

$T$ = Report year – incurred year

$v$ = Discount rate

$\text{tPaid Claims}_{i_y}$ = Paid claims during current or prior calendar year $t$ from claims incurred in year $i_y$

$\text{Case Reserve}_{i_y}$ = Case reserve at end of calendar year $t$ from claims incurred in $i_y$

$\text{Transferred Reserve}_{i_y}$ = Transferred reserve at end of calendar year $t$ from claims incurred in $i_y$ and

$t = i_y, i_y+1, i_y+2, \ldots, i_y+T$

then the Present Value of Incurred Claims for incurred year $i_y$:

For $T=0$

$$\text{tPaid Claims}_{i_y} \times v^{t/4} + \text{Case Reserve}_{i_y} \times v^{t/2} + \text{IBNR}_{i_y} \times v^{t/2} + \text{Transferred Reserve}_{i_y} \times v^{t/2}$$

For $T>0$

$$\text{tPaid Claims}_{i_y} \times v^{T/4} + \text{tPaid Claims}_{i_y+1} \times v^{T} + \text{tPaid Claims}_{i_y+2} \times v^{T} + \ldots + \text{tPaid Claims}_{i_y+T} \times v^{T}$$

$$+ \text{Case Reserve}_{i_y} \times v^{T+T/2} + (\text{IBNR}_{i_y} \times v^{T+T/2}) + \text{Transferred Reserve}_{i_y} \times v^{T+T/2}$$

If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the total direct liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities that are incurred but not yet paid, both reported and not reported.
INSTRUCTIONS FOR FORM 4
Direct Group Experience – Stand-Alone Only ($000 Omitted)

OVERVIEW

Long-Term Care Insurance Experience Reporting Form 4 is intended to track life insurance and annuity products that have long-term care benefits provided by acceleration of certain benefits within these products. Include only the products that are not exempt as outlined in the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio, and premium rate increases also defined as “incidental” at the beginning of these experience forms instructions). This form is not to include stand-alone LTC products. Individual and group business is separated in this form.

DEFINITIONS AND FORMULAS

Current

Current calendar year of reporting.

Example: For a specific policy form category, the first year of issue was 2001. This Form 4 is required starting for the year 2009 and the reporting year is 2010. The current year would be 2010.

Prior

The year immediately prior to the year of reporting.

Example: 2009

2nd Prior

Two years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

Total Inception-to-Date

Aggregate experience data since issuance of policies or certificates.

Example: Data from 2001 through 2010.

Comprehensive

Certificates that provide a combination of institutional or facility and non-institutional coverage. These include institutional only certificates with non-institutional riders.

Institutional Only

Certificates that provide institutional coverage only.

Non-Institutional Only

Certificates that provide only non-institutional coverage.

Column 1 – Calendar Year of Peak Issues

Calendar year in which the largest number of certificates in the block were distributed. When reporting figures for inception-to-date, include all certificates ever issued in the block. For the current year, include only those certificates that remain in force as of 12/31.
<table>
<thead>
<tr>
<th>Column 1</th>
<th>Number of Policies In Force</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>The total number of policies in force as of end of calendar year.</td>
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<table>
<thead>
<tr>
<th>Column 2</th>
<th>Number of Certificates</th>
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<tr>
<td></td>
<td>The total number of certificates as of end of calendar year.</td>
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</tbody>
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<thead>
<tr>
<th>Column 3</th>
<th>Death Claims</th>
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<tbody>
<tr>
<td></td>
<td>The total number of death claims for a calendar year.</td>
</tr>
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<table>
<thead>
<tr>
<th>Column 4</th>
<th>Long-Term Care Accelerated Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The total number of long-term care accelerated claims for a calendar year. Only the long-term claims that have been triggered due to acceleration should be totaled.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 5</th>
<th>Total Reserves</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>The total amount of non-claim reserves for these life insurance or annuity products.</td>
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</table>

<table>
<thead>
<tr>
<th>Column 2</th>
<th>Third Party Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicate whether premiums are paid in whole or in part by a third party such as an employer.</td>
</tr>
<tr>
<td></td>
<td>Example: If the level of third-party funding is 25%, enter “25” in this column.</td>
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<tr>
<td></td>
<td>Calculate this in aggregate as [Third Party Premiums ÷ Total Premiums]</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Column 3</th>
<th>Average Attained Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Arithmetic mean of the attained ages of all inforce certificate holders in the block at year end.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 4</th>
<th>Earned Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 5</th>
<th>Incurred Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Developed claim amounts for claims incurred during the calendar year. Equal to the present value of all claim payments and any claim reserve. The discount rate is the statutory valuation interest rate for case reserve.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 6</th>
<th>Number of Lives In-force Year End</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total number of lives in force at the end of the year. Joint certificates are to be counted as two lives.</td>
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</table>

<table>
<thead>
<tr>
<th>Column 7</th>
<th>Number of Terminations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total number of certificate holders whose coverage ended during the year for any reason including death, lapse, or benefit exhaustion.</td>
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</table>

<table>
<thead>
<tr>
<th>Column 8</th>
<th>Number of New Lives Insured</th>
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<tbody>
<tr>
<td></td>
<td>Total number of new lives issued LTC certificates during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.</td>
</tr>
</tbody>
</table>
INSTRUCTIONS FOR FORM 5
Standalone and Hybrid Products – Direct State Reporting ($000 Omitted)

Form 5 provides LTC sales and claims experience on a state-by-state basis. These are the state’s portion of a number of statistics reported on a nationwide basis elsewhere in these experience forms. Form 5 also includes data on products that include extension of and/or acceleration of LTC benefits on life policies or annuity contracts.

OVERVIEW

For long-term care insurance reported in the Long-Term Care Insurance Experience Reporting Form 1, Form 2 and Form 3, these lines are the state’s portion of the earned premium, incurred claims and number of in force count of lives at end of the year. A schedule must be prepared for each jurisdiction in which the company has long-term care direct earned premiums and/or has direct incurred claims. In addition, a schedule must be prepared that contains the grand total (GT) for the company.

DEFINITIONS AND FORMULAS

Current

Current calendar year of reporting.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Stand-alone LTC

An LTC product that is sold by itself, not as a rider on another type of insurance.

Life/LTC Hybrid Accelerated Benefits Riders

Riders attached to life insurance or annuity products that allow for a benefit to be claimed upon the occurrence of a long-term care need at the cost of reduction in the death benefit or annuity payout benefit.

LTC Hybrid Extension of Extended Benefit Riders

Riders attached to life insurance or annuity products that allow for a benefit to be claimed above and beyond the initial benefit amount in the event that all accelerated benefits have been claimed and the insured is still in need of long-term care services.

Column 1 – Number of New Lives Insured

Total number of new lives issued LTC or hybrid policies during the year. Values in rows that are labeled “inception-to-date” should be the sum of all new lives insured in each year during which the form was sold.

Column 2 – Number of Lives In-force Year End

Total number of lives in force at the end of the year. Joint policies are to be counted as two lives.

Column 3 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

If necessary, the premium may be derived as the gross premium of the policy with the inclusion of LTC coverage less the gross premium of that policy without LTC coverage.
Column 4 — Incurred LTC Claims

Developed claim amounts for LTC claims incurred during the calendar year including accelerated claims, but not including payments due to extension of benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 5 — Incurred Extended Benefits Claims

Developed claim amounts for LTC claims incurred during the calendar year due to extension of benefits after exhaustion of accelerated benefits. Equal to the present value of all claim payments and any claim reserves. The discount rate is the statutory valuation interest rate for case reserves.

Column 6 — Number of Claims Remaining Open

Open claims are all claims that have been opened at any date but have not been closed as of the end of the year.

Column 7 — Number of Claims Opened

The number of claims that have at least one LTC benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A claim that has terminated by the end of the year should be included in the count.

Column 8 — Number of New Extended Benefits Claims

The number of claims that have at least one benefit payment made during the year resulting from extension of benefits but have no extension of benefits payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. A claim that has terminated by the end of the year should be included in the count.

Column 9 — Accelerated Benefits Available

Maximum amount of death benefits available to be paid on an accelerated basis due to LTC Acceleration of Benefits riders on in force business.

Column 10 — Extended Benefits Available

Maximum amount of extended benefits available to policyholders with extension of benefit riders on in force business.

Policy forms should be grouped by individual and group and reported on Lines 1 and 2, respectively. The subtotals for these two classes (i.e., individual and group) must be provided. Line 3 is the sum of Lines 1 and 2.

Column 1 — Earned Premiums

Earned premiums reported should be the state amount that is included in the current year of Form 2, Part C, Column 4.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 4, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 4, Line 4.
Line 3 should equal the amount in Form 2, Part C, Column 4, Line 7.

For Line 4 “Actual total reported experience through prior year”, the amount will be Line 5 from the previous year’s report.

For Line 5 “Actual total reported experience through statement year”: should be the state’s allocated earned premium for the current year (as reported on Line 3) added to the state’s cumulative experience through prior year (as reported on Line 4).

Column 2 — Incurred Claims

Incurred claims reported should be the state amount that is included in the current year of Form 2, Part C, Column 5. Incurred claims should be paid claims in the state plus a reasonable allocation of claim reserves less the reported allocated portion of the prior year’s claim reserve. The allocation method should be consistent from year to year when estimating reserves for each state.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 5, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 5, Line 4.

Line 3 should equal the amount in Form 2, Part C, Column 5, Line 7.

For Line 4 “Actual total reported experience through prior year”, the amount will be Line 5 from the previous year’s form.

For Line 5 “Actual total reported experience through statement year”: This should be the state’s allocated incurred claims for the current year (as reported on Line 3) added to the state’s cumulative experience through prior year (as reported on Line 4).

Column 3 — In Force Count End of Year

The In Force Count End of Year should be the state total used in calculating the In Force Count End of Year in Form 2, Part C, Column 11.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 11, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 11, Line 4.

Line 3 should equal the amount in Form 2, Part C, Column 11, Line 7.

Column 4 — Lives In force End of Year

Actual number of lives in force at the end of the year. Joint policies should be counted by number of lives. Once the state forms are completed, the Lives In force End of Year for all states (Grand Total State Page) LTC Form 5, Column 4, Line 01 should equal LTC Form 1, Column 7, Line A01 + A09 + A17 and Form 5, Line 02 should equal Form 1, Line B01 + B09 + B17. The number of lives for each state for individual policies should be based on the policies that were issued in that state. The number of lives for each state in group policies should be based on the certificates that were issued in that state.
### Annual Statement Blank – Life/Fraternity, Health and Property

#### Long-term Care Experience Reporting Form 1

**Stand-alone LTC Only ($000 Omitted)**

**Actual vs. Expected Claims and Persistency**

**Reporting Year 20__**

(To Be Filed By April 1)

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#### Individual

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#### Direct

1. Current
2. Total Inception-to-date
3. Current
4. Current

#### Assumed

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<td>Number of Claims Opened</td>
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#### Indicate whether policies on claim that have triggered waiver of premium are considered paid-up or paid by waiver.

- [ ] Paid by Waiver
- [ ] Paid Up
## Long-Term Care Experience Reporting Form 2

**Direct Individual Experience - Stand-Alone Only ($000 Omitted)**

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**Primarily 2002 and Prior Issue Years**

1. Current (Comprehensive)
2. Current (Institutional only)
3. Current (Non-Institutional only)
4. Total Inception-to-date (Comprehensive)
5. Total Inception-to-date (Institutional only)
6. Total Inception-to-date (Non-Institutional only)
7. Current (Grand Total)
8. Total Inception-to-date (Grand Total)
9. Current (Comprehensive)
10. Total Inception-to-date (Comprehensive)
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12. Total Inception-to-date (Institutional only)
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19. Current (Institutional only)
20. Total Inception-to-date (Institutional only)
21. Current (Non-Institutional only)
22. Total Inception-to-date (Non-Institutional only)
23. Current (Grand Total)
24. Total Inception-to-date (Grand Total)

**Primarily 2001 and Later Issue Years**

25. Current (Comprehensive)
26. Total Inception-to-date (Comprehensive)
27. Current (Institutional only)
28. Total Inception-to-date (Institutional only)
29. Current (Non-Institutional only)
30. Total Inception-to-date (Non-Institutional only)
31. Current (Grand Total)
32. Total Inception-to-date (Grand Total)

Indicate whether policies are assigned to a Primary Issue Period on a per-policy or per-policy form basis: [ ] Policy [ ] Policy Form

© 2020 National Association of Insurance Commissioners
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LONG-TERM CARE EXPERIENCE REPORTING FORM 3
LTC EXPERIENCE DEVELOPMENT ($000 OMITTED)
REPORTING YEAR 20__
(To Be Filed By April 1)

## A. Individual

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### PART 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

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### PART 4 – Present Value of Incurred Claims

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LONG-TERM CARE EXPERIENCE REPORTING FORM 3 (continued)

**LTC EXPERIENCE DEVELOPMENT ($000 OMITTED)**

### B. Group

**PART 1 – Total (Direct and Transferred) Amount Paid Policyholders**

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**PART 2 – Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year**

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**PART 4 – Present Value of Incurred Claims**

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**LONG-TERM CARE EXPERIENCE REPORTING FORM 3 (continued)**

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<td>7. 2018</td>
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<td>8. 2019</td>
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<td>9. 2020</td>
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</tbody>
</table>

| **PART 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year** | | | | | | | | |
| 1. Prior | | | | | | | | |
| 2. 2013 | | | | | | | | |
| 3. 2014 | | XXX | | | | | | |
| 4. 2015 | XXX | XXX | XXX | | | | | |
| 5. 2016 | XXX | XXX | XXX | XXX | | | | |
| 6. 2017 | XXX | XXX | XXX | XXX | XXX | | | |
| 7. 2018 | XXX | XXX | XXX | XXX | XXX | XXX | | |
| 8. 2019 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | |
| 9. 2020 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |

| **PART 3 – Transferred Reserves** | | | | | | | | |
| 1. Prior | | | | | | | | |
| 2. 2013 | | | | | | | | |
| 3. 2014 | XXX | | | | | | | |
| 4. 2015 | XXX | XXX | | | | | | |
| 5. 2016 | XXX | XXX | XXX | | | | | |
| 6. 2017 | XXX | XXX | XXX | XXX | | | | |
| 7. 2018 | XXX | XXX | XXX | XXX | XXX | | | |
| 8. 2019 | XXX | XXX | XXX | XXX | XXX | XXX | | |
| 9. 2020 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |

| **PART 4 – Present Value of Incurred Claims** | | | | | | | | |
| 1. Prior | | | | | | | | |
| 2. 2013 | | | | | | | | |
| 3. 2014 | XXX | | | | | | | |
| 4. 2015 | XXX | XXX | | | | | | |
| 5. 2016 | XXX | XXX | XXX | | | | | |
| 6. 2017 | XXX | XXX | XXX | XXX | | | | |
| 7. 2018 | XXX | XXX | XXX | XXX | XXX | | | |
| 8. 2019 | XXX | XXX | XXX | XXX | XXX | XXX | | |
| 9. 2020 | XXX | XXX | XXX | XXX | XXX | XXX | XXX | XXX |

Indicate whether claim reserves and liabilities for prior years are based on historical or current reserving assumptions:

- [ ] Historical
- [ ] Current
LONG-TERM CARE EXPERIENCE REPORTING FORM 4
DIRECT GROUP EXPERIENCE - STAND-ALONE ONLY ($000 OMITTED)
LIFE AND ANNUITY PRODUCTS WITH LTC ACCELERATED BENEFITS
REPORTING YEAR 20__
(To Be Filed By April 1)

<table>
<thead>
<tr>
<th>NAIC Group Code</th>
<th>NAIC Company Code</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>1. Current (Comprehensive)</th>
<th>2. Total Inception-to-date (Comprehensive)</th>
<th>3. Current (Institutional only)</th>
<th>4. Total Inception-to-date (Institutional only)</th>
<th>5. Current (Non-Institutional only)</th>
<th>6. Total Inception-to-date (Non-Institutional only)</th>
<th>7. Current (Grand Total)</th>
<th>8. Total Inception-to-date (Grand Total)</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>9. Individual</th>
<th>A. Total Inception-to-date</th>
<th>10. Group</th>
<th>B. Total Inception-to-date</th>
<th>11. Summary</th>
<th>C. Total Inception-to-Date</th>
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<th>12. A. Individual</th>
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<td>14. 1. Current</td>
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<td>15. 2. Prior</td>
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<tr>
<td>16. 2nd Prior</td>
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<td>17. 3. Current</td>
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<td>18. 2. Prior</td>
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<td>19. 2nd Prior</td>
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</table>

Total Reserves are reserves for these particular life products with LTC accelerated benefits.
Incurred claims are only the policies that claims have been triggered due to acceleration.
LONG-TERM CARE EXPERIENCE REPORTING FORM 5
EXPERIENCE IN THE STATE OF
STAND-ALONE AND HYBRID PRODUCTS - DIRECT STATE REPORTING ($000 OMITTED)
REPORTING YEAR 20__________
(To Be Filed By April 1)

<table>
<thead>
<tr>
<th>NAIC Group Code</th>
<th>NAIC Company Code</th>
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<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>Number of New Lives Insured</td>
<td>Number of Lives In-force Year-End</td>
<td>Earned Premiums</td>
<td>Incurred LTC Claims</td>
<td>Incurred Extended Benefits Claims</td>
<td>Number of Claims Remaining Open</td>
<td>Number of Claims Opened</td>
<td>Number of New Extended Benefits Claims</td>
<td>Accelerated Benefits Available</td>
<td>Extended Benefits Available</td>
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<tr>
<td>Stand-alone LTC</td>
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<td>Life/LTC Hybrid Policies and Riders</td>
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<td>4. Total Inception-to-Date (Acceleration only)</td>
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<td>5. Current (Extended Benefits Policies)</td>
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<td>6. Total Inception-to-Date (Extended Benefits)</td>
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<tbody>
<tr>
<td>Number of New Lives Insured</td>
<td>Number of Lives In-force Year-End</td>
<td>Incurred LTC Claims</td>
<td>In-force Count End of Year</td>
<td>Lives In-force End of Year</td>
</tr>
<tr>
<td>1. Individual</td>
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<tr>
<td>2. Group</td>
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<tr>
<td>3. Total</td>
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<tr>
<td>4. Actual total reported experience through prior year</td>
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<tr>
<td>5. Actual total reported experience through statement year</td>
<td></td>
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## NAIC BLANKS (E) WORKING GROUP

**Blanks Agenda Item Submission Form**

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Aaron Brandenburg</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELEPHONE:</td>
<td>816 783 8271</td>
</tr>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:abrandenburg@naic.org">abrandenburg@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>Property &amp; Casualty Insurance (C) Committee</td>
</tr>
</tbody>
</table>

### FOR NAIC USE ONLY

**Agenda Item # 2020-15BWG MOD**

<table>
<thead>
<tr>
<th>Year</th>
<th>2020</th>
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</thead>
</table>

**Changes to Existing Reporting** [ X ]

**New Reporting Requirement** [ X ]

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [ X ] Modifies Required Disclosure | [ ] |

### DISPOSITION

[ ] Rejected For Public Comment

[ ] Referred To Another NAIC Group

[ ] Received For Public Comment

[ X ] Adopted Date 05/28/2020

[ ] Rejected Date

[ ] Deferred Date

[ ] Other (Specify)

### BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ ] QUARTERLY STATEMENT
- [ X ] BLANK
- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ ] Health
- [ ] Life, Accident & Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

### IDENTIFICATION OF ITEM(S) TO CHANGE

A new Private Flood Insurance Supplement collecting residential and commercial private flood insurance data and revisions to the Credit Insurance Experience Exhibit (CIEE) to collect lender-placed flood coverages.

### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The State Page currently collects private flood insurance data but does not split residential from commercial coverages. Regulators, as well as industry and consumers, have a desire to better monitor and assess the growth of the residential private flood insurance market as that market begins to grow. A new Supplement will separate residential from commercial as well as capturing stand-alone/endorsement and first dollar/excess policy information. The revisions to the CIEE will allow for the collection of lender-placed flood coverages in order to get a more complete picture of the private flood insurance market.

### NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

**This section must be completed on all forms.**

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ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

PRIVATE FLOOD INSURANCE SUPPLEMENT

This supplement should be completed by those reporting entities including surplus line insurers and Risk Retention Groups that provide private flood insurance in a stand-alone policy or as part of a package policy. If the reporting entity’s answer to all of the question for Part 1 – Interrogatories would be “NO,” the reporting entity should not complete the supplement. If the reporting entity answers “YES” to any of those questions, the supplement should be completed. The supplement should be reported on a direct basis (before assumed and ceded reinsurance).

If the reporting entity reports any premium, losses or loss adjustment expense for Annual Statement Line 2.5 on the Exhibit of Premiums and Losses (State Page), it should answer “YES” to at least one of the Part 1 – Interrogatories questions and complete this supplement.

Stand-alone Policy: Private flood coverage sold as an individual policy or as a policy bundled with other policies.

Endorsement: Private flood coverage sold as an endorsement to another policy. If a rider, endorsement or floater acts like a separate policy with separate premium, deductible and limit, then it is to be recorded on the same annual statement line as if it were a stand-alone policy regardless of whether it is referred to as a rider, endorsement or floater. If there is no additional premium, separate deductible or limit, the rider, endorsement or floater should be reported on the same annual statement line as the base policy.

Creditor-placed (also known as lender-placed and force-placed insurance) is insurance that is placed by the lender subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to collateralized property as a result of fire, theft, collision or other risks of loss that would either impair a creditor’s interest or adversely affect the value of collateral covered by limited dual-interest insurance. It is purchased by the lender according to the terms of the credit agreement as a result of the borrower’s failure to provide required insurance, with the cost of the coverage being charged to the borrower. It may be either single-interest insurance or limited dual-interest insurance.

Part 1 - Interrogatories

1 Answer “YES” if the reporting entity writes stand-alone first-dollar private flood insurance on residential property. Complete Part 2 if the question is answered “YES.”

2 Answer “YES” if the reporting entity writes stand-alone excess private flood insurance on residential property. Complete Part 3 if the question is answered “YES.”

3 Answer “YES” if the reporting entity writes first-dollar private flood insurance as an endorsement on residential property. Complete Part 4 if the question is answered “YES.”

4 Answer “YES” if the reporting entity writes excess private flood insurance as an endorsement on residential property. Complete Part 5 if the question is answered “YES.”

5 Answer “YES” if the reporting entity writes stand-alone or excess private flood insurance as a stand-alone policy or an endorsement on commercial property. Complete Part 6 if the question is answered “YES.”
**GENERAL INSTRUCTIONS – PARTS 2 THROUGH 6**

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Direct Written Premium</td>
<td>For Lines 1 through 56, the sum of Parts 2 through 6 should equal Column 1, Line 2.5 of the corresponding Exhibit of Premiums and Losses (State Page) for the state. For Line 57, the sum of Parts 2 through 6 should equal Column 1, Line 2.5 of the Exhibit of Premiums and Losses (State Page) – Grand Total.</td>
</tr>
<tr>
<td>2</td>
<td>Direct Premium Earned</td>
<td>For Lines 1 through 56, the sum of Parts 2 through 6 should equal Column 2, Line 2.5 of the corresponding Exhibit of Premiums and Losses (State Page) for the state. For Line 57, the sum of Parts 2 through 6 should equal Column 2, Line 2.5 of the Exhibit of Premiums and Losses (State Page) – Grand Total.</td>
</tr>
<tr>
<td>3</td>
<td>Direct Losses Paid (Deducting Salvage)</td>
<td>For Lines 1 through 56, the sum of Parts 2 through 6 should equal Column 5, Line 2.5 of the corresponding Exhibit of Premiums and Losses (State Page) for the state. For Line 57, the sum of Parts 2 through 6 should equal Column 5, Line 2.5 of the Exhibit of Premiums and Losses (State Page) – Grand Total.</td>
</tr>
<tr>
<td>4</td>
<td>Direct Losses Incurred</td>
<td>For Lines 1 through 56, the sum of Parts 2 through 6 should equal Column 6, Line 2.5 of the corresponding Exhibit of Premiums and Losses (State Page) for the state. For Line 57, the sum of Parts 2 through 6 should equal Column 6, Line 2.5 of the Exhibit of Premiums and Losses (State Page) – Grand Total.</td>
</tr>
<tr>
<td>5</td>
<td>Direct Losses Unpaid</td>
<td>For Lines 1 through 56, the sum of Parts 2 through 6 should equal Column 7, Line 2.5 of the corresponding Exhibit of Premiums and Losses (State Page) for the state. For Line 57, the sum of Parts 2 through 7 should equal Column 6, Line 2.5 of the Exhibit of Premiums and Losses (State Page) – Grand Total.</td>
</tr>
<tr>
<td>6</td>
<td>Defense and Cost Containment Expense Paid</td>
<td>For Lines 1 through 56, the sum of Parts 2 through 6 should equal Column 8, Line 2.5 of the corresponding Exhibit of Premiums and Losses (State Page) for the state. For Line 57, the sum of Parts 2 through 6 should equal Column 8, Line 2.5 of the Exhibit of Premiums and Losses (State Page) – Grand Total.</td>
</tr>
</tbody>
</table>
### Column 7 – Defense and Cost Containment Case Incurred

For Lines 1 through 56, the sum of Parts 2 through 6 should equal Column 9, Line 2.5 of the corresponding Exhibit of Premiums and Losses (State Page) for the state.

For Line 57, the sum of Parts 2 through 6 should equal Column 9, Line 2.5 of the Exhibit of Premiums and Losses (State Page) – Grand Total.

### Column 8 – Defense and Cost Containment Case Unpaid

For Lines 1 through 56, the sum of Parts 2 through 6 should equal Column 10, Line 2.5 of the corresponding Exhibit of Premiums and Losses (State Page) for the state.

For Line 57, the sum of Parts 2 through 6 should equal Column 10, Line 2.5 of the Exhibit of Premiums and Losses (State Page) – Grand Total.

### Column 29 – Number of Policies In Force End of the Prior Year

Provide the number of policies in force as of the end of the prior reporting year, Dec. 31.

### Column 310 – Number of Policies In Force End of Current Year

Provide the number of policies in force as of the end of the current reporting year, Dec. 31.

### Column 311 – Number of Claims Open Beginning of the Current Year

Provide the number of claims open at the beginning of the reporting year, Jan. 1.

### Column 312 – Number of Claims Opened During the Reporting Year

Provide the number of claims opened during the reporting year.

### Column 313 – Number of Claims Open End of the Current Year

Provide the number of claims open at the end of the reporting year, Dec. 31.

### Column 314 – Number of Claims Closed with Payment

Provide the number of claims closed with payment for reporting year.
ANNUAL STATEMENT INSTRUCTIONS – PROPERTY AND LIFE/FRATERNAL

CREDIT INSURANCE EXPERIENCE EXHIBIT

10. Part 4 Coverage Definitions

Creditor-placed (also known as lender-placed and force-placed insurance) is insurance that is placed by the lender subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to collateralized property as a result of fire, theft, collision or other risks of loss that would either impair a creditor’s interest or adversely affect the value of collateral covered by limited dual-interest insurance. It is purchased by the lender according to the terms of the credit agreement as a result of the borrower’s failure to provide required insurance, with the cost of the coverage being charged to the borrower. It may be either single-interest insurance or limited dual-interest insurance. “Creditor Placed Insurance” means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to property as a result of fire, theft, collision or other risks of loss that would either impair a creditor’s interest or adversely affect the value of collateral. “Creditor Placed Home Hazard” means “Creditor Placed Insurance” on homes, mobile homes and other real estate. “Creditor Placed Auto” means insurance on automobiles, boats or other vehicles.

“Single Interest” means insurance that protects only the creditor’s interest in the collateral securing a debtor’s credit transaction.

“Dual Interest” means insurance that protects the creditor’s and the debtor’s interest in the collateral securing the debtor’s credit transaction. “Dual Interest” includes insurance commonly referred to as “Limited Dual Interest.”

“Wind Only” means named-peril coverage for losses due to wind.
“Flood Only” means named-peril coverage for losses due to flood.

“First Dollar” means coverage for first dollar losses, not contingent to alternate coverage (for example, an NFIP policy).

“Excess” means coverage for excess amounts over and above another policy (for example, an NFIP policy).

“Credit Personal Property Insurance” means insurance written in connection with a credit transaction where the collateral is not a motor vehicle, mobile home or real estate and that:

1. Covers perils to the goods purchased through a credit transaction or used as collateral for a credit transaction and that concerns a creditor’s interest in the purchased goods or pledged collateral, either in whole or in part; or

2. Covers perils to goods purchased in connection with an open-end credit transaction.

11. Written Exposures (Line 6 – Part 4 only)

The total number of exposures, in car-years, of all policies issued during a given time period.
12. **Earned Exposures (Line 7 – Part 4 only)**

The portion of the total amount of exposure (risk) corresponding to the coverage provided during a given time period.

4+13. **Part 5 Coverage Definitions**

GAP insures the excess of the outstanding indebtedness over the primary property insurance benefits in the event of a total loss to a collateral asset. Primary property insurance refers to the underlying P&C insurance policy insuring the property, such as automobile physical damage insurance. For reporting experience in the CIEE, “Personal GAP” refers to contributory coverage for which the borrower pays the premium for the insurance and receives a certificate or policy of coverage.

“Credit Family Leave” provides a monthly or lump sum benefit during an unpaid leave of absence from employment resulting from specified causes, such as illness of a close relative, adoption or birth of a child. If the Credit Family Leave benefit is included with the involuntary unemployment benefit without a specific identifiable charge, Credit Family Leave experience may be included with the Involuntary Unemployment Experience in Part 3.

4214. **Part 6 Coverage Definitions**

This exhibit is to be completed on a nationwide basis. The expense definitions follow those used in the Insurance Expense Exhibit.

---

**Detail Eliminated to Conserve Space**
ANNUAL STATEMENT BLANK – PROPERTY

PRIVATE FLOOD INSURANCE SUPPLEMENT
For The Year Ended December 31, 2020
(To Be Filed by March 31/April 1)

NAIC Group Code ......................................... NAIC Company Code ...................................

Company Name  ................................................................................................................. ........................................................................................................

Part 1 - Interrogatories

Private Flood Insurance Coverage:

1. Does the reporting entity write any stand-alone first-dollar residential private flood

   Yes [ ] No [ ]

   If yes, complete Part 2

2. Does the reporting entity write any stand-alone excess residential private flood?

   Yes [ ] No [ ]

   If yes, complete Part 3

3. Does the reporting entity write any first-dollar residential private flood provided as an endorsement?

   Yes [ ] No [ ]

   If yes, complete Part 4

4. Does the reporting entity write any excess residential private flood insurance provided as an endorsement?

   Yes [ ] No [ ]

   If yes, complete Part 5

5. Does the reporting entity write any commercial private flood insurance provided as either a stand-alone or package policy? (include both first-dollar and excess)

   Yes [ ] No [ ]

   If yes, complete Part 6
## Part 2 – Stand-alone Residential Private Flood Policies
### Policy and Claims Data
#### First Dollar

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<tr>
<th>State, Etc.</th>
<th>Direct Premium Earned</th>
<th>Direct Premium Earned</th>
<th>Case Reserves (Beginning)</th>
<th>Case Reserves (Ending)</th>
<th>Paid Expense Incurred</th>
<th>Number of Policies Issued in the Prior Year</th>
<th>Number of Policies Issued in the Prior Year</th>
<th>Number of Claimants to Concern During the Year</th>
<th>Number of Claims Open in the Reporting Year</th>
<th>Number of Claims Open in the Reporting Year</th>
<th>Number of Claims Closed or Paid in the Reporting Year</th>
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<tbody>
<tr>
<td>Alabama</td>
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<tr>
<td>Arizona</td>
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### Part 3 – Stand-alone Residential Private Flood Policies

#### Policy and Claims Data

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## Part 4 - Residential Private Flood Policy Endorsements
### Policy and Claims Data

| State, Etc. | Two Year Premium | Direct Premium Earned | Policy in Force End of Prior Year | Premium in Force End of Current Year | Number of Policies In Force End of Prior Year | Number of Policies In Force End of Current Year | Number of Claims Open End of Prior Year | Number of Claims Open End of Current Year | Number of Lawsuits Pending End of Prior Year | Number of Lawsuits Pending End of Current Year
|-------------|------------------|-----------------------|-----------------------------------|-------------------------------------|---------------------------------------------|---------------------------------------------|------------------------------------------|------------------------------------------|---------------------------------------------|---------------------------------------------
| Alabama     |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Alaska      |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Arizona     |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Arkansas    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| California  |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Colorado    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Connecticut |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Delaware    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| District of Columbia | | | | | | | | | | |
| Florida     |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Georgia     |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Hawaii      |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Idaho       |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Illinois    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Indiana     |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Iowa        |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Kansas      |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Kentucky    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Louisiana   |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Maine       |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Maryland    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Massachusetts |               |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Michigan    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Minnesota   |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Mississippi |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Missouri    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Montana     |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Nebraska    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Nevada      |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| New Hampshire |               |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| New Jersey  |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| New Mexico  |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| New York    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| North Carolina |            |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| North Dakota |               |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Ohio        |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Oklahoma    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Oregon      |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Pennsylvania |               |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Rhode Island |               |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| South Carolina |           |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| South Dakota |               |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Tennessee   |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Texas       |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Utah        |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Virginia    |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Washington  |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| West Virginia |              |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Wyoming     |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| American Samoa |           |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Guam        |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| Puerto Rico |                  |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| U.S. Virgin Islands |         |                       |                                   |                                     |                                             |                                             |                           |                           |                                             |                                             |
| U.S. Minor Outlying Islands | | | | | | | | | | |
# Part 5 - Residential Private Flood Policy Endorsements

## Policy and Claims Data

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### ANNUAL STATEMENT BLANK – PROPERTY AND LIFE/FRATERNAL

#### PART 4 – CREDIT PROPERTY INSURANCE

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#### Incurred Claims

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#### Incurred Loss Adjustment Expense

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#### Writings Expense

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#### (a) Other coverages (including their percent of Line 1.6, Column 7):

Provide a description of "other" coverages (including their percent of Line 1.6, Column 7): ____________

---

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Attachment Four-A18 8/3/20

Accounting Practices and Procedures (E) Task Force
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 02/21/2020

CONTACT PERSON: 

TELEPHONE: 

EMAIL ADDRESS: 

ON BEHALF OF: 

NAME: James W. Borrowman

TITLE: Financial Analyst

AFFILIATION: OR Dept. of Consumer & Business Services
Div of Financial Reg Ins Institutions

ADDRESS: 

FOR NAIC USE ONLY

Agenda Item # 2020-16BWG MOD
Year 2020
Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) 

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ ] QUARTERLY STATEMENT
[ ] Life, Accident & Health/Fraternal
[ X ] Property/Casualty
[ ] Health
[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Modify Questions 3.1 and 3.2 of General Interrogatories Part 2 and provide instructions for the questions.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to clarify capturing whether reporting entities have written participating policies in the current calendar year and reporting amount of premium written for both participating and non-participating policies.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.

© 2020 National Association of Insurance Commissioners 1
3.1 Answer “YES” if the reporting entity has issued participating policies during the calendar year.

Participating Policies:

An insurance contract where the ultimate policy premium is affected by profitability which could result in a change of premium for the policy period written. The effect on premium could be in the form of a dividend, a refund in premium, experienced based premium or additional premium billable.

3.2 If “Yes”, provide the amount of premium written for participating and/or non-participating policies during the calendar year.

ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

GENERAL INTERROGATORIES

PART 2 – PROPERTY & CASUALTY INTERROGATORIES

3.1 Did the reporting entity issue both participating and non-participating policies during the calendar year?

Yes [   ] No [   ]

3.2 If yes, state the amount of premium written for participating and/or non-participating policies during the calendar year.

$ _____________________

3.21 Participating policies
3.22 Non-participating policies

W:\National Meetings\2020\Summer\TF\App\BlanksWG\minutes\Att Four-A19 2020-16BWG_Modified.doc
**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

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<td>ON BEHALF OF:</td>
<td>Capital Adequacy Task Force</td>
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<tr>
<td>NAME:</td>
<td>Tom Botsko</td>
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**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ X ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ X ] INSTRUCTIONS
- [ X ] CROSSCHECKS
- [ X ] LIFE, ACCIDENT & HEALTH/FRATERNAL
- [ ] PROPERTY/CASUALTY
- [ ] SEPARATE ACCOUNTS
- [ ] PROTECTED CELL
- [ ] LIFE (LIFE SUPPLEMENT)
- [ ] HEALTH (LIFE SUPPLEMENT)

Anticipated Effective Date: Annual 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Adjust the AVR presentation to include separate lines for each of the expanded bond designation categories.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The Blanks Working Group and the Security Valuation Office have adopted the 20 bond designations for 2020 reporting. The reported designations will flow into the RBC but will not include factors. The current factor for designations 1-6 will remain in the RBC until an impact analysis can be done to confirm the new factors for the 20 designations. This proposal applies the same expanded presentation to the AVR as it is used to populate the life RBC formula.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:

Other Comments:

**This section must be completed on all forms.**

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### Asset Valuation Reserve

#### Basic Contribution, Reserve Objective and Maximum Reserve Calculations

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# ASSET VALUATION RESERVE (Continued)

## BASIC CONTRIBUTION, RESERVE OBJECTIVE AND MAXIMUM RESERVE CALCULATIONS

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### ASSET VALUATION RESERVE (Continued)

#### BASIC CONTRIBUTION, RESERVE OBJECTIVE AND MAXIMUM RESERVE CALCULATIONS

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<td></td>
<td>Residential Mortgages – All Other</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0005</td>
<td>0.0034</td>
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<td>42</td>
<td></td>
<td>Commercial Mortgages – Insured or Guaranteed</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0003</td>
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<td>43</td>
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<td>Commercial Mortgages – All Other – CM1 - Highest Quality</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
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<td>0.0057</td>
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<td>44</td>
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<td>Commercial Mortgages – All Other – CM2 - High Quality</td>
<td>XXX</td>
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<td>XXX</td>
<td>0.0040</td>
<td>0.0114</td>
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<td>45</td>
<td></td>
<td>Commercial Mortgages – All Other – CM3 - Medium Quality</td>
<td>XXX</td>
<td></td>
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<td>XXX</td>
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<td>Commercial Mortgages – All Other – CM4 - Low Medium Quality</td>
<td>XXX</td>
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<td>XXX</td>
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<td></td>
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<td>48</td>
<td></td>
<td>Farm Mortgages</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0480</td>
<td>0.0868</td>
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<td>49</td>
<td></td>
<td>Residential Mortgages – Insured or Guaranteed</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0006</td>
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<td>Commercial Mortgages - Insured or Guaranteed</td>
<td>XXX</td>
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<td>Commercial Mortgages - All Other</td>
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<td></td>
<td></td>
<td>XXX</td>
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<td>53</td>
<td></td>
<td>Farm Mortgages</td>
<td>XXX</td>
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<td>0.0000</td>
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<tr>
<td>55</td>
<td></td>
<td>Residential Mortgages - All Other</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0000</td>
<td>0.0149</td>
<td>0.0149</td>
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<td></td>
<td>Commercial Mortgages - Insured or Guaranteed</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0000</td>
<td>0.0046</td>
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<td></td>
</tr>
<tr>
<td>57</td>
<td></td>
<td>Commercial Mortgages - All Other</td>
<td>XXX</td>
<td></td>
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<td>0.0000</td>
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<td>58</td>
<td></td>
<td>Total Schedule B Mortgages (Sum of Lines 35 through 57)</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0034</td>
<td>0.0114</td>
<td>0.0149</td>
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<td>59</td>
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<td>Schedule DA Mortgages</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0034</td>
<td>0.0114</td>
<td>0.0149</td>
<td></td>
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<tr>
<td>60</td>
<td></td>
<td>Total Mortgage Loans on Real Estate (Lines 58 + 59)</td>
<td>XXX</td>
<td></td>
<td></td>
<td>XXX</td>
<td>0.0034</td>
<td>0.0114</td>
<td>0.0149</td>
<td></td>
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</tr>
</tbody>
</table>
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 02/21/2020
CONTACT PERSON: Charles Therriault
TELEPHONE: 212 386-1920
EMAIL ADDRESS: CTheriault@naic.org
ON BEHALF OF:
NAME: Kevin Fry
TITLE: Chair, VOS Task Force
AFFILIATION:
ADDRESS:

FOR NAIC USE ONLY

Agenda Item # 2020-18BWG MOD
Year 2020
Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ X ] QUARTERLY STATEMENT
[ ] INSTRUCTIONS
[ ] CROSSCHECKS
[ ] BLANK
[ ] Separate Accounts
[ X ] Title
[ ] Protected Cell
[ ] Other ______________________
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

See next page for details.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to clarify where to find the list of funds that must have NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol provided on Schedule D, Part 2, Section 2 (annual filing) and Schedules D, Parts 3 and 4 (quarterly filing). Modify the reference to the Purposes and Procedures Manual of the NAIC Investment Analysis Office found in other investment instructions due to changes in the manual.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

Clarify the instructions for what funds reported on Schedule D, Part 2, Section 2 (annual filing) and Schedules D, Part 3 and 4 (quarterly filing) must have NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol.

Modify the reference to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* found in the following investment instructions.

**Annual Statement:**

- Investment Schedules General Instructions
- Summary Investment Schedule
- Schedule D, Part 1, Section 1
- Schedule D, Part 2, Section 2
- Schedule E, Part 2
- Supplemental Investment Interrogatories

**Quarterly Statement:**

- Investment Schedules General Instructions
- Schedule E, Part 2
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE D – PART 2 – SECTION 2

COMMON STOCKS OWNED DECEMBER 31 OF CURRENT YEAR

Detail Eliminated to Conserve Space

Column 18 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

For securities reported on Line 9499999 (Mutual Funds), Line 9599999 (Unit Investment Trusts) and Line 9699999 (Closed-End Funds), provide the appropriate NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol combination as assigned by the Securities Valuation Office and published in AVS+ per the instructions in the Purposes and Procedures Manual of the NAIC Investment Analysis Office on the Compilation and Publication of the SVO List of Investment Securities. A list of these funds can be found on the Securities Valuation Office Web page (https://www.naic.org/svo.htm).

NAIC Designation and NAIC Designation Modifier should not be provided for securities reported on these lines that have not been assigned one by the Securities Valuation Office. For all other common stock line categories, the NAIC Designation and NAIC Designation Modifier field should not be left blank provided.

Detail Eliminated to Conserve Space

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on Line 9499999 (Mutual Funds), Line 9599999 (Unit Investment Trusts) and Line 9699999 (Closed-End Funds) if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should not be left blank provided.

The Designation Modifier should not be left blank provided for securities reported on lines below.

- Industrial and Miscellaneous (Unaffiliated) Publicly Traded Line 9099999
- Industrial and Miscellaneous (Unaffiliated) Other Line 9199999
- Parent, Subsidiaries and Affiliates Publicly Traded Line 9299999
- Parent, Subsidiaries and Affiliates Other Line 9399999
- Unit Investment Trusts Line 9599999
- Closed-End Funds Line 9699999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should not be left blank provided.

Refer to the P&P Manual for the application of these modifiers.

Detail Eliminated to Conserve Space
SCHEDULE D – PART 1

LONG-TERM BONDS OWNED DECEMBER 31 OF CURRENT YEAR

Detail Eliminated to Conserve Space

Column 34 – Capital Structure Code

Please identify the capital structure of the security using the following codes consistent with the SVO Notching Guidelines in Part One, Section 3 of the Purposes and Procedures Manual of the NAIC Investment Analysis Office:

Capital structure is sometimes referred to as rank or payment priority and can be found in feeds from the sources listed in the Issue and Issuer column.

As a general rule, a security is senior unsecured debt unless legal terms of the security indicate another position in the capital structure. Securities are senior or subordinated and are secured or unsecured. Municipal bonds, Federal National Mortgage Association securities (FNMA or Fannie Mae) and Federal Home Loan Mortgage Corporation securities (FHLMC or Freddie Mac) generally are senior debt, though there are examples of subordinated debt issued by Fannie and Freddie. 1st Lien is a type of security interest and not capital structure but could be used to determine which capital structure designation the security should be reported under. The capital structure of “Other” should rarely be used.

Capital structure includes securities subject to SSAP No. 26R—Bonds and SSAP No. 43R—Loan-Backed and Structured Securities.

1. Senior Secured Debt

   Senior secured is paid first in the event of a default and also has a priority above other senior debt with respect to pledged assets.

2. Senior Unsecured Debt

   Senior unsecured securities have priority ahead of subordinated debt for payment in the event of default.

3. Subordinated Debt

   Subordinated is secondary in its rights to receive its principal and interest payments from the borrower to the rights of the holders of senior debt (e.g., for loan-backed and structured securities, this would include mezzanine tranches).

   (Subordinated means noting or designating a debt obligation whose holder is placed in precedence below secured and general unsecured creditors e.g., another debtholder could block payments to that holder or prevent that holder of that subordinated debt from taking any action.)

4. Not Applicable

   Securities where the capital structure 1 through 3 above do not apply (e.g., Line 5899999 Exchange Traded Funds – as Identified by the SVO and Line 5999999 Bond Mutual Funds – as Identified by the SVO).
### SUMMARY INVESTMENT SCHEDULE

**Line 1.01 – U.S. Governments**


Column 1 should equal the Schedule D, Part 1, Line 0599999.

**Line 1.05 – U.S. Special Revenue & Special Assessment Obligations, etc. Non-Guaranteed**

Include: The value of those U.S. government issues not listed as “Securities That Are Considered “Exempt Obligations” For Purposes of Determining The Asset Valuation Reserve And The Risk-Based Capital Calculation” in Part Six, Section 2(c) of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, yet included as “Filing Exemptions for Other U.S. Government Obligations” in Part Two, Section 4(c)(ii). This category also includes bonds that are issued by states, territories, possessions and other political subdivisions that are issued for a specific financing project rather than as general obligation bonds.

Column 1 should equal the Schedule D, Part 1, Line 3199999.

**Line 1.09 – SVO Identified Funds**

Include: The value of all Bond Mutual Funds included on the “NAIC Bond Mutual Fund List” as listed in Part Six, Section 2(b) of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* and Exchange Traded Funds (ETF) included on the “SVO-Identified Bond ETF List” as published on the Securities Valuation Office Web page ([https://www.naic.org/svo.htm](https://www.naic.org/svo.htm)) that the SVO has determined are in scope of SSAP No. 26R - Bonds and can be reported on Schedule D, Part 1 and the SVO assigned a NAIC Designation, NAIC Designation Category and SVO Administrative Symbol published in the NAIC’s AVS+ system per the instructions in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* on the Compilation and Public Release of the SVO List of Investment Securities listed in Part Six, Section 2(i) of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*.

Column 1 should equal the Schedule D, Part 1, Line 6099999.
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

Line 2 – Report the single 10 largest exposures to a single issuer/borrower/investment.

Determine the ten largest exposures by first, aggregating investments from all investment categories (except the excluded categories) by issuer. The first six digits of the CUSIP number can be used as a starting point; however, please note that the same issuer may have more than one unique series of the first six digits of the CUSIP. For example, the reporting entity owns bonds issued by the XYZ Company of $500,000 and common stock of the XYZ Company of $600,000. In addition the reporting entity has a mortgage loan to the XYZ Company of $300,000. The total exposure to Issuer XYZ Company is $1.4 million ($500,000+$600,000+$300,000).

For funds that are not diversified within the meaning of the Investment Company Act of 1940, insurance reporting entities are required to identify actual exposures and aggregate those exposures with directly held investments to determine the 10 largest exposures. For example, if a reporting entity directly holds a significant number of investments in Exxon Mobil and holds a non-diversified closed-end fund with a high concentration of Exxon Mobil, the reporting entity shall aggregate the direct investments with the investments in the closed-end funds to determine the aggregate investment risk to Exxon Mobil.

SEC registered investment funds are required by law to disclose holdings within 60 days following the fund’s fiscal quarter end. Insurers who own funds classified as “non-diversified” are to use the last publicly available fund holding disclosure to account for holdings that should be included in their Top 10 holdings.

Exclude: U.S. government and U.S. Government Agency securities listed as “Securities That Are Considered “Exempt Obligations” For Purposes of Determining The Asset Valuation Reserve And The Risk-Based Capital Calculation” (Part Six, Section 2(e)), U.S. government agency securities (Part Six, Section 2(e)).


Property occupied by the company;

Policy loans

All SEC and foreign registered funds (open-end, closed-end, UIT and ETFs) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b) (1)].

In Column 2, list the categories of securities that are included in the total for each issuer (e.g., bonds, mortgage loans, etc.)
Line 13.02 through 13.11 — Report the amounts and percentages of admitted assets held in the ten largest equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other equity securities (including Schedule BA equity interests), and excluding money market included on the “NAIC U.S. Direct Obligations/Full Faith and Credit Exemption Money Market Fund List”, exchange traded funds included on the “SVO-Identified Bond ETF List” and bond mutual funds included on the “NAIC Bond Mutual Fund List” as found on the Securities Valuation Office Web page (https://www.naic.org/svo.htm) listed in Part Six, Sections 2(f) and (g) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office as exempt or NAIC 1).

Determine the ten largest equity interests by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000 and common stock of the XYZ Company of $300,000. The total is $900,000 ($600,000+$300,000). The reporting entity also owns bonds issued by the XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA classified as equity.
QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE D – PART 3

LONG-TERM BONDS AND STOCKS ACQUIRED DURING THE CURRENT QUARTER

Detail Eliminated to Conserve Space

Column 10 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

Provide the appropriate combination of NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol (see below) at the end of the quarter for each security shown. The list of valid SVO Administrative Symbols is shown below.

Detail Eliminated to Conserve Space

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should not be left blank provided.

- Bonds Lines 0199999 through 8299999
- Preferred Stocks Line 8499999 and 8599999
- Common Stocks Lines 9499999 through 9699999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should not be left blank provided.

For securities reported on Line 9499999 (Mutual Funds), Line 9599999 (Unit Investment Trusts) and Line 9699999 (Closed-End Funds) provide the appropriate NAIC Designation and NAIC Modifier as assigned by the Securities Valuation Office. NAIC Designation and NAIC Designation Modifier should not be provided for securities reported on these lines that have not been assigned one by the Securities Valuation Office and published in AVS+ per the instructions in the Purposes and Procedures Manual of the NAIC Investment Analysis Office on the Compilation and Publication of the SVO List of Investment Securities. For all other common stock line categories, the NAIC designation and NAIC Modifier a should not be provided.

Refer to the P&P Manual for the application of these modifiers.

SVO Administrative Symbol:

Detail Eliminated to Conserve Space
Common Stock:

For securities reported on Line 9499999 (Mutual Funds) provide the appropriate NAIC Designation (1 through 6) and NAIC Modifier as assigned by the Securities Valuation Office. For all other common stock the NAIC designation, NAIC Modifier and SVO Administrative Symbol field should be left blank.

Following are valid SVO Administrative Symbols for common stock. Refer to the P&P Manual for the application of these symbols.

YE Year-end carry over

SCHEDULE D – PART 4

LONG-TERM BONDS AND STOCKS SOLD, REDEEMED OR OTHERWISE DISPOSED OF DURING THE CURRENT QUARTER

Column 22 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol

Provide the appropriate combination of the NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol (see below) at date of disposal for each security shown. The list of valid SVO Administrative Symbols is shown below.

NAIC Designation Modifier:

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), otherwise, the field should not be left blank provided.

- Bonds Lines 0199999 through 8299999
- Preferred Stocks Line 8499999 and 8599999
- Common Stocks Lines 9499999 through 9699999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should not be left blank provided.
For securities reported on Line 9499999 (Mutual Funds), Line 9599999 (Unit Investment Trusts) and Line 9699999 (Closed-End Funds) provide the appropriate NAIC Designation and NAIC Modifier as assigned by the Securities Valuation Office. NAIC Designation and NAIC Designation Modifier should not be provided for securities reported on these lines that have not been assigned one by the Securities Valuation Office and published in AVS+ per the instructions in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office on the Compilation and Publication of the SVO List of Investment Securities*. For all other common stock line categories, the NAIC designation and NAIC Modifier a should not be provided.

Refer to the P&P Manual for the application of these modifiers.

SVO Administrative Symbol:

Common Stock:

For securities reported on Line 9499999 (Mutual Funds) provide the appropriate NAIC Designation (1 through 6) and NAIC Modifier as assigned by the Securities Valuation Office. For all other common stock the NAIC designation, NAIC Modifier and SVO Administrative Symbol field should be left blank.

Following are valid SVO Administrative Symbols for common stock. Refer to the P&P Manual for the application of these symbols.

YE Year-end carry over

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A money market fund shall be reported in this schedule as an Exempt Money Market Mutual Fund if such money market fund is identified by the SVO as meeting the required conditions found in Part Six, Section 2(b)(i) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office. A “NAIC U.S. Direct Obligations/Full Faith and Credit Exemption Money Market Fund List” can be found on the Securities Valuation Office Web page (https://www.naic.org/svo.htm). All money market mutual funds that are not identified by the SVO on the U.S. Direct Obligations/Full Faith and Credit Exempt List shall be reported in this schedule as an “all other money market mutual fund.”

Column 1 – CUSIP Identification

All CUSIP numbers entered in this column must conform to those as published in the Purposes and Procedures Manual of the NAIC Investment Analysis Office, Part Six, Sections 2(f) and (g).

CUSIP identification is required and valid only for Exempt Money Market Mutual Funds – as Identified by SVO (Line 8599999) and All Other Money Market Mutual Funds (Line 8699999).
INVESTMENT SCHEDULES GENERAL INSTRUCTIONS
(Applies to all investment schedules)

General Classifications Bonds Only:

Refer to SSAP No. 26R—Bonds, SSAP No. 43R—Loan-Backed and Structured Securities and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities for additional guidance.

U.S. Government:

U.S. Government shall be defined as U.S. Government Obligations as defined per the Purposes and Procedures Manual of the NAIC Investment Analysis Office, Part Two, Section 4:

(i) Filing Exemption for Direct Claims on, or Backed Full Faith and Credit of the United States

“U.S. Government Obligations” means all direct claims (including securities, loans, and leases) on, and the portions of claims that are directly and unconditionally guaranteed by the United States Government or its agencies.

“U.S. Government agency” means an instrumentality of the U.S. Government the debt obligations of which are fully guaranteed as to the timely payment of principal and interest by the full faith and credit of the U.S. Government. This category includes in addition to direct claims on, and the portions of claims that are directly and unconditionally guaranteed by, the United States Government agencies listed below, claims collateralized by securities issued or guaranteed by the U.S. government agencies listed below for which a positive margin of collateral is maintained on a daily basis, fully taking into account any change in the insurance company's exposure to the obligor or counterparty under a claim in relation to the market value of the collateral held in support of that claim.

U.S. Special Revenue and Special Assessment Obligations and All Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions:

Those U.S. government issues not listed as “Securities That Are Considered “Exempt Obligations” For Purposes of Determining The Asset Valuation Reserve And The Risk-Based Capital Calculation” in Part Six, Section 2(e) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office, yet included as “Filing Exemptions for Other U.S. Government Obligations” in Part Two, Section 4(c)(ii). This category also includes bonds that are issued by states, territories, possessions and other political subdivisions that are issued for a specific financing project rather than as general obligation bonds. Also include mortgage reference securities that are within the scope of SSAP No. 43R—Loan-Backed and Structured Securities.

Industrial and Miscellaneous (Unaffiliated):

This category includes all non-governmental issues that do not qualify for some other category in Schedule D, Part 1, including privatized (non-government ownership) utility companies. Include Public Utilities.
SVO Identified Funds:

This category includes all Bond Mutual Funds included on the “List of Bond Mutual Funds Filed with the SVO (Bond Fund List)” as listed in Part Six, Section 2(h) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office and Exchange Traded Funds included on the “List of Exchange Traded Funds Eligible for Reporting as a Schedule D Bond (the ETF Bond List)” as found on the Securities Valuation Office Web page ([https://www.naic.org/svo.htm](https://www.naic.org/svo.htm)) listed in Part Six, Section 2(i) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

---

Detail Eliminated to Conserve Space

---

General Classifications Preferred Stock Only:

Refer to SSAP No. 32—Preferred Stock and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.

Industrial and Miscellaneous (Unaffiliated):

All unaffiliated preferred stocks. Include Public Utilities, Banks, Trusts and Insurance Companies. This category includes Exchange Traded Funds included on the “List of Exchange Traded Funds Eligible for Reporting as a Schedule D Preferred Stock” as found on the Securities Valuation Office Web page ([https://www.naic.org/svo.htm](https://www.naic.org/svo.htm)) listed in Part Six, Section 2 of the Purposes and Procedures Manual of the NAIC Investment Analysis Office.

---

Detail Eliminated to Conserve Space

---
# NAIC BLANKS (E) WORKING GROUP

## Blanks Agenda Item Submission Form

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<tr>
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<tr>
<td>EMAIL ADDRESS:</td>
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<tr>
<td>ON BEHALF OF:</td>
</tr>
<tr>
<td>NAME: Dale Bruggeman</td>
</tr>
<tr>
<td>TITLE: Chair SAPWG</td>
</tr>
<tr>
<td>AFFILIATION: Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS: 50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
</tr>
</tbody>
</table>

**Agenda Item # 2020-19BWG MOD**

**Year 2020**

- Changes to Existing Reporting [X]
- New Reporting Requirement [ ]

**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

- No Impact [X]
- Modifies Required Disclosure [ ]

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<td>[ ] Deferred Date</td>
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**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [X] ANNUAL STATEMENT
- [X] QUARTERLY STATEMENT
- [X] INSTRUCTIONS
- [X] CROSSCHECKS
- [ ] LIFEBLANK
- [ ] SEPARATE ACCOUNTS
- [ ] PROTECTED CELL
- [ ] HEALTH (LIFE SUPPLEMENT)

**Anticipated Effective Date:** Annual 2020

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add a code of “%” to the code column for all investments which have been reported Schedule DA, Part 1 and Schedule E, Part 2 for more than one consecutive year. Add certification to the General Interrogatories, Part 1 inclusion of these investments on Schedule DA, Part 1 and Schedule E, Part 2.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

To identify instances where cash equivalents and/or short-term investments (or substantially similar investments) remain on the applicable investment schedule for more than one reporting period (i.e. reported as a short-term investment for more than one consecutive year due to the investment being re-underwritten and renewed).

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:

Other Comments:

---

**This section must be completed on all forms.**

Revised 7/18/2018

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**ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE**

**SCHEDULE DA – PART 1**

**SHORT-TERM INVESTMENTS OWNED DECEMBER 31 OF CURRENT YEAR**

Detail Eliminated to Conserve Space

<table>
<thead>
<tr>
<th>Column 2</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter “*” in this column for all SVO Identified Funds designated for systematic value.

Enter “@” in this column for all Principal STRIP Bonds or other zero coupon bonds.

Enter “%” in this column for all investments which have been reported on this schedule for more than one consecutive year.

Enter “^” in this column for all assets that are bifurcated between the insulated separate account filing and the non-insulated separate account filing.

If short-term investments are not under the exclusive control of the company as shown in the General Interrogatories, they are to be identified by placing one of the codes (identified in the Investment Schedules General Instructions) in this column.

If the security is an SVO Identified Fund designated for systematic value or Principal STRIP bond or other zero coupon bond and is not under the exclusive control of the company, the “*”, “@” or “%” should appear first, immediately followed by the appropriate code (identified in the Investment Schedules General Instructions).

If the “%” code is used in conjunction with the “*” or “@” codes, the “%” code should appear after the “*” or “@” codes immediately followed by the appropriate code for not being under the exclusive control of the company (identified in the Investment Schedules General Instructions).

**Separate Account Filing Only:**

If the asset is a bifurcated asset between the insulated separate account filing and the non-insulated separate account filing, the “^” should appear first and may be used simultaneously with the “*”, “@” or “%” with the “^” preceding the “*”, “@” or “%” depending on the asset being reported, immediately followed by the appropriate code for not being under the exclusive control of the company (identified in the Investment Schedules General Instructions).

If the “%” code is used in conjunction with the “*” or “@” codes, the “%” code should appear after the “*” or “@” codes immediately followed by the appropriate code for not being under the exclusive control of the company (identified in the Investment Schedules General Instructions).
<table>
<thead>
<tr>
<th>Column 3</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter “%” in this column for all investments except qualifying cash pooling structures per SSAP No. 2R and money market mutual funds which have been reported on this schedule for more than one consecutive quarter.

Enter “^” in this column for all assets that are bifurcated between the insulated separate account filing and the non-insulated separate account filing.

If a cash equivalent is not under the exclusive control of the company as shown in the General Interrogatories, it is to be identified by placing one of the codes identified in the Investment Schedules General Instructions in this column.

If the “%” code is used, the “%” code should appear first, immediately followed by the appropriate code for not being under the exclusive control of the company (identified in the Investment Schedules General Instructions).

Separate Account Filing Only:

If the asset is a bifurcated asset between the insulated separate account filing and the non-insulated separate account filing, the “^” should appear first and may be used simultaneously with the “%” code, immediately followed by the appropriate code for not being under the exclusive control of the company (identified in the Investment Schedules General Instructions).
OTHER

36. The purpose of this General Interrogatory is to capture information about payments to any trade association, service organization, and statistical or rating bureau. A “service organization” is defined as every person, partnership, association or corporation that formulates rules, establishes standards, or assists in the making of rates or standards for the information or benefit of insurers or rating organizations.

37. The purpose of this General Interrogatory is to capture information about legal expenses paid during the year. These expenses include all fees or retainers for legal services or expenses, including those in connection with matters before administrative or legislative bodies. It excludes salaries and expenses of company personnel, legal expenses in connection with investigation, litigation and settlement of policy claims, and legal fees associated with real estate transactions, including mortgage loans on real estate. Do not include amounts reported in General Interrogatories No. 36 and No. 39.

38. The purpose of this General Interrogatory is to capture information about expenditures in connection with matters before legislative bodies, officers or departments of government paid during the year. These expenses are related to general legislative lobbying and direct lobbying of pending and proposed statutes or regulations before legislative bodies and/or officers or departments of government. Do not include amounts reported in General Interrogatories No. 36 and No. 38. 

Detail Eliminated to Conserve Space
QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE E – PART 2 – CASH EQUIVALENTS

INVESTMENTS OWNED END OF CURRENT QUARTER

<table>
<thead>
<tr>
<th>Column 3</th>
<th>Code</th>
</tr>
</thead>
</table>

Detail Eliminated to Conserve Space

Enter “%” in this column for all investments except qualifying cash pooling structures per SSAP No. 2R and money market mutual funds which have been reported on this schedule for more than one consecutive quarter.

If a cash equivalent is not under the exclusive control of the reporting entity, it is to be identified by placing one of the codes identified in the Investment Schedules General Instructions in this column.

If the “%” code is used, the “%” code should appear first, immediately followed by the appropriate code for not being under the exclusive control of the company (identified in the Investment Schedules General Instructions).

Detail Eliminated to Conserve Space
35. By assigning FE to a Schedule BA non-registered private fund, the reporting entity is certifying the following elements of each self-designated FE fund:
   a. The shares were purchased prior to January 1, 2019.
   b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
   c. The security had a public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO prior to January 1, 2019.
   d. The fund only or predominantly holds bonds in its portfolio.
   e. The current reported NAIC Designation was derived from the public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO.
   f. The public credit rating(s) with annual surveillance assigned by an NAIC CRP has not lapsed.

   Has the reporting entity assigned FE to Schedule BA non-registered private funds that complied with the above criteria? Yes [    ] No [   ]

36. By rolling/renewing short-term or cash equivalent investments with continued reporting on Schedule DA, Part 1 or Schedule E Part 2 (identified through a code % in those investment schedules), the reporting entity is certifying to the following:
   a. The investment is a liquid asset that can be terminated by the reporting entity on the current maturity date.
   b. If the investment is with a nonrelated party or nonaffiliate then it reflects an arms-length transaction with renewal completed at the discretion of all involved parties.
   c. If the investment is with a related party or affiliate then the reporting entity has completed robust re-underwriting of the transaction for which documentation is available for regulator review.
   d. Short-term and cash equivalent investments that have been renewed/rolled from the prior period that do not meet the criteria in 36.a -36.c are reported as long-term investments.

   Has the reporting entity rolled/renewed short-term or cash equivalent investments in accordance with these criteria? Yes [    ] No [   ] N/A [   ]

OTHER

36.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any? $ ____________________

36.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations, and statistical or rating bureaus during the period covered by this statement.

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
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<tr>
<td></td>
<td>$</td>
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<td></td>
<td>$</td>
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<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>
GENERAL INTERROGATORIES

3738.1 Amount of payments for legal expenses, if any? $ ________________

3738.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount Paid</th>
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</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

3839.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers, or departments of government, if any? $ ________________

3839.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers, or departments of government during the period covered by this statement.

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount Paid</th>
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NAIC BLANKS (E) WORKING GROUP

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<td>ON BEHALF OF:</td>
</tr>
<tr>
<td>NAME: Dale Bruggeman</td>
</tr>
<tr>
<td>TITLE: Chair SAPWG</td>
</tr>
<tr>
<td>AFFILIATION: Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS: 50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
</tr>
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** BLANK(S) TO WHICH PROPOSAL APPLIES **

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<th>CROSSCHECKS</th>
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<td>[ X ]</td>
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<td>[ ]</td>
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<td>Life, Accident &amp; Health/Fraternal</td>
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<tr>
<td>Health</td>
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<td>Health (Life Supplement)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Anticipated Effective Date: Annual 2020

** IDENTIFICATION OF ITEM(S) TO CHANGE **

For Schedule D, Part 1, add code “10” to Column 26 – Collateral Type for ground lease financing. Renumber “Other” code to 11.

** REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE **

During the 2019 Fall National Meeting, the Valuation of Securities (E) Task Force adopted an amendment to add ground lease financing transactions as a newly defined asset class to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) effective January 1, 2020, and referred such action to the SAPWG for consideration. While an update was not required in the Accounting Procedures and Practices Manual (AP&P Manual), specific identification of such activities is warranted for analysis and reporting purposes.

** NAIC STAFF COMMENTS **

Comment on Effective Reporting Date:________________________

Other Comments:

** This section must be completed on all forms. **

Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE D – PART 1

LONG-TERM BONDS OWNED DECEMBER 31 OF CURRENT YEAR

Detail Eliminated to Conserve Space

Column 26 – Collateral Type

Use only for securities included in the following subtotal lines.

Industrial and Miscellaneous (Unaffiliated)

<table>
<thead>
<tr>
<th>Collateral Type</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Residential Mortgage-Backed/Securities</td>
<td>3399999</td>
</tr>
<tr>
<td>Commercial Mortgage-Backed Securities</td>
<td>3499999</td>
</tr>
<tr>
<td>Other Loan-Backed and Structured Securities</td>
<td>3599999</td>
</tr>
</tbody>
</table>

Enter one of the following codes to indicate collateral type. Pick exactly one collateral type for each reported security. For securities that fit in more than one type, pick the predominant one. Judgment may need to be used when making selections involving prime, Alt-A and subprime, as there are no uniform definitions for these collateral types. In the description field, use abbreviations like ABS, CDO or CLO to disclose the type of the loan-backed/structured security. Note: various investments below require SVO review and approval, please refer to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) for further description.

1  Residential Mortgage Loans/RMBS

Include all types of residential first lien mortgage loans as collateral (e.g., prime, subprime, Alt-A).

2  Commercial Mortgage Loans/CMBS

Include all types of commercial mortgage loans as collateral (e.g., conduits, single name, etc.).

3  Home Equity

Include all home equity loans and/or home equity lines of credit as collateral. These are not first liens and are deemed loans to individuals. Bonds that are collateralized by home equity loans/lines of credit are considered asset-backed securities (ABS) rather than RMBS.

4  Individual Obligations – Credit Card, Auto, Student Loans and Recreational Vehicles

Include bonds collateralized by individual obligations. Do not include individual obligations that have a real-estate aspect.

5  Corporate/Industrial Obligations – Tax Receivables, Utility Receivables, Trade Receivables, Small Business Loans, Commercial Paper

Include bonds collateralized by corporate or industrial obligations (sometimes referred to as commercial obligations).
6  Lease Transactions – Aircraft Leases, Equipment Leases and Equipment Trust Certificates

Include bonds collateralized by leases. Equipment leases are loans on heavy equipment. Equipment trust certificates are certificates that entitle the holder to the lease payments on the underlying assets.

7  CLO/CBO/CDO

Include bank loans, which securitize CLOs; investment grade and high-yield corporate bonds, which securitize CBOs; and corporate bonds and structured securities, which securitize CDOs.

8  Manufactured Housing and Mobile Home Loans

Include manufactured housing loans and mobile home loans as collateral. These are not typical residential mortgage loans, and when they securitize bonds, they are considered ABS.

9  Credit Tenant Loans

Real estate loans secured by the obligation of a single (usually investment grade) company to pay debt service by means of rental payments under a lease, where real estate is pledged as collateral also referred to as credit tenant lease, sale-leaseback or CTL.

10  Ground Lease Financing

Real estate loans secured by the obligation to pay debt service by means of rental payments of subleased property; where a long-term ground lease was issued in which the lessee intends significant land development and the subleasing of such property to other long-term tenants.

11  Other

Include other collateral types that do not fit into categories 1 through 910.

For Columns 27 through 29, make whole call information is not required.
NAIC BLANKS (E) WORKING GROUP

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DATE: 02/21/2020

CONTACT PERSON: ____________________________

TELEPHONE: ____________________________

EMAIL ADDRESS: ____________________________

ON BEHALF OF: ____________________________

NAME: Dale Bruggeman

TITLE: Chair SAPWG

AFFILIATION: Ohio Department of Insurance

ADDRESS: 50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215

FOR NAIC USE ONLY

Agenda Item # 2020-21BWG MOD

Year 2020

Changes to Existing Reporting [ X ]

New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]

Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment

[ ] Referred To Another NAIC Group

[ ] Received For Public Comment

[ X ] Adopted Date 05/28/2020

[ ] Rejected Date

[ ] Deferred Date

[ ] Other (Specify) ____________________________

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT

[ ] QUARTERLY STATEMENT

[ X ] INSTRUCTIONS

[ X ] CROSSCHECKS

[ X ] BLANK

[ ] Separate Accounts

[ ] Protected Cell

[ X ] Title

[ ] Other ____________________________

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Add new Line 4.05 for valuation allowance for mortgage loans to the Summary Investment Schedule and renumber existing Line 4.05 to 4.06. Modify the instructions to include a crosscheck for new Line 4.05 back to Schedule B – Verification Between years. Clarify the instructions for 4.01-4.04 to explicitly show crosschecking to Column 8 of Schedule B, Part 1.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this schedule is to address the fact that the amount reported on Schedule B, Part 1, Column 8 excludes the valuation allowance but the total reported for mortgage loans in the Summary Investment Schedule must tie to the asset page which includes the valuation allowance.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ____________________________

Other Comments:

** This section must be completed on all forms.

Revised 7/18/2018

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ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SUMMARY INVESTMENT SCHEDULE

Detail Eliminated to Conserve Space

Line 4.01 – Mortgage Loans – Farm Mortgages

Include: The value of loans secured by farmland and improvements thereon, as evidenced by mortgages or other liens. Farmland includes all land known to be used or usable for agricultural purposes, such as crop and livestock production. Farmland includes grazing or pasturage, whether tillable or not and whether wooded or not. Include loans secured by farmland that are guaranteed by the Farmers Home Administration (FmHA) or by the Small Business Administration (SBA) and that are extended, serviced and collected by any party other than the FmHA or SBA.

Column 1 should equal the sum of Lines 0199999, 0999999, 1799999 and 2599999 on Schedule B, Part 1, Column 8.

Line 4.02 – Mortgage Loans – Residential Mortgages

Include: The value of loans secured by real estate as evidenced by mortgages (FHA, FmHA, VA or conventional) or other liens on nonfarm property containing one to four dwelling units (including vacation homes) or more than four dwelling units if each is separated from other units by dividing walls that extend from ground to roof (e.g., row houses, townhouses or the like); mobile homes where (a) state laws define the purchase or holding of a mobile home as the purchase or holding of real property and where (b) the loan to purchase the mobile home is secured by that mobile home as evidenced by a mortgage or other instrument on real property; individual condominium dwelling units and loans secured by an interest in individual cooperative housing units, even if in a building with five or more dwelling units; and housekeeping dwellings with commercial units combined where use is primarily residential and where only one to four family dwelling units are involved.

Column 1 should equal the sum of Lines 0299999, 0399999, 1099999, 1199999, 1899999, 1999999, 2699999 and 2799999 on Schedule B, Part 1, Column 8.

Line 4.03 – Mortgage Loans – Commercial Mortgages

Include: The value of loans secured by real estate as evidenced by mortgages or other liens on business and industrial properties, hotels, motels, churches, hospitals, educational and charitable institutions, dormitories, clubs, lodges, association buildings, "homes" for aged persons and orphans, golf courses, recreational facilities, and similar properties.

Column 1 should equal the sum of Lines 0499999, 0599999, 1299999, 1399999, 2099999, 2199999, 2899999 and 2999999 on Schedule B, Part 1, Column 8.
Line 4.04 – Mortgage Loans – Mezzanine Real Estate Loans

Include: Mezzanine real estate loans as defined in SSAP No. 83—Mezzanine Real Estate Loans.

Column 1 should equal the sum of Lines 0699999, 1499999, 2299999 and 3099999 on Schedule B, Part 1, Column 8.

Line 4.05 – Total Valuation allowance

Column 1 should equal Schedule B – Verification Between Years Line 12.

Line 4.0506 – Total Mortgage Loans

Sum of Lines 4.01 to 4.0405.

The amount reported in Column 1 should equal the amount reported in Line 3.1 plus Line 3.2, Column 1, Page 2, Assets.

The amount reported in Column 3 should equal the amount reported in Line 3.1 plus Line 3.2, Column 3, Page 2, Assets.

Detail Eliminated to Conserve Space
### ANNUAL STATEMENT BLANK – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

#### SUMMARY INVESTMENT SCHEDULE

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<th>Gross Investment Holdings</th>
<th>Admitted Assets as Reported in the Annual Statement</th>
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</thead>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
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<tr>
<td><strong>Amount</strong></td>
<td><strong>Amount</strong></td>
<td><strong>%</strong></td>
</tr>
<tr>
<td><strong>Line 13</strong></td>
<td><strong>Line 13</strong></td>
<td><strong>Line 13</strong></td>
</tr>
</tbody>
</table>

#### Detail Eliminated to Conserve Space

4. Mortgage loans (Schedule B):
   4.01 Farm mortgages.......................................................................................................................
   4.02 Residential mortgages...............................................................................................................
   4.03 Commercial mortgages...............................................................................................................
   4.04 Mezzanine real estate loans.......................................................................................................
   4.05 Total valuation allowance.......................................................................................................  

5. Real estate (Schedule A):
   5.01 Properties occupied by company............................................................................................
   5.02 Properties held for production of income...............................................................................  
   5.03 Properties held for sale............................................................................................................
   5.04 Total real estate.....................................................................................................................  

6. Cash, cash equivalents and short-term investments:
   6.01 Cash (Schedule E, Part 1)........................................................................................................
   6.02 Cash equivalents (Schedule E, Part 2).......................................................................................
   6.03 Short-term investments (Schedule DA)..................................................................................
   6.04 Total cash, cash equivalents and short-term investments.......................................................  

7. Contract loans..............................................................................................................................

8. Derivatives (Schedule DB)...........................................................................................................

9. Other invested assets (Schedule BA)............................................................................................

10. Receivables for securities...........................................................................................................

11. Securities lending (Schedule DL, Part 1)........................................................................................

12. Other invested assets (Page 2, Line 11).....................................................................................  

13. Total invested assets.....................................................................................................................  

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>DATE: 02/21/2020</th>
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</thead>
</table>

| CONTACT PERSON:  | Dale Bruggeman |
| TELEPHONE:       |               |
| EMAIL ADDRESS:   |               |

ON BEHALF OF:

NAME: Dale Bruggeman
TITLE: Chair SAPWG
AFFILIATION: Ohio Department of Insurance
ADDRESS: 50W. Town St., 3rd Fl., Ste. 300
Columbus, OH 43215

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Agenda Item # 2020-23BWG MOD
Year 2020
Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
No Impact [ X ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ X ] Adopted Date 05/28/2020
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT  [ X ] INSTRUCTIONS  [ ] CROSSCHECKS
[ ] QUARTERLY STATEMENT  [ X ] BLANK
[ X ] Life, Accident & Health/Fraternal  [ X ] Separate Accounts  [ ] Title
[ ] Property/Casualty  [ ] Protected Cell  [ ] Other
[ ] Health  [ X ] Health (Life Supplement)

Anticipated Effective Date: Annual 2020

IDENTIFICATION OF ITEM(S) TO CHANGE

Add footnote to Exhibit 5 (life/fraternal & health – life supplement) and Exhibit 3 separate accounts.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

While this update did not result in a statutory accounting change, this footnote will disclose cases when a mortality risk is no longer present or a significant factor – i.e. due to a policyholder electing a payout benefit.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

Proposal is being exposed concurrently with the changes being considered by the Statutory Accounting Principles (E) Working Group.

** This section must be completed on all forms.

© 2020 National Association of Insurance Commissioners 1
## ANNUAL STATEMENT BLANK – LIFE/FRATERNAL AND HEALTH (LIFE SUPPLEMENT)

### EXHIBIT 5 – AGGREGATE RESERVE FOR LIFE CONTRACTS

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(a) Included in the above table are amounts of deposit-type contracts that originally contained a mortality risk. Amounts of deposit-type contracts in Column 2 that no longer contain a mortality risk are (Life Insurance) $__________, (Annuities) $__________, (Supplementary Contracts with Life Contingencies) $__________, (Accidental Death Benefits) $__________, (Disability—Active Lives) $__________, (Disability—Disabled Lives) $__________, (Miscellaneous Reserves) $__________.

(b) Included in the above table are amounts of deposit-type contracts that originally contained a mortality risk. Amounts of deposit-type contracts in Column 2 that no longer contain a mortality risk are (Life Insurance) $__________, (Annuities) $__________, (Supplementary Contracts with Life Contingencies) $__________, (Accidental Death Benefits) $__________, (Disability—Active Lives) $__________, (Disability—Disabled Lives) $__________, (Miscellaneous Reserves) $__________.

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ANNUAL STATEMENT BLANK – SEPARATE ACCOUNTS

EXHIBIT 3 – AGGREGATE RESERVE FOR LIFE, ANNUITY AND ACCIDENT AND HEALTH CONTRACTS

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(a) Included in the above table are amounts of deposit-type contracts that originally contained a mortality risk. Amounts of deposit-type contracts that no longer contain a mortality risk are: in Column 2 Life Insurance $, in Column 2 Annuities $, in Column 2 Supplementary Contracts with Life Contingencies $, in Column 2 Accident and Health Contracts $, in Column 2 Miscellaneous Reserves $, in Column 2 (Annuities) $, in Column 2 (Supplementary Contracts with Life Contingencies) $, in Column 2 (Accidental Death Benefits) $, in Column 2 (Disability – Active Lives) $, in Column 2 (Disability – Disabled Lives) $, in Column 2 (Miscellaneous Reserves) $.

EXHIBIT 3 – INTERROGATORIES

1.1 Has the reporting entity ever issued both participating and non-participating variable life insurance contracts?
Yes [ ] No [ ]

2.1 Does the reporting entity at present issue both participating and non-participating variable life insurance contracts?
Yes [ ] No [ ]

2.2 If not, state which kind is issued...

3.1 Is any surrender value promised in excess of the reserve as legally computed?
Yes [ ] No [ ]

3.2 If so, the amount of such excess must be included in surrender values in excess of reserves otherwise required and carried in this schedule. Has this been done?
Yes [ ] No [ ]

Attach a statement of methods employed in the valuation of variable life insurance contracts issued at, or subsequently subject to, an extra premium or in the valuation of contracts otherwise issued on lives classified as substandard for the plan of contract issued or on special class lives (including paid-up variable life insurance).

EXHIBIT 3A – CHANGES IN BASES OF VALUATION DURING THE YEAR

(Including supplementary contracts set up on a basis other than that used to determine benefits)

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© 2020 National Association of Insurance Commissioners
ANNUAL STATEMENT BLANK – LIFE/FRATERNAL AND HEALTH (LIFE SUPPLEMENT)

EXHIBIT 5 – AGGREGATE RESERVES FOR LIFE CONTRACTS

Footnote (a):

Deposit-type contracts such as GICs and supplemental contracts are generally reported in Exhibit 7 – Deposit Type Contracts. However, certain contracts (which have similar characteristics to deposit-type contracts) incorporate mortality risk components which qualify those contracts to be reported in Exhibit 5 – Aggregate Reserve for Life Contracts. A common example is a supplemental contract which provides for a life-contingent payout with a specified certain period. Because the contract was life-contingent at issue, it is reported in Exhibit 5 and remains in Exhibit 5 after the death of the annuitant as remaining guaranteed payments continue to the beneficiary. Additionally, state insurance departments have the discretion to approve or require a contract to be classified as a life insurance contract. This footnote captures the amounts reported on Exhibit 5 for deposit-type contracts that originally contained a mortality risk, but no longer contain that risk.

EXHIBIT 3 – AGGREGATE RESERVE FOR LIFE, ANNUITY AND ACCIDENT AND HEALTH CONTRACTS

Footnote (a):

Deposit-type contracts such as GICs and supplemental contracts are generally reported in Exhibit 4 – Deposit Type Contracts. However, certain contracts (which have similar characteristics to deposit-type contracts) incorporate mortality risk components which qualify those contracts to be reported in Exhibit 3 – Aggregate Reserve for Life, Annuity and Accident and Health Contracts. A common example is a supplemental contract which provides for a life-contingent payout with a specified certain period. Because the contract was life-contingent at issue, it is reported in Exhibit 3 and remains in Exhibit 3 after the death of the annuitant as remaining guaranteed payments continue to the beneficiary. Additionally, state insurance departments have the discretion to approve or require a contract to be classified as a life insurance contract. This footnote captures the amounts reported on Exhibit 3 for deposit-type contracts that originally contained a mortality risk, but no longer contain that risk.

W:\National Meetings\2020\Summer\TF\App\BlanksWG\minutes\Att Four-A25 2020-23BWG_Modified.doc
**Blanks (E) Working Group**  
**Editorial Revisions to the Blanks and Instructions**  
*(presented at the May 28, 2020, Meeting)*

Statement Type:  
H = Health; L/F = Life/Fraternal Combined; P/C = Property/Casualty; SA = Separate Accounts; T = Title

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<th>Description</th>
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<th>Filing Type</th>
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Remove reference to Web address as it is no longer valid and new location can’t be found. No alternate is being provided. | H, L/F, P/C, T | Annual |
| 2020      | Schedule D, Part 1 | CHANGE TO INSTRUCTION  
Modify the instruction for Column 1 – CUSIP Identification as shown below to better clarify zero filling CUSIP.  
If no valid CUSIP, CINS or PPN number exists, then report the CUSIP field should be zero-filled and a valid ISIN security number should be reported in (Column 33) security number. The CUSIP field should be zero-filled. | H, L/F, P/C, T | Annual |
| 2020      | Schedule D, Part 2, Section 1 | CHANGE TO INSTRUCTION  
Modify the instruction for Column 1 – CUSIP Identification as shown below to better clarify zero filling CUSIP.  
If no valid CUSIP, CINS or PPN number exists, then report the CUSIP field should be zero-filled and a valid ISIN security number should be reported in (Column 27) security number. The CUSIP field should be zero-filled. | H, L/F, P/C, T | Annual |
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<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instruction for Column 1 – CUSIP Identification as shown below to better clarify zero filling CUSIP. If no valid CUSIP, CINS or PPN number exists, then report the CUSIP field should be zero-filled and a valid ISIN security number should be reported in (Column 14) security number. The CUSIP field should be zero-filled.</td>
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<td>H, L/F, P/C, T</td>
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<td>Make the edit below for Column 7 to remove “Supplementary Contracts” from the table below for consistency with the table in the Life/Fraternal instructions because it is no longer reported separately on the Life/Fraternal Analysis of Operations by Lines of Business.</td>
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**Abbreviations:**

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**NOTE:** The Type of Business Assumed code should be entered in all upper-case letters.
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| 2020      | Schedule S, Part 3, Section 1 (Life Supplement) | **CHANGE TO INSTRUCTION**  
Make the edit below for Column 7 to remove “Supplementary Contracts” from the table below for consistency with the table in the Life/Fraternal instructions because it is no longer reported separately on the Life/Fraternal Analysis of Operations by Lines of Business. | H | Annual |

**Abbreviations:**

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**NOTE:** The Type of Business Assumed code should be entered in 3 letters.

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| 2020      | Schedule DB, Part D, Section 1 | **CHANGE TO INSTRUCTION**  
Replace “statement value” reference with “Book/Adjusted Carrying Value” reference.  
Column 5 – Contracts with Book/Adjusted Carrying Value > 0 (i.e., debit balance on balance sheet)  
On the first line, show the aggregate sum for exchange traded derivatives that have a positive Book/Adjusted Carrying Value.  
For futures, this equals the sum of the positive cumulative variation margin for highly effective futures (Part B, Section 1, Column 15), plus the sum of the ending balance of all cash deposits with brokers (Part B, Section 1, Broker Name/Net Cash Deposits Footnote – Ending Cash Balance).  
On subsequent lines, show the sum of the Book/Adjusted Carrying Values of all derivative instruments with the | H, L/F, P/C, T | Annual |
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<td>Replace “statement value” reference with “Book/Adjusted Carrying Value” reference.</td>
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<td>Column 5 – Contracts with Book/Adjusted Carrying Value &gt; 0 (i.e., debit balance on balance sheet)</td>
<td>For futures, this equals the sum of the positive cumulative variation margin for highly effective futures (Part B, Section 1, Column 15), plus the sum of the ending balance of all cash deposits with brokers (Part B, Section 1, Broker Name/Net Cash Deposits Footnote – Ending Cash Balance).</td>
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<td>On subsequent lines, show the sum of the Book/Adjusted Carrying Values of all derivative instruments with the counterparty or central clearinghouse that have a positive Book/Adjusted Carrying Value.</td>
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<td>Column 6 – Contracts with Book/Adjusted Carrying Value &lt; 0 (i.e., credit balance on balance sheet)</td>
<td>For futures, this equals the sum of the negative cumulative variation margin for highly effective futures (Part B, Section 1, Column 15).</td>
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<td>On subsequent lines, show the sum of the Book/Adjusted Carrying Values in parentheses ( ) of all derivative instruments with the counterparty or central clearinghouse that have a negative Book/Adjusted Carrying Value.</td>
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<td>Column 6</td>
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<td>On the first line, show the sum of the Book/Adjusted Carrying Value statement values in parentheses ( ) of all exchange traded derivatives that have a negative Book/Adjusted Carrying Value.</td>
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<td>For futures, this equals the sum of the negative cumulative variation margin for highly effective futures (Part B, Section 1, Column 15).</td>
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<td>Column 5 – Contracts with Book/Adjusted Carrying Value &gt; 0 (i.e., debit balance on balance sheet)</td>
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<td>On the first line, show the aggregate sum for exchange traded derivatives that have a positive Book/Adjusted Carrying Value.</td>
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<td>For futures, this equals the sum of the positive cumulative variation margin for highly effective futures (Part B, Section 1, Column 15), plus the sum of the ending balance of all cash deposits with brokers (Part B, Section 1, Broker Name/Net Cash Deposits Footnote – Ending Cash Balance).</td>
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**Effective** | **Table Name** | **Description** | **Statement Type** | **Filing Type**
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2020 | Equity and Other Invested Asset Component – Basic Contribution, Reserve Objective and Maximum Reserve Calculations | **Column 6** – Contracts with Book/Adjusted Carrying Value < 0 (i.e., credit balance on balance sheet)

On the first line, show the sum of the Book/Adjusted Carrying Value statement values in parentheses ( ) of all exchange traded derivatives that have a negative Book/Adjusted Carrying Value.

For futures, this equals the sum of the negative cumulative variation margin for highly effective futures (Part B, Section 1, Column 15).

On subsequent lines, show the sum of the Book/Adjusted Carrying Values in parentheses ( ) of all derivative instruments with the counterparty or central clearinghouse that have a negative Book/Adjusted Carrying Value. | L/F | Annual

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**CHANGE TO INSTRUCTION**

Update reserve factors as shown below.

**Line 1** – Unaffiliated Common Stocks – Public

Report the book/adjusted carrying value of all publicly issued common stock, including mutual funds (except money market mutual funds appropriately reported on Schedule E, Part 2) in unaffiliated companies in Columns 1 and 4. Multiply Column 4 by the reserve factor calculated for Columns 5, 7 and 9, and report the products in Columns 6, 8 and 10, respectively.

The Line 1, Column 7 and 9 reserve factors must be at least 4012.15% but not more than 2024.31%.

The reserve factor is equal to 1315.80% times the company’s weighted average portfolio beta. The weighted average portfolio beta is the market value weighted average of four (4) portfolio betas, one from the end of the prior year and the remaining from the first three (3) quarters of the current year. Calculation of this weighted average portfolio beta is illustrated in the following worksheet.
### Equity and Other Invested Asset Component – Basic Contribution, Reserve Objective and Maximum Reserve Calculations

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<td>Update reserve factors as shown below.</td>
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<td>Lines 65 through 69 – Other Invested Assets with Underlying Characteristics of Common Stocks</td>
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<td>Report the book/adjusted carrying value of all Schedule BA assets owned where the characteristics of the underlying investments are similar to common stock (Lines 1999999 and 2099999) in Columns 1 and 4. Line 68 should show all Schedule BA assets owned where the characteristics of the underlying investments are similar to subsidiary, controlled or affiliated company common stocks owned and these assets should be valued according to the <em>Purposes and Procedures Manual of the NAIC Investment Analysis Office</em>. Categorize these assets consistent with the directions for Pages 32 and 33, Lines 1 through 4, 15 and 16. For Line 65, the reserve factor must be calculated on an individual company basis. It is equal to $1315.80%$ times the beta factor as discussed in the Pages 32 and 33, Line 1 instructions, and must be at least $1012.15%$ but not more than $2024.31%$. Multiply the amount in Column 4 by the calculated reserve factors in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively. For Lines 66 through 69, multiply the amounts in Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.</td>
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### Notes to Financial Statements

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<td>The change below was not reflected in proposal 2019-07BWG but was part of the changes adopted by the SAPWG for SSAP No. 100R—<em>Fair Value</em>.</td>
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</tbody>
</table>
| 2021      | Notes to Financial Statements | **CHANGE TO INSTRUCTION**  
The change below was not reflected in proposal 2019-07BWG but was part of the changes adopted by the SAPWG for SSAP No. 100R—Fair Value.  

20. **Fair Value Measurements**  

**Instruction:**  
A. The objective of the disclosure requirements is to provide information about assets and liabilities measured at fair value in the financial statements as well as fair value amounts disclosed in the Notes to Financial Statements or reporting schedules. A reporting entity shall disclose information that helps users of the financial statements to assess both of the following:  

   For assets and liabilities that are measured and reported at fair value or net asset value (NAV) in the statement of financial position after initial recognition, the valuation techniques and the inputs used to develop those measurements.  

   For fair value measurements in the statement of financial position determined using significant unobservable inputs (Level 3), the effect of the measurements on earnings (or changes in net assets) for the period. | H, L/F, P/C, T | Quarterly |
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>Schedule BA, Part 1</td>
<td>For fair value measurements in the statement of financial position determined using significant unobservable inputs (Level 3), the effect of the measurements on earnings (or changes in net assets) for the period.</td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Schedule D, Part 1</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Schedule D, Part 2 Sections 1 &amp; 2</td>
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<td></td>
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<tr>
<td></td>
<td>CHANGE TO INSTRUCTION</td>
<td>Add the following to the Administrative Symbol List.</td>
<td>H, L/F, P/C, T</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Z* Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.</td>
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<tr>
<td>2021</td>
<td>Schedule BA, Part 2</td>
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<td>Schedule D, Parts 2 &amp; 3</td>
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<tr>
<td></td>
<td>CHANGE TO INSTRUCTION</td>
<td>Add the following to the Administrative Symbol List.</td>
<td>H, L/F, P/C, T</td>
<td>Quarterly</td>
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<tr>
<td></td>
<td>Z* Regulatory review initiated by either the SVO Director, Financial Condition (E) Committee, Executive (EX) Committee or VOSTF.</td>
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<tr>
<td>2020</td>
<td>Schedule DB, Part A, Section 1</td>
<td>CHANGE TO INSTRUCTION</td>
<td>H, L/F, P/C, T</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modify the instruction for Column 32 as shown below to match the annual instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Column 32 – CDHS Identifier</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Provide a unique identifier for each Clearly Defined Hedging Strategy (CDHS) reported on this schedule (e.g., 001, 002, etc.). This identifier will also be used for reporting of the CDHS in Column 1 of Schedule DB, Part E.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This column should only be used for the following line numbers:</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Purchased Options Lines 0089999999 through 0139999999</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Written Options Lines 0579999999 through 0629999999</td>
<td></td>
<td></td>
</tr>
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<td>Effective</td>
<td>Table Name</td>
<td>Description</td>
<td>Statement Type</td>
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</tr>
<tr>
<td>2020</td>
<td>Supplemental Exhibits and Schedules Interrogatories</td>
<td>CHANGE TO BLANK</td>
<td>L/F</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add the word “confidential” to Line 50, new lines 51 and 52 and renumbering subsequent lines. Also assign document identifiers for the documents in Lines 51 and 52.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50. Will the confidential Executive Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>51. Will the confidential Life Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>52. Will the confidential Variable Annuities Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>Schedule D, Part 2, Section 2</td>
<td>CHANGE TO INSTRUCTION</td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
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<td></td>
<td></td>
<td>Make the following changes to the instructions for Column 18.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Column 18 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>For securities reported on Line 9499999 (Mutual Funds), provide the appropriate NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol combination as assigned by the Securities Valuation Office. For all other common stock, the NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol field should be left blank.</td>
<td></td>
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</tr>
<tr>
<td>2020</td>
<td>Schedule D, Part 2, Section 2</td>
<td>CHANGE TO INSTRUCTION</td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
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<td></td>
<td>Make the following changes to the instructions for Column 18.</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Column 18 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</td>
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<td>Description</td>
<td>Statement Type</td>
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<tr>
<td>2020</td>
<td>Schedule D, Part 2, Section 2</td>
<td>CHANGE TO INSTRUCTION</td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
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<tr>
<td></td>
<td></td>
<td>Make the changes below to remove the crosscheck.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NAIC Designation Category Footnote:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The sum of the amounts reported for each NAIC Designation Category in the footnote should equal Line 9499999.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>Schedule DA, Part 1</td>
<td>CHANGE TO INSTRUCTION</td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modify the instruction for Column 22 as shown below and move to new location within the column instructions to reflect it doesn’t pertain just to the modifier.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Column 22 – NAIC Designation Category</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The NAIC Designation and NAIC Designation Modifier Equivalent should be left blank for the following lines:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Parent, Subsidiaries and Affiliates – Mortgage Loans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective</td>
<td>Table Name</td>
<td>Description</td>
<td>Statement Type</td>
<td>Filing Type</td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>2020</td>
<td>Schedule E, Part 2</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Modify the instruction for Column 11 as shown below and move to new location within the column instructions to reflect it doesn’t pertain just to the modifier.&lt;br&gt;&lt;br&gt;Column 11 – NAIC Designation Category&lt;br&gt;&lt;br&gt;The NAIC Designation and NAIC Designation Modifier Equivalent should be left blank for the following lines:&lt;br&gt;&lt;br&gt;• Sweep Accounts&lt;br&gt;• Exempt Money Market Mutual Funds – as Identified by the SVO&lt;br&gt;• All Other Money Market Mutual Funds&lt;br&gt;• Other Cash Equivalents</td>
<td>H, L/F, P/C, T</td>
<td>Annual</td>
</tr>
<tr>
<td>2020</td>
<td>Exhibit of Premium and Losses</td>
<td><strong>CHANGE TO BLANK</strong>&lt;br&gt;Change the description for Column 7 from “Direct Premiums Earned” to “Net Premiums Earned”. The change will make the column consistent with the column on Schedule T and the crosscheck between the schedules.</td>
<td>Title</td>
<td>Annual</td>
</tr>
<tr>
<td>Effective</td>
<td>Table Name</td>
<td>Description</td>
<td>Statement Type</td>
<td>Filing Type</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>-------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 2020      | Exhibit of Premium and Losses | CHANGE TO INSTRUCTION  
Change the description for Column 7 from “Direct Premiums Earned” to “Net Premiums Earned”. The change will make the column consistent with the column on Schedule T and the crosscheck between the schedules.  
Column 7 – Net Direct Premiums Earned  
Total to agree with Schedule T, Column 7, for the appropriate state. | Title | Annual |
| 2020      | Combined Statement | CHANGE TO INSTRUCTION  
Modify instructions to indicate the footnote for Schedule D, Parts 1 and 2 should not be completed.  
6. With the exception of Schedule Z, the format to be used is that of the NAIC Annual Statement blank for property/casualty insurers. The specific pages, exhibits, and schedules to be included are as follows:  
Title Page (in part)  
Assets  
Liabilities, Surplus and Other Funds  
Statement of Income  
Cash Flow  
Underwriting and Investment Exhibit, Parts 1 through 3  
Exhibit of Net Investment Income  
Exhibit of Capital Gains (Losses)  
Schedule D, Summary by Country  
Schedule D, Part 1A, Sections 1 and 2  
Schedule D, Parts 1 and 2, Totals (Line 8399999, 8999999 or 9899999) only  
Note: Do not complete the footnote for Schedule D, Parts 1 and 2  
Schedule F, Parts 1, 2 and 3, Subtotals and Totals only  
Schedule H, Parts 1 through 4 only  
Schedule P except interrogatories  
Schedule T  
Schedule Z  
Insurance Expense Exhibit (Supplemental Filing) | P/C | Annual |
<table>
<thead>
<tr>
<th>CHANGES TO INSTRUCTION</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make the changes below to correct line references for Column 7.</td>
<td></td>
</tr>
<tr>
<td>Column 7 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol</td>
<td></td>
</tr>
<tr>
<td>This column must be completed for those investments included on Lines 0799999, 0899999, 1599999 and 151699999.</td>
<td></td>
</tr>
<tr>
<td>For Schedule BA investments with the underlying characteristics of a bond or a preferred stock instrument, insert the appropriate combination of the NAIC Designation (1 through 6), NAIC Designation Modifier (A through G) and SVO Administrative Symbol. The list of valid SVO Administrative Symbols is shown below.</td>
<td></td>
</tr>
<tr>
<td>*** Detail Eliminated to Conserve Space ***</td>
<td></td>
</tr>
<tr>
<td>NAIC Designation Modifier:</td>
<td></td>
</tr>
<tr>
<td>The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&amp;P Manual), otherwise, the field should be left blank.</td>
<td></td>
</tr>
<tr>
<td>Underlying Characteristics of Bonds Lines 0799999 through 0899999</td>
<td></td>
</tr>
<tr>
<td>Underlying Characteristics of Preferred Stocks Lines 131599999 through 141699999</td>
<td></td>
</tr>
<tr>
<td>As defined in the P&amp;P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation Modifier field should be left blank.</td>
<td></td>
</tr>
</tbody>
</table>

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### Schedule BA, Part 1

#### CHANGE TO INSTRUCTION

Make the changes below to correct line references for Column 6.

**Column 6 – NAIC Designation, NAIC Designation Modifier and SVO Administrative Symbol**

**NAIC Designation Modifier:**

The NAIC Designation Modifier should only be used for securities reported on the lines below if eligible to receive one, as defined in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), otherwise, the field should be left blank.

- **Underlying Characteristics of Bonds**
  - Lines 0799999 through 0899999

- **Underlying Characteristics of Preferred Stocks**
  - Line 41599999 through 41699999

As defined in the P&P Manual, there is not an NAIC Designation Modifier for investments reporting an NAIC Designation 6, therefore, the NAIC Designation Modifier field should be left blank.

### Supplemental Exhibits and Schedules Interrogatories

#### CHANGE TO BLANK

For 2020 show Lines 29, 30, 31 and 32 as struck through and remove from specs data table. Proposal to formally remove the lines will be made for 2021.

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Filing Type</th>
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<tr>
<td>29</td>
<td>Will the Actuarial Certifications Related to Hedging required by Actuarial Guideline XLIII be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>L/F</td>
</tr>
<tr>
<td>30</td>
<td>Will the Financial Officer Certification Related to Clearly Defined Hedging Strategy required by Actuarial Guideline XLIII be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>L/F</td>
</tr>
<tr>
<td>31</td>
<td>Will the Management Certification That the Valuation Reflects Management’s Intent required by Actuarial Guideline XLIII be filed with the state of domicile and electronically with the NAIC by March 1?</td>
<td>L/F</td>
</tr>
</tbody>
</table>
Make the following changes to Note 32.

Instructions:
- Amount with current surrender charge of 5% or more included in A(1)b, B(1)b and C(1)b (from the tables illustrated below) in the current year that will have less than a 5% surrender charge (and thus be reported in A(1)e, B(1)e and C(1)e (from the tables illustrated below) for the first time within the year subsequent to the balance sheet year (% column is not required).

Illustration:

A. INDIVIDUAL ANNUITIES:
- Subject to discretionary withdrawal:
  - With market value adjustment
  - At book value less current surrender charge of 5% or more
  - At fair value
  - Total with market value adjustment or at fair value (total of a through c)
  - At book value without adjustment (minimal or no charge or adjustment)
- Not subject to discretionary withdrawal
- Total (gross: direct + assumed)
- Reinsurance ceded
- Total (net) (3) – (4)
- Amount included in A(1)b above that will move to A(1)e for the first time within the year after the statement date:

B. GROUP ANNUITIES:
- Subject to discretionary withdrawal:
  - With market value adjustment
  - At book value less current surrender charge of 5% or more
  - At fair value
  - Total with market value adjustment or at fair value (total of a through c)
  - At book value without adjustment (minimal or no charge or adjustment)
- Not subject to discretionary withdrawal
- Total (gross: direct + assumed)
- Reinsurance ceded
- Total (net) (3) – (4)
<table>
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<th>Description</th>
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<th>Filing Type</th>
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<td>(6)</td>
<td>Amount included in B(1)b above that will move to B(1)e for the first time within the year after the statement date:</td>
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<td>C. DEPOSIT-TYPE CONTRACTS</td>
<td>(no life contingencies):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>Subject to discretionary withdrawal:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>With market value adjustment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>At book value less current surrender charge of 5% or more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>At fair value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Total with market value adjustment or at fair value (total of a through c)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>At book value without adjustment (minimal or no charge or adjustment)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(2)</td>
<td>Not subject to discretionary withdrawal</td>
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<td></td>
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<tr>
<td>(3)</td>
<td>Total (gross: direct + assumed)</td>
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<tr>
<td>(4)</td>
<td>Reinsurance ceded</td>
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<tr>
<td>(5)</td>
<td>Total (net) (3) – (4)</td>
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<tr>
<td>(6)</td>
<td>Amount included in C(1)b above that will move to C(1)e for the first time within the year after the statement date:</td>
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<td></td>
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</table>
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(Attachment Five-C1)......................................................................................................... 10-1285
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The Capital Adequacy (E) Task Force met via conference call Aug. 5, 2020. The following Task Force members participated: Jillian Froment, Chair, represented by Tom Botsko (OH); Todd E. Kiser, Vice Chair, represented by Jake Garn (UT); Jim L. Ridling represented by Shelia Travis (AL); Alan McClain represented by Mel Heaps (AR); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmair represented by Ray Spudeck and Carolyn Morgan (FL); Doug Ommon represented by Mike Yanacheak (IA); Dean L. Cameron represented by Nathan Faragher (ID); Robert H. Muriel represented by Kevin Fry (IL); Vicki Schmidt represented by Tish Becker (KS); Steve Kelley represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by Debbie Doggett (MO); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Lindsay Crawford (NE); Marlene Caride represented by Diana Sherman (NJ); Barbara D. Richardson represented Kelsey Barlow (NV); Glen Mulready represented by Diane Carter (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Raymond G. Farmer represented Will Davis (SC); Kent Sullivan represented by Jamie Walker (TX); Mike Kriedler represented by Steve Drutz (WA); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted its June 30 Minutes**

   Mr. Yanacheak made a motion, seconded by Mr. Chou, to adopt the Task Force’s June 30 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its Working Group Reports and Minutes**

   Mr. Chou made a motion, seconded by Mr. Davis, to adopt the reports of the Health Risk-Based Capital (E) Working Group (Attachment Two), the Investment Risk-Based Capital (E) Working Group (Attachment Three), the Life Risk-Based Capital (E) Working Group (Attachment Four), and the Property and Casualty Risk-Based Capital (E) Working Group (Attachment Five). The motion passed unanimously.

3. **Adopted its Working Agenda**

   a. Mr. Drutz said the health risk-based capital (RBC) working agenda has been updated to add the following items: 1) proposal 2020-02CA for the deletion of the federal Affordable Care Act (ACA) Fee Sensitivity test that was added as part of the evaluation of the impact of the federal health care law; 2) review and consideration of the formula for the inclusion of the MAX function of Line 17 of the excessive growth charge as proposal 2020-04-H; and 3) consideration of the impact of COVID-19 and pandemic risk on the health RBC formula.

   b. Mr. Barlow added that the Life Risk-Based Capital (E) Working Group is focused on C-3 updates and the two new items that were referred by the Investment Risk-Based Capital (E) Working Group.

   c. Mr. Botsko said the Property and Casualty Risk-Based Capital (E) Working Group is focused on restructuring mechanisms and two referrals that were received regarding installment fees and expenses and retroactive reinsurance. The Task Force will focus on hybrids for its next conference call.

   d. Mr. Botsko also said the items previously listed under Investment Risk-Based Capital (E) Working Group will move to the Task Force or the individual working groups for further discussion. Mr. Fry made a motion, seconded by Mr. Barlow, to disband the Investment Risk-Based Capital (E) Working Group. The motion passed unanimously.
   
   Mr. Botsko also thanked Mr. Fry for his expertise and dedication to this project.

   Mr. Chou made a motion, seconded by Mr. Yanacheak, to adopt the working agenda (Attachment Six). The motion passed unanimously.

4. **Exposed Proposal 2020-02-CA (ACA Fee Sensitivity Test Removal)**

   Mr. Drutz said the ACA fee was repealed for 2021. This proposal would delete the ACA Fee Sensitivity test from each RBC formula. The Working Group is asking the Task Force to expose it since this will affect all formulas, and comments can be sent to the Health Risk-Based Capital (E) Working Group to address.

   Mr. Botsko agreed that the Task Force will expose proposal 2020-02-CA (Attachment Seven) for a 30-day public comment period ending Sept. 4.
5. Exposed its 2021 Proposed Charges

Mr. Botsko explained that the charges were updated to reflect the disbandment of the Investment Risk-Based Capital (E) Working Group, and its sole charge will be placed under the Task Force. The proposed charges (Attachment Eight) will be exposed for a 30-day public comment period ending Sept. 4. Mr. Chou noted that the heading still says 2020. Jane Barr (NAIC) said she would update the charges before the exposure email is sent.

6. Adopted Proposal 2020-03-L (C-3 Instructions and C-3 Guidance)

Mr. Botsko said proposal 2020-03-L (C-3 Instructions and C-3 Guidance) was inadvertently missed in the Task Force’s June 30 agenda. Since this instructional update is past the RBC cutoff date, the Task Force will need to vote on whether to consider the proposal. The Task Force unanimously agreed to accept the proposal after the cutoff date.

Mr. Barlow said the changes to the instructions for C-3 were clarifying language on potential issues in 2019, which is no longer applicable, so that language was removed.

Mr. Barlow made a motion, seconded by Ms. Orth, to adopt proposal 2020-03-L (Attachment Nine). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

W:\National Meetings\2020\Summer\TF\CapAdequacy/08_CapitalAdequacyTFmin
The Capital Adequacy (E) Task Force met via conference call June 30, 2020. The following Task Force members participated: Jillian Froment, Chair, represented by Tom Botsko (OH); Todd E. Kiser, Vice Chair, represented by Jake Garn (UT); Lori K. Wing-Heier represented by David Phifer and Wally Thomas (AK); Jim L. Ridling represented by Blase Abreo (AL); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Jason Reynolds (FL); Doug Ommen represented by Mike Yanacheak (IA); Dean L. Cameron represented by Eric Fletcher (ID); Robert H. Muriel represented by Kevin Fry (IL); Vicki Schmidt represented by Tish Becker (KS); Chlora Lindley-Myers represented by John Rehagen and William Leung (MO); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Rhonda Ahrens (NE); Barbara D. Richardson represented by Joel Beng (NV); Glen Mulfrey represented by Andrew Schallhorn and Diane Carter (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Raymond G. Farmer represented by Michael Shull (SC); Kent Sullivan represented by Mike Boerner (TX); Mike Kreidler represented by Steve Drutz (WA); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted its 2019 Fall National Meeting Minutes**

   Mr. Yanacheak made a motion, seconded by Mr. Boerner, to adopt the Task Force’s Dec. 8, 2019, minutes (*see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force*). The motion passed unanimously.

2. **Adopted its Jan. 27 and April 30 Minutes**

   The Task Force met Jan. 27 to adopt the 2019 Catastrophe Event List and its April 30 minutes. The Task Force met April 30 and took the following action: 1) adopted proposal 2019-16-CA (20 Designation Bond Structure for Year-End 2020); and 2) adopted proposal 2019-13-L (Longevity Risk Structure).

   Mr. Phifer made a motion, seconded by Mr. Yanacheak, to adopt the Task Force’s Jan. 27 (Attachment One-A) and April 30 (Attachment One-B) minutes. The motion passed unanimously.

3. **Adopted Proposal 2020-05-CA**

   Mr. Botsko explained that the purpose of this proposal is to insert the word “Overview” in the page heading and modify the table of contents in the risk-based capital (RBC) instructions for page references. The proposal was exposed for a 30-day public comment period ending May 15, and no comments were received.

   Mr. Leung made a motion, seconded by Mr. Chou, to adopt proposal 2020-05-CA (Attachment One-C). The motion passed unanimously.

4. **Adopted Proposal 2020-06-L (Longevity Risk for Life/Fraternal Instructions)**

   Mr. Barlow explained that a new schedule in the life/fraternal RBC formula for longevity risk should be considered to determine the appropriate guardrails and factor. Therefore, more information must be obtained in order to develop the guardrails and factors, and it is important that the instructions indicate that the 2020 year-end factors will be zero in order to collect this information for analysis in determining the factor for 2021.

   Mr. Barlow made a motion, seconded by Ms. Crawford, to adopt proposal 2020-06-L (Attachment One-D). The motion passed unanimously.
5. **Adopted Property/Casualty Proposals**

a. Proposal 2018-19-P (Vulnerable 6 or Unrated Risk Charge) is to modify the instructions to reflect that the factors for all uncollateralized reinsurance recoverables from unrated reinsurers be the same for authorized, unauthorized, certified and reciprocal reinsurance. The factor is being updated to be more aligned with risk-indicated factors used by rating agencies.

b. Proposal 2020-01-P (Line 1 Premium and Reserve Underwriting Factors) is an annual update for the underwriting factors for premium and reserves.

Mr. Chou made a motion, seconded by Mr. Milquet, to adopt proposal 2018-19-P (Attachment One-E) and proposal 2020-01-P (Attachment One-F). The motion passed unanimously.

6. **Discussed Other Matters**

Mr. Botsko said the Task Force will be discussing hybrid bonds on its next conference call to determine if it should receive the same 20 designations as other bonds. NAIC staff mentioned that the Securities Valuation Office (SVO) would be treating hybrids like all other bonds with a designation classification between 1 and 20.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
Capital Adequacy (E) Task Force
Conference Call
January 27, 2020

The Capital Adequacy (E) Task Force met via conference call Jan. 27, 2020. The following Task Force members participated:
Jillian Froment, Chair, represented by Tom Botsko (OH); Todd E. Kiser, Vice Chair, represented by Jake Garn (UT); Jim L. Ridling represented by Richard Ford (AL); Allen W. Kerr represented by Mel Anderson (AR); Richard Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Carolyn Morgan and Virginia Christy (FL); Doug Ommen represented by Kim Cross (IA); Robert H. Muriel represented by Kevin Fry and Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); Steve Kelley represented by John Robinson (MN); Chlora Lindley-Myers represented by Julie Lederer (MO); Mike Causey represented by Jackie Obusek (NC); Marlene Caride represented by Diana Sherman (NJ); Barbara D. Richardson represented Joel Bengo (NV); Glen Mulready represented by Joel Sander (OK); Kent Sullivan represented by Mike Boerner (TX); Mike Kreidler represented by Patrick McNaughton and Steve Drutz (WA); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted its Dec. 30, 2019, Minutes**

During its Dec. 30, 2019, meeting, the Task Force exposed a revised structure for reporting bond designations at year-end 2020 for a 45-day public comment period.

Mr. Chou made a motion, seconded by Ms. Obusek, to adopt the Task Force’s Dec. 30, 2019, minutes (Attachment One-A1). The motion passed unanimously.


Mr. Boerner made a motion, seconded by Mr. Milquet, to adopt the U.S. and non-U.S. list of catastrophes to be used for 2019 property/casualty (P/C) risk-based capital (RBC) reporting, subject to several nonsubstantive edits suggested by Mr. Robinson (Attachment One-A2). The motion passed unanimously.

3. **Agreed to Sponsor Blanks (E) Working Group Proposal**

The Task Force members agreed to sponsor proposed changes to Interrogatory #24 in all 2020 annual financial statement blanks. The change improves clarity on reporting of conforming versus non-conforming collateral related to securities lending. All RBC formulas rely on data from that interrogatory. The proposed blanks change will go to the Blanks (E) Working Group for further action.

Mr. Botsko thanked Commissioner Altmaier for his leadership as former chair of the Task Force.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
The Capital Adequacy (E) Task Force met via conference call Dec. 30, 2019. The following Task Force members participated:

David Altmaier, Chair (FL); Ricardo Lara represented by Shaoping Chang (CA); Andrew N. Mais represented by Wanchin Chou (CT); Stephen C. Taylor represented by Philip Barlow (DC); Doug Ommen represented by Carrie Mears (IA); Robert H. Muriel represented by Kevin Fry (IL); Vicki Schmidt represented by Tish Becker (KS); Chlora Lindley-Myers represented by John Rehagen and Julie Lederer (MO); Mike Causey represented by Jackie Obusek (NC); Marlene Caride represented by John Sirovetz (NJ); John G. Franchini represented by Anna Krylova (NM); Jillian Froment represented by Dale Bruggeman and Tom Botsko (OH); Glen Mulready represented by Joel Sander (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Kent Sullivan represented by Mike Boerner (TX); and Mike Kreidler represented by Steve Drutz (WA).

1. Exposed the Bond Structure Proposal

Commissioner Altmaier said the purpose of this conference call is to consider exposure of a proposed structure change to the risk-based capital (RBC) formula to accommodate the expansion of bond factors from six designations to 20 designations.

Commissioner Altmaier said that although the Investment Risk-Based Capital (E) Working Group is still working on the factors associated with the expanded designations, the structure change is a logical step forward given that: 1) there is wide consensus about the expansion; 2) the Blanks (E) Working Group and the NAIC Securities Valuation Office (SVO) have adopted the expansion; and 3) the structure change would give the Task Force the opportunity to collect data that will allow for impact testing as the Health Risk-Based Capital (E) Working Group, the Investment Risk-Based Capital (E) Working Group, the Life Risk-Based Capital (E) Working Group and the Property and Casualty Risk-Based Capital (E) Working Group continue developing the factors.

Commissioner Altmaier added that, logistically, this structure change would, as mentioned, expand the current six designations to 20, but it would group these 20 factors in a manner that would allow the current six factors to be applied the same way that they have historically been applied.

Mr. Barlow explained that the life RBC formula will need to make adjustment to its formula for the portfolio adjustment, which is not reflected in the current proposal.

Commissioner Altmaier said the reason for the exposure now is to meet the RBC procedural deadline of Jan. 30, 2020, for any structure changes to be proposed. He stressed that if this structure change is ultimately adopted, it would not expedite or impose any deadline on the development of the associated factors. Having the 20 designations continue to hold their six factors will allow for the development of the factors to continue as it has, with some discussions on that front to continue shortly after the beginning of 2020.

The Task Force agreed to expose the bond structure proposal for a 45-day public comment period ending Feb. 14, 2020.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
### Capital Adequacy (E) Task Force

**RBC Proposal Form**

| [ ] Capital Adequacy (E) Task Force | [ ] Health RBC (E) Working Group | [ ] Life RBC (E) Working Group |
| [ ] Catastrophe Risk (E) Subgroup | [ ] Investment RBC (E) Working Group | [ ] Op Risk RBC (E) Subgroup |
| [ ] C3 Phase II/ AG43 (E/A) Subgroup | [ ] P/C RBC (E) Working Group | [ ] Stress Testing (E) Subgroup |

**DATE:** 11/8/2019

**CONTACT PERSON:** Eva Yeung

**TELEPHONE:** 816-783-8407

**EMAIL ADDRESS:** eyeung@naic.org

**ON BEHALF OF:** Catastrophe Risk (E) Subgroup

**NAME:** Tom Botsko

**TITLE:** Chair

**AFFILIATION:** Ohio Department of Insurance

**ADDRESS:** 50 West Town Street, Suite 300

Columbus, OH 43215

**FOR NAIC USE ONLY**

**Agenda Item # 2019-14-CR**

**Year 2019**

**DISPOSITION**

[ x ] ADOPTED 12/8/19

[ ] REJECTED

[ ] DEFERRED TO

[ ] REFERRED TO OTHER NAIC GROUP

[ x ] EXPOSED 11/8/19 / 1/7/20

[ ] OTHER (SPECIFY)

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

[ ] Health RBC Blanks  [ ] Property/Casualty RBC Blanks  [ ] Life RBC Instructions

[ ] Fraternal RBC Blanks  [ ] Health RBC Instructions  [ ] Property/Casualty RBC Instructions

[ ] Life RBC Blanks  [ ] Fraternal RBC Instructions  [ x ] OTHER __Cat Event Lists__

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**DESCRIPTION OF CHANGE(S)**

2019 U.S. and non-U.S. Catastrophe Event Lists

**REASON OR JUSTIFICATION FOR CHANGE **

New events were determined based on the sources from Swiss Re and Aon Benfield.

Additional Staff Comments:

11/8/19 The Catastrophe Risk SG exposed the proposal for 14 days public comment period ending 11/24/19.
12/6/19 The Catastrophe Risk SG adopted the lists. For any additional events that occur between 11/1 and 12/31, the SG will either schedule a call or conduct an email vote to adopt the updated list.
12/8/19 The PCRBC WG adopted the lists. For any additional events that occur between 11/1 and 12/31, the SG will either schedule a call or conduct an email vote to adopt the updated list.
1/7/20 The Catastrophe Risk SG exposed the additional events for 14 days public comment period ending 1/21/20. One earthquake event was added to the non-U.S. Catastrophe Event Lists.

**This section must be completed on all forms.**

Revised 11-2013
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Source: Munich Re's NAT CAT Service, Swiss Re Sigma and Aon Benfield
The Capital Adequacy (E) Task Force met via conference call April 30, 2020. The following Task Force members participated: Jillian Froment, Chair, represented by Tom Botsko (OH); Todd E. Kiser, Vice Chair, represented by Jake Garn (UT); Jim L. Ridling represented by Richard Ford (AL); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Perry Kupferman (CA); Andrew N. Mais represented by Kathy Belfi and Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Ray Spadeck (FL); Doug Ommen represented by Mike Yanacheak (IA); Robert H. Muriel represented by Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); Chloria Lindley-Myers represented by John Rehagen and William Leung (MO); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Lindsay Crawford (NE); Raymond G. Farmer represented by Michael Shull (SC); Kent Sullivan represented by Mike Boerner (TX); Mike Kreidler represented by Steve Drutz (WA); and Mark Afable represented by Amy Malm (WI).

1. **Heard Introductory Remarks**

   Mr. Botsko announced that the Task Force was given special allowances to hold its April 30 conference call in order to adopt the required changes for 2020 year-end reporting and to meet its risk-based capital (RBC) forecasting publication deadlines. All other non-COVID-19 related topics or discussion items will resume after the Summer National Meeting.

2. **Adopted Proposal 2019-16-CA (Bond Designation Structure)**

   Mr. Rehagen made a motion, seconded by Mr. Drutz, to adopt proposal 2019-16-CA (Attachment One-B1). The motion passed unanimously.


   Mr. Barlow explained that a new schedule in the life/fraternal RBC formula for longevity risk should be considered to determine the appropriate guardrails and factor. Therefore, more information must be obtained in order to develop the guardrails and factors, and it is important that the structure be in place for 2020 year-end with zero factors in order to collect this information.

   Mr. Barlow made a motion, seconded by Mr. Boerner, to adopt proposal 2019-13-L (Attachment One-B2). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Catastrophe Risk (E) Subgroup  [ X ] Investment RBC (E) Working Group  [ ] Operational Risk (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup  [X ] P/C RBC (E) Working Group  [ ] Longevity Risk (A/E) Subgroup

DATE: 12-20-2019

CONTACT PERSON: Jane Barr
TELEPHONE: 
EMAIL ADDRESS: 
ON BEHALF OF: Capital Adequacy Task Force & Investment Risk-Based Capital Working Group

NAME: Kevin Fry
TITLE: 
AFFILIATION: 
ADDRESS: 

FOR NAIC USE ONLY

Agenda Item # 2019-16-CA
Year 2020

DISPOSITION
[ ] ADOPTED 
[ ] REJECTED 
[ ] DEFERRED TO 
[ ] REFERRED TO OTHER NAIC GROUP 
[ X ] EXPOSED 45-day Due 2-5-20, 10-day Due 3-22-20
[ ] OTHER (SPECIFY) 

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

[ X ] Health RBC Blanks  [ X ] Property/Casualty RBC Blanks  [ ] Life and Fraternal RBC Instructions
[ ] Health RBC Instructions  [ ] Property/Casualty RBC Instructions  [ X ] Life and Fraternal RBC Blanks
[ ] OTHER ____________________________

DESCRIPTION OF CHANGE(S)
Incorporate the 20 designations for Bonds structure into the RBC formula in order to conduct an impact analysis for 2020 year-end reporting.

REASON OR JUSTIFICATION FOR CHANGE **
The Blanks Working Group and the Security Valuation Office have adopted the 20 bond designations for 2020 reporting. The reported designations will flow into the RBC but will not include factors. The current factor for designations 1-6 will remain in the RBC until an impact analysis can be done to confirm the new factors for the 20 designations.

Additional Staff Comments:
2/25/20 – Based on NAIC Staff reviewed the comments received along with changes to the 2020 Annual Statement blanks, modifications were made to the following pages, for property: PR006, PR015, PR030 and for health: XR006, XR007.1-XR007.h, XR007.2 and XR023. Because the life formula pulls from the Asset Valuation Reserve, there were only minor changes needed to two total lines on LR002, one on the AVR page and one line description change each on LR030 and LR031. Eky
3/5/20 – Modifications were made to 1) exclude the Hybrid Securities in the PRBC and HRBC PR006 and XR007 Electronic Tables and 2) adjust the XR007 Line 27 to pick up the correct line #. Eky

** This section must be completed on all forms. Revised 2-2019
## Off-Balance Sheet Security Lending Collateral and Schedule DL, Part I Assets

### Asset Category

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</table>

### Denotations
- **Red** denotes items that must be manually entered on the filing software.
- **Blue** denotes items will be used for internal analysis to determine the future RBC charge and will not be reflected in the RBC calculation.

---

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Attachment One-B1

Capital Adequacy (E) Task Force

10-1134

NAIC Proceedings – Summer 2020
## FIXED INCOME ASSETS

### BONDS

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<tr>
<th>Category</th>
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(27) Total Bonds RBC = L(1) + (9A) + L(13) + L(17) + L(21) + L(25) + L(26)

Denotes items will be used for internal analysis to determine the future RBC charge and will not be reflected in the RBC calculation.

Denotes items that must be manually entered on filing software.
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<th>Schedule DA, Part I - Short Term Bonds</th>
<th>Schedule E, Part 2 - Cash Equivalents</th>
<th>All Bonds</th>
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Denotes items that must be vendor linked.
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</table>

Denotes items that must be manually entered on filing software.

* These bonds appear in Schedule D Part 1A Section 1 and are already recognized in the Bond portion of the formula.
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<th>NAIC Designation Category 2.A Bonds</th>
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Note: Ten issuer sections and a grand total page will be available on the filing software. The grand total page is calculated as the sum of issuers 1-10 by asset type.

Denotes items that must be manually entered on filing software.
## CALCULATION OF TOTAL RISK-BASED CAPITAL AFTER COVARIANCE

### H0 - AFFILIATES W/RBC AND MISC. OTHER AMOUNTS

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<td>(5)</td>
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<td>(6)</td>
<td>Directly Owned Alien Insurer</td>
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<td>Indirectly Owned Alien Insurers</td>
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### H1 - ASSET RISK - OTHER

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<td>(11)</td>
<td>Investment in Parent</td>
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<td>(12)</td>
<td>Other Affiliates</td>
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<td>Fair Value Excess Affiliate Common Stock</td>
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<td>Fixed Income Assets</td>
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### H2 - UNDERWRITING RISK

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<td>Other Underwriting Risk</td>
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XR023
Denotes items that must be manually entered on filing software.

(23) Disability Income

(24) Long-Term Care

(25) Limited Benefit Plans

(26) Premium Stabilization Reserve

(27) Total H2

XR014, Underwriting Risk Page, L(26.3)+L(27.3)+L(28.3)+
(29.3)+(30.6)+(31.3)+(32.3)

XR015, Underwriting Risk Page, L(41)

XR016, Underwriting Risk Page, L(42.2)+L(43.6)+L(44)

XR016, Underwriting Risk Page, L(45)

Sum L(21) through L(26)
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<th>(2) RBC Requirement</th>
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(Column (1) should equal Page 2 Column 3 Line 1 + Schedule DL Part 1 Column 6 Line 78999999 + Schedule DL Part 4 Section 4 Column 4 Line 745604325)
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<td>(pre-MODCO/Funds Withdrawn) Line (8) + (16)</td>
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<td>(including MODCO/Funds Withdrawn and Credit for Hedging adjustments)</td>
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<td>Bonds Subject to Size Factor</td>
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<td>(25)</td>
<td>Size Factor for Bonds</td>
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<td>(26)</td>
<td>Total Bonds</td>
<td>Line (22) + Line (26)</td>
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† Only investments in NAIC-1 U.S. Government agency bonds previously reported in Lines (2.8) and (10.8), net of those included on Line (19), plus the portion of Line (20) attributable to ceding companies’ Lines (2.8) and (10.8) should be included on Line (22). No other non-exempt bonds should be included on this line. Exempt U.S. Government bonds shown on Lines (1) and (9) should not be included on Line (22). Refer to the bond section of the risk-based capital instructions for more clarification.

Denotes items that must be manually entered on the filing software.
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| (15) Total Unaffiliated Preferred Stock Including Hybrids | Line (7) + Line (14) | | | | |

| (16) Reduction in RBC for MODCO/Funds Withheld | Company Records (enter a pre-tax amount) | | | | |
| (17) Increase in RBC for MODCO/Funds Withheld | Company Records (enter a pre-tax amount) | | | | |

| (18) Total Unaffiliated Preferred Stock (including MODCO/Funds Withheld) | Lines (7) - (8) + (9) | | | | |
| (19) Total Common Stock | Schedule D Summary Column 1 Line 25 | | | | |
| (20) Less Admitted Unaffiliated Common Stock | Schedule D Summary Column 1 Line 24 | | | | |

| (21) Less Non-Admitted Unaffiliated Common Stock | Company Records | | | | |

| (22) Less Federal Home Loan Bank Common Stock | AVR Equity Component Column 1 Line 3 | | | | |
| (23) Less Unaffiliated Private Common Stock | AVR Equity Component Column 1 Line 4 | | | | |

| (24) Net Other Unaffiliated Public Common Stock | Lines (11) - (12) - (13) - (14) - (15) | | | | |

| (25) Total Admitted Unaffiliated Common Stock | Lines (14) + (15) + (16) | | | | |

| (26) Credit for Hedging | LR015 Hedged Asset Common Stock Schedule Column 10 Line 0299999 | | | | |
| (27) Reduction in RBC for MODCO/Funds Withheld | Company Records (enter a pre-tax amount) | | | | |

| (28) Increase in RBC for MODCO/Funds Withheld | Company Records (enter a pre-tax amount) | | | | |

| (29) Total Admitted Unaffiliated Common Stock (including MODCO/Funds Withheld and Credit for Hedging) | Lines (17) - (18) + (19) + (20) | | | | | |

† The factor for publicly traded common stock should equal 30 percent adjusted up or down by the weighted average beta for the publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent in the same manner that the similar 13 percent factor for publicly traded common stock in the Asset Valuation Reserve (AVR) calculation is adjusted up or down. The rules for calculating the beta adjustment are set forth in the AVR section of the annual statement instructions.
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† After the ten largest issuer exposures are chosen, any NAIC 1 bonds or preferred stocks from any of these issuers should be included.
‡ Refer to the instructions for the Asset Concentration Factor for details of this calculation.

Denotes items that must be manually entered on the filing software.
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<td>(44) Unaffiliated Mortgages - Delinquent with Government Securities</td>
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<td>(45) Unaffiliated Mortgages - Primarily Senior</td>
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<td>(46) Unaffiliated Mortgages - All Other</td>
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<td>(47) Affiliated Mortgages - Category CM2</td>
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<td>(48) Affiliated Mortgages - Category CM3</td>
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<td>(49) Affiliated Mortgages - Category CM4</td>
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<td>(51) Schedule BA Mortgages - 90 Days Overdue</td>
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<td>(52) Schedule BA Mortgages in Process of Foreclosure</td>
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<td>(53) Schedule BA Mortgages Foreclosed - Cumulative Writedowns</td>
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<td>(54) Federal Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(55) Federal Non-Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(56) State Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(57) State Non-Guaranteed Low Income Housing Tax Credits</td>
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<tr>
<td>(58) All Other Low Income Housing Tax Credits</td>
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<tr>
<td>(59) NAIC 02 Working Capital Finance Notes</td>
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<td>(60) Other Schedule BA Assets</td>
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</tbody>
</table>

(62) Total of Issuer = Sum of Lines (1) through (61)

**NOTE:** Ten issuer sections and a grand total page will be available on the filing software. The grand total page is calculated as the sum of issuers 1-10 by asset type.

‡ Refer to the instructions for the Asset Concentration Factor for details of this calculation.

Denotes items that must be manually entered on the filing software.
### HEDGED ASSET BOND SCHEDULE

As of:

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
<th>(7)</th>
<th>(8)</th>
<th>(9)</th>
<th>(10)</th>
<th>(11)</th>
<th>(12)</th>
<th>(13)</th>
<th>(14)</th>
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<tbody>
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<td>Type of Hedged Asset</td>
<td>Hedging Instruments</td>
<td>Relationship Type of the Hedging Instrument and Hedged Asset</td>
<td>Maturity Date</td>
<td>Description</td>
<td>CUSIP</td>
<td>Book / Adjusted Carrying Value</td>
<td>Overlap with Insurer’s Bond Portfolio</td>
<td>NAIC Designation Category</td>
<td>RBC Factor</td>
<td>Gross RBC Charge</td>
<td>RBC Credit for Hedging Instruments</td>
<td>Net RBC Charge</td>
<td></td>
</tr>
<tr>
<td>Bonds</td>
<td>Description</td>
<td>Notional Amount</td>
<td>Maturity Date</td>
<td>Description</td>
<td>CUSIP</td>
<td>Book / Adjusted Carrying Value</td>
<td>Overlap with Insurer’s Bond Portfolio</td>
<td>NAIC Designation Category</td>
<td>RBC Factor</td>
<td>Gross RBC Charge</td>
<td>RBC Credit for Hedging Instruments</td>
<td>Net RBC Charge</td>
<td></td>
</tr>
<tr>
<td>Subtotal - NAIC 1 Through 5 Bonds</td>
<td>xxxxx</td>
<td>xxxxx</td>
<td></td>
<td>Subtotal</td>
<td>xxxxx</td>
<td>xxxxx</td>
<td>xxxxx</td>
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<td>xxxxx</td>
<td>xxxxx</td>
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<tr>
<td>Subtotal - NAIC 6 Bonds</td>
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<td></td>
<td>Subtotal</td>
<td>xxxxx</td>
<td>xxxxx</td>
<td>xxxxx</td>
<td>xxxxx</td>
<td>xxxxx</td>
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<tr>
<td>Total</td>
<td>xxxxx</td>
<td>xxxxx</td>
<td></td>
<td>Total</td>
<td>xxxxx</td>
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<td>xxxxx</td>
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</tr>
</tbody>
</table>

Note: For the intermediate category of hedging, we recommend that the risk mitigation and resulting RBC credit be determined as if each specific security common to both the index/basket hedge and the portfolio is a basic hedge with the entire basic hedge methodology applied to each matching name. This includes the application of the maturity mismatch formula and the maximum RBC credit of 94% of the C-1 asset charge for fixed income hedges.

† Columns are derived from investment schedules.
‡ The portion of Column (2) Notional Amount of the Hedging Instrument that hedges Column (7) Book / Adjusted Carrying Value. This amount cannot exceed Column (7) Book / Adjusted Carrying Value.
§ Factor based on Column (10) NAIC Designation and NAIC C-1 RBC factors table.
* Column (7) Book / Adjusted Carrying Value multiplied by Column (11) RBC Factor.
£ Column (13) is calculated according to the risk-based capital instructions.
** Column (12) Gross RBC Charge minus Column (13) RBC Credit for Hedging Instruments.

Denotes manual entry items that do not arise directly from the annual statement.
### Off-Balance Sheet Collateral

(Including any Schedule DL, Part 1 Assets not Included in the Asset Valuation Reserve)

#### Fixed Income - Bonds

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
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<tbody>
<tr>
<td><strong>Annual Statement Source</strong></td>
<td><strong>Carrying Value</strong></td>
<td><strong>Factor</strong></td>
</tr>
<tr>
<td>(1) Exempt Obligations</td>
<td>Company Records</td>
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<tr>
<td>(2.1) NAIC Designation Category 1.A</td>
<td>Company Records</td>
<td>X 0.0059</td>
</tr>
<tr>
<td>(2.2) NAIC Designation Category 1.B</td>
<td>Company Records</td>
<td>X 0.0059</td>
</tr>
<tr>
<td>(2.3) NAIC Designation Category 1.C</td>
<td>Company Records</td>
<td>X 0.0059</td>
</tr>
<tr>
<td>(2.4) NAIC Designation Category 1.D</td>
<td>Company Records</td>
<td>X 0.0059</td>
</tr>
<tr>
<td>(2.5) NAIC Designation Category 1.E</td>
<td>Company Records</td>
<td>X 0.0059</td>
</tr>
<tr>
<td>(2.6) NAIC Designation Category 1.F</td>
<td>Company Records</td>
<td>X 0.0059</td>
</tr>
<tr>
<td>(2.7) NAIC Designation Category 1.G</td>
<td>Company Records</td>
<td>X 0.0059</td>
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<tr>
<td>(2.8) Subtotal NAIC 1</td>
<td>Sum of Lines (2.1) through (2.7)</td>
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<tr>
<td>(3.1) NAIC Designation Category 2.A</td>
<td>Company Records</td>
<td>X 0.0126</td>
</tr>
<tr>
<td>(3.2) NAIC Designation Category 2.B</td>
<td>Company Records</td>
<td>X 0.0126</td>
</tr>
<tr>
<td>(3.3) NAIC Designation Category 2.C</td>
<td>Company Records</td>
<td>X 0.0126</td>
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<tr>
<td>(3.4) Subtotal NAIC 2</td>
<td>Sum of Lines (3.1) through (3.3)</td>
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<tr>
<td>(4.1) NAIC Designation Category 3.A</td>
<td>Company Records</td>
<td>X 0.0446</td>
</tr>
<tr>
<td>(4.2) NAIC Designation Category 3.B</td>
<td>Company Records</td>
<td>X 0.0446</td>
</tr>
<tr>
<td>(4.3) NAIC Designation Category 3.C</td>
<td>Company Records</td>
<td>X 0.0446</td>
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<tr>
<td>(4.4) Subtotal NAIC 3</td>
<td>Sum of Lines (4.1) through (4.3)</td>
<td>=</td>
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<tr>
<td>(5.1) NAIC Designation Category 4.A</td>
<td>Company Records</td>
<td>X 0.0970</td>
</tr>
<tr>
<td>(5.2) NAIC Designation Category 4.B</td>
<td>Company Records</td>
<td>X 0.0970</td>
</tr>
<tr>
<td>(5.3) NAIC Designation Category 4.C</td>
<td>Company Records</td>
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<tr>
<td>(5.4) Subtotal NAIC 4</td>
<td>Sum of Lines (5.1) through (5.3)</td>
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<td>(6.1) NAIC Designation Category 5.A</td>
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<tr>
<td>(6.2) NAIC Designation Category 5.B</td>
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<tr>
<td>(6.3) NAIC Designation Category 5.C</td>
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<td>X 0.2231</td>
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<tr>
<td>(6.4) Subtotal NAIC 5</td>
<td>Sum of Lines (6.1) through (6.3)</td>
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<tr>
<td>(7) NAIC 6</td>
<td>Company Records</td>
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</tr>
<tr>
<td>(8) Total Bonds</td>
<td>Sum of Lines (1) + (2.8) + (3.4) + (4.4) + (5.4) + (6.4) + (7)</td>
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</table>

#### Fixed Income - Preferred Stock

<table>
<thead>
<tr>
<th>(9)</th>
<th>(10)</th>
<th>(11)</th>
<th>(12)</th>
<th>(13)</th>
<th>(14)</th>
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<tbody>
<tr>
<td><strong>Annual Statement Source</strong></td>
<td><strong>Carrying Value</strong></td>
<td><strong>Factor</strong></td>
<td><strong>RBC Requirement</strong></td>
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<td></td>
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<tr>
<td>(9) Asset NAIC 1</td>
<td>Company Records</td>
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<td></td>
</tr>
<tr>
<td>(10) Asset NAIC 2</td>
<td>Company Records</td>
<td>X 0.0126</td>
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</tr>
<tr>
<td>(11) Asset NAIC 3</td>
<td>Company Records</td>
<td>X 0.0446</td>
<td>=</td>
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<tr>
<td>(12) Asset NAIC 4</td>
<td>Company Records</td>
<td>X 0.0970</td>
<td>=</td>
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<tr>
<td>(13) Asset NAIC 5</td>
<td>Company Records</td>
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<td>(14) Asset NAIC 6</td>
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<tr>
<td>(15) Total Preferred Stock</td>
<td>Sum of Lines (9) through (14)</td>
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<tr>
<td>(16) Common Stock</td>
<td>Company Records</td>
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<td>(17) Schedule BA - Other Invested Assets</td>
<td>Company Records</td>
<td>X 0.300</td>
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<td>(18) Other Invested Assets</td>
<td>Company Records</td>
<td>X 0.300</td>
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<tr>
<td>(19) Total Off-Balance Sheet Collateral</td>
<td>Lines (8) + (15) + (16) + (17) + (18)</td>
<td>=</td>
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</tbody>
</table>

† The factor for common stock can vary depending on the type of stock. The factor would be subject to a minimum of 22.5 percent and a maximum of 45 percent.

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

<table>
<thead>
<tr>
<th>Source</th>
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<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
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<tbody>
<tr>
<td>(001) Long-term Bonds – NAIC 1</td>
<td>LR002 Bonds Column (2) Line (2.8) + LR018 Off-Balance Sheet Collateral Column (3) Line (2.8)</td>
<td>X</td>
<td>0.1575</td>
<td>=</td>
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<tr>
<td>(002) Long-term Bonds – NAIC 2</td>
<td>LR002 Bonds Column (2) Line (3.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (3.4)</td>
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<tr>
<td>(003) Long-term Bonds – NAIC 3</td>
<td>LR002 Bonds Column (2) Line (4.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (4.4)</td>
<td>X</td>
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<tr>
<td>(004) Long-term Bonds – NAIC 4</td>
<td>LR002 Bonds Column (2) Line (5.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (5.4)</td>
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<td>0.1575</td>
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<tr>
<td>(005) Long-term Bonds – NAIC 5</td>
<td>LR002 Bonds Column (2) Line (6.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (6.4)</td>
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<tr>
<td>(006) Long-term Bonds – NAIC 6</td>
<td>LR002 Bonds Column (2) Line (7) + LR018 Off-Balance Sheet Collateral Column (3) Line (7)</td>
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<td>(007) Short-term Bonds – NAIC 1</td>
<td>LR002 Bonds Column (2) Line (10.8)</td>
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<td>(008) Short-term Bonds – NAIC 2</td>
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<td>(009) Short-term Bonds – NAIC 3</td>
<td>LR002 Bonds Column (2) Line (12.4)</td>
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<td>(010) Short-term Bonds – NAIC 4</td>
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<td>(011) Short-term Bonds – NAIC 5</td>
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<td>(012) Short-term Bonds – NAIC 6</td>
<td>LR002 Bonds Column (2) Line (15)</td>
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<td>0.2100</td>
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<td>(013) Credit for Hedging - NAIC 1 Through 5 Bonds</td>
<td>LR014 Hedged Asset Bond Schedule Column (13) Line (0199999)</td>
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<td>(014) Credit for Hedging - NAIC 6 Bonds</td>
<td>LR014 Hedged Asset Bond Schedule Column (13) Line (0299999)</td>
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<td>(015) Bond Reduction - Reinsurance</td>
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<td>(016) Bond Increase - Reinsurance</td>
<td>LR002 Bonds Column (2) Line (20)</td>
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<td>(017) Non-Exempt NAIC 1 U.S. Government Agency</td>
<td>LR002 Bonds Column (2) Line (22)</td>
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<td>(018) Bonds Size Factor</td>
<td>LR002 Bonds Column (2) Line (26) - LR002 Bonds Column (2) Line (21)</td>
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### Mortgages

<table>
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<th>Source</th>
<th>Source</th>
<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>(019) Residential Mortgages - Insured</td>
<td>LR004 Mortgages Column (6) Line (1)</td>
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<tr>
<td>(020) Residential Mortgages - Other</td>
<td>LR004 Mortgages Column (6) Line (2)</td>
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<td>0.1575</td>
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<tr>
<td>(021) Commercial Mortgages - Insured</td>
<td>LR004 Mortgages Column (6) Line (3)</td>
<td>X</td>
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<tr>
<td>(022) Total Commercial Mortgages - All Other</td>
<td>LR004 Mortgages Column (6) Line (9)</td>
<td>X</td>
<td>0.1575</td>
<td>=</td>
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<tr>
<td>(023) Total Farm Mortgages</td>
<td>LR004 Mortgages Column (6) Line (15)</td>
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<tr>
<td>(024) Farm Mortgages</td>
<td>LR004 Mortgages Column (6) Line (16)</td>
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<td>(026) Residential Mortgages - Other</td>
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<td>(027) Commercial Mortgages - Insured</td>
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<td>X</td>
<td>0.1575</td>
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<tr>
<td>(028) Commercial Mortgages - Other</td>
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<tr>
<td>(029) Farm Mortgages</td>
<td>LR004 Mortgages Column (6) Line (21)</td>
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<td>0.1575</td>
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</tbody>
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† Denotes lines that are deducted from the total rather than added.

Denotes items that must be manually entered on the filing software.
## CALCULATION OF TAX EFFECT FOR LIFE RISK-BASED CAPITAL (CONTINUED)

<table>
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<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Mortgages - Insured</td>
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<tr>
<td>Residential Mortgages - Other</td>
<td>LR004 Mortgages Column (6) Line (23)</td>
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<td>Commercial Mortgages - Insured</td>
<td>LR004 Mortgages Column (6) Line (24)</td>
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</tr>
<tr>
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<td>LR004 Mortgages Column (6) Line (25)</td>
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<td>Due &amp; Unpaid Taxes Mortgages</td>
<td>LR004 Mortgages Column (6) Line (26)</td>
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</tr>
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<td>Mortgage Reduction - Reinsurance</td>
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<td>LR004 Mortgages Column (6) Line (30)</td>
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<td>Preferred Stock and Hybrid Securities - Preferred Stock</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (1) X</td>
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<td>LR006 Separate Accounts Column (3) Line (8) X</td>
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<td>Separate Account Surplus</td>
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<td>Investment Real Estate</td>
<td>LR007 Real Estate Column (3) Line (9)</td>
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<tr>
<td>Real Estate Reduction - Reinsurance</td>
<td>LR007 Real Estate Column (3) Line (11)</td>
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<tr>
<td>Real Estate Increase - Reinsurance</td>
<td>LR007 Real Estate Column (3) Line (12)</td>
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<td>Schedule BA - Real Estate Excluding Low Income Housing Tax Credits</td>
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<td>Guaranteed Low Income Housing Tax Credits</td>
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<td>Non-Guaranteed and All Other Low Income Housing Tax Credits</td>
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<td>SCH BA Real Estate Reduction - Reinsurance</td>
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<tr>
<td>(093) Derivatives - Collateral and Exchange Traded</td>
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<tr>
<td>not Subject to Risk-Based Capital</td>
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<td>Subtotal for C-0 Affiliated Common Stock</td>
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### CALCULATION OF TAX EFFECT FOR LIFE RISK-BASED CAPITAL (CONTINUED)

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<td>(136) Group Insurance C-2 Risk</td>
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<tr>
<td>(137) Disability and Long-Term Care Health Claim Reserves</td>
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<td>(139) Total C-2 Risk</td>
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<td>(145) Total Tax Effect</td>
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### CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL

**Asset Risk - Affiliated Amounts (C-0)**

1. Affiliated US Property-Casualty Insurers Directly Owned
2. Affiliated US Life Insurers Directly Owned
3. Affiliated US Health Insurers Directly and Indirectly Owned
4. Affiliated US Property-Casualty Insurers Indirectly Owned
5. Affiliated US Life Insurers Indirectly Owned
6. Affiliated Alien Life Insurers - Canadian
7. Affiliated Alien Life Insurers - All Others
8. Off-Balance Sheet and Other Items
9. Total (C-0) - Pre-Tax
10. (C-0) Tax Effect
11. Net (C-0) - Post-Tax

**Asset Risk – Unaffiliated Common Stock and Affiliated Non-Insurance Stock (C-1cs)**

12. Schedule D Unaffiliated Common Stock
13. Schedule BA Unaffiliated Common Stock
14. Common Stock Concentration Factor
15. Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subsidiaries
16. Total (C-1cs) - Pre-Tax
17. (C-1cs) Tax Effect
18. Net (C-1cs) - Post-Tax

**Asset Risk - All Other (C-1o)**

20. Affiliated Preferred Stock and Common Stock - Investment Subsidiaries
21. Affiliated Preferred Stock and Common Stock - Parent
22. Affiliated Preferred Stock and Common Stock - Property and Casualty Insurers not Subject to Risk-Based Capital
23. Affiliated Preferred Stock and Common Stock - Life Insurers not Subject to Risk-Based Capital
24. Affiliated Preferred Stock and Common Stock - Publicly Traded Insurers Held at Fair Value (excess of statement value over book value)
25. Separate Accounts with Guarantees

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### CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL (CONTINUED)

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<td><strong>Total Risk-Based Capital After Covariance Before Basic Operational Risk</strong></td>
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<td>(67) C-0 + C-4a + Square Root of [(C-1o + C-3a)^2 + (C-1cs + C-3c)^2 + (C-2)^2 + (C-3b)^2]</td>
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<td>+ [(L(42) + L(52))^2 + (L(20) + L(58))^2 + L(49)^2 + L(55)^2 + L(66)^2]</td>
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<td>(68) Gross Basic Operational Risk 0.03 x L(67)</td>
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<td>(70) Net Basic Operational Risk Line (68) - (Line (63) + Line (69)) (Not less than zero)</td>
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<td>(71) Total Risk-Based Capital After Covariance (Including Basic Operational Risk and Primary Security Shortfall multiplied by 2) Line (67) + Line (70) + Line (71)</td>
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<td>(72) Total Risk-Based Capital After Covariance Times Fifty Percent Line (71) x 0.50</td>
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## Asset Valuation Reserve

**Basic Contribution, Reserve Objective and Maximum Reserve Calculations**

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#### Book/Adjusted Carrying Value - RBC Requirement

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#### Bond Size Factor

\[
L(1) = \frac{L(2A) + L(27) - L(30)}{1.500}
\]

---

**Notes:**
- **NAIC 01 - U.S. Government - Direct and Guaranteed and NAIC U.S. Direct Obligations/Ful...**
- **Exempt Money Market Funds List/SVO Ident. Bond ETF List**
- **Electronic only Tables Source**
- **Book/Adjusted Carrying Value Annual Statement Source:**
  - **Book/Adjusted Carrying Value Factor RBC Requirement**
### Electronic Table

#### Tbl A - Schedule D Part 1:

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**All Bonds**

### Electronic Table

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**Denotes items that must be vendor linked.**

**Denotes items that must be manually entered on the filing software.**
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## OFF-BALANCE SHEET COLLATERAL AND SCHEDULE DL, PART 1 ASSETS

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<td>(20E) NAIC 05 Unaffiliated Preferred Stock</td>
<td>Company Records</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Total Unaffiliated Preferred Stock</td>
<td>Company Records</td>
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<td>(21A) Total Unaffiliated Common Stock</td>
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<td>(22A) Real Estate and Schedule RA - Other Invested Assets</td>
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<td>(23A) Other Invested Assets</td>
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<td>(24A) Mortgage Loans on Real Estate</td>
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<td>0</td>
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<tr>
<td>(25A) Cash, Cash Equivalents, non-government money market fund and Short-Term Investments</td>
<td>Company Records</td>
<td>0</td>
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<tr>
<td>(26A) Total</td>
<td>1.077<em>1.034</em>1.03<em>1.054</em>1.057<em>1.038</em>1.039</td>
<td>0</td>
<td>0</td>
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*Denotes items that must be manually entered on the filing software.*
*Denotes items will be used for internal analysis to determine the future RBC charge and will not be reflected in the RBC calculation.*
### Calculation of Total Risk-Based Capital After Covariance PR030 R0-R1

<table>
<thead>
<tr>
<th>Subsidiary Insurance Companies and Misc. Other Amounts</th>
<th>PRBC Or I Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Affiliated US P&amp;C Insurers - Directly Owned</td>
<td>PR004 L(1) C(4)</td>
<td>0</td>
</tr>
<tr>
<td>(2) Affiliated US P&amp;C Insurers - Indirectly Owned</td>
<td>PR004 L(4) C(4)</td>
<td>0</td>
</tr>
<tr>
<td>(3) Affiliated US Life Insurers - Directly Owned</td>
<td>PR004 L(2) C(4)</td>
<td>0</td>
</tr>
<tr>
<td>(4) Affiliated US Life Insurers - Indirectly Owned</td>
<td>PR004 L(6) C(4)</td>
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</tr>
<tr>
<td>(5) Affiliated US Health Insurer - Directly Owned</td>
<td>PR004 L(3) C(4)</td>
<td>0</td>
</tr>
<tr>
<td>(6) Affiliated US Health Insurer - Indirectly Owned</td>
<td>PR004 L(7) C(4)</td>
<td>0</td>
</tr>
<tr>
<td>(7) Affiliated Alien Insurers - Directly Owned</td>
<td>PR004 L(5) C(4)</td>
<td>0</td>
</tr>
<tr>
<td>(8) Affiliated Alien Insurers - Indirectly Owned</td>
<td>PR004 L(9) C(4)</td>
<td>0</td>
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<tr>
<td>(9) Misc Off-Balance Sheet - Non-Controlled Assets</td>
<td>PR004 L(15) C(3)</td>
<td>0</td>
</tr>
<tr>
<td>(10) Misc Off-Balance Sheet - Guarantee for Affiliates</td>
<td>PR004 L(16) C(3)</td>
<td>0</td>
</tr>
<tr>
<td>(11) Misc Off-Balance Sheet - Contingent Liabilities</td>
<td>PR004 L(17) C(3)</td>
<td>0</td>
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<tr>
<td>(12) Misc Off-Balance Sheet - SSAP No 101 Par. 11A DTA</td>
<td>PR004 L(18) C(3)</td>
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<tr>
<td>(13) Misc Off-Balance Sheet - SSAP No 101 Par. 11B DTA</td>
<td>PR004 L(20) C(3)</td>
<td>0</td>
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</tbody>
</table>

Total R0: \( L(1)+L(2)+L(3)+L(4)+L(5)+L(6)+L(7)+L(8)+L(9)+L(10)+L(11)+L(12)+L(13) \)

<table>
<thead>
<tr>
<th>Asset Risk - Fixed Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>(15) NAIC 01 U.S. Government Agency Bonds</td>
</tr>
<tr>
<td>(16) Bonds Subject to Size Factor</td>
</tr>
<tr>
<td>(17) Bond Size Factor RBC</td>
</tr>
<tr>
<td>(18) Off-balance Sheet Collateral &amp; Sch DL, PT1 - Total Bonds</td>
</tr>
<tr>
<td>(19) Other Long-Term Assets - Mortgage Loans, LIHTC &amp; WCFI</td>
</tr>
<tr>
<td>(21) Misc Assets - Collateral Loans</td>
</tr>
<tr>
<td>(22) Misc Assets - Cash</td>
</tr>
<tr>
<td>(23) Misc Assets - Cash Equivalents</td>
</tr>
<tr>
<td>(24) Misc Assets - Other Short-Term Investments</td>
</tr>
<tr>
<td>(25) Replication - Synthetic Asset - One Half</td>
</tr>
<tr>
<td>(26) Asset Concentration RBC - Fixed Income</td>
</tr>
</tbody>
</table>

Total R1: \( L(15)+L(16)+L(17)+L(18)+L(19)+L(20)+L(21)+L(22)+L(23)+L(24)+L(25)+L(26) \)
## Capital Adequacy (E) Task Force

### RBC Proposal Form

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>Capital Adequacy (E) Task Force</td>
<td>[ ] Health RBC (E) Working Group</td>
</tr>
<tr>
<td>[ ]</td>
<td>Catastrophe Risk (E) Subgroup</td>
<td>[ ] Investment RBC (E) Working Group</td>
</tr>
<tr>
<td>[ ]</td>
<td>C3 Phase II/ AG43 (E/A) Subgroup</td>
<td>[ ] P/C RBC (E) Working Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE: 6/6/19</th>
<th>FOR NAIC USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT PERSON: Dave Fleming</td>
<td>Agenda Item # 2019-13-L</td>
</tr>
<tr>
<td>TELEPHONE: 816-783-8121</td>
<td>Year 2019</td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:dfleming@naic.org">dfleming@naic.org</a></td>
<td>DISPOSITION</td>
</tr>
<tr>
<td>ON BEHALF OF: Longevity Risk (A/E) Subgroup</td>
<td>[ X ] ADOPTED 2/14/20</td>
</tr>
<tr>
<td>NAME: Rhonda Ahrens, Chair</td>
<td>[ ] REJECTED</td>
</tr>
<tr>
<td>TITLE: Chief Actuary</td>
<td>[ ] DEFERRED TO</td>
</tr>
<tr>
<td>AFFILIATION: Nebraska Department of Insurance</td>
<td>[ ] REFERRED TO OTHER NAIC GROUP</td>
</tr>
<tr>
<td>ADDRESS: 1135 M Street, Suite 300</td>
<td>[ X ] EXPOSED 11/4 12/4</td>
</tr>
<tr>
<td>Lincoln, NE 68501-2089</td>
<td>[ ] OTHER (SPECIFY)</td>
</tr>
</tbody>
</table>

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>Health RBC Blanks</td>
<td>[ ] Property/Casualty RBC Blanks</td>
</tr>
<tr>
<td>[ ]</td>
<td>Health RBC Instructions</td>
<td>[ ] Property/Casualty RBC Instructions</td>
</tr>
<tr>
<td>[ ]</td>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

### DESCRIPTION OF CHANGE(S)

This proposal creates a new schedule in the life and fraternal RBC formula along with the necessary instructions to incorporate a charge for longevity risk.

### REASON OR JUSTIFICATION FOR CHANGE **

The Longevity Risk (A/E) Subgroup was charged with providing recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate. This represents the Subgroup’s recommendation as it applies to RBC.

### Additional Staff Comments:

- 11-4-19: Proposal was exposed for comments (DBF)
- 12-4-19: Proposal was re-exposed for comments by the Life Risk-Based Capital (E) Working Group (DBF)
- 2-14-20: Proposal was adopted by the Life Risk-Based Capital (E) Working Group (DBF)

** This section must be completed on all forms.  

Revised 2-2019
<table>
<thead>
<tr>
<th>Factor</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>General Account Life Contingent Annuity Reserve Exhibit 5 Column 2 Line 0299999, in part†</td>
</tr>
<tr>
<td>(2)</td>
<td>General Account Life Contingent Supplemental Contract Reserves Exhibit 5 Column 2 Line 0399999, in part‡</td>
</tr>
<tr>
<td>(3)</td>
<td>General Account Life Contingent Miscellaneous Reserves Exhibit 5 Column 2 Line 0799999, in part‡</td>
</tr>
<tr>
<td>(4)</td>
<td>Separate Account (SA) Life Contingent Annuity Reserve S/A Exhibit 3 Column 2 Line 0299999, in part‡</td>
</tr>
<tr>
<td>(5)</td>
<td>Total Life Contingent Annuity Reserves Lines (1) + (2) + (3) + (4) X † =</td>
</tr>
</tbody>
</table>

† The tiered calculation is illustrated in the Longevity Risk section of the risk-based capital instructions.  
‡ Include only the portion of reserves for products in scope per the instructions.
<table>
<thead>
<tr>
<th>Source</th>
<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>(134) Long-Term Care LR019 Health Premiums Column (2) Line (28) + LR023 Long-Term Care X 0.2100 =</td>
<td>Column (4) Line (7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(135) Life Insurance C-2 Risk LR025 Life Insurance Column (2) Line (8) X 0.2100 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(136) Group Insurance C-2 Risk LR025 Life Insurance Column (2) Line (8) X 0.2100 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(136b) Longevity C-2 Risk LRtbd Longevity Risk Column (2) Line (5) X 0.2100 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(137) Disability and Long Term Care Health LR024 Health Claim Reserves Column (4) Line (9) + Line (15) X 0.2100 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(138) Premium Stabilization Credit LR026 Premium Stabilization Reserves Column (2) Line (10) X 0.0000 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(139) Total C-2 Risk L(133) + L(134) + L(137) + L(138) + Square Root of [ (L(135) + L(136))2 + 2 * (TBD Correlation Factor) * (L(135) + L(136)) * L(136b) ]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(140) Interest Rate Risk LR027 Interest Rate Risk Column (3) Line (36) X 0.2100 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(141) Health Credit Risk LR028 Health Credit Risk Column (2) Line (7) X 0.0000 =</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(142) Market Risk LR027 Interest Rate Risk Column (3) Line (37) X 0.2100 =</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(143) Business Risk LR029 Business Risk Column (2) Line (40) X 0.2100 =</td>
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<td>(144) Health Administrative Expenses LR029 Business Risk Column (2) Line (57) X 0.0000 =</td>
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<tr>
<td>(145) Total Tax Effect Line (109) + (120) + (132) + (140) + (142) + (143) + (144)</td>
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</tr>
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</table>
CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL (CONTINUED)

(1) RBC

Insurance Risk (C-2)

(43) Individual and Industrial Life Insurance LR025 Life Insurance Column (2) Line (8)

(44) Group and Credit Life Insurance and FEGI/SGLI LR025 Life Insurance Column (2) Lines (20) and (21)

(44b) Longevity Risk LRtbd Longevity Risk Column

(45) Total Health Insurance LR024 Health Claim Reserves Column (4) Line (18)

(46) Premium Stabilization Reserve Credit LR026 Premium Stabilization Reserves Column (2) Line (10)

Alternative with Guardrail Factor:

(47) Total (C-2) - Pre-Tax

L(45) + L(46) + Square Root of [ (L(43) + L(44))2 + L(44b)2 + 2 * (TBD Correlation Factor) * (L(43) + L(44)) * L(44b) ]

(48) Total (C-2) - Post-Tax

L(47) + Greatest of [ Guardrail Factor * (L(43)+L(44)), Guardrail Factor * L(44b), Square Root of [ (L(43) + L(44))2 + L(44b)2 + 2 * (TBD Correlation Factor) * (L(43) + L(44)) * L(44b) ] ]

Interest Rate Risk (C-3a)

(50) Total Interest Rate Risk - Pre-Tax LR027 Interest Rate Risk Column (3) Line (36)

(51) Total Interest Rate Risk - Post-Tax LR027 Interest Rate Risk Column (3) Line (36)

(52) Total Interest Rate Risk - Post-Tax LR027 Interest Rate Risk Column (3) Line (36)

Health Credit Risk (C-3b)

(53) Total Health Credit Risk - Pre-Tax LR028 Health Credit Risk Column (2) Line (7)

(54) Total Health Credit Risk - Pre-Tax LR028 Health Credit Risk Column (2) Line (7)

(55) Total Health Credit Risk - Post-Tax LR028 Health Credit Risk Column (2) Line (7)

(56) Total Health Credit Risk - Post-Tax LR028 Health Credit Risk Column (2) Line (7)

Market Risk (C-3c)

(56) Total Market Risk - Pre-Tax LR027 Interest Rate Risk Column (3) Line (37)

(57) Total Market Risk - Post-Tax LR027 Interest Rate Risk Column (3) Line (37)

(58) Total Market Risk - Post-Tax LR027 Interest Rate Risk Column (3) Line (37)

Company Name

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LONGEVITY RISK
LRtbd

Basis of Factors

The factors chosen represent surplus needed to provide for claims in excess of reserves resulting from increased policyholder longevity calibrated to a 95th percentile level. For the purpose of this calibration aggregate reserves were assumed to provide for an 85th percentile outcome.

Longevity risk was considered over the entire lifetime of the policies since these annuity policies are generally not subject to repricing. Calibration of longevity risk considered both trend risk based on uncertainty in future population mortality improvements, as well as level or volatility risk which derives from misestimation of current population mortality rates or random fluctuations. Trend risk applies equally to all populations whereas level and volatility risk factors decrease with larger portfolios consistent with the law of large numbers.

Statutory reserve was chosen as the exposure base as a consistent measure of the economic exposure to increased longevity. Factors were also scaled by reserve level since number of insured policyholders is a less accessible measure of company specific volatility risk. Factors provided are pre-tax and were developed assuming a 21% tax adjustment would be subsequently applied.

Specific Instructions for Application of the Formula

Annual statement reference is for the total life contingent reserve for the products in scope. The scope includes annuity products with life contingent payments where benefits are to be distributed in the form of an annuity. It does not include annuity products that are not life contingent, or deferred annuity products where the policyholder has a right but not an obligation to annuitize. Line (3) for General Account Life Contingent Miscellaneous reserves is included in the event there are any reserves for products in scope reported on Exhibit 5 line 079999; it is not meant to include cash flow testing reserves reported on this line. Included in scope are:

- Single Premium Immediate Annuities (SPIA) and other payout annuities in pay status
- Deferred Payout Annuities which will enter annuity pay status in the future upon annuitization
- Structured Settlements for annuitants with any life contingent benefits
- Group Annuities, such as those associated with pension liabilities with both immediate and deferred benefits

The total reserve exposure is then further broken down by size as in a tax table. This breakdown will not appear on the RBC filing software or on the printed copy, as the application of factors to reserves is completed automatically. The calculation is as follows:

<table>
<thead>
<tr>
<th>Line (5)</th>
<th>Life Contingent Annuity Reserves</th>
<th>(1) Statement Value</th>
<th>Factor</th>
<th>(2) RBC Requirement</th>
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</thead>
<tbody>
<tr>
<td>First 250 Million</td>
<td></td>
<td></td>
<td>X 0.0171</td>
<td></td>
</tr>
<tr>
<td>Next 250 Million</td>
<td></td>
<td></td>
<td>X 0.0108</td>
<td></td>
</tr>
<tr>
<td>Next 500 Million</td>
<td></td>
<td></td>
<td>X 0.0095</td>
<td></td>
</tr>
<tr>
<td>Over 1,000 Million</td>
<td></td>
<td></td>
<td>X 0.0089</td>
<td></td>
</tr>
<tr>
<td>Total Life Contingent Annuity Reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Capital Adequacy (E) Task Force**

**RBC Proposal Form**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>[ ] Catastrophe Risk (E) Subgroup</td>
<td>[ ] Investment RBC (E) Working Group</td>
<td>[ ] SMI RBC (E) Subgroup</td>
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<td>[ ] C3 Phase II/ AG43 (E/A) Subgroup</td>
<td>[ ] P/C RBC (E) Working Group</td>
<td>[ ] Stress Testing (E) Subgroup</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DATE:** 04/15/2020

**CONTACT PERSON:** Jane Barr

**TELEPHONE:** 816-783-8413

**EMAIL ADDRESS:** jbarr@naic.org

**ON BEHALF OF:** Capital Adequacy (E) Task Force

**NAME:** Tom Botsko

**TITLE:** Chair

**AFFILIATION:** Ohio Department of Insurance

**ADDRESS:** 50 West Town Street, Suite 300

**Columbus, OH 43215**

---

**FOR NAIC USE ONLY**

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th>2020-05-CA</th>
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<tr>
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<tr>
<td>[ ] ADOPTED</td>
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</tr>
<tr>
<td>[ ] REJECTED</td>
<td></td>
</tr>
<tr>
<td>[ ] DEFERRED TO</td>
<td></td>
</tr>
<tr>
<td>[ ] REFERRED TO OTHER NAIC GROUP</td>
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<tr>
<td>[x] EXPOSED</td>
<td>Ending 5/15/20</td>
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<tr>
<td>[ ] OTHER (SPECIFY)</td>
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</tr>
</tbody>
</table>

---

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

| [ ] Health RBC Blanks | [x] Health RBC Instructions | [ ] Other ________________ |
| [ ] Life and Fraternal RBC Blanks | [x] Life and Fraternal RBC Instructions |
| [ ] Property/Casualty RBC Blanks | [x] Property/Casualty RBC Instructions |

**DESCRIPTION OF CHANGE(S)**

Insert the word “Overview” in the page heading on page iv and modify the Table of Contents to include only the page heading and delete references to the individual sections of the Overview.

**REASON OR JUSTIFICATION FOR CHANGE **

The purpose of the proposal to clarify the overview of the RBC pages and make the references for this page consistent with the other page references in the Table of Contents.

**Additional Staff Comments:**

4/15/20 Exposed for 30-day comment period ending on May 15, 2020.
5/15/20 No comments received during comment period.

**This section must be completed on all forms.**

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### Overview of the NAIC Health Risk-Based Capital Report

**Introduction**

Risk-based capital (RBC) is a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile. It provides an elastic means of setting the capital requirement in which the degree of risk taken by the insurer is the primary determinant. The five major categories of risks involved are:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Affiliates H–0 And Misc. Other</td>
<td>This is the risk from declining value of insurance subsidiaries as well as risk from off-balance sheet and other misc. accounts (e.g. DTAs).</td>
</tr>
<tr>
<td>Asset Risk – Other H–1</td>
<td>This is the risk of assets’ default of principal and interest or fluctuation in market value.</td>
</tr>
</tbody>
</table>

**Detail Eliminated To Conserve Space**
Overview of the NAIC Life and Fraternal Risk-Based Capital Report

Introduction

Risk-based capital (RBC) is a method of measuring the minimum amount of capital appropriate for an insurance company to support its overall business operations in consideration of its size and risk profile. It provides an elastic means of setting the capital requirement in which the degree of risk taken by the insurer is the primary determinant. The five major categories of risks involved are:

- **Insurance Affiliates and Misc. Other (C-0)**
  This is the risk from declining value of insurance subsidiaries as well as risk from off-balance sheet and other misc. accounts (e.g., DTAs).

- **Asset Risk - Other (C-1)**
  This is the risk of assets' default of principal and interest or fluctuation in fair value.

- **Insurance Risk (C-2)**
  This is the risk of underestimating liabilities from business already written or inadequately pricing business to be written in the coming year.
Overview of the NAIC Property and Casualty Risk-Based Capital Report

Introduction

Risk-based capital is a method of establishing the minimum amount of capital appropriate for an insurance company to support its overall business operations in consideration of its size and risk profile. It provides an elastic means of setting the minimum capital requirement in which the degree of risk taken by the insurer is the primary determinant.

A company’s risk-based capital is calculated by applying factors to various asset, premium and reserve items. The factor is higher for those items with greater underlying risk and lower for less risky items. The adequacy of a company’s actual capital may then be measured by a comparison to its risk-based capital as determined by the formula.

Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions relating to insurers that show indications of weak or deteriorating conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in conservatorship.
Capital Adequacy (E) Task Force

RBC Proposal Form

DATE: 6/4/20

CONTACT PERSON: Dave Fleming

TELEPHONE: 816-783-8121

EMAIL ADDRESS: dfleming@naic.org

ON BEHALF OF: Longevity Risk (A/E) Subgroup

NAME: Rhonda Ahrens, Chair

TITLE: Chief Actuary

AFFILIATION: Nebraska Department of Insurance

ADDRESS: 1135 M Street, Suite 300
Lincoln, NE 68501-2089

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

Health RBC Blanks
Health RBC Instructions
[ X ] Life and Fraternal RBC Blanks

PROPERTY/CASUALTY RBC Blanks
Property/Casualty RBC Instructions
[ X ] Life and Fraternal RBC Instructions

Life and Fraternal RBC Instructions

DESCRIPTION OF CHANGE(S)

This proposal creates the instructions necessary to complete the new longevity risk schedule.

REASON OR JUSTIFICATION FOR CHANGE **

The Longevity Risk (A/E) Subgroup was charged with providing recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate. The Subgroup’s recommendation for the structure necessary was adopted by the Life Risk-Based Capital (E) Working Group on 2-14-20 in proposal 2019-13-L.

Additional Staff Comments:

• 4-30-20: The instructions including zero factors was exposed for comment (DBF)

** This section must be completed on all forms.

Revised 2-2019
LONGEVITY RISK

Basis of Factors

The factors chosen represent surplus needed to provide for claims in excess of reserves resulting from increased policyholder longevity calibrated to a 95th percentile level. For the purpose of this calibration aggregate reserves were assumed to provide for an 85th percentile outcome.

Longevity risk was considered over the entire lifetime of the policies since these annuity policies are generally not subject to repricing. Calibration of longevity risk considered both trend risk based on uncertainty in future population mortality improvements, as well as level or volatility risk which derives from misestimation of current population mortality rates or random fluctuations. Trend risk applies equally to all populations whereas level and volatility risk factors decrease with larger portfolios consistent with the law of large numbers.

Statutory reserve was chosen as the exposure base as a consistent measure of the economic exposure to increased longevity. Factors were also scaled by reserve level since number of insured policyholders is a less accessible measure of company specific volatility risk. Factors provided are pre-tax and were developed assuming a 21% tax adjustment would be subsequently applied.

Specific Instructions for Application of the Formula

Annual statement reference is for the total life contingent reserve for the products in scope. The scope includes annuity products with life contingent payments where benefits are to be distributed in the form of an annuity. It does not include annuity products that are not life contingent, or deferred annuity products where the policyholder has a right but not an obligation to annuitize. Line (3) for General Account Life Contingent Miscellaneous reserves is included in the event there are any reserves for products in scope reported on Exhibit 5 line 0799999; it is not meant to include cash flow testing reserves reported on this line. Included in scope are:

- Single Premium Immediate Annuities (SPIA) and other payout annuities in pay status
- Deferred Payout Annuities which will enter annuity pay status in the future upon annuitization
- Structured Settlements for annuitants with any life contingent benefits
- Group Annuities, such as those associated with pension liabilities with both immediate and deferred benefits

The total reserve exposure is then further broken down by size as in a tax table. This breakdown will not appear on the RBC filing software or on the printed copy, as the application of factors to reserves is completed automatically. The calculation is as follows:

<table>
<thead>
<tr>
<th>Line (5)</th>
<th>Life Contingent Annuity Reserves</th>
<th>(1) Statement Value</th>
<th>Factor</th>
<th>(2) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 250 Million</td>
<td></td>
<td></td>
<td>0.0000</td>
<td></td>
</tr>
<tr>
<td>Next 250 Million</td>
<td></td>
<td></td>
<td>0.0000</td>
<td></td>
</tr>
<tr>
<td>Next 500 Million</td>
<td></td>
<td></td>
<td>0.0000</td>
<td></td>
</tr>
<tr>
<td>Over 1,000 Million</td>
<td></td>
<td></td>
<td>0.0000</td>
<td></td>
</tr>
<tr>
<td>Total Life Contingent Annuity Reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Longevity Risk

<table>
<thead>
<tr>
<th>Life Contingent Annuity Reserves</th>
<th>Annual Statement Source</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) General Account Life Contingent Annuity Reserves</td>
<td>Exhibit 5 Column 2 Line 0299999, in part‡</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) General Account Life Contingent Supplemental Contract Reserves</td>
<td>Exhibit 5 Column 2 Line 0399999, in part‡</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) General Account Life Contingent Miscellaneous Reserves</td>
<td>Exhibit 5 Column 2 Line 0799999, in part‡</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Separate Account (SA) Life Contingent Annuity Reserves</td>
<td>S/A Exhibit 3 Column 2 Line 0299999, in part‡</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Total Life Contingent Annuity Reserves</td>
<td>Line + (1) + (2) + (3) + (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† The tiered calculation is illustrated in the Longevity Risk section of the risk-based capital instructions.
‡ Include only the portion of reserves for products in scope per the instructions.

Denotes items that must be manually entered on the filing software.
## CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

<table>
<thead>
<tr>
<th>Source</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>RBC Amount</td>
<td>Tax Factor</td>
</tr>
<tr>
<td>(134)</td>
<td></td>
<td>Long-Term Care LR019 Health Premiums Column (2) Line (28) + LR023 Long-Term Care X 0.2100 =</td>
<td></td>
</tr>
<tr>
<td>(135)</td>
<td></td>
<td>Life Insurance C-2 Risk LR025 Life Insurance Column (2) Line (8) X 0.2100 =</td>
<td></td>
</tr>
<tr>
<td>(136)</td>
<td></td>
<td>Longevity C-2 Risk LR025 Longevity Risk Column (2) Line (5) X 0.2100 =</td>
<td></td>
</tr>
<tr>
<td>(137)</td>
<td></td>
<td>Disability and Long-Term Care Health Column LR019 Health Premiums Column (2) Line (28) + Line (29) + Line (30) X 0.2100 =</td>
<td></td>
</tr>
<tr>
<td>(138)</td>
<td></td>
<td>Premium National Credit LR025 Life Insurance Column (2) Line (10) X 0.0000 =</td>
<td></td>
</tr>
<tr>
<td>(139)</td>
<td></td>
<td>Total C-2 Risk LR027 Interest Rate Risk Column (3) Line (36) X 0.2100 =</td>
<td></td>
</tr>
<tr>
<td>(140)</td>
<td></td>
<td>Interest Rate Risk LR028 Health Credit Risk Column (2) Line (7) X 0.0000 =</td>
<td></td>
</tr>
<tr>
<td>(141)</td>
<td></td>
<td>Health Credit Risk LR027 Interest Rate Risk Column (3) Line (36) X 0.2100 =</td>
<td></td>
</tr>
<tr>
<td>(142)</td>
<td></td>
<td>Market Risk LR029 Business Risk Column (2) Line (40) X 0.2100 =</td>
<td></td>
</tr>
<tr>
<td>(143)</td>
<td></td>
<td>Business Risk LR029 Business Risk Column (2) Line (57) X 0.0000 =</td>
<td></td>
</tr>
<tr>
<td>(144)</td>
<td></td>
<td>Health Administrative Expenses LR027 Interest Rate Risk Column (3) Line (36) X 0.2100 =</td>
<td></td>
</tr>
<tr>
<td>(145)</td>
<td></td>
<td>Total Tax Effect Line (134) + Line (135) + Line (137) + Line (138) + Line (139) =</td>
<td></td>
</tr>
</tbody>
</table>

### Notes
- **LR030**

### References
- LR019: Health Premiums Column (2) Line (28)
- LR023: Long-Term Care X 0.2100
- LR025: Life Insurance Column (2) Line (8)
- LR026: Premium National Credit
- LR027: Interest Rate Risk Column (3) Line (36)
- LR028: Health Credit Risk Column (2) Line (7)
- LR029: Business Risk Column (2) Line (40)
- LR030: Total Tax Effect

### Calculation Details
- **Total C-2 Risk**
  - LR027: Interest Rate Risk Column (3) Line (36) X 0.2100
- **Interest Rate Risk**
  - LR028: Health Credit Risk Column (2) Line (7) X 0.0000
- **Health Credit Risk**
  - LR027: Interest Rate Risk Column (3) Line (36) X 0.2100
- **Market Risk**
  - LR029: Business Risk Column (2) Line (40) X 0.2100
- **Business Risk**
  - LR029: Business Risk Column (2) Line (57) X 0.0000
- **Health Administrative Expenses**
  - LR027: Interest Rate Risk Column (3) Line (36) X 0.2100
- **Total Tax Effect**
  - Line (134) + Line (135) + Line (137) + Line (138) + Line (139)
CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL (CONTINUED)

RBC

Insurance Risk (C-2)

(43) Individual and Industrial Life Insurance LR025 Life Insurance Column
Line (2)

(44) Group and Credit Life Insurance LR025 Life Insurance Column
Lines (20) and (21)

(44b) Longevity Risk LRtbd Longevity Risk Column (2) Line (5)

Total Health Insurance LR024 Health Claim Reserves Column
Line (4)

Premium Stabilization Reserve Credit LR026 Premium Stabilization Reserves Column
Line (2)

Total (C-2) - Pre-Tax

L(45) + L(46) + Greatest of [Guardrail Factor * (L(43)+L(44)), Guardrail Factor * L(44b), Square Root of [L(43)+L(44)]^2 + L(44b)^2 + 2 * (TBD Correlation Factor) * (L(43)+L(44)) * L(44b)]

Total (C-2) - Pre-Tax

(47) Total (C-2) - Pre-Tax

L(45) + L(46) + Square Root of [L(43)+L(44)]^2 + L(44b)^2 + 2 * (TBD Correlation Factor) * (L(43)+L(44)) * L(44b)

Net (C-2) - Post-Tax Line (47) - Line (48)

Interest Rate Risk (C-3a)

Total Interest Rate Risk LR027 Interest Rate Risk Column (3)
Line (36)

(C-3a) Tax Effect LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column
Line (2)

Net (C-3a) - Post-Tax Line (50) - Line (51)

Health Credit Risk (C-3b)

Total Health Credit Risk LR028 Health Credit Risk Column (2)
Line (7)

(C-3b) Tax Effect LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column
Line (2)

Net (C-3b) - Post-Tax Line (53) - Line (54)

Market Risk (C-3c)

Total Market Risk LR027 Interest Rate Risk Column (3)
Line (37)

(C-3c) Tax Effect LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column
Line (2)

Net (C-3c) - Post-Tax Line (56) - Line (57)
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Capital Adequacy (E) Task Force
[ ] Health RBC (E) Working Group
[ ] Life RBC (E) Working Group
[ ] Catastrophe Risk (E) Subgroup
[ ] Investment RBC (E) Working Group
[ ] Operational Risk (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup
[ x ] P/C RBC (E) Working Group
[ ] Stress Testing (E) Subgroup

DATE: 12/3/2018

CONTACT PERSON: Eva Yeung
TELEPHONE: 816-783-8407
EMAIL ADDRESS: eyeung@naic.org
ON BEHALF OF: P/C RBC WG
NAME: Tom Botsko
TITLE: Chair
AFFILIATION: Ohio Department of Insurance
ADDRESS: 50 W. Town Street, Third Floor – Suite 300
Columbus, OH 43215

FOR NAIC USE ONLY
Agenda Item # 2018-19-P
Year 2020

DISPOSITION
[ x ] ADOPTED 4/30/20
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ x ] EXPOSED 12/8/19
[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[ ] Health RBC Blanks
[ ] Property/Casualty RBC Blanks
[ ] Life RBC Instructions
[ ] Fraternal RBC Blanks
[ ] Health RBC Instructions
[ x ] Property/Casualty RBC Instructions
[ ] Life RBC Instructions
[ ] Fraternal RBC Instructions
[ ] OTHER ______________

DESCRIPTION OF CHANGE(S)
Modify the instruction to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified, and reciprocal reinsurance.

REASON OR JUSTIFICATION FOR CHANGE **
1. The factor for reinsurance recoverable from uncollateralized, unrated reinsurers is being updated to move towards a charge that is more aligned with risk-indicated factors used by the ratings agencies.
2. With respect to the broader implementation of the Covered Agreement, the PCRBC WG identified the need to eliminate the different treatment of uncollateralized reinsurance recoverable from authorized versus unauthorized, unrated reinsurers.

Additional Staff Comments:
12/8/19 – The PCRBC WG agreed to expose this proposal for a 45-day public comment period ending Jan. 21.
1/9/20 – The RAA submitted a comment letter.
1/21/20 – The APCIA submitted a comment letter.
2/3/20 – The PCRBC WG adopted the proposal at the Joint Property and Casualty Risk-Based Capital (E) Working Group and the Catastrophe Risk (E) Subgroup conference call. Also the Blank’s proposal has been forwarded to the Blank’s (E) Working Group.

** This section must be completed on all forms.

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For the purpose of the credit risk-based capital charge, the equivalent rating category assigned will correspond to current financial strength rating received from an approved rating agency as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. If the reinsurer does not have at least one financial strength rating, it should be assigned the “Vulnerable 6 or Unrated Reinsurers” equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the “Secure 3” equivalent rating. An authorized association including incorporated and individual unincorporated underwriters or a member thereof may utilize the lowest financial strength group rating received from an approved rating agency. The table below shows the R3 reinsurer equivalent rating categories and corresponding factors for A.M. Best, Standard and Poor’s, Moody’s and Fitch ratings.

<table>
<thead>
<tr>
<th>Description</th>
<th>Secure 1</th>
<th>Secure 2</th>
<th>Secure 3</th>
<th>Secure 4</th>
<th>Secure 5</th>
<th>Vulnerable 6 or Unauthorized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moody’s</td>
<td>Aaa</td>
<td>Aa1, Aa2, Aa3</td>
<td>A1, A2</td>
<td>A3</td>
<td>Baa1, Baa2, Baa3</td>
<td>Ba1, Ba2, Ba3, B1, B2, B3, Ca, Ca, C</td>
</tr>
<tr>
<td>Collateralized Amounts Factors</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Uncollateralized Amounts Factors</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.3%</td>
<td>7.1%</td>
<td>14%</td>
</tr>
</tbody>
</table>
### NAIC BLANKS (E) WORKING GROUP

**Blanks Agenda Item Submission Form**

<table>
<thead>
<tr>
<th>Date:</th>
<th>2/3/20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact Person:</strong></td>
<td>Eva Yeung</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>816-783-8407</td>
</tr>
<tr>
<td><strong>Email Address:</strong></td>
<td><a href="mailto:eyeung@naic.org">eyeung@naic.org</a></td>
</tr>
<tr>
<td><strong>On Behalf Of:</strong></td>
<td>P/C RBC WG</td>
</tr>
<tr>
<td><strong>Name:</strong></td>
<td>Tom Botsko</td>
</tr>
<tr>
<td><strong>Title:</strong></td>
<td>Chair</td>
</tr>
<tr>
<td><strong>Affiliation:</strong></td>
<td>Ohio Department of Insurance</td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td>50 W. Town Street, Third Floor – Suite 300 Columbus, OH 43215</td>
</tr>
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</table>

#### FOR NAIC USE ONLY

<table>
<thead>
<tr>
<th>Agenda Item #</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2020</td>
</tr>
<tr>
<td>Changes to Existing Reporting</td>
<td>X</td>
</tr>
<tr>
<td>New Reporting Requirement</td>
<td></td>
</tr>
</tbody>
</table>

**Reviewed for Accounting Practices and Procedures Impact**

| No Impact | X |
| Modifies Required Disclosure |  |

**Disposition**

- [ ] Rejected For Public Comment
- [ ] Referred To Another NAIC Group
- [ ] Received For Public Comment
- [ ] Adopted Date
- [ ] Rejected Date
- [ ] Deferred Date
- [ ] Other (Specify)

**Blank(s) to Which Proposal Applies**

<table>
<thead>
<tr>
<th>Annual Statement</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Statement</td>
<td></td>
</tr>
<tr>
<td>Life, Accident &amp; Health/Fraternal</td>
<td></td>
</tr>
<tr>
<td>Property/Casualty</td>
<td>X</td>
</tr>
<tr>
<td>Health</td>
<td></td>
</tr>
<tr>
<td>Instructions</td>
<td>X</td>
</tr>
<tr>
<td>Separate Accounts</td>
<td></td>
</tr>
<tr>
<td>Protected Cell</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Health (Life Supplement)</td>
<td></td>
</tr>
<tr>
<td>Crosschecks</td>
<td></td>
</tr>
</tbody>
</table>

**Anticipated Effective Date:** Annual 2020

#### Identification of Item(s) to Change

Modify the Annual Statement Instructions to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified, and reciprocal reinsurers.

**Reason, Justification for and/OR Benefit of Change**

1. The factor for reinsurance recoverable from uncollateralized, unrated reinsurers is being updated by PCRCB WG to move towards a charge that is more aligned with risk-indicated factors used by the ratings agencies.

2. With respect to the broader implementation of the Covered Agreement, the PCRCB WG identified the need to eliminate the different treatment of uncollateralized reinsurance recoverable from authorized versus unauthorized, unrated reinsurers.

#### NAIC Staff Comments

Comment on Effective Reporting Date:

Other Comments:

**This section must be completed on all forms.**

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ANNUAL STATEMENT INSTRUCTIONS – PROPERTY

SCHEDULE F – PART 3

CEDED REINSURANCE
AS OF DECEMBER 31, CURRENT YEAR

Detail Eliminated to Conserve Space

Column 34 – Reinsurer Designation Equivalent

Following is a listing of the valid codes.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
</table>

Utilize the table below and report a reinsurer designation equivalent code of 1 through 6 (where 6 represented vulnerable 6 or unrated). The equivalent designation category assigned will correspond to a current financial strength rating received from an approved rating agency as outlined in the table below. Ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. If the reinsurer does not have at least one financial strength rating, it should be assigned the “Vulnerable 6 or Unrated Reinsurers” equivalent rating. Amounts recoverable from unrated voluntary pools should be assigned the “reinsurer equivalent code of 3.” An authorized association including incorporated and individual unincorporated underwriters or a member thereof may utilize the lowest financial strength group rating received from an approved rating agency.

<table>
<thead>
<tr>
<th>Reinsurer Designation Equivalent Category</th>
<th>Code</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moody’s</td>
<td>Aaa</td>
<td>Aa1, Aa2, Aa3</td>
<td>A1, A2</td>
<td>A3</td>
<td>Baa1, Baa2, Baa3</td>
<td>Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C</td>
<td></td>
</tr>
</tbody>
</table>
Column 35  – Credit Risk on Collateralized Recoverables

Following is a table of factors applicable to the respective reinsurer designation equivalent categories in Column 34

<table>
<thead>
<tr>
<th>Code</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Column 36  – Credit Risk on Uncollateralized Recoverables

Following is a table of factors applicable to the respective reinsurer designation equivalent categories in Column 34

<table>
<thead>
<tr>
<th>Code</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.3%</td>
<td>7.1%</td>
<td>14.0%</td>
</tr>
</tbody>
</table>
### Capital Adequacy (E) Task Force

#### RBC Proposal Form

- [ ] Capital Adequacy (E) Task Force
- [ ] Health RBC (E) Working Group
- [ ] Life RBC (E) Working Group
- [ ] Catastrophe Risk (E) Subgroup
- [ ] Investment RBC (E) Working Group
- [ ] Operational Risk (E) Subgroup
- [ ] C3 Phase II/ AG43 (E/A) Subgroup
- [ ] P/C RBC (E) Working Group
- [ ] Longevity Risk (A/E) Subgroup

| CONTACT PERSON: | Eva Yeung |
| TELEPHONE: | 816-783-8407 |
| EMAIL ADDRESS: | eyeung@naic.org |
| ON BEHALF OF: | P/C RBC (E) Working Group |
| NAME: | Tom Botsko |
| TITLE: | Chair |
| AFFILIATION: | Ohio Department of Insurance |
| ADDRESS: | 50 West Town Street, Suite 300, Columbus, OH 43215 |

**DATE:** 4/9/20

- Agenda Item # 2020-01-P
- Year: 2020

**DISPOSITION**
- [ ] ADOPTED
- [ ] REJECTED
- [ ] DEFERRED TO
- [ ] REFERRED TO OTHER NAIC GROUP
- [x] EXPOSED 4/9/20
- [ ] OTHER (SPECIFY)

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

- [ ] Health RBC Blanks
- [x] Property/Casualty RBC Blanks
- [ ] Life and Fraternal RBC Instructions
- [ ] Health RBC Instructions
- [ ] Property/Casualty RBC Instructions
- [ ] Life and Fraternal RBC Blanks
- [ ] OTHER ____________________________

**DESCRIPTION OF CHANGE(S)**

The proposed change would update the Line 1 Factors for PR017 and PR018.

**REASON OR JUSTIFICATION FOR CHANGE **

The proposed change would provide routine annual update of the industry underwriting factors (premium and reserve) in the PCRBC formula.

**Additional Staff Comments:**

The P/C RBC WG exposed this proposal for a 30-day public comment period ending May 9.

**This section must be completed on all forms.**

Revised 2-2019

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## PRO17 Line 1 Reserves

<table>
<thead>
<tr>
<th>Schedule P Line of Business</th>
<th>LOB</th>
<th>Short tailed</th>
<th>Proposed for adoption - 2020 PR017 Line 1</th>
<th>2019 PR017 Line 1</th>
<th>2018 PR017 Line 1</th>
<th>2017 PR017 Line 1</th>
<th>2016 PR017 Line 1</th>
<th>2015 PR017 Line 1</th>
<th>2014 PR017 Line 1</th>
<th>2013 PR017 Line 1</th>
<th>2012 PR017 Line 1</th>
<th>2011 PR017 Line 1</th>
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<th>2009 PR017 Line 1</th>
<th>2008 PR017 Line 1</th>
<th>2007 PR017 Line 1</th>
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</thead>
<tbody>
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<td>0.989</td>
<td>0.989</td>
<td>0.984</td>
<td>0.972</td>
<td>0.962</td>
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10-1185
Attachment One-F
8/5/20
Capital Adequacy (E) Task Force
NAIC Proceedings – Summer 2020
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call July 30, 2020. The following Working Group members participated: Steve Drutz, Chair (WA); Steve Ostlund (AL); Eric Unger (CO); Wanchin Chou (CT); Carolyn Morgan (FL); Tish Becker (KS); Rhonda Ahrens (NE); Kelsey Barlow (NV); Tom Dudek (NY); Kimberly Rankin (PA); and Mike Boerner (TX).

1. **Adopted its Dec. 17, 2019, Minutes**

The Working Group met Dec. 17, 2019, and took the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) discussed the draft health bond structure and factors; 3) discussed the bond portfolio adjustment; 4) discussed investment grade bond factors; 5) discussed investment income included in the development of the bond factors; and 6) discussed using a five-year time horizon in the development of the bond factors.

Mr. Ostlund made a motion, seconded by Mr. Dudek, to adopt the Working Group’s Dec. 17, 2019, minutes (Attachment Two-A). The motion passed unanimously.

2. **Approved the 2019 Health RBC Statistics**

Mr. Drutz said the 2019 health statistics were run on July 13, and there were 1,012 health risk-based capital (RBC) filings loaded onto the NAIC database compared to 965 in 2018. He said there were 15 companies that triggered an action level and 14 companies that triggered the trend test. He noted that an inconsistency was found and corrected in the 2017 Health RBC Excluding ACA Fees in Companies column on the “Action Level” lines and the “# of companies with an RBC ratio less < 200%” line.

Hearing no objections, the Working Group approved the 2019 Health RBC Statistics (Attachment Two-B). They will be posted on the Working Group’s webpage.

3. **Referred the ACA Fee Sensitivity Test Proposal (2020-02-CA) to the Capital Adequacy (E) Task Force for Exposure**

Mr. Drutz said the federal Affordable Care Act (ACA) fee was repealed for 2021. As a result, proposal 2020-02-CA was developed to delete the sensitivity test from the health, life and fraternal, and property/casualty (P/C) RBC formulas. Mr. Drutz suggested that the Working Group refer the proposal to the Capital Adequacy (E) Task Force for a 30-day public comment period.

Hearing no objections, the Working Group referred proposal 2020-02-CA to the Capital Adequacy (E) Task Force for a 30-day public comment period.

4. **Adopted Proposal 2020-04-H for the MAX Function in Line 17 of the Excessive Growth Charge**

Mr. Drutz said NAIC staff received an inquiry from a software vendor on an inconsistency between the health RBC forecasting formula and the validation in Line 17 of the excessive growth charge on page XR021. The validation included the MAX function, while the formula in the forecasting spreadsheet did not. The MAX function will convert a negative amount to zero. Mr. Drutz said the proposal was exposed for comment in April to incorporate the MAX function, and no comments were received.

Mr. Boerner made a motion, seconded by Mr. Unger, to adopt proposal 2020-04-H (Attachment Two-C) to add the MAX function to Line 17 of the health RBC forecasting formula for 2021 reporting. The motion passed unanimously.
5. **Received an Update on the Health Bond Factors**

a. **Investment Income**

Mr. Drutz said the Working Group asked the American Academy of Actuaries (Academy) to address comments brought forward on the inclusion of investment income in the proposed bond factors. Derek Skoog (Academy) summarized the Academy’s response letter (Attachment Two-D) that considering investment income is a reasonable argument; and while the Academy’s approach does consider the investment income on the assets that underlie the asset risk that is being evaluated, it does not contemplate all of the investment income. He said based on the comments received, the desire is to account for investment income in the asset risk charges, and that would result in diluting the size of the asset risk charges and potentially have zero asset risk charges for some asset risk classes. He said that underestimates the risk of default because there is real default risk. He said the Academy suggests that an alternative way forward may be to match the P/C approach, where investment income for other assets like the assets that underly a company’s reserves are used as an offset for underwriting risk, rather than applying all investment income to the bond default risk.

James Braue (UnitedHealth Group—UHG) said the suggestion of investment income was proposed in a previous comment letter from UHG, and the Academy’s response does not fully address the issue that was raised. He said in the Academy’s letter, it noted that using a discount rate on the factor only reflects investment income on the bonds that support the RBC for bond default itself, which, generally speaking, is only going to be a tiny fraction of the total bond holdings. He said some portion of that investment income is essentially, explicitly for bond default risk. He said bonds generally have a spread above the risk free rate, unless you are talking about U.S. Treasury in which there is usually a proxy for the risk free rate, and the purpose of that spread is to compensate for the bond default risk; so not reflecting this is comparable to modeling underwriting losses on the assumption that there is no premium so that the first dollar of losses has to be paid out of surplus. He said this is not a conceptually correct approach to the modeling. He said it is true that the spread is not the entire amount of interest income, and UHG suggested using the entire interest rate as a matter of simplicity, not just the credit spread, and this approach still has merit, particularly when you consider how the risk free portion of the rate would otherwise be reflected. He said the Academy suggested including it in other risk factors, such as underwriting risk. He said there are several issues with this: 1) it is unlikely that it would happen in practice, as there is no current initiative to update the underwriting risk factors, and it is unknown on when it would be taken into account; and 2) if it were done, the Academy group responsible for doing modeling might decline to include investment income on the grounds that difficulties and uncertainties related to doing so outweigh the usefulness of the inclusion. He said even if it was included in the modeling, the current unwriting factors are pretty heavily rounded, so it is very possible that the impact would be rounded away; or conversely, if the rounding went in the other direction, the factors might be reduced by much more than the investment income actually warranted. He said this seems to be a problem with saying that it should be included in the underwriting risk factors. He said applying interest income to underwriting risk rather than default risk is actually a lot less risk-based from an RBC perspective. He said if you are modeling investment income in your underwriting risk factors, assumptions have to be made about the amount of assets held for a given line of business, how much of those assets are bonds versus things like premiums receivables or health care receivables or other types of investments, and the credit quality distribution or average credit quality of the bond held. He said if you model investment income in bond default risk, you automatically take into account the actual amount of bonds held and the actual credit quality distribution of the bond. He said UHG believes it is more appropriate to apply the investment income in the credit risk default factors, and the Working Group was correct in directing the Academy to do that; and if there is a concern about the factors being reduced too much, there is already a minimum being applied. Given the simplified approach that UHG has suggested, it believes that it would be possible for someone other than the Academy to undertake doing that work if the Working Group agreed that it should be done. Mr. Braue said if there were no preferable alternatives, UHG would undertake to do that itself.

Mr. Skoog said the overarching idea from the Academy was to ascribe investment income to the assets that were underlying to the risk-factor risks, as opposed to all of the investment income, with the understanding that a significant portion of the assets of a health insurer balance sheet would be supporting underwriting risk; therefore, it thought it was more appropriate to mirror the P/C approach and not create a third approach between each of the formulas, but instead ascribe investment income to the assets underlying the underwriting risk. He said the Academy understands the arguments on both sides, but the most straightforward approach would be to ascribe the investment income to the assets that underly each respective risk type.

Mr. Drutz suggested that based on the Academy’s findings, and for added consistency between the health and P/C formulas, the Working Group requests that the Academy look at adding investment income into the underwriting portion of the health formula. He suggested that this project would run parallel to the bond risk factors project, and it would look at changing the
underwriting risk factors to include the investment income, such that both could occur within a reasonable amount of time to each.

Mr. Braue said this approach would address his concerns if it was shown that investment income could, as a practical matter, be properly reflected in the underwriting risk factors. He said the Academy may be overlooking some of the practical difficulties associated with that. He said he would be happy to see it attempted; however, depending on the outcome, we could be back in the same place we are now.

The Working Group agreed to direct NAIC staff to draft a letter to the Academy to request that it evaluate and consider incorporating investment income into the underwriting risk factors. The Working Group will review the letter on its Aug. 18 conference call.

b. Time Horizon

Mr. Drutz said during the Dec. 17, 2019, call, the Working Group discussed incorporating a longer time horizon of five years into the bond factors, due to several factors: 1) the duration of assets for health insurers is about 5.2 years, which is longer than the duration of liabilities; 2) using a two-year time horizon makes it harder from regulatory framework to support an amortized cost basis rather than a market value-based valuation; and 3) increased consistency with the P/C formula. During this call, the Working Group asked the Academy to provide it with both two-year and five-year time horizon factors.

Lou Felice (NAIC) said amortized cost is a key underpinning of our solvency system and accounting basis. When you have a two-year duration, it is hard to make a case that it is compatible with amortized cost since it is more compatible with the risk of changes in value; so for bonds, that would be interest rate fluctuations and other mechanisms that adjust the value of the bond. He said in the current formula, NAIC designation 1 and 2 bonds are treated at amortized cost; if a two-year duration is applied that is more generally associated to market risk, it does open it up for criticism for use of amortized cost more generally. He said based on the Academy report, health bond investments cover both claims and surplus, so there is no reason that you should solely look to the duration of liabilities for a health filer. He said it is important to keep a strong adherence to what amortized cost was intended to mean. He said the data seems to indicate a five-year holding period for these bonds, then the default risk should relate more to that holding period. That being said, something less than five or more than two could still be considered. Mr. Ostlund said he is concerned that a company with shorter duration bonds would be penalized for going to a longer duration due to the significant difference in the two-year and five-year factors. Mr. Felice said every formula uses some duration that is applied to the factor, and the durations used in the other formulas are more consistent with an amortized cost or smoothing over time of the change in the value of investment grade bonds. He said the fact that the factor is more in a five-year versus a two-year duration is something to consider; however, it should be balanced against the potential of losing value on the valuation side when using a two-year duration, because it would be unlikely to continue to use amortized cost if a two-year duration was used.

Mr. Ostlund asked if the intent of the change was to decrease the RBC ratio for all companies. Mr. Felice said the intent of the project was to be more risk-focused and expand the designations from six to 20. He said the current NAIC 1 and 2 designations would expand into about 11 designations under the new structure, and the idea would be that the spectrum of the NAIC 1 and 2 designations would be split out, and that would determine if it increased or decreased. He also said they would still go through covariance, which would further reduce the impact of the increase or decrease. Mr. Ostlund said he would not want the expansion of the bond factors to cause a reduction in the RBC ratio for the additional designation classes; he would want the effect to be neutral. He said if this is for allocation between categories, he does not have a concern, but if the change would affect every company’s RBC ratio because of the increase in the designations, it seems inappropriate.

Mr. Drutz said the original intent of the project was to increase the bond designations from six to 20, and the appropriate factors then have to be applied to each of those new designations. He suggested that the Working Group expose the Academy’s letter containing the two- and five-year factors for comment. Those factors would then be used in an impact analysis in early 2021 to evaluate the differences of the two sets of factors based on the data reported in the new bond structure implemented for year-end 2020. This will allow the Working Group to get a handle on the whether it is causing a significant change in the RBC ratio. Mr. Drutz said the Working Group is not making a determination of the final factors, but instead on which factors to use in an impact analysis, and then using that analysis to make the final determination of the factors.
Mr. Skoog summarized the Academy’s letter (Attachment Two-E), which included the two- and five-year duration; the model was run using the five-year time horizon. He said the significant differences in the factors was because with a longer time horizon, there is a greater chance that a particular bond would default over that time horizon. He said the model is reflecting that increased probability. Otherwise, an identical methodology was maintained to the two-year factors that were previously exposed.

Crystal Brown (NAIC) noted that the proposed factors include an adjustment for the bond portfolio adjustment since the current health formula does not have a bond portfolio adjustment calculation. Mr. Chou asked if the Working Group is ready to finalize the factors for the health formula, because the bond factors in the life formula have not yet been finalized. Mr. Drutz said the health factors were separated from the life factors at this time due to differences in a life and health company. He said before final factors are determined for year-end 2021, the Working Group plans to do the impact analysis on the year-end 2020 data.

Hearing no objections, the Working Group agreed to expose the Academy’s bond factor letter for a 32-day public comment period ending Aug. 31.

6. **Adopted Updates to its 2020 Working Agenda**

Mr. Drutz said the 2020 working agenda has been updated to add the following items: 1) proposal 2020-02-CA for the deletion of the ACA Fee Sensitivity Test that was originally added as part of the evaluation of the impact of the Federal Health Care Law; 2) review and consideration of the formula for the inclusion of the MAX function on Line 17 of the excessive growth charge as proposal 2020-04-H; and 3) consideration of the impact of COVID-19 and pandemic risk on the health RBC formula.

Mr. Ostlund made a motion, seconded by Mr. Chou, to adopt the updates to the 2020 health RBC working agenda. The motion passed unanimously.

7. **Discussed the Impact of COVID-19 and Pandemic Risk in the Health RBC Formula**

Mr. Drutz said the Solvency Modernization Initiative Risk-Based Capital (E) Subgroup tasked the Working Group in 2011 with looking at catastrophic risks, such as pandemic and biological risks, should such an event occur. He said the Working Group added interrogatory questions for informational purposes only that were included in the formula for several years. However, the Working Group found that only a small number of companies indicated that they allocated a component of surplus for pandemic and biological risks. Mr. Drutz asked the Working Group if there is a need to reevaluate the pandemic and biological risk interrogatories that had previously been included in the health RBC formula. He said with the information that we have currently, it seems like it would be timely for the Working Group to review the previous interrogatories and expand upon those based on the real time lessons we are learning now.

The Working Group agreed to discuss this topic on future calls.

8. **Exposed the Health Care Receivable Guidance**

Mr. Drutz said the health care receivable guidance was exposed for comment at the 2019 Fall National Meeting, and one comment letter was received.

Connie Jasper Woodroof (Sapiens) summarized her comments on the health care receivable guidance (Attachment Two-F). She agreed that extra guidance on the health care receivables would be beneficial, and she suggested incorporating this language into the official annual statement instructions. She also suggested including examples of how Exhibit 3 and Exhibit 3A should be completed.

Mr. Drutz said based on the comments received and ongoing conversations with the Academy, we are working to better clarify the instructions and develop examples. He said the plan is to work on guidance for 2020 annual statement reporting and a proposal to clarify the annual statement instructions for 2021 reporting. He said the goal is to bring the guidance and proposal to the Working Group on either the August or September call to expose for comment and then refer them to the Blanks (E) Working Group for consideration.
9. Received an Update on the Health Test Ad Hoc Group

Mr. Drutz said the Health Test Ad Hoc Group has not met since prior to the COVID-19 pandemic; however, the revised health test language was exposed on Feb. 13, and one comment letter was received during that exposure period from America’s Health Insurance Plans (AHIP).

Ray Nelson (AHIP) summarized his comment letter (Attachment Two-G), which included editorial changes to the health test language.

Mr. Drutz said since the exposure, NAIC staff have performed additional analysis of the companies that could be affected by the changes to the health test language, and through this analysis, additional questions were brought to light. NAIC staff sent a brief survey to the states regarding the methodology to be used in modifying the health test. Mr. Drutz said based on the responses received, he plans to ask the Ad Hoc Group to re-evaluate the approach, put a pause on the health test language, and begin looking at changes that could be considered in the annual statement blanks. He said the Ad Hoc Group has developed a good starting point with the current revisions; however, it may be beneficial to first look at the annual statement blanks to determine how to continue to move forward. He said the Ad Hoc Group will meet again on Sept. 1 and discuss how to continue moving the project forward. He asked that anyone interested in participating in the Ad Hoc Group contact Ms. Brown.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

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Health Risk-Based Capital (E) Working Group
Conference Call
December 17, 2019

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Dec. 17, 2019. The following Working Group members participated: Patrick McNaughton, Chair, and Steve Drutz (WA); Steve Ostlund (AL); Eric Unger (CO); Wanchin Chou (CT); Gilbert Moreau and Kyle Collins (FL); Chut Tee (KS); Kristi Bohn (MN); Michael Muldoon (NE); Annette James (NV); Tom Dudek (NY); and Aaron Hodges (TX).

1. **Adopted its Fall National Meeting Minutes**

The Working Group met Dec. 8 and took the following action: 1) adopted its Oct. 21 and Sept. 9 minutes; 2) discussed the draft health bond structure; 3) received an update on the Health Test Ad Hoc Group; 4) exposed the health care receivables guidance for 30-day public comment period; 5) adopted updates to the 2020 working agenda; and 6) received an update on the Excessive Growth Charge Ad Hoc Group.

Mr. Chou made a motion, seconded by Mr. Dudek, to adopt the Working Group’s Dec. 8 minutes (see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Two). The motion passed.

2. **Discussed the Draft Health Bond Structure**

Mr. McNaughton said that the Working Group will discuss comments previously received from UnitedHealth Group and America’s Health Insurance Plans (AHIP) on the health bond structure and factors.

a. **Bond Portfolio Adjustment**

Mr. McNaughton said the July 29 comment letter from AHIP expressed concerns with the recommended American Academy of Actuaries (Academy) factors that included the bond portfolio adjustment for the speculative grade bonds. AHIP noted that it could find no basis for the assumption that the statistical fluctuation based on the portfolio size from the default/no-default variation is appropriate for any presumed variation by portfolio size due to market value fluctuations.

Mr. McNaughton said that from a consistency standpoint, the health formula is deviating from the treatment of the bond portfolio adjustment used in the life and property/casualty (P/C) formulas by incorporating the bond portfolio adjustment into the factor itself. He said that the life and P/C formulas do not differentiate between investment grade and speculative grade bonds when calculating the bond portfolio adjustment. Therefore, excluding the bond portfolio adjustment from the speculative bond factors would be an additional inconsistency incorporated into the health formula.

Mr. McNaughton said that through discussions with the Academy, it was noted that the data was not split between investment grade and speculative grade bonds and if this approach was taken, the Academy would need to go back and reevaluate the data. The Academy indicated that removing the bond portfolio adjustment from the speculative grade bond factors could increase the investment grade bond factors.

Mr. McNaughton said it was his recommendation at the Fall National Meeting not to bifurcate the investment grade and speculative grade bonds due to the effort needed to reanalyze the data, which does not appear to provide a material change. He said that from a conservatism perspective, the health formula is a generic formula, and increased granularity can result in a lot of work with little gain from a regulatory perspective in capturing a weakly capitalized company. Mr Ostlund and Mr. Chou agreed with Mr. McNaughton’s assessment.

Bill Weller (AHIP) said that the approach being suggested was to take the modeled bond factor from a default point of view and increase that by the portfolio adjustment factor recommended by the Academy and compare that result for certain speculative grade bonds to that increased bond factor. He said that the higher of the two factors would be used: market risk factor or the bond factor adjusted for portfolio risk. He said there would be no additional work required by the Academy and if the market risk factor unadjusted for portfolio is higher than the default risk factor adjusted for portfolio size, the default risk for all classes is covered. Mr. Weller said that AHIP does not see a basis for saying that there should be portfolio adjustment on the market risk factor and that AHIP is not suggesting to use a lower factor. However, AHIP is asking for consideration to
not apply the portfolio adjustment factor to the market risk factor when it exceeds the calculated default risk factor with the portfolio adjustment. He said it is a matter of comparing the factors for NAIC 3, NAIC 4 and NAIC 5 bonds and then picking the higher of the two. Crystal Brown (NAIC) asked if the recommendation to use the market risk factor would not reflect the bond portfolio adjustment in the factor. Mr. Weller said the Academy report had a default model risk factor for each of the six classes before the bond portfolio adjustment. He said one would take those factors and apply the portfolio adjustment and then compare those to the market risk factors without any portfolio adjustment because there is no basis for the size of the portfolio changes the market risk. He said the higher of the two factors would be used. He said the AHIP proposal would use the market risk factor without portfolio adjustment for NAIC 3 and NAIC 4 and the default risk adjusted for portfolio for NAIC 5 because it is higher of the two factors.

Mr. Ostlund asked if the proposed changes would improve precision in the formula. Mr. Weller said the point of the modeling and coming up with factors is to apply an inherently consistent structure to risk-based capital (RBC) and when developing factors on the basis of default and no default, the size of the portfolio matters. He said when looking at market risk, it applies to all bonds, and there is no effect on the portfolio size. Mr. Ostlund said that the Working Group is using a consistent approach with the other formulas, but this proposed change may not improve predictability.

Derek Skoog (Academy) said that in the Academy’s study, the speculative grade bonds tended to be a very small percentage of the overall health portfolio. He said that it may not add a lot of value to the health RBC formula. Mr. Chou asked when the Working Group plans to implement the changes into the health formula. Mr. McNaughton said that the Working Group has already agreed with the structure and would like to finalize the factor discussion as soon as possible.

b. Investment Grade Bond Factors

Mr. McNaughton said that UnitedHealth Group indicated that the Aaa and Aa1 bonds are less risky than the Aa2 bonds and recommended that a lower factor of 0.1% be applied to these types of bonds. UnitedHealth Group suggested factors of 0.03% and 0.07%, respectively. In the Academy’s report, it recommended a factor of 0.1% for Aaa, AA1 and Aa2 bonds for reasons of conservatism. The Academy noted that if cash had a risk charge, then bonds should have a charge at least as great. It also said that there could be other risks outside of the modeled risk of misuse or loss that should also be taken into consideration. Mr. McNaughton said that from a solvency and conservatism perspective, it seems reasonable that the Working Group would consider retaining the recommended factor of 0.1% for the Aaa and AA1 bonds. Mr. Chou agreed with retaining the 0.1% factor for consistency.

Jim Braue (UnitedHealth Group) said that the cash factor is not literally for cash in the bank but also for cash, cash equivalents and short-term bonds and that it is not necessarily clear that the factor for cash should be less than a two-year AAA-rated bond. If the Academy analysis shows the factor is less than 1/10 of a percent, then it could imply that the cash factor is too high, and it should be reevaluated. Mr. Braue said any factors in the formula that are derived from the bond factors should be reviewed and reevaluated. Mr. Skoog agreed that the Working Group should consider the relationship between those factors. Mr. McNaughton agreed but said it has broader implications across all formulas as the factors for cash would have to be looked at in all formulas.

c. Investment Income

Mr. McNaughton said that UnitedHealth Group brought forth the suggestion of including investment income in the development of the bond risk factors for the health RBC formula. UnitedHealth Group indicated that just as the health formula would not reflect losses from insurance claims and operating expenses without also reflecting the insurance premium that is charged to fund those losses, likewise the formula should not reflect the losses from investments without reflecting the income from those investments. The Academy responded that investment income was used in the development of the underwriting risk in the P/C RBC formula, and it would be redundant to include it in the development of the bond factors. However, it was unclear if the health formula used a similar consideration in the development of the underwriting risk. The Academy further noted that updating the factors to include the investment income would require a number of considerations and assumptions to accommodate the impact. The Academy asked the Working Group to consider and review if investment income is already included in the formula.

Mr. McNaughton said that NAIC staff performed a review of past Working Group minutes and did not find that the investment income was considered in the development of the factors in the health RBC formula. During the Working Group’s discussion at the Fall National Meeting, Donna Novak (NovaRest Consulting) commented that she worked on the underwriting risk
modeling when the health formula was developed and indicated that she did not recall that investment income was considered in the development of the formula.

Mr. Braue said that UnitedHealth Group offered a simplified approach in moving forward with further studies on incorporating investment income into the factors. Mr. Weller agreed with incorporating a simplified approach for incorporating the investment income and that investment income was not incorporated in the underwriting factors. Lou Felice (NAIC) also agreed that investment income was not included in the health underwriting factors as they were in P/C because average duration of liabilities in P/C is longer and this leads to a more aligned period of assets to liabilities. He said that that due to the short duration of liabilities in the health formula at the time investment risk was not a material consideration of underwriting risk.

d. Time Horizon

Mr. McNaughton said that the proposed factors from the Academy were based on a two-year time horizon. However, the Academy noted on page 27 of its report that a longer time horizon of three, four or five years could be considered. The Academy specifically noted that the duration of assets for health insurers is about 5.2 years, which is longer than the duration of health liabilities. It further noted that the health bond risk factors could be calibrated with time horizons of three, four or five years. The inclusion of investment income could further be considered if a longer time horizon were included. Mr. Felice said that there is a concern of the short two-year time horizon being consistent with the regulatory framework of amortized cost basis valuation and analysis that used default and recovery periods in tandem to determine the default rate. He said that when using a two-year time horizon, it makes it harder from a regulatory framework to support an amortized cost basis rather than a market value-based valuation. He said there can be a lot of ups and downs in a two-year bond.

Mr. McNaughton suggested that due to the duration of time in which assets are held, the Working Group should ask the Academy to provide factors with a five-year time horizon without the inclusion of investment income and similar to that which UnitedHealth Group appears to be suggesting. Once these factors are received, they could then be exposed for comment. Alabama and New York agreed with moving forward with a five-year time horizon.

Mr. Weller asked why we are going to a five-year time horizon rather than a three- or four-year time horizon. Mr. McNaughton said that there are a two reasons: 1) this is more consistent with the property formula; and 2) the asset duration for health is 5.2 years.

The Working Group agreed to move forward with the Academy’s recommendation to include the bond portfolio adjustment in the speculative grade bond factors, to keep the 0.1% factor for Aaa and Aa1 bonds and to ask the Academy to look at factors with a five-year time horizon without the inclusion of investment income and with the inclusion of investment income.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
## Aggregated Health Risk-Based Capital Data

### 2019 Data as of 7/13/2020

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### Companies that have an RBC loaded on the database

- Total Companies with an RBC 1,012
- Total Companies with an RBC loaded 1,012
- Percentage of total RBC's loaded 1.48%
- Companies with action levels: 31
  - 2019 31
  - 2018 18
  - 2017 10
  - 2016 5
  - 2015 3

### Total Revenue

- Total Revenue 731,800,228,651
- Underwriting Deductions 715,077,656,883
- Aggregate Premium 268,818,431,635
- Aggregate Net Incurred Claims 985,439,850,096

### Total RBC Before Covariance

- Total RBC Before Covariance 68,762,077,526
- Total Adjusted Capital 160,266,143,771
- ACA Fees 11,039,690,995
- Authorized Control Level RBC * 27,216,649,996

### Aggregate RBC %

- Total RBC Before Covariance 68,762,077,526
- Total Adjusted Capital 160,266,143,771
- ACA Fees 11,039,690,995
- Authorized Control Level RBC * 27,216,649,996

### Source

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* Authorized Control Level RBC amount reported in the Health RBC Excluding ACA Fees column is pulled from Line (18), page XR026, and the Authorized Control Level RBC amount reported in the Health RBC column is pulled from Line (4), page XR027.

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Attachment B

Attachment Two-B

Capital Adequacy (E) Task Force

8/5/2020
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Catastrophe Risk (E) Subgroup [ ] Investment RBC (E) Working Group [ ] SMI RBC (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup [ ] P/C RBC (E) Working Group [ ] Stress Testing (E) Subgroup

DATE: 04/01/2020

CONTACT PERSON: Crystal Brown
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EMAIL ADDRESS: cbrown@naic.org
ON BEHALF OF: Health RBC (E) Working Group
NAME: Steve Drutz
TITLE: Chief Financial Analyst/Chair
AFFILIATION: WA Office of Insurance Commissioner
ADDRESS: 5000 Capitol Blvd SE
            Tumwater, WA 98501

FOR NAIC USE ONLY
Agenda Item # 2020-04-H
Year _______ 2021____

DISPOSITION
[ ] ADOPTED
[ ] REJECTED
[ ] DEFERRED TO
[ ] REFERRED TO OTHER NAIC GROUP
[ ] EXPOSED
[ ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[ x ] Health RBC Blanks [ ] Health RBC Instructions [ ] Other ________________
[ ] Life and Fraternal RBC Blanks [ ] Life and Fraternal RBC Instructions
[ ] Property/Casualty RBC Blanks [ ] Property/Casualty RBC Instructions

DESCRIPTION OF CHANGE(S)
Add a MAX function to the calculation of Line 17 – RBC Safe Growth Safe Harbor on Page XR021 to match the validation and start the calculation at 0.

REASON OR JUSTIFICATION FOR CHANGE **

NAIC staff received an inquiry from a software vendor on an inconsistency between the HRBC formula within the forecasting file and the validation for the MAX function in the validation of line 17 of the excessive growth charge. The attachment shows how the current calculation in the formula of the forecasting file is working without the MAX function while the validation includes the MAX function which will convert a negative amount to 0. The last screen shot shows the difference in the charge if the MAX function were incorporated into the formula within the forecasting file. The MAX function is included within other parts of the HRBC formula, while it is specifically excluded from the Underwriting portion on page XR012.

Additional Staff Comments:
4-3-2020 – cgb – exposed for comment until 5-4-2020
7-8-2020 – cgb – no comments received during comment period.

** This section must be completed on all forms.

Revised 11-2013
### BUSINESS RISK

<table>
<thead>
<tr>
<th>Administrative Expense Risk</th>
<th>Annual Statement Source</th>
<th>(1) Amount</th>
<th>Factor</th>
<th>(2) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Claims Adjustment Expenses</td>
<td>Page 4, Column 2, Line 20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) General Administrative Expenses</td>
<td>Page 4, Column 2, Line 21</td>
<td></td>
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</tr>
<tr>
<td>(3) Loss the Net Amount of ASC Revenue and Expenses Included in Lines 1 and 2</td>
<td>Company Records</td>
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<tr>
<td>(4) Loss the Net Amount of ASO Revenue and Expenses Included in Lines 1 and 2</td>
<td>Company Records</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(5) Loss Admin Expenses for Commission &amp; Premium Taxes</td>
<td>Underwriting &amp; Investment Exhibit Part 3, Line 3, in part</td>
<td>$0</td>
<td>0.070</td>
<td>$0</td>
</tr>
<tr>
<td>(6) Administrative Expenses Base RBC</td>
<td>Lines (1) + (2) - (3) - (4) - (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Proportion of Admin Expense to Experience Fluctuation Risk</td>
<td>Lines (6) x (20)/(Lines (21) + (22))</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Underwritten and Limited Risk</th>
<th>Annual Statement Source</th>
<th>(1) Amount</th>
<th>Factor</th>
<th>(2) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(8) Administrative Expenses for ASC Arrangements</td>
<td>Company Records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) Administrative Expenses for ASO Arrangements</td>
<td>Company Records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10) Medical Costs Paid Through ASC Arrangements (Including Fee For Service Received From Other Health Entities)</td>
<td>Company Records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(11) Non-Underwritten and Limited Risk Business RBC</td>
<td>Company Records</td>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Guaranty Fund Assessment Risk</th>
<th>Annual Statement Source</th>
<th>(1) Amount</th>
<th>Factor</th>
<th>(2) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(12) Premiums Subject to Guaranty Fund Assessment</td>
<td>Included in Sch T - Company Records</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Excessive Growth Risk</th>
<th>Annual Statement Source</th>
<th>(1) Amount</th>
<th>Factor</th>
<th>(2) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(13) UW Risk Revenue, Prior Year</td>
<td>2019 XR012, Column (7), Line 6 (manual entry)</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>(14) UW Risk Revenue, Current Year</td>
<td>2020 XR012, Column (7), Line 6</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>(15) Net UW Risk RBC, Prior Year</td>
<td>2019 XR012, Column (7), Line 21 (manual entry)</td>
<td>$0</td>
<td></td>
<td>$0</td>
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<tr>
<td>(16) Net UW Risk RBC, Current Year</td>
<td>2020 XR012, Column (7), Line 21</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>(17) RBC Growth Safe Harbor</td>
<td>[Lines (14)/(13)+10] x Line (15)</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>(18) Excess of RBC Growth Over Safe Harbor</td>
<td>Max(0, Lines (16) - (17))</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>(19) Excessive Growth Risk RBC</td>
<td>5 x Line (18)</td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

### Note

- The formula highlighted in the image is:
  
  \[ \text{MAX}\left(\text{IF}\left(+E27>+E28,0,\text{IF}\left(+E27=0,0,\left(\frac{E28}{E27}\right)+0.1\right)E29\right),0\right) \]
March 4, 2020

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Draft Bond Structure and Instructions

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries\(^1\) Health Solvency Subcommittee, I am pleased to provide this response letter to the NAIC Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the HRBC Working Group comment letters received on the exposure of the Draft Bond Structure and Instructions, specifically as they relate to the treatment of investment income. In particular, this is in response to the comment letters from UnitedHealth Group dated Oct. 4, 2018, and Nov. 13, 2018.

In the Aug. 3, 2015, Academy CI Work Group report titled “Model Construction and Development of RBC Factors for Fixed Income Securities for the NAIC’s Life Risk-Based Capital Formula,” the group noted that “C1 capital represents the amount of funds needed such that this amount is sufficient to cover losses in excess of those anticipated in policy reserves that could occur within the bond portfolio over the specified time horizon within the stated confidence level. In essence, the C1 capital is equivalent to pre-funding future excess losses at the chosen confidence level and time horizon (i.e., ten years).” Given the design of the bond factor model, the group goes on to note that “[t]he required capital for a given scenario is calculated as the amount of initial funds needed such that the accumulation of this initial fund and subsequent cash flows will not become negative at any point throughout the modeling period. … There are additions and subtractions from this required capital fund:

- Additions to the capital fund include fund interest, tax recoveries on the loss, and an annual ‘risk premium’
- Subtractions to the capital fund include default losses net of recoveries and any taxes paid.”

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
In our modeling for the health bond factors,\textsuperscript{2} we utilized a discount rate of 2\% over the time horizon. This was based on June 2018 US Treasury rates and LIBOR Swap rates, and 20-year average interest rates for durations of 1-5 years ranging from 2\% to 3\%. While this modeling approach does not explicitly account for coupon income, the 2\% rate is largely consistent with yield data we reviewed, which was provided by the NAIC. Additionally, the indicated risk factors are not very sensitive to the interest rate selection.

While an argument could be made that this approach does not consider \textit{all} investment income—namely, it ignores investment income related to assets supporting other risk capital or excess capital—we do not think it would be appropriate to ascribe all that income to offset asset default risk. A more appropriate approach would utilize investment income to offset specific risk charges. For example, within the property/casualty RBC formula, investment income is explicitly included as an offset to underwriting risk factors by considering the investment income related to claims and claim adjustment expenses unpaid as well as unearned premium. This issue might be considered for the health RBC formula the next time other significant risk factors are evaluated, when there are associated assets, e.g., underwriting risk and associated claims unpaid.

We appreciate the opportunity to provide these comments and would welcome the opportunity to speak with you regarding these comments in more detail and answer any questions you might have. If you have any questions or would like to discuss further, please contact Devin Boerm (boerm@actuary.org) or Craig Hanna (hanna@actuary.org) at 202-223-8196.

Sincerely,
Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

June 24, 2020

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Draft Bond Structure and Instructions

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries1 Health Solvency Subcommittee, I am pleased to provide this response letter to the NAIC Health Risk-Based Capital (HRBC) Working Group. This letter is in response to the request from the HRBC Working Group to provide the health bond factors over both a two-year and five-year time horizon.

The table below shows the health base risk factors over a two-year and five-year time horizon before any adjustments have been made to account for minimum risk factors.

<table>
<thead>
<tr>
<th>Moody's Rating Class</th>
<th>S&amp;P Rating Class</th>
<th>Indicated Base Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td>AAA</td>
<td>0.0% 0.3%</td>
</tr>
<tr>
<td>Aa1</td>
<td>AA+</td>
<td>0.0% 0.5%</td>
</tr>
<tr>
<td>Aa2</td>
<td>AA</td>
<td>0.1% 0.8%</td>
</tr>
<tr>
<td>Aa3</td>
<td>AA-</td>
<td>0.2% 1.1%</td>
</tr>
<tr>
<td>A1</td>
<td>A+</td>
<td>0.3% 1.4%</td>
</tr>
<tr>
<td>A2</td>
<td>A</td>
<td>0.5% 1.6%</td>
</tr>
<tr>
<td>A3</td>
<td>A-</td>
<td>0.7% 1.9%</td>
</tr>
<tr>
<td>Baa1</td>
<td>BBB+</td>
<td>1.0% 2.2%</td>
</tr>
<tr>
<td>Baa2</td>
<td>BBB</td>
<td>1.2% 2.5%</td>
</tr>
<tr>
<td>Baa3</td>
<td>BBB-</td>
<td>1.5% 3.1%</td>
</tr>
</tbody>
</table>

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
No adjustments have been made to the bond risk factor model utilized to develop the original results, beyond adjusting the time horizon to illustrate bond factors for the two-year and five-year time horizons.

*****

We appreciate the opportunity to provide this analysis and would welcome the opportunity to speak with you regarding these comments in more detail and answer any questions you might have. If you have any questions or would like to discuss further, please contact Devin Boerm (boerm@actuary.org) or Craig Hanna (hanna@actuary.org) at 202-223-8196.

Sincerely,

Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

Cc: Crystal Brown: Senior Insurance Reporting Analyst

---

Patrick McNaughton, Chair  
Health Risk-Based Capital Working Group  
RE: Health Care Receivables Guidance proposal  

Although the intent of the guidance is clear, its effectiveness would be questionable. Companies must first know guidance on a topic is available before they will search for it. Additionally, in the past the NAIC has indicated that guidance posted to a NAIC website is not the same as official instructions, making it even less likely industry will be searching for it. How will companies be notified the guidance is posted?  

Wouldn’t it be more effective to revise the instructions for preparing Exhibit 3 and Exhibit 3A? Part of the revised instructions should be examples of different circumstances. It is not unusual for the statement instructions to include examples of expected reporting; for example, that is done in the Property/Casualty Statement Instructions for Schedule P. Specific examples would provide more clarity. There is still time to get an instructional change adopted for the 2020 statement instructions.  

A statement proposal for revising the instructions would need to be submitted to the Blanks Working Group (BWG) by April 1, 2020. To be effective for year-end 2020, the proposal has to be adopted by BWG no later than their scheduled May conference call. (According to recently revised and adopted BWG procedures.)  
At the very least, if the Working Group moves forward with posting guidance, examples should be included in that guidance. The current proposed guidance provides background and explains why Exhibit 3 and Exhibit 3A reporting is currently not felt to be accurate, but provides no specific information to companies on how to rectify their reporting.

Connie Jasper Woodroof  
NAIC Liaison, Sapiens StatementPro  

Sapiens  
Email: c.jasperwoodroof@sapiens.com  
Mobile: 913-709-4192  
Phone: 800-373-3366 xt 5761  
Visit us on www.sapiens.com  
Follow us on LinkedIn, Facebook and Twitter
March 13, 2020 - sent electronically -

Mr. Steve Drutz, Health Risk-Based Capital (E) Working Group Chair
and Ms. Crystal Brown, NAIC Staff
National Association of Insurance Commissioners
701 Hall of the States
444 North Capitol Street, N.W.
Washington, D.C.  20001-1509

Re:  AHIP’s Comments on the February 2020 exposure of Health Test Language

Dear Mr. Drutz and Ms. Brown:

America’s Health Insurance Plans (AHIP) appreciates the opportunity to provide the following comments regarding the Health Test Language exposed in February 2020.

AHIP appreciates the work done by the NAIC’s Health Risk Based Capital (E) Working Group, Health Test Ad Hoc Group, and NAIC staff in creating the revised wording for the Health Test Language.  AHIP believes that the February 2020 exposure draft captures the essence of discussions held by Health Test Ad Hoc Group over previous calls.

During final review of the exposure draft, AHIP did notice a few minor typos and places for suggested editorial changes.  We have discussed these changes with NAIC staff and are providing these suggestions via the attached document (with track changes and comments noted on pages 5, 6, 8 and 9 of the attached Microsoft Word file).

We thank you for your consideration of these comments and would be happy to address any questions the Working Group may have.

Sincerely,

Ray Nelson, TriPlus Service – Consultant to AHIP
rnelson@triplusservices.com

cc:  Heather Jerbi, Executive Director, Product Policy – AHIP
Health Annual Statement

**GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the health annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The Health Statement Threshold result should be considered a starting point for the domestic regulator in considering which blank the reporting entity should file to most appropriately reflect the data and risks associated with the type of business written. The 90% threshold could be used as a trigger; however, the domestic regulator may begin the discussion before the percentage threshold is triggered. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Threshold calculation:**

   If a reporting entity completes the health annual statement for the reporting year, the reporting entity must complete the Health Statement Threshold calculation.

   The Health Statement Threshold calculation is designed to determine whether a reporting entity reports predominantly health lines of business. The purpose of this threshold is to identify a reporting entity writing predominantly health business (premium ratio of 90% or more) that should continue to file on a Health Statement and the associated Health RBC filing (if required) resulting in better disclosures and analysis of the health business being written. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts, which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, and Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVII, Medicaid Title XIX, Medicare Pass-Through Payments, and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, and Hospital Indemnity and Specified Disease Limited Benefit Plans, and Medicaid Pass-Through Payments. Other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies should be excluded.

   Core and non-core health business are split is to help guide the conversation between the reporting entity and the domiciliary regulator when determining which blank the reporting entity should file on. Core health business generally reflects business that is captured in more detail on the Health Blank, and therefore better captures the risks associated with writing that business. Non-core health business is generally not captured in as much detail on the Health Blank, and therefore might have less influence in determining which blank the reporting entity should file on.

**Meeting the Threshold:**

A reporting entity is deemed to have met the Health Statement Threshold if the values for the premium ratio in the Health Statement Threshold calculation (General Interrogatories, Part 2) equal or exceed 90% for both the reporting and prior year.

**Not Meeting the Threshold:**

Once the reporting entity has met the health threshold and is currently filing on the Health Statement (Health RBC filing), the health threshold calculation will be used to demonstrate that the insurer is still predominantly writing health business as defined above. If the premium ratio falls below 90% the company could still be viewed as writing predominantly health business and should continue to file on the Health Statement (and Health RBC Filing) but notify the domestic regulator as indicated below.
Variances from following these instructions:

If the reporting entity has consistently reported a premium ratio of 90% or greater in prior years and filed on the health blank but falls below the 90% premium ratio in the current year, the reporting entity shall apprise the domestic regulator and should advise of any changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the health annual statement and risk-based capital report or if the reporting entity should begin completing the life, accident and health and fraternal or property and casualty annual statement blank and associated risk-based capital report. The domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Threshold is submitted if a change in statement blank will be required in a following year.

Consideration may be given by the domestic regulator as to the break-out of business written on a percentage basis by the reporting entity. For example, the reporting entity wrote 90% core business and 9% non-core business in the first year in which it filed on the health blank and in the subsequent years, the writings went down to 80% core health business and 9% non-core health business. The domestic regulator should consider the reporting entity’s overall business plan going forward to determine if the reporting entity should continue to report on the health blank and whether the health blank provides adequate disclosures and identification of significant risks associated with the type of business the company plans to write in the future.

The closer the reporting entity comes to a Health Premium Ratio of 90%, the more importance the split between core and non-core health business might have on the domiciliary regulator’s decision as to which blank the reporting entity should file on. The more non-core health business drives the Health Premium Ratio result, the more the domiciliary regulator may consider other factors when determining which blank to file on, such as the reporting entity’s future business plans, which blank the reporting entity is currently filing on, or what other lines of business the reporting entity writes. In making the blanks determination, the larger the percentage of core health business written, the more likely the Health Blank would better capture the risks and detailed health data that regulators use to make informed decisions in analysis and regulation of the reporting entity.

<table>
<thead>
<tr>
<th>GENERAL INTERROGATORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART 2 – HEALTH INTERROGATORIES</td>
</tr>
</tbody>
</table>

2. Health Threshold Calculation:

<table>
<thead>
<tr>
<th></th>
<th>1 Current Year</th>
<th>2 Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Core Health Business Premium Numerator</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.2 Non-Core Health Business Premium Numerator</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.3 Total Health Premium Numerator (2.1+2.2)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.4 Total Premium Denominator</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.5 Core Health Business Premium Ratio (2.1/2.4)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.6 Non-Core Health Business Premium Ratio (2.2/2.4)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.7 Health Premium Ratio (2.3/2.4)</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

PART 2 – HEALTH INTERROGATORIES

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts, which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX.
Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans. Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, and Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments. Other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies should be excluded.

All reporting entities should file the health threshold calculation.

Premium information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Reporting Year Annual Statement Data</th>
<th>Prior Year Annual Statement Data</th>
</tr>
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<tbody>
<tr>
<td>2.1</td>
<td>Core Health Business Premium Numerator</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1</td>
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<tr>
<td></td>
<td>Comprehensive – Commercial – Individual (Column 2, in part)</td>
<td>Comprehensive – Commercial – Individual (Column 2, in part)</td>
<td>Comprehensive – Commercial – Individual (Column 2, in part)</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Commercial – Group (Column 2, in part)</td>
<td>Comprehensive Commercial – Group (Column 2, in part)</td>
<td>Comprehensive Commercial – Group (Column 2, in part)</td>
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<tr>
<td></td>
<td>Comprehensive – Commercial – Minimum Premium (Column 2, in part)</td>
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<td>Comprehensive – Commercial – Minimum Premium (Column 2, in part)</td>
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<tr>
<td></td>
<td>Medicaid – Title XXI (SCHIP) (Column 2, in part)</td>
<td>Medicaid – Title XXI (SCHIP) (Column 2, in part)</td>
<td>Medicaid – Title XXI (SCHIP) (Column 2, in part)</td>
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<tr>
<td></td>
<td>TRICARE (Column 2, in part)</td>
<td>TRICARE (Column 2, in part)</td>
<td>TRICARE (Column 2, in part)</td>
</tr>
<tr>
<td></td>
<td>Medicare Supplement (Column 3)</td>
<td>Medicare Supplement (Column 3)</td>
<td>Medicare Supplement (Column 3)</td>
</tr>
<tr>
<td></td>
<td>Dental Only (Column 4)</td>
<td>Dental Only (Column 4)</td>
<td>Dental Only (Column 4)</td>
</tr>
<tr>
<td></td>
<td>Vision Only (Column 5)</td>
<td>Vision Only (Column 5)</td>
<td>Vision Only (Column 5)</td>
</tr>
<tr>
<td></td>
<td>Federal Employees Health Benefits Plan (FEHBP) (Column 6)</td>
<td>Federal Employees Health Benefits Plan (FEHBP) (Column 6)</td>
<td>Federal Employees Health Benefits Plan (FEHBP) (Column 6)</td>
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<tr>
<td></td>
<td>Medicare – Title XVIII (Column 7)</td>
<td>Medicare – Title XVIII (Column 7)</td>
<td>Medicare – Title XVIII (Column 7)</td>
</tr>
<tr>
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<td>Medicaid – Title XIX (Column 8, in part)</td>
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<td>Medicaid – Title XIX (Column 8, in part)</td>
</tr>
<tr>
<td></td>
<td>Medicaid – Title XIX – Pass Through Payments (Column 8, in part)</td>
<td>Medicaid – Title XIX – Pass Through Payments (Column 8, in part)</td>
<td>Medicaid – Title XIX – Pass Through Payments (Column 8, in part)</td>
</tr>
<tr>
<td></td>
<td>Stand-Alone Medicare Part D (Column 9, in part)</td>
<td>Stand-Alone Medicare Part D (Column 9, in part)</td>
<td>Stand-Alone Medicare Part D (Column 9, in part)</td>
</tr>
<tr>
<td></td>
<td>Other Stand-Alone Rx Plans (Column 9, in part)</td>
<td>Other Stand-Alone Rx Plans (Column 9, in part)</td>
<td>Other Stand-Alone Rx Plans (Column 9, in part)</td>
</tr>
<tr>
<td></td>
<td>(in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies)</td>
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<td>(in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies)</td>
</tr>
</tbody>
</table>
### Life Annual Statement

**GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the life, accident and health annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The Health Statement Threshold should be considered a starting point for the domestic regulator in considering which blank the reporting entity should file to most appropriately reflect the data and risks associated with the type of business written. The 90% threshold could be used as a trigger; however, the domestic regulator may begin the discussion before the percentage threshold is reached. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Threshold Calculation:**

   If a reporting entity is licensed as a life and health insurer and completes the life, accident and health annual statement for the reporting year, the reporting entity must complete the Health Statement Threshold calculation.
The purpose of the Health Statement Threshold calculation is to identify a reporting entity writing predominantly health lines of business (premium ratio of 90% or more), that should move and file on a Health Statement and the associated Health RBC filing (if required). The Health Statement provides for better disclosure and analysis of the health business written compared to other statement types. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans. Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments. Other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies should be excluded.

Core and non-core health business are split is to help guide the conversation between the reporting entity and the domiciliary regulator when determining which blank the reporting entity should file on. Core health business generally reflects business that is captured in more detail on the Health Blank, and therefore better captures the risks associated with writing that business. Non-core health business is generally not captured in as much detail on the Health Blank, and therefore might have less influence in determining which blank the reporting entity should file on.

Meeting the Threshold:

A reporting entity is deemed to have met the Health Statement Threshold if:

The values for the premium ratio in the Health Statement Threshold calculation equal or exceed 90% for both the reporting and prior year. The 90% threshold would include core and non-core health business, however, if the reporting entity falls below 90%, the domestic regulator may consider if there is a benefit to the reporting entity to file on the health blank.

If a reporting entity completes the Life, Accident and Health annual statement for the reporting year and b) meets the threshold of the Health Statement Threshold calculation (as described above), the reporting entity must begin completing the health statement with the first quarter’s statement for the second year following the reporting year in which the reporting entity passes the Health Statement Threshold and must also file the corresponding risk-based capital report and the life supplements for that year-end. (e.g. If the company passed the health threshold for year-end-2019 reporting, the company must begin filing the health blank with first quarter 2021). With permission from the domiciliary regulator, the reporting entity may begin filing on the Health Statement with the first quarter’s statement for the first year following the reporting year (e.g. first quarter 2020).

Variance from following these instructions:

If the reporting entity has consistently reported a premium ratio below 90% or greater in prior years and filed on the health life blank but falls below 90% in the current year, the reporting entity shall apprise the domestic regulator if they fall below 90% and should advise of significant changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the health life annual statement and associated risk-based capital report or if the reporting entity should begin completing the life, accident and health and fraternal or property and casualty health annual statement form and risk-based capital report. The domestic regulator shall
notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Threshold is submitted if a change in the statement blank will be required in the following year.

To determine if the reporting entity should move from the life blank to the health blank consideration may be given by the domestic regulator as to the break-out of business written on a percentage basis by the reporting entity. For example, the reporting entity wrote 80% core business and 9% non-core business in the a prior year and in the subsequent years, the writings increased to 85% core health business and 9% non-core health business. In this instance, the domestic regulator should consider the reporting entity’s overall business plan going forward and determine if the reporting entity should move to report on the health blank as this would provide better disclosures and risks associated to this type of business.

The closer the reporting entity comes to a Health Premium Ratio of 90%, the more importance the split between core and non-core health business might have on the domiciliary regulator’s decision as to which blank the reporting entity should file on. The more non-core health business drives the Health Premium Ratio result, the more the domiciliary regulator may consider other factors when determining which blank to file on, such as the reporting entity’s future business plans, which blank the reporting entity is currently filing on, or what other lines of business the reporting entity writes. In making the blanks determination, the larger the percentage of core health business written, the more likely the Health Blank would better capture the risks and detailed health data that regulators use to make informed decisions in analysis and regulation of the reporting entity.

GENERAL INTERROGATORIES

PART 2 – LIFE ACCIDENT AND HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

2. Health Threshold Calculation:

<table>
<thead>
<tr>
<th></th>
<th>1 Current Year</th>
<th>2 Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Core Health Business Premium Numerator</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.2 Non-Core Health Business Premium Numerator</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.3 Total Health Premium Numerator (2.1+2.2)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.4 Total Health Premium Denominator</td>
<td>$</td>
<td>$</td>
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<tr>
<td>2.5 Core Health Business Premium Ratio (2.1/2.4)</td>
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<tr>
<td>2.6 Non-Core Health Business Premium Ratio (2.2/2.4)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.7 Health Premium Ratio (2.3/2.4)</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

PART 2 – LIFE ACCIDENT HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XIX, Medicare Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans. Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XIX, Medicaid Title XIX and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments. Other health coverage such as credit insurance, disability income...
coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies should be excluded.

All reporting entities should file the threshold calculation.

Premium information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Reporting Year Annual Statement Data</th>
<th>Prior Year Annual Statement Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Core Health Business Premium Numerator</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business – Accident and Health, Line 1</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business – Accident and Health, Line 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive – Commercial – Individual (Column 2, in part)</td>
<td>Comprehensive – Commercial – Individual (Column 2, in part)</td>
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<tr>
<td></td>
<td></td>
<td>Comprehensive Commercial – Group (Column 3, in part)</td>
<td>Comprehensive Commercial – Group (Column 3, in part)</td>
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<td>Comprehensive – Commercial – Minimum Premium (Column 3, in part)</td>
<td>Comprehensive – Commercial – Minimum Premium (Column 3, in part)</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td>TRICARE (Column 3, in part)</td>
<td>TRICARE (Column 3, in part)</td>
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<td></td>
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<td>Dental Only (Column 6)</td>
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<td>Vision Only (Column 5)</td>
<td>Vision Only (Column 5)</td>
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<td>Federal Employees Health Benefits Plan (FEHBP) (Column 7)</td>
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<td>Medicare – Title XVII (Column 8)</td>
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<td>Medicaid – Title XIX (Column 9, in part)</td>
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<tr>
<td></td>
<td></td>
<td>Medicaid – Title XIX – Pass Through Payments (Column 9, in part)</td>
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<td>Stand-Alone Medicare Part D (Column 13, in part)</td>
<td>Stand-Alone Medicare Part D (Column 13, in part)</td>
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<tr>
<td></td>
<td></td>
<td>Other Stand-Alone RX Plans (Column 13, in part)</td>
<td>Other Stand-Alone RX Plans (Column 13, in part)</td>
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<td></td>
<td></td>
<td>(excluding credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies)</td>
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<tr>
<td>2.2</td>
<td>Non-Core Health Premium Numerator</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business – Accident and Health, Line 1</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business – Accident and Health, Line 1</td>
</tr>
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<td></td>
<td></td>
<td>Stop Loss (Column 13, in part)</td>
<td>Stop Loss (Column 13, in part)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited Benefit Plans (Column 13, in part)</td>
<td>Limited Benefit Plans (Column 13, in part)</td>
</tr>
<tr>
<td></td>
<td>ASC Business Reported as Revenue (Column 13, in part)</td>
<td>ASC Business Reported as Revenue (Column 13, in part)</td>
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<td>------------------------------------------------------</td>
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<tr>
<td></td>
<td>Other Health (Column 13, in part)</td>
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<td></td>
<td>(in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies)</td>
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<table>
<thead>
<tr>
<th>2.3</th>
<th>Total Health Premium Numerator</th>
<th>Line 2.1 + 2.2</th>
<th>Line 2.1 + 2.2</th>
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</table>

<table>
<thead>
<tr>
<th>2.4</th>
<th>Total Health Premium Denominator</th>
<th>Premium and Annuity Considerations (Page 4, Line 1) of the reporting year’s annual statement</th>
<th>Premium and Annuity Considerations (Page 4, Line 1) of the prior year’s annual statement</th>
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<tr>
<th>2.5</th>
<th>Core Health Premium Ratio</th>
<th>2.1/2.4</th>
<th>2.1/2.4</th>
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<tr>
<th>2.6</th>
<th>Non-Core Health Premium Ratio</th>
<th>2.2/2.4</th>
<th>2.2/2.4</th>
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<thead>
<tr>
<th>2.7</th>
<th>Health Premium Ratio</th>
<th>2.3/2.4</th>
<th>2.3/2.4</th>
</tr>
</thead>
</table>

**Property/Casualty Annual Statement**

**GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the property and casualty annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The Health Statement Threshold result should be considered a starting point for the domestic regulator in considering which blank the reporting entity should file to most appropriately reflect the data and risks associated with the type of business written. The 90% threshold could be used as a trigger; however, the domestic regulator may begin the discussion before the percentage threshold is triggered. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Threshold Calculation:**

   If a reporting entity is licensed as a property and casualty insurer and completes the property and casualty annual statement for the reporting year, the reporting entity must complete the Health Statement Threshold calculation.

   The purpose of Health Statement Threshold calculation is to identify a reporting entity writing predominantly health lines of business (premium ratio of 90% or more), that should move and file on a Health Statement and the associated Health RBC filing (if required). The Health Statement provides for better disclosure and analysis of the health business written compared to other statement types. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans. Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and...
Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments. Other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies should be excluded.

Core and non-core health business are split is to help guide the conversation between the reporting entity and the domiciliary regulator when determining which blank the reporting entity should file on. Core health business generally reflects business that is captured in more detail on the Health Blank, and therefore better captures the risks associated with writing that business. Non-core health business is generally not captured in as much detail on the Health Blank, and therefore might have less influence in determining which blank the reporting entity should file on.

Meeting the Threshold:

A reporting entity is deemed to have met the Health Statement Threshold if:

The values for the premium ratio in the Health Statement Threshold calculation equal or exceed 90% for both the reporting and prior year. The 90% threshold would include core and non-core health business, however, if the reporting entity falls below 90%, the domestic regulator may consider if there is a benefit to the reporting entity to begin filing on the health blank.

If a reporting entity completes the property and casualty annual statement for the reporting year and b) meets the threshold of the Health Statement Threshold (as described above), the reporting entity must begin completing the health statement with the first quarter’s statement for the second year following the reporting year in which the reporting entity passes the Health Statement Threshold and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end. (e.g. If the company passed the health threshold for YE-2019 reporting, the company must begin filing the health blank with first quarter 2021). With the permission of the domiciliary regulator, the reporting entity may begin filing on the health blank with the first quarters statement for the first year following the reporting year (e.g. first quarter 2020).

Variance from following these instructions:

If the reporting entity has consistently reported a premium ratio of below 90% or greater in prior years and filed on the health-property/casualty blank but [RN5] falls below exceeds the 90% premium ratio in the current year, the reporting entity shall apprise the domestic regulator if they fall below 90% and should advise of significant changes in their business at the time of their annual statement filing. This will allow the domestic regulator to work with the reporting entity to determine if the company should continue to complete the property/casualty health annual statement and risk-based capital report or if the reporting entity should begin completing the life, accident and health and fraternal or property and casualty health annual statement form and associated risk-based capital report. The domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which the Health Statement Threshold is submitted if a change in statement blank will be required in the following year [RN7].

To determine if the reporting entity should move from the property/casualty blank to the health blank consideration may be given by the domestic regulator as to the break-out of business written on a percentage basis by the reporting entity. For example, the reporting entity wrote 90% core business and 9% non-core business in a prior year and one and in the subsequent years, the writings increased down to 85% core health business and 9% non-core health business. The domestic regulator should consider the reporting company’s overall business plan going forward to determine if the reporting entity should move to report on the health blank and whether the health blank provides adequate disclosures and identification of significant risks associated with the type of business the reporting entity plans to write in the future.

The closer the reporting entity comes to a Health Premium Ratio of 90%, the more importance the split between core and non-core health business might have on the domiciliary regulator’s decision as to which blank the reporting entity should
file on. The more non-core health business drives the Health Premium Ratio result, the more the domiciliary regulator may consider other factors when determining which blank to file on, such as the reporting entity’s future business plans, which blank the reporting entity is currently filing on, or what other lines of business the reporting entity writes. In making the blanks determination, the larger the percentage of core health business written, the more likely the Health Blank would better capture the risks and detailed health data that regulators use to make informed decisions in analysis and regulation of the reporting entity.

GENERAL INTERROGATORIES
PART 2 – PROPERTY & CASUALTY INTERROGATORIES

2. Health Threshold Calculation:

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Reporting Year Annual Statement Data</th>
<th>Prior Year Annual Statement Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Core Health Business Premium Numerator</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.2 Non-Core Health Business Premium Numerator</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.3 Total Health Premium Numerator (2.1+2.2)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.4 Total Health Premium Denominator</td>
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<td>$</td>
</tr>
<tr>
<td>2.5 Core Health Business Premium Ratio (2.1/2.4)</td>
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<td>$</td>
</tr>
<tr>
<td>2.6 Non-Core Health Business Premium Ratio (2.2/2.4)</td>
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</tr>
<tr>
<td>2.7 Health Premium Ratio (2.3/2.4)</td>
<td>$</td>
<td>$</td>
</tr>
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</table>

PART 2 – PROPERTY AND CASUALTY INTERROGATORIES

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts which can further be broken out into two main types: core health business and non-core health business. Core health business would include comprehensive medical – commercial individual, group and minimum premium, Medicaid Title XXI (SCHIP), TRICARE, Medicare Supplement, Dental only, Vision only, Stand-Alone Medicare Part D Coverage, Other Stand-Alone RX Plans, Medicare Title XVIII, Medicaid Title XIX, Medicaid Pass-Through Payments and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC Business Reported as Revenue, and Limited Benefit Plans. Core health business would include comprehensive medical, Medicare Supplement, Dental and Vision, Stand-Alone Medicare Part D Coverage, Medicare Title XVIII, Medicaid Title XIX and Federal Employee Health Benefit Plans. Non-core health business would include such lines as Other Health, Stop Loss, ASC and ASO Business Reported as Revenue, Hospital Indemnity and Specified Disease and Medicaid Pass-Through Payments. Other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies should be excluded.

All reporting entities should file the threshold calculation.

Premium information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.
<table>
<thead>
<tr>
<th>Non-Core Health Premium Numerator</th>
<th>Health Premiums values listed in the statement value column (Column 1) of the reporting year’s Life RBC report:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop Loss</td>
<td>Stop Loss</td>
</tr>
<tr>
<td>Limited Benefit Plans</td>
<td>Limited Benefit Plans</td>
</tr>
<tr>
<td>ASC Business Reported as Revenue</td>
<td>ASC Business Reported as Revenue</td>
</tr>
<tr>
<td>Other Health</td>
<td>Other Health</td>
</tr>
<tr>
<td>(in part, excluding credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies)</td>
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<table>
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<tr>
<th>Total Health Premium Numerator</th>
<th>Line 2.1 + 2.2</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Total Health Premium Denominator</th>
<th>Premiums earned and Annuity Considerations (Page 4, Line 1) of the reporting year’s annual statement</th>
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<table>
<thead>
<tr>
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</tr>
<tr>
<td>Health Premium Ratio</td>
<td>2.3/2.4</td>
</tr>
</tbody>
</table>
The Investment Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Feb. 25, 2020. The following Working Group members participated: Kevin Fry, Chair, and Vincent Tsang (IL); Philip Barlow, Vice Chair (DC); Kathy Belfi, Wanchin Chou and Manny Hidalgo (CT); Robert Ridenour (FL); Chut Tee (KS); Anna Taam and Victor Agbu (NY); Tom Botsko (OH); Tim Hays (WA); and Randy Milquet (WI). Also participating were: Steve Ostlund (AL); Alice Fontaine (AZ); Mitchell Bronson (CO); Adrienne Lupo (DE); Carrie Mears (IA); Rhonda Ahrens (NE); and Mike Boerner and Rachel Hemphill (TX).

1. Discussed Comments Regarding Bond Proposals

Mr. Fry said that during the Capital Adequacy (E) Task Force conference call held Dec. 30, 2019, the proposed expansion for risk-based capital (RBC) bond structures were exposed for a 45-day public comment period ending Feb. 14, 2020. He indicated that the proposed structure would provide an opportunity to collect data needed for the sensitivity analysis in the future. He also stated that the Task Force and Working Group received four comment letters during the exposure period.

Nancy Bennett (American Academy of Actuaries—Academy) said the Academy supports the expansion of the bond designations to a 20-factor structure for any asset type that currently utilizes a six-factor structure. However, the current exposure does not expand the designations for unaffiliated preferred stock, surplus and capital notes, derivative instruments, and separate accounts with guarantees or synthetic guaranteed investment contracts. She also recommended that the Working Group consider adopting the expanded structure at the same time for both asset valuation reserves (AVR) and life RBC.

Mr. Fry said it will make sense to have the same expansion to other types of assets.

Dave Fleming (NAIC) said a proposal that will apply the same expanded presentation to the AVR as it is used to populate the life RBC formula will be exposed by the Blanks (E) Working Group during the Spring National Meeting.

Paul S. Graham (American Council of Life Insurers—ACLI) said that the ACLI continues to support the expansion of the bond factors from six categories to 20 categories. Additionally, the same issues that the Academy presented earlier were identified. He said the ACLI recommended that the Working Group consider clarifying language in the RBC bond instructions.

Mr. Fleming said the Working Group will expose the modified instruction in April.

Jonathan Rogers (National Association of Mutual Insurance Companies—NAMIC) said NAMIC supports the NAIC performing an impact analysis of the 20 new bond designations against the current factors for designation 1 through designation 6. He believed that performing a cost-benefit analysis is necessary, as the purpose of the RBC is for state insurance regulators to have the ability to identify weakly capitalized companies. He also recommended that the Working Group expose the analysis for public comment in the future.

Mr. Fry agreed that the sensitivity analysis will be able to determine how material affects the industry. The Working Group will be sure to provide a proper exposure period to the interested parties to analyze the results.

Connie Jasper Woodroof (Sapiens) said that as she noticed some inconsistency between the RBC proposed structure and the Annual Statement instructions, suggested mechanical corrections related to the bond proposals for each of the RBC formulas were submitted to the NAIC staff.

Eva Yeung (NAIC) said the modified structure that the Working Group will consider exposing will address most of the issues that Ms. Woodroof identified. She encouraged her to review the modified structure and provide feedback to the Working Group afterward.
Julie Gann (NAIC) suggested the change of Line 1 description in property/casualty (P/C) and health structures to “NAIC U.S. Government – Direct and Guaranteed / NAIC U.S. Direct Obligations / Full Faith and Credit Exempt Money Market Mutual Funds List.”

Mr. Fry said all the changes will be included in the upcoming exposure.

2. Re-Exposed Bond Proposals

Mr. Fry said that after the NAIC staff reviewed the comments received, along with the changes to the 2020 annual financial statement blanks, the structure modifications were made to the P/C and health RBC formulas. He also indicated that the life formula pulls from the annual financial statement AVR; there were only minor changes needed to the life RBC formula and AVR. He also stated that the purpose of this structure change is to allow NAIC staff to perform an impact analysis on the 2020 data; further modification of the structure will likely be necessary for year-end 2021 reporting for the purpose of increased transparency and auditability.

Ms. Belfi said Connecticut supports looking into the mechanism to get a second opinion on this proposal.

Mr. Barlow commented that he does not see the need for engaging a third party to do the review. He believes the work that the Academy did supports the factor that they developed.

Mr. Graham said the ACLI supports the comment from Connecticut. The ACLI will discuss the project funding aspect with the members soon; funding will be provided in the upcoming meeting.

Mr. Fry said the outstanding discussion will be continued at the Spring National Meeting.

In order to allow the industry parties to have time to review the changes of the structures, the Working Group agreed to re-expose the structures for a 10-day public comment period ending March 6.

3. Discussed Other Matters

Mr. Fry said the Working Group plans to meet at the Spring National Meeting on Sunday, March 22. The main purpose of this meeting is to hear the Academy’s final summary of the bond report. He stated that the Working Group plans to finalize the bond and real estate equity proposal for 2021 RBC reporting.

Having no further business, the Investment Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 30, 2020. The following Working Group members participated: Philip Barlow, Chair (DC); Steve Ostlund (AL); Perry Kupferman (CA); Deborah Batista (CO); Wanchin Chou (CT); Caroline Morgan (FL); Vincent Tsang (IL); William Leung (MO); Rhonda Ahrens (NE); Dave Wolf (NJ); Bill Carmello (NY); Diane Carter (OK); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Adopted its July 10, June 30, June 11 and Spring National Meeting Minutes

The Working Group met July 10, June 30, June 11 and March 23. During its July 10 and June 30 meetings, the Working Group discussed an industry request for risk-based capital (RBC) mortgage reporting guidance. During its June 11 meeting, the Working Group took the following action: 1) adopted the instructions for incorporating a longevity risk charge; and 2) discussed the American Council of Life Insurers’ (ACLI) request for guidance on the life RBC reporting of mortgages.

Mr. Ostlund made a motion, seconded by Mr. Boerner, to adopt the Working Group’s July 10 (Attachment Four-A), June 30 (Attachment Four-B), June 11 (Attachment Four-C) and March 23 (Attachment Four-D) minutes. The motion passed unanimously.

2. Adopted the 2020 Life RBC Newsletter

Mr. Wolf made a motion, seconded by Mr. Ostlund, to adopt the 2020 life RBC newsletter (Attachment Four-E). The motion passed unanimously.

3. Discussed the 2019 Life and Fraternal Statistics

Mr. Barlow said because the life and fraternal formulas were combined, there is no longer a separate section for each. He said he has noted this previously, but he would like to have in-depth discussions about the statistics to determine if the right ones are being captured and what these might mean with respect to decisions the Working Group makes. He said the statistics are to be posted to the Working Group’s page on the NAIC website.

Paul Graham (ACLI) suggested that it would be more helpful to have the breakouts of RBC ratios be shown as 300%–500% as opposed to 250%–500%.

Dave Fleming (NAIC) said that not all states have yet adopted the 300% threshold and, as such, it is still necessary to include the 250% threshold.

4. Continued Discussion of Industry Request for RBC Mortgage Reporting Guidance

Mr. Barlow reminded the Working Group that the industry has brought forth four requests for RBC mortgage reporting guidance and that the Working Group has addressed the three that would be applicable to year-end 2020 RBC reporting and deferred action on the fourth while agreeing to reconsider as new information is presented. He said the industry has continued to work on this to provide additional information to assist the Working Group in deciding on the fourth item, which is net operating income (NOI).

John Waldeck (Pacific Life Insurance) said he is representing the Mortgage Bankers Associations (MBA) and the ACLI and presented an update on the status of their work (Attachment Four-F). He asked Working Group members for anything else that they would like to have specific focus on as they continue their work to provide more information for the Working Group.

Ms. Ahrens said the proposed approach is to use the greater of 2020 NOI or 85% of 2019 NOI and asked if it was possible to use more timely information such as the third quarter of 2020.
Mr. Waldeck indicated that many of the loans on the books of insurers are smaller loans that only receive annual financial statements and that this was one of the reasons for the current RBC calculation.

Instead of changing the underlying data point because of the credibility of the data point, Mr. Chou suggested the possibility of changing the weight given to the data points.

Because the calculation for 2020 could not be changed, Mr. Waldeck said this request was just for guidance on how to treat the NOI as an input into the calculation. He said he believes using 85% of 2019 results in an outcome very similar to changing the weights given.

Mr. Barlow asked if some analysis could be done with the actual worksheet calculations to determine the RBC category for each loan for previous years substituting the 85% of the prior year NOI as the proposal is requesting for 2020 to see if it materially changes the categorization of loans.

Mr. Waldeck indicated that some information to that end could be provided.

Mr. Barlow said the Working Group will continue to look at this issue and consider it again as more information is presented.

5. Discussed the Working Agenda and Upcoming Conference Calls

Mr. Barlow said the American Academy of Actuaries (Academy) has had a couple of projects it has been working on, specifically C-3 and C-2, which it is ready to present to and get feedback from the Working Group but have been delayed due to the focus on work relating to the pandemic. He said the Working Group has conference calls scheduled for Aug. 21 and Sept. 11 to discuss these items and other items on the working agenda.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call July 10, 2020. The following Working Group members participated: Philip Barlow, Chair (DC); Steve Ostlund (AL); Perry Kupferman (CA); Deborah Batista (CO); Wanchin Chou (CT); Gilbert Moreau (FL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Discussed and Deferred an Industry Request for RBC Mortgage Reporting Guidance

Mr. Barlow said two of the four items the industry is requesting risk-based capital (RBC) reporting guidance on were addressed on the June 30 conference call with the Working Group adopting the requested guidance for construction loans and origination date, valuation date, property value and 90 days past due.

Mr. Barlow said this call is to address the two remaining items, net operating income (NOI) and contemporaneous property values. With respect to the remaining two items, he said there were some concerns that the requested guidance seems to completely discount any potential impact on commercial mortgages of the current pandemic. He said the Mortgage Bankers Association (MBA) and the American Council of Life Insurers (ACLI) have provided updated recommendations (Attachment Four-A1 and Attachment Four-A2) based on the feedback from the Working Group’s last call.

John Waldeck (Pacific Life Insurance) said he is representing the MBA and the ACLI. With respect to NOI, he said the first proposal suggested using the greater of 2020 or 2019 NOIs. He said they went back to see what would be more justifiable and have updated the proposal to use the greater of 2020 or 85% of 2019 NOI, and he presented the rationale supporting this revision.

Mr. Barlow suggested addressing the two issues one at a time. He said the NOI guidance would not affect the 2020 RBC calculation, but it would affect the three subsequent years. He suggested that if the Working Group is inclined to support this proposal as-is or with some modification, it should indicate this but consider revising the worksheet for 2021.

Mr. Robinson noted the existing weighted average for NOI, and he is inclined to let it work in the way it was intended. He said he is in favor of gathering the information for the 2020 NOI and considering revisiting the construct for 2021 when they have information to base the decision on.

Mr. Carmello asked about the timing requirements for getting the information and making the changes. Mr. Barlow said he believes these would be instructional changes subject to the June 30 deadline.

Dave Fleming (NAIC) said changes would need to be exposed for comment by the end of April.

Mr. Barlow said this is not information that will be captured in an NAIC filing, and he believes the Working Group would need to look to the industry to provide that information.

Mr. Waldeck indicated that the time frame for getting this information for individual properties for the 2020 filings would be around June or July, which would be outside of the Working Group’s timeline.

Mr. Barlow asked if there is information that could be obtained that could serve as a proxy in order for the Working Group make a more informed decision.

Mr. Waldeck indicated that there may be some potential data points that could be used. He reminded the Working Group that part of the reason for this request is that the decision on the treatment of 2020 NOI will have an impact on the desire to place new investments this year, and that is why guidance now is important. He said this guidance is also important to companies in order to plan for their capital needs.

Mr. Robinson made a motion, seconded by Ms. Eom, to defer the request subject to more information being provided.
Mr. Waldeck said he would appreciate reconsideration of rejecting the proposal, and he reiterated the importance of having the Working Group address this now. He said the likelihood is that the additional information on the 2020 NOI might come late in the second quarter next year, which is past the time the Working Group would need to address it.

So the industry has some indication on how to move forward, Mike Monahan (ACLI) suggested adopting the change for 2021, with it to be reconsidered for 2022 and 2023 as additional information becomes available.

Mr. Carmello suggested that the Working Group indicate that it would reconsider before the end of this year.

Mr. Barlow asked if industry could provide information that would influence the Working Group’s decision by the end of the year.

Mr. Waldeck said one concern is decisions about new investments being made without clarity on the RBC considerations. He said another concern is that the 2020 NOI is not impactful to the 2020 RBC calculation but is for planning companies will do for the following year and the investments they make based on the 2020 NOI.

Mr. Robinson and Ms. Eom accepted a friendly amendment to the motion to reconsider in time to make changes for next year. California, Colorado, Connecticut, Florida, Minnesota, Missouri and New Jersey voted in favor of the motion. Nebraska, New York, Oklahoma, Texas and Utah voted against the motion. Alabama abstained. The motion passed.

2. Adopted Requested Guidance on Contemporaneous Property Values

Mr. Waldeck said the requested guidance on contemporaneous property values affects only the 2020 year-end RBC calculation, and it is designed solely to adjust out any shock effect that could be in the National Council of Real Estate Investment Fiduciaries (NCREIF) price index. He said the proposal is to use the average of the 2019 and 2020 NCREIF values. If there is a decline, he said this would reflect only half of that decline, and it reflects the state insurance regulators’ concerns about totally discounting the decline.

Mr. Carmello made a motion, seconded by Ms. Ahrens, to adopt the requested guidance on contemporaneous property values (Attachment Four-A2). The motion passed, with Minnesota voting against the motion.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
July 7, 2020

Philip A. Barlow, FSA, MAAA
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197
Re: Supplement to June 8, 2020 Request for Risk-Based Capital Reporting Guidance

Dear Mr. Barlow:

The Mortgage Bankers Associations (MBA) and the American Council of Life Insurers (ACLI) on behalf of our respective member insurers, respectfully submit to the Life Risk-Based Capital Working Group of the National Association of Insurance Commissioners (NAIC) this Supplement to our June 8, 2020 request for risk-based capital reporting guidance.

We appreciate the Working Group’s approval on June 30, 2020 of our requested reporting guidance for Construction Loans and for Origination Date, Valuation Date, Property Value, and 90 Days Past Due.

We also appreciate the thoughtful feedback regulators provided in the Working Group’s discussion of our requested reporting guidance on Net Operating Income and on Contemporaneous Property Values. In response to that feedback, our organizations convened a large working group of insurers to consider modifications of the reporting guidance we recommended for those two items.

The attached Supplement describes revised recommendations developed by that working group that we believe address the concerns raised by the regulators. We look forward to discussing these proposed recommendations on the Working Group call scheduled for July 10, 2020.

1 The Mortgage Bankers Association (MBA) is the national association representing the real estate finance industry, an industry that employs more than 280,000 people in virtually every community in the country. Its membership of over 2,300 companies includes all elements of real estate finance: mortgage companies, mortgage brokers, commercial banks, credit unions, thrifts, REITs, Wall Street conduits, 70 life insurance companies engaged in real estate finance, and others in the mortgage lending field. For additional information, visit MBA’s website: www.mba.org

2 The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States. Learn more at www.acli.com
We want to thank you and other regulators, and NAIC staff, for your considerable time and attention to this request. Please feel free to contact Bruce Oliver at boliver@mba.org or 202-557-2840 or Mike Monahan at mikemonahan@acli.com or 202-624-2324 for any additional information.

Sincerely,

Mike Flood

Paul Graham

Attachment: Supplement to June 8, 2020 Request for Risk-Based Capital Reporting Guidance

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst
Supplement to June 8, 2020 letter to the Life Risk-Based Capital Working Group
Revised RBC Reporting Guidance Proposals
July 7, 2020

This document supplements the proposal submitted to the Life Risk-Based Capital Working Group of the National Association of Insurance Commissioners, submitted by the Mortgage Bankers Association and the American Council of Life Insurers on June 8, 2020, following up on the Working Group call of June 30, 2020.

I. NET OPERATING INCOME

Background

Net Operating Income (NOI) inputs are reported in items (14), (15), and (16), and those inputs are used to compute a Rolling Average NOI under item (36).

The Rolling Average NOI is weighted as follows:

- 50% of NOI at year-end of preceding year
- 30% of NOI at year-end of next preceding year
- 20% of NOI at year-end of next preceding year

As a result, 2020 NOI will be an input into reporting for 2021, 2022, and 2023 reporting, and will not to be an input into 2020 RBC reporting.

June 8 proposed reporting guidance

For 2020 NOI inputs used to compute rolling average NOI for 2021, 2022, and 2023 reporting, use the greater of:

- 2020 NOI; or
- 2019 NOI.

Revised proposed reporting guidance

For 2020 NOI inputs used to compute rolling average NOI for 2021, 2022, and 2023 reporting, use the greater of—

- 2020 NOI; or
- 85% of 2019 NOI.

Rationale

Industry recognizes that substituting 2019 NOI for properties whose NOIs have decreased could be viewed as ignoring the credit risk impact of temporary business shutdowns resulting from the COVID-19 pandemic.
On the other hand, direct application of 2020 NOI for properties affected by temporary business shutdowns resulting from the COVID-19 pandemic would overstate the actual increase in the credit risk exposure presented by temporary impacts to properties.

Direct application of the 2020 NOI would also create disincentives for insurers to work prudently with borrowers. Lenders retain approval rights for many leasing actions, including forgiveness or reductions in rent, and granting approval of rent forgiveness or reductions directly reduces NOI.

The revised proposal is an effort to balance these competing concepts. It recognizes reductions in NOI, and so does not ignore the credit risk impact of the pandemic. At the same time, it also proposes an 85% floor on reductions from 2019 NOI. That floor reduces the likelihood of overstating the actual change in credit risk. It also reduces disincentives for insurers to approve rent concessions that would reduce NOI, but that also are in the best interests of the insurer, the borrower, the tenants, and the economy generally.

The revised proposal also reflects practical considerations. Specifically, it is supportable by readily available reports. NOI for most properties is reported only annually, typically three to four months after year-end. As a result, 2019 and 2020 NOI year-end values will be readily available for 2021 reporting. In contrast, information necessary to support a possible approach based on quarterly NOI would generally not be available at all, and information to support an approach based on 2021 NOI would generally not be available in time for timely 2021 year-end reporting.

The 85% floor was identified as reasonable because a 15% drop in NOI represents roughly three times the worst four-quarter decline in NCREIF NOI values over the past 20 years. From the NCREIF data, the largest four-quarter decline in NOI (across all property types) during the Global Financial Crisis was 3.15% in Q1 2010. During the 2001 Recession (which was harder on NOIs), there was a 5.91% four-quarter decline in 2003 Q3 – with an aggregate 11.5% decline between 2001 Q2 and 2004 Q1.

Moreover, a 15% reduction in NOI has been recognized to be substantial in another regulatory capital context. Specifically, the Federal Housing Finance Agency (FHFA) used a 15% reduction in NOI as a stress input to calibrate multifamily mortgage credit risk for Fannie Mae and Freddie Mac in its recently proposed risk-based capital regulations.

- See 85 Fed. Reg. 39274, 39322 (June 30, 2020) (“FHFA generally calibrated the base risk weights and risk multipliers for multifamily mortgage exposures to require credit risk capital sufficient to absorb the lifetime unexpected losses incurred on multifamily mortgage exposures experiencing a shock to property values similar to that observed during the 2008 financial crisis. … For the purpose of the proposed rule, the multifamily-specific stress scenario assumes an NOI decline of 15 percent ….”).
While the FHFA used a 15% reduction for a somewhat different regulatory capital purpose, its use of a 15% reduction in NOI to calibrate the multifamily mortgage credit risk element of its proposed risk-based capital regulations does support identifying 85% of 2019 NOI (i.e., a 15% reduction in NOI) as a reasonable floor here.

II. CONTEMPORANEOUS PROPERTY VALUE

Background

Contemporaneous Property Value (40) is a field computed as: the Property Value (20) at the time the loan was originated, was revalued due to impairment underwriting, restructure, extension, or other re-writing; times that ratio (rounded to 4 decimal places) of the Price Index current to the Price Index at valuation (39).

The Price Index at Valuation is the value of the NCREIF Price Index on the last day of the calendar quarter that includes the date defined in (21) and (22). However, the “Price Index current” is not a defined or numbered input into risk-based capital reporting.

The Contemporaneous Property Value (40) becomes an input into the computation of RBC LTV. RBC LTV is computed as Total Loan Value (13) divided by the Contemporaneous Property Value (40), rounded to the nearest percent. RBC LTV is then a factor in determining the risk category (from CM1 to CM5) for any loan that is not 90 days or more overdue, which is then used to determine the risk-based capital requirement for the loan.

The Contemporaneous Property Value is the property value at origination, adjusted by applying the NCREIF Price Index. That value becomes an input into the computation of RBC LTV, which affects the classification of the loan.

June 8 proposed reporting guidance

As “Price Index current” input used to compute Property Value for 2020 year-end reporting, use:

- The 2019 NCREIF Price Index.

Revised proposed reporting guidance

As “Price Index current” input used to compute Property Value for 2020 year-end reporting, use:

- Use the average of:
  1. The year-end 2019 NCREIF Price Index; and
  2. The 2020 NCREIF Price Index.
Rationale

Industry recognized that substituting 2019 NCREIF Price Index could be viewed as ignoring the credit risk impact of temporary business shutdowns resulting from the COVID-19 pandemic.

On the other hand, direct application of 2020 NCREIF Price Index could introduce anomalous 2020 market activity and so could overstate the actual increase in the credit risk exposure presented by changes in the continuing value of those properties.

The revised proposal is an effort to balance these two competing concepts. It does so by recognizing that reductions in property values may occur in 2020, and so does not ignore the credit risk impact of the pandemic, but it also moderates the distortive effects of anomalous 2020 market activity by averaging the indexes for 2019 and 2020.

The information needed to implement this proposal would be readily available for 2020 reporting because the only additional information not already required for 2020 reporting would be the 2019 year-end NCREIF Price Index.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call June 30, 2020. The following Working Group members participated: Philip Barlow, Chair (DC); Perry Kupferman (CA); Manuel Hidalgo (CT); Gilbert Moreau (FL); John Robinson (MN); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Discussed an Industry Request for Risk-Based Capital Mortgage Reporting Guidance

Mr. Barlow said the Working Group received a request from industry for risk-based capital (RBC) commercial reporting guidance (Attachment Four-B1).

Mr. Barlow said it is too late to make changes to the 2020 RBC instructions and what the Working Group will be considering is whether to provide some guidance to companies on completing the commercial mortgage worksheets in the life RBC formula for this year-end due to the impact of the current pandemic.

John Waldeck (Pacific Life Insurance) said he is representing the Mortgage Banking Association (MBA) and the American council of Life Insurers (ACLI). He said the request is to deal with the year 2020 but that it does impact more than just the 2020 year-end RBC calculation. With respect to construction loans and origination date, valuation date, property value, and 90 days past due, he said the requested guidance is to extend guidance provided by the Financial Condition (E) Committee until Dec. 31, which, while most companies typically calculate RBC on a quarterly basis, is the period for which most companies will be submitting RBC filings.

With respect to the requested guidance on net operating income (NOI), Mr. Waldeck said the calculation for 2020 is going to be hampered by the fact that there was a long-term closure the economy had that impacted, in terms of the deferment of rent, on many of the commercial real estate properties held by insurers. He said the NOI for 2020 is used in the 2021, 2022 and 2023 RBC calculations done by insurers and this is used in making new loans for 2020, as well as RBC needs going forward so they are asking for the requested guidance at this time in order to understand the RBC impact in that process.

Mr. Waldeck said the assumption is that the NOI is reflective of how the property operates and, unfortunately, during the COVID-19 closures the properties are not operating anywhere near a normal situation. Many of these were doing well or exceeding prior year expectations but, with the closures, he said most of 2020 is going to be impacted. He said the request is to use the greater of the 2019 or 2020 NOI in the calculation as a proxy for how the property could have performed in 2020 absent the COVID-19 issue.

Mr. Barlow said it seems like the implication of making that change is that the current situation had zero impact on the riskiness of the underlying commercial mortgages.

Mr. Waldeck said it is not that COVID-19 had no impact but that the 2020 statistics will not reflect that riskiness if the properties were allowed to be open and operating.

While some commercial mortgages will revert to normal after the current situation, Mr. Barlow expressed concern that others will not and that those lingering impacts will not be reflected in the RBC calculation.

Mr. Waldeck said that is accurate in that the components of the previous year’s NOI are weighted.

With respect to the requested guidance on contemporaneous property values, Mr. Waldeck said the two main statistics used in the RBC calculation are the debt coverage ratio (DCR), which is impacted by the NOI, and the loan-to-value (LTV) and this is impacted by property value. This takes the origination value and brings it forward to a current value by use of the NCREIF price index.
Mr. Waldeck said the concern is that this will be impacted in a similar fashion as the NOI by COVID-19 in that this component of LTV will drive down and cause an RBC change. He said the requested guidance is to have these values held at the 2019 year-end NCREIF values for RBC calculations through 2020 year-end but revert back to the current NCREIF values with the first quarter 2021 calculation. He said this change would impact only the 2020 RBC calculation.

Mr. Barlow asked if, assuming the pandemic does not continue past 2020, the request for NOI guidance will affect 2021 through 2023 but will not affect 2020 year-end RBC calculations while the requested guidance for contemporaneous property values, construction loans and the origination date, valuation date, property value, and 90 days past due will affect the 2020 RBC calculation but not 2021 through 2023.

Mr. Waldeck said that is correct and noted that what all four requests share is they are each dealing with the impact that occurs in 2020.

Mr. Barlow asked if, similar to the concern he expressed on NOI, the request on contemporaneous property values would effectively treat the calculation as if the current situation had zero impact on the riskiness of the mortgages.

Mr. Waldeck said that is correct but noted that none of these conditions really change the fact that, on an accounting basis, they are required to have each transaction as more than a short-term impact where other than temporary impairments would be addressed through the accounting guidance in a separate manner.

While acknowledging that the impact is not going to be uniform on commercial mortgages and some will come through fine, Mr. Barlow reiterated his concern that some are less likely to and said he is concerned with modifying the RBC calculation to ignore the impact of the current pandemic on the ultimate riskiness of commercial mortgages.

Mr. Hidalgo said he is also hesitant and suggested, if the Working Group is going to make a change, using an average of the values as opposed to just using the 2019 values.

Ms. Ahrens said 2020 may be an extreme measure and using 2019 values may be a more realistic indicator of the true behavior. She said some averaging may be better and suggested this is why there is a three-year average used in the NOI calculation. She said the purpose of having a measurement of required capital is for cases like the current situation and, in this scenario, is it going to be a requirement to increase that measure, in effect, doubling down by increasing the denominator in the RBC calculation while the numerator is already impacted.

Mr. Barlow said RBC does not work like the asset valuation reserve (AVR) where it is built up and released to help with a bad situation but is a snapshot of the risk of a company at year-end and determining how much capital is needed. When bad situations occur, he said not only is the reported capital impacted but by the nature of the RBC calculation the riskiness increases and puts an additional element into the requirement.

Mr. Barlow suggested continuing the discussion on the request with respect to the NOI and contemporaneous property values on the Working Group’s July 10 conference call. With respect to the requested guidance on construction loans and the requested guidance for the origination date, valuation date, property value, and 90 days past due, Mr. Barlow said he has no issue with these and is comfortable with continuing the guidance provided by the Financial Condition (E) Committee through Dec. 31 for use in the 2020 RBC calculation.

Mr. Boerner made a motion, seconded by Mr. Carmello, to continue the guidance provided by the Financial Condition (E) Committee through Dec. 31 as it relates to construction loans and the origination date, valuation date, property value and 90 days past due. The motion passed unanimously.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.

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June 8, 2020

Philip A. Barlow, FSA, MAAA
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Request for Risk-Based Capital Reporting Guidance

Dear Mr. Barlow:

The Mortgage Bankers Associations (MBA)\(^1\) and the American Council of Life Insurers (ACLI)\(^2\), on behalf of our respective member insurers, respectfully submit this request for risk-based capital reporting guidance to the Life Risk-Based Capital Working Group of the National Association of Insurance Commissioners (NAIC).

We appreciate all that you and other regulators, and NAIC staff, have done to date to help insurers navigate the COVID-19 pandemic, and we look forward to working with you on this request. Please feel free to contact Bruce Oliver at boliver@mba.org or 202-557-2840 or Mike Monahan at mikemonahan@acli.com, 202-624-2324 for any additional information.

Sincerely,

Mike Flood Paul Graham

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst

\(^1\) The **Mortgage Bankers Association (MBA)** is the national association representing the real estate finance industry, an industry that employs more than 280,000 people in virtually every community in the country. Its membership of over 2,300 companies includes all elements of real estate finance: mortgage companies, mortgage brokers, commercial banks, credit unions, thrifts, REITs, Wall Street conduits, life insurance companies, and others in the mortgage lending field. For additional information, visit MBA’s website: [www.mba.org](http://www.mba.org).

\(^2\) The **American Council of Life Insurers (ACLI)** is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States. Learn more at [www.acli.com](http://www.acli.com).
Request for Guidance for 2020 RBC Reporting

Introduction

Some risk-based capital reporting impacts of the COVID-19 pandemic have been addressed in Guidance for Troubled Debt Restructurings for March 31-June 30 Statutory Financial Statements and Related Interim Risk-Based Capital Filings (where required), issued by the Financial Condition (E) Committee on March 27, 2020, and in subsequent NAIC staff Questions and Answers. However, additional guidance is necessary on the application of Risk-Based Capital Reporting Instructions to reasonably apply them to the unusual circumstances of 2020.

Specifically, we request guidance on the application of Risk-Based Capital Reporting Instructions to the 2020 reporting of:

- Net Operating Income
- Contemporaneous Property Values
- Construction Loans
- Origination Date, Valuation Date, Property Value, and 90 Days Past Due

These requests were previously brought to the attention of the Financial Condition (E) Committee in a joint trades letter of April 10, 2020 (link below). As is reflected in NAIC staff questions and answers (link below), we understand that consideration of these requests has been referred to the Life Risk-Based Capital (E) Working Group. This request is intended to facilitate the Working Group’s consideration of these requests.

Net Operating Income

Background

Net Operating Income (NOI) inputs are reported in items (14), (15), and (16), and those inputs are used to compute a Rolling Average NOI under item (36). Note 1 references under items (14), (15), and (16) provides in relevant part as follows:

The majority of commercial mortgage loans require the borrower to provide the lender with at least annual financial statements. The NOI would be determined at the RBC calculation date based on the most recent annual period from financial statements provided by the borrower and analyzed based on accepted industry standards. …

The accepted industry standards for determining NOI were developed by the Commercial Mortgage Standards Association now known as CRE Financial Council (CREFC). The company must develop the NOI using the standards provided by the CREFC Methodology for Analyzing and Reporting Property Income Statements v.5.1. (www.crefc.org/irp). These standards are part of the CREFC Investor Reporting Package (CREFC IRP Section VII.) developed to support consistent reporting for commercial real estate loans owned by third-party investors. This guidance would be a standardized basis for determining NOI for RBC.
Discussion/Analysis

NOI inputs and computations are used to assess and quantify the credit risk of commercial loans, based on the expectation that a reduction in a borrower’s NOI for any particular year will be highly correlated to credit risk in the future. However, NOI becomes less reliable as a measure of credit risk under unusual circumstances that are being experienced as a result of the COVID-19 pandemic, because reductions in NOI during 2020 will often reflect temporary conditions. Therefore, NOI values for 2020 may provide misleading indications of future credit risk. As a result, a strict application of 2020 NOIs in risk-based capital reporting would likely result in required capital levels that are not commensurate with the future credit risk that capital is intended to address.

For example, many properties have closed for an extended period of time and are reopening in a limited capacity only as phased-in easing of restrictions occurs. As a result, 2020 NOI may reflect less than six months of NOI in normal operating capacity. A borrower affected by such closures may not seek relief, but, absent the requested guidance, insurers could nevertheless be forced to reclassify a loan as a CM4, or CM5 for a property that will return to normal NOI in 2021, was a CM1 in 2019, and where the borrower made every payment through the shutdown. The need for the guidance to address all loans arises, not because the properties are necessarily problematic, but because the data insurers feed into the RBC calculation may be flawed. The recommended guidance below attempts to address that, without continuing that into additional periods. In that manner, it would adjust for the data flaws of 2020, without ignoring the long-term impacts that a property could face beyond 2020.

The CREF-C IRP standards include a restriction on reporting financial information when less than 6 months of relevant data is available. The COVID-19 pandemic is creating that circumstance, where relevant data, due to the closure of properties and the lack of economic activity due to stay at home orders, is leading to less than 6 months of relevant data for 2020 operations. A strict read of the CREF-C IRP standards would lead to a non-reporting of 2020 NOI in this circumstance, but that is not workable where the RBC calculations require a value.

Recommended Guidance

On March 27, 2020, the Financial Condition (E) Committee issued Guidance for Troubled Debt Restructurings for March 31-June 30 Statutory Financial Statements and Related Interim Risk-Based Capital Filings (where required) (the “RBC Guidance”). The RBC Guidance stated that COVID-19 related modifications would not affect the net operating income utilized during the December 31, 2019 RBC Filing.

Based on the CREF-C IRP standards and the RBC Guidance and for purposes of the inputs at (14), (15), (16), and the computation at (36), it will be deemed to be consistent with industry standards for an insurer to report NOI for any 12-month fiscal period ending after June 30, 2020 but not later than June 30, 2021 to be equal to the greater of: (1) actual NOI as determined under the CREFC IRP Standards or (2) NOI determined for the immediate preceding fiscal year’s annual report. This guidance with respect to 2020 NOI applies to the application of the 2020 NOI in risk-based capital reporting for 2021, 2022, and 2023.

By using the 2019 NOI for use in calculations where 2020 NOI would otherwise be used, Insurers would be using the most relevant estimate for property operations in 2020 absent COVID-19. This guidance would apply to all mortgages and not just those mortgages where a COVID-19
modification occurred, because every commercial real estate property was impacted by COVID-19 and the same impacts of using irrelevant data for 2020 applies whether a modification was granted or not.

It should also be made clear that this change is for 2020 NOI only and not subsequent years. As the economy reopens and properties operate within the affected economy, their future year operations will be relevant to the risk classification of Insurer’s mortgages, absent a similar event with stay at home orders and government mandated property closures. This means that the long-term impacts of COVID-19 will affect the risk ratings for Insurers mortgages as those future NOI values are factored into the analysis.

Contemporaneous Property Values

Background

Contemporaneous Property Value (40) is a field computed as: the Property Value (20) at the time the loan was originated, was revalued due to impairment underwriting, restructure, extension, or other re-writing; times that ratio (rounded to 4 decimal places) of the Price Index current to the Price Index at valuation (39).

The Price Index at Valuation is the value of the NCREIF Price Index on the last day of the calendar quarter that includes the date defined in (21) and (22). However, the “Price Index current” is not a defined or numbered input into risk-based capital reporting.

The Contemporaneous Property Value (40) becomes an input into the computation of RBC LTV. RBC LTV is computed as Total Loan Value (13) divided by the Contemporaneous Property Value (40), rounded to the nearest percent. RBC LTV is then a factor in determining the risk category (from CM1 to CM5) for any loan that is not 90 days or more overdue, which is then used to determine the risk-based capital requirement for the loan.

Discussion/Analysis

The “Price Index current” applied in item (40) is not a defined or numbered input into risk-based capital reporting, but it is generally assumed to mean the most recent available NCREIF Price Index. Ordinarily, this is a reasonable practice in that it is widely considered to be a reasonable indication of changes in the current value of a diverse portfolio of properties, as the index is based on appraisals that generally are based on a robust set of market information.

These are not ordinary times, however, in that various segments of markets for commercial properties may not provide adequate information to develop conclusive values for commercial properties. In addition, as we describe above, NOIs in 2020 will be artificially low as a result of temporary business shutdowns and other temporary impacts of the pandemic. Because appraisals leverage both NOIs and capitalization rates when estimating the current market value of commercial properties, the level of confidence one can place in appraisal estimates of value at year-end 2020 will be less than it ordinarily would be, and those estimates may systematically skew low. Therefore, an index based on such appraisals could create a prejudice that all properties have lost value as of the end of 2020 and cause the life companies to show a corresponding prejudiced increase in credit risk for 2020. Incorporating those lowered values into the computation of RBC LTV then results in capital requirements that are not commensurate with the credit risk they face going forward.
The alternative of applying the year-end 2019 NCREIF Price Index as the “Price Index current” for purposes of 2020 risk-based capital reporting is also imperfect in that it will be a year old at the time it is applied. However, we believe that, given the unusual circumstances, it would serve as a less imperfect measure of contemporaneous value for establishing required capital levels for insurers at year-end 2020, for the credit risk they face going into 2021.

Recommended Guidance

To prevent computed Contemporaneous Property Values from providing a misleading picture of credit risk, one that could result in artificially high risk-based capital requirements, for purposes of computing the Contemporaneous Property Value (40) for any period ending in 2020, an insurer may use the NCREIF Price Index as of 12/31/2019 for the Price Index current value.

Using the 12/31/2019 NCREIF Price Index for the Price Index current is consistent with the RBC Guidance. The RBC Guidance stated that COVID-19 related modifications are not required to be reclassified to a different RBC Category than was utilized during the December 31, 2019 RBC filing. By using the 12/31/2019 NCREIF Price Index, the Contemporaneous Property Value (40) for the filings for any period ending in 2020 will be equal. Therefore, the LTV component of the RBC calculation will not change or cause the RBC Category to change as the RBC Guidance stated.

This guidance would apply to all mortgages and not just those mortgages where a COVID-19 modification occurred, because every commercial real estate property will be impacted by COVID-19 related prejudice in valuation data, whether a modification was granted or not.

It should also be made clear that this change is for the filings for any period ending in 2020 only and not subsequent years. As the economy reopens and properties operate within the affected economy, their future year valuations will be relevant to the risk classification of Insurers’ mortgages, absent a similar event with stay at home orders and government mandated property closures. In addition, the short-term prejudice in property valuation will no longer be occurring. This means that the long-term impacts of COVID-19 will affect the risk ratings for Insurers’ mortgages as those future Contemporaneous Property Values are factored into the analysis.

Construction Loans

Background

Under Note 4 of the Risk-Based Capital Reporting Instructions, construction loans are categorized CM5 based on a determination by the loan servicer that “construction issues exist.”

On April 22, 2020, NAIC staff posted a question and answer for the RBC Guidance regarding the treatment of construction loans affected by the COVID-19 pandemic, as follows:

Q3—Some construction projects are not allowed to operate because of government imposed stay-at-home orders. Current RBC rules specify that a loan with “construction loan issues” (e.g., abandoned) is required to have a CM5 rating. Is the guidance that loans are not required to be reclassified to a different RBC category as a result of government-mandated delays in any required principal and interest payments in the first and second quarters of 2020 also intended not to require recategorization of construction loans in cases of government-mandated delays in construction?
A3 - Yes. No RBC category change is required to be changed for March 31 and June 30 as a result of government-mandated construction delays in the first and second quarters of 2020. The expectation is that further, more deliberative discussion is expected to occur in the future, likely through the Life Risk-Based Capital (E) Working Group, regarding these loans for future reporting periods.

Consistent with the RBC Guidance the Question and Answer was interpreting, Question and Answer 3 applies only to March 31 and June 30, 2020 reporting.

Recommended Guidance

For purposes of Note 4 to the Risk-Based Capital Reporting Instructions, government-mandated construction delays due to COVID-19 that occur at any time during 2020 are not “construction issues.” This guidance would apply to all mortgages and not just those mortgages where a COVID-19 modification occurred.

Origination Date, Valuation Date, Property Value, and 90 Days Past Due

Background

Under Description/explanation of item in the Risk-Based Capital Reporting Instructions for Date of Origination (2), Property Value (20), Year of Valuation (21, and by reference Quarter of Valuation - 22), the filer is instructed to update these values if the loan has been restructured, extended, or otherwise re-written, or refinanced. A loan is traditionally treated as restructured when a loan modification or forbearance occurs.

In addition, the Description/explanation of item 90 Days past Due? (29) requires an insurer to specify if a loan is 90 days past due. Depending on the structure of the forbearance related to COVID-19, a loan in forbearance may be shown on an insurers statements as being 90 days past due, even though the Borrower is abiding by the terms of the forbearance. This is done when lender is protecting its rights under the loan agreement for a loan that may have gone into default prior to requesting forbearance.

On April 22, 2020, NAIC staff posted a question and answer for the RBC Guidance regarding the treatment of these values, as follows:

Q2 - Is this guidance intended to apply to all COVID-19 loan modifications that occur through June 30, 2020, so that an insurer that modifies a loan in accordance with the parameters of the guidance within that period is not required to adjust the origination date, valued date, or property value as of the modification date (as required under current RBC rules for loan restructures) for current or future RBC reporting periods?

A2 - Yes. The intent of the guidance is to encourage insurers to make prudent loan modifications for borrowers who are temporarily unable to meet their contractual payment obligations because of the effects of COVID-19 and is not intended to have long-term negative impacts under current RBC rules. Consistent with this intent, if an insurer modifies a loan in accordance with the parameters of the guidance, the insurer is not required to adjust the origination date, valued date, or property value for current or future RBC reporting periods. In addition, an insurer is not required to reclassify to a different RBC category (such as within CM categories (e.g., CM1 to CM2) or within standing categories (e.g., In Good Standing, Overdue, Not in Process, In Process of
Foreclosure) for March 31 and June 30. The expectation is that further, more deliberative discussion is expected to occur in the future, likely through the Life Risk-Based Capital (E) Working Group, regarding these loans for future reporting periods.

Consistent with the RBC Guidance the Question and Answer was interpreting, Question and Answer 2 applies only to March 31 and June 30, 2020 reporting.

Recommended Guidance

For purposes of the Description/explanation of item in the Risk-Based Capital Reporting Instructions for Date of Origination (2), Property Value (20), Year of Valuation (21 and by reference Quarter of Valuation - 22), and 90 Days Past Due? (29), no changes to these values are required for any COVID-19 related modifications that occur during 2020. This guidance is consistent with the Question and Answer issued by the NAIC, but extended for COVID-19 modifications that occur through the end of 2020. As insurers deal with COVID-19 related issues with their mortgages, it is common for insurers to make interim modifications that provide a short initial period of mortgage relief.

This is being done to provide additional clarity to what assistance is needed for the mortgage. At the onset of the COVID-19 pandemic, insurers had no clarity around the length of stay at home orders, which businesses would be allowed to reopen in which phases, and how fast economic activity would return after these orders ended. To provide long term relief for a mortgage that possibly could be facing only a short closure would be unnecessary and imprudent. Therefore, many of these initial modifications will likely be re-looked at during the 3rd and 4th quarters to provide relief consistent with the COVID-19 impacts for the individual mortgage. Insurers need the balance of 2020 to make these informed decisions. Not providing this extension of time will force insurers into modifications prior to the RBC Guidance end date of June 30 that may not be necessary or prudent but is the only way to preserve the RBC treatment provided under the RBC Guidance.

Links

- RBC Instructions: file:///Q:/Policy%20-%20Commercial-Multifamily/Active%20Documents/Life%20company%20RBC/committees_e_capad_lrbc_final_instructions.pdf
- March 27, 2020 RBC Guidance: https://content.naic.org/sites/default/files/inline-files/Guidance%20for%20Insurers%20from%20Financial%20Condition%20%28E%29%20Commitee_0.pdf
- April 22, 2020 Q&A: https://content.naic.org/sites/default/files/inline-files/QA%20on%20Guidance%20for%20Insurers%20from%20Financial%20Condition%20%28E%29%20Commitee_2.pdf
### Appendix: Selected RBC Reporting Instructions

<table>
<thead>
<tr>
<th>Column</th>
<th>Description / explanation of item</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>Heading</td>
</tr>
<tr>
<td>(2)</td>
<td>Date of Origination</td>
</tr>
<tr>
<td></td>
<td>Input</td>
</tr>
<tr>
<td></td>
<td>Enter the year and month that the loan was originated. If the loan has been restructured, extended, or otherwise re-written, enter that new date.</td>
</tr>
<tr>
<td>(14)</td>
<td>NOI second prior</td>
</tr>
<tr>
<td></td>
<td>Input</td>
</tr>
<tr>
<td></td>
<td>Enter the NOI from the year prior to the value in (15) See Note 1.</td>
</tr>
<tr>
<td>(15)</td>
<td>NOI prior</td>
</tr>
<tr>
<td></td>
<td>Input</td>
</tr>
<tr>
<td></td>
<td>Enter the NOI from the prior year to the value in (16) See Note 1.</td>
</tr>
<tr>
<td>(16)</td>
<td>NOI</td>
</tr>
<tr>
<td></td>
<td>Input</td>
</tr>
<tr>
<td></td>
<td>Enter the Net Operating Income for the most recent 12-month fiscal period with an end-date between July 1 of the year prior to this report and June 30 of the year of this report. The NOI should be reported following the guidance of the Commercial Real Estate Finance Council Investor Reporting Profile v.5.0. Section VII. See Notes 1, 3, 4, 5, and 6 below.</td>
</tr>
<tr>
<td>(20)</td>
<td>Property Value</td>
</tr>
<tr>
<td></td>
<td>Input</td>
</tr>
<tr>
<td></td>
<td>Property Value is the value of the Property at time of loan origination, or at time of revaluation due to impairment underwriting, restructure, extension, or other re-writing. (Note 9.)</td>
</tr>
<tr>
<td>(21)</td>
<td>Year of valuation</td>
</tr>
<tr>
<td></td>
<td>Input</td>
</tr>
<tr>
<td></td>
<td>Year of the valuation date defining the value in (20). This will be either the date of origination, or time of restructure, refinance, or other event which precipitates a new valuation.</td>
</tr>
<tr>
<td>(22)</td>
<td>Quarter of valuation</td>
</tr>
<tr>
<td></td>
<td>Input</td>
</tr>
<tr>
<td></td>
<td>Calendar quarter of the valuation date defining the value in (20).</td>
</tr>
<tr>
<td>(29)</td>
<td>90 days past due?</td>
</tr>
<tr>
<td></td>
<td>Input</td>
</tr>
<tr>
<td></td>
<td>Enter ‘Yes’ if payments are 90 days past due.</td>
</tr>
<tr>
<td>(36)</td>
<td>Rolling Average NOI</td>
</tr>
<tr>
<td></td>
<td>Computation</td>
</tr>
<tr>
<td></td>
<td>For 2013 – 100% of NOI</td>
</tr>
<tr>
<td></td>
<td>For 2014 – 65% NOI + 35% NOI Prior</td>
</tr>
<tr>
<td></td>
<td>For 2015 – 50% NOI + 30% NOI Prior + 20% NOI 2nd Prior</td>
</tr>
<tr>
<td></td>
<td>For loans originated or valued within the current year use 100% NOI. For loans originated 2013 or later and within 2 years, use 65% NOI and 35% NOI Prior</td>
</tr>
<tr>
<td>(39)</td>
<td>NCREIF Price Index at Valuation</td>
</tr>
<tr>
<td></td>
<td>Computation</td>
</tr>
<tr>
<td></td>
<td>Price index [at valuation] is the value of the NCREIF Price Index on the last day of the calendar quarter that includes the date defined in (21) and (22).</td>
</tr>
<tr>
<td>(40)</td>
<td>Contemporaneous Property Value</td>
</tr>
<tr>
<td></td>
<td>Computation</td>
</tr>
<tr>
<td></td>
<td>Contemporaneous Value is the Property Value times the ratio (rounded to 4 decimal places) of the Price Index current to the Price Index at valuation (39).</td>
</tr>
<tr>
<td>(41)</td>
<td>RBC LTV</td>
</tr>
<tr>
<td></td>
<td>Computation</td>
</tr>
<tr>
<td></td>
<td>The Loan to Value ratio is the Total Loan Value (13) divided by the Contemporaneous Value (40) rounded to the nearest percent.</td>
</tr>
<tr>
<td>*</td>
<td>[Price Index Current]</td>
</tr>
<tr>
<td></td>
<td>[Input]</td>
</tr>
<tr>
<td></td>
<td>[Not defined, and not a numbered input or computation.]</td>
</tr>
</tbody>
</table>
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call June 11, 2020. The following Working Group members participated: Philip Barlow, Chair (DC); Steve Ostlund (AL); Perry Kupferman (CA); Deborah Batista (CO); Wanchin Chou (CT); Carolyn Morgan (FL); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Adopted the Instructions and Factors for 2020 Longevity Risk

Ms. Ahrens reminded the Working Group that potential factors of zero were exposed for longevity risk for 2020 implementation. She said this would allow companies to complete the new structure, which will allow a study of the impact of the various methodologies, correlation and guardrail factors so they can be finalized in time for year-end 2021.

Mr. Barlow said there were two comment letters received.

Brian Bayerle (American Council of Life Insurers—ACLI) summarized the ACLI’s comment letter, indicating support for the proposed zero factors for year-end 2020 reporting. He said the ACLI believes this approach will provide the NAIC with the appropriate information for the necessary impact analysis of the factors, as well as give state insurance regulators valuable information to determine the level of correlation and guardrail factors.

Paul Navratil (American Academy of Actuaries—Academy) presented the Academy’s comment letter. He said there are two main sections with the first section being focused on suggested changes to the instructions for 2020 to provide added clarity along with suggested changes to the instructions and blank for the inclusion of adjustments for modified coinsurance. He said the second section of the letter may be something for discussion in conjunction with the review of 2020 results, but it deals with the impact of correlation and what the overall C2 component is going to look like.

Mr. Barlow suggested that it was too late to make changes to the 2020 instructions.

Dave Fleming (NAIC) said it was because the deadline for exposure of the changes was the end of April.

Mr. Barlow suggested exposing the suggested edits for clarification so companies could have them available.

Mr. Ostlund made a motion, seconded by Ms. Ahrens, to adopt the instructions before any of the Academy’s suggested edits indicating base factors of zero with the correlation and guardrail factors included in the blank schedules are determined (see NAIC Proceedings – Summer 2020, Capital Adequacy (E) Task Force, Attachment One-D). The motion passed unanimously.

The Working Group agreed to expose the Academy’s suggested changes for a 60-day public comment period (Attachment Four-C1).

2. Discussed Other Matters

Mr. Barlow said the Mortgage Bankers Association (MBA) and the ACLI have submitted a letter requesting guidance on the risk-based capital (RBC) reporting of commercial mortgages for 2020 in light of the pandemic emergency and the impact it is having on commercial mortgages. He suggested having this distributed to Working Group members, and he said the Working Group will be scheduling calls in the short term to address this.

Mr. Barlow said there are a number of areas in which work is being done by the Academy so when calls not related to the pandemic can resume, these will be scheduled. He asked for a brief update on the work the Academy is doing on mortality.
Chris Trost (Academy) said that during the Working Group’s March 23 conference call, the Academy’s C2 Work Group introduced some of the work it is doing around a component of catastrophe risk or a more sustained event. He said it would be beneficial to get more detailed feedback from the Working Group on a future call.

Ms. Ahrens said the longevity risk component currently adopted does not include in scope longevity reinsurance transactions, which are currently not that common in the U.S. insurance industry. She said the Longevity Risk (E/A) Subgroup will be discussing this, and she asked for industry volunteers to contribute to these discussions.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
May 29, 2020

Mr. Philip Barlow  
Chair, Life Risk Based Capital (E) Working Group  
National Association of Insurance Commissioners (NAIC)

Via email: Dave Fleming (dfleming@naic.org)

Re: Longevity Risk Charge

Dear Philip,

On behalf of the C-2 Longevity Risk Work Group of the American Academy of Actuaries,¹ I am providing suggested edits to the risk-based capital (RBC) forms and instructions for C-2b longevity risk to address some questions and ambiguities that have come to our attention. I am also providing additional information on the impact of adding a longevity risk charge together with correlation would have on Life Risk-Based Capital (LRBC) results. There was discussion on the February 14, 2020, LRBC call on the potential for C-2 to decrease with correlation and the ability for a ‘guardrail’ factor to prevent such decrease. We want to ensure the impact of correlation is clear when the Life RBC Working Group decides on a correlation factor to implement.

Included with this letter are several updated documents which include redlined suggested changes that address several areas where we believe additional clarification is warranted to promote uniform application across companies:

- Revised draft of RBC instructions C-2b longevity risk with clarification of scope.
- Revised form LRtbd for C-2b longevity risk including adjustment for modified coinsurance (MODCO) reinsurance.
- Suggested forms LRtbdCeded and LRtbdAssumed to adjust the C-2b amount to reflect reserves ceded and/or assumed via MODCO.
- Revised draft of RBC instructions for MODCO reinsurance arrangements.

There were three clarifications to Scope in the instructions for C-2b longevity risk:

1. Clarification that the entire reserve for contracts with both certain and life contingent payments are in scope for C-2. Some companies may have interpreted the prior instructions to allow for exclusion of the portion of the reserve associated with the non-

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
life contingent payments. The recommended factors we provided at the 2019 Spring Meeting were calibrated to apply to the entire reserve for these contracts, and field study results confirmed that this approach was reasonable across different product types.

2. Specific mention that variable immediate annuities under VM-21 are in scope.

3. Specific exclusion of variable deferred annuities under VM-21, including those where the contract account value has reached zero but a lifetime benefit is still payable by the insurer. Deferred variable annuity benefits were excluded from scope for this phase of work on longevity risk. The currently exposed factors could conceptually be applied to the reserves for living benefit policies whose account values have reached zero. In practice it may be difficult to allocate VM-21 reserves for policies with zero account value. We continue to recommend future work to determine a method for longevity C-2 that can be applied consistently for all variable annuity living benefits.

The suggested edits in the documents accompanying this letter provide an adjustment to align the C-2b longevity risk with the assuming company rather than the ceding company under modified coinsurance (MODCO). This adjustment is analogous to what is done in LR045, LR046, LR047, and LR048 for C-1 risk under MODCO or funds withheld reinsurance. For C-2b longevity risk, which is calculated as a factor applied to reserves, this adjustment is only needed for MODCO where reserves are retained by the direct writer or ceding company. Reserves under coinsurance or funds withheld reinsurance are reported by the assuming company and longevity risk capital would apply to the reinsurer without further adjustment.

None of these suggested edits address the circumstance where only longevity risk is reinsured as this type of reinsurance has been specifically excluded from C-2b pending further regulator discussion.

*****

Overall, the introduction to LRBC of longevity risk correlated with mortality risk will identify companies with concentrated exposure to longevity risk, while appropriately having little impact on companies with low or balanced levels of longevity risk.

A negative correlation factor between mortality and longevity risk will have the potential to result in a small decrease to C-2 for some companies. The following illustrative graphs both show how C-2 would change for a company with $100 of C-2 mortality risk following the addition of C-2 longevity risk at different amounts. The two graphs show the same underlying information but with different scales which highlight different observations:

1. The first graph shows that total C-2 changes vary little when longevity risk is less than mortality risk but increases materially once longevity is the larger risk.
   - This appropriately results in little change to RBC for companies with low or balanced exposure to longevity risk.
   - It is also successful in identifying and increasing RBC for companies with concentrated exposure to longevity risk.
2. The second graph is zoomed in on the left portion of the first graph and more clearly shows the decrease to total C-2 that would result when longevity exposure is low relative to mortality.
   - For C-2 Longevity amounts less than $66 the resulting total C-2 is less than $100.
   - The lowest possible resulting C-2 is $94.4, representing a 5.6% decrease. (With a -25% correlation assumption, the lowest possible result is $96.8, or a 3.2% decrease.)
   - Total C-2 increases for C-2 Longevity amounts greater than $66. (Total C-2 increases for C-2 Longevity amounts greater than $50 under the -25% correlation assumption.)

The results and impacts to actual companies are unknown; it is unclear what proportion of companies will fall in the left portion of the graph with minimal impact to RBC vs. the right portion where total C-2 would increase with the introduction of longevity C-2. A future impact study would provide a better understanding of how the introduction of C-2 would affect actual companies across the industry but would not change our recommendation for the correlation factor that appropriately reflects the relationship between longevity and mortality risk.

It may also be useful to recall examples that have previously been shared with Life RBC Working Group illustrating hypothetical company impacts of adding Longevity C-2. These examples start with the 2017 aggregate Life RBC Working Group results and show the hypothetical impact of adding Longevity C-2 for a company with Low, Balanced, and Concentrated exposure to longevity risk.
   - The low longevity exposure example results in a two-percentage point increase (from 517% to 519%) to the hypothetical company CAL RBC ratio under the proposed -33% correlation factor.
   - The balanced longevity exposure example results in a 7% decrease to the hypothetical company CAL RBC ratio.
   - The concentrated longevity exposure example results in a 105% decrease to the hypothetical company CAL RBC ratio.
We believe these examples demonstrate that the introduction of the longevity risk charge would be effective in identifying companies with concentrated exposure to longevity risk, while having appropriately little impact on companies with limited or balanced exposure to longevity risk. While a guardrail factor could be implemented as a floor to total C-2, this floor would have little impact on RBC results as these examples illustrate. We would be glad to further discuss or provide additional analysis to assist the Life RBC Working Group in this matter.

Also note that the analysis used to develop both capital and correlation factors was long term in nature and is not based on the actual or projected impact of recent longevity or mortality events.

Should you have any questions or comments regarding this letter, please contact Ian Trepanier, life policy analyst at the Academy (trepanier@actuary.org).

Sincerely,

Paul Navratil, MAAA, FSA
Chairperson, C-2 Longevity Risk Work Group
American Academy of Actuaries
LONGEVITY RISK
LRtbd

Basis of Factors

The factors chosen represent surplus needed to provide for claims in excess of reserves resulting from increased policyholder longevity calibrated to a 95th percentile level. For the purpose of this calibration aggregate reserves were assumed to provide for an 85th percentile outcome.

Longevity risk was considered over the entire lifetime of the policies since these annuity policies are generally not subject to repricing. Calibration of longevity risk considered both trend risk based on uncertainty in future population mortality improvements, as well as level or volatility risk which derives from misestimation of current population mortality rates or random fluctuations. Trend risk applies equally to all populations whereas level and volatility risk factors decrease with larger portfolios consistent with the law of large numbers.

Statutory reserve was chosen as the exposure base as a consistent measure of the economic exposure to increased longevity. Factors were also scaled by reserve level since number of insured policyholders is a less accessible measure of company specific volatility risk. Factors provided are pre-tax and were developed assuming a 21% tax adjustment would be subsequently applied.

Specific Instructions for Application of the Formula

Annual statement reference is for the total life contingent reserve for the products in scope. The scope includes annuity products with life contingent payments where benefits are to be distributed in the form of an annuity. The entire reserve amount for contracts in scope that include any life contingent payments are in scope. For example, under a certain-and-life style annuity, the entire reserve for both the certain payments and life contingent payments are in scope. Variable immediate annuity reserves under VM-21 are also in scope where there are life contingent payments.

Included in scope are:
- Single Premium Immediate Annuities (SPIA) and other payout annuities in pay status
- Deferred Income Payout Annuities which will enter annuity pay status in the future upon annuitization
- Structured Settlements for annuitants with any life contingent benefits
- Group Annuities, such as those associated with pension liabilities with both immediate and deferred benefits

Scope does not include annuity products that are not life contingent, or deferred annuity products where the policyholder has a right but not an obligation to annuitize. A certain-and-life style annuity, where only certain payments remain (such as following the death of the annuitant), is out of scope. Variable deferred annuity contract reserves under VM-21 are out of scope, including reserves valued under VM-21 for any contracts where policyholder account value has reached zero, but a lifetime benefit may still be payable by the insurer. Line (3) for General Account Life Contingent Miscellaneous reserves is included in the event there are any reserves for products in scope reported on Exhibit 5 line 0799999; it is not meant to include cash flow testing reserves reported on this line.

(additional instructions would be required if Longevity Reinsurance product remains in scope — placeholder pending decision on scope)

The total reserve exposure is then further broken down by size as in a tax table. This breakdown will not appear on the RBC filing software or on the printed copy, as the application of factors to reserves is completed automatically. The calculation is as follows:

<table>
<thead>
<tr>
<th>Line (69)</th>
<th>Life Contingent Annuity Reserves</th>
<th>(1) Statement Value</th>
<th>Factor</th>
<th>(2) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 250 Million</td>
<td>X 0.0171</td>
<td>=</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next 250 Million</td>
<td>X 0.0108</td>
<td>=</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next 500 Million</td>
<td>X 0.0095</td>
<td>=</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Over 1,000 Million

\[ \times 0.00089 = \]

Total Life Contingent Annuity Reserves
MODCO OR FUNDS WITHHELD REINSURANCE AGREEMENTS
LR045, LR046, LR047, and LR048, LRtbdCeded, and LRtbdAssumed

References to MODCO and funds withheld reinsurance agreements apply to all treaties in effect.

Basis of Factors

When the default risk in modified coinsurance (MODCO) and other reinsurance transactions with funds withheld is transferred, this transfer should be recognized by reducing the RBC for the ceding company and increasing it for the assuming company. In the event that the entire asset credit or variability in statement value risk associated with the assets supporting the business reinsured is not transferred to the assuming company for the entire duration of the reinsurance treaty, the RBC for the ceding company should not be reduced.

When the longevity risk in modified coinsurance (MODCO) is transferred, this transfer should be recognized by reducing the RBC for the ceding company and increasing it for the assuming company. The longevity risk adjustment is not required under funds withheld reinsurance as the RBC for longevity risk is assessed based on the reserves which are already reported by the assuming company. In the event that the entire longevity risk associated with the liability is not transferred to the assuming company for the entire duration of the reinsurance treaty, the RBC for the ceding company should not be reduced.

Assets

The total RBC related to assets (i.e., bonds, mortgages, unaffiliated preferred and common stock, separate accounts, real estate and other long-term assets) in MODCO or Funds Withheld reinsurance agreements, should be reduced (increased) by the amounts of RBC ceded (assumed). There is a separate line in each asset section to achieve this reduction (i.e., “Reduction in RBC for MODCO or Funds Withheld reinsurance ceded agreements”). The amount ceded is determined using the assets supporting the ceded liabilities as of Dec. 31. (In some instances, there may be assets in a trust that exceed the amount needed to support the liabilities; only the portion of assets used to support the ceded liabilities is used to determine the ceded RBC). The ceding company will need to supply the assuming company with sufficient information in order for the assuming company to determine the amount of RBC assumed. With the exception of the impact of the size factor, the amount of RBC ceded should be equal to the amount of RBC assumed. Put another way, there should be “mirror imaging” of RBC, except for the impact of the size factor. For MODCO or Funds Withheld reinsurance agreements, there will be no specific, line-by-line inventory of ceded assets and corresponding ceded RBC; however, ceding and assuming companies must keep detailed records and be prepared to produce those records upon request. The ceding company is required to supply the assuming company with sufficient information in order for the assuming company to determine the amount of RBC assumed.

A reinsurer that has not received such information shall calculate MODCO adjustments for reinsurance assumed as follows:

- If the reinsurer has received data for periods prior to the effective date of the RBC filing, a “MODCO liability ratio” will be developed by comparing the MODCO liabilities at the filing date to the MODCO liabilities as of the last date for which data were received. The required capital for MODCO assumed is the required capital as calculated based on these data multiplied by the “MODCO liability ratio.”
- If the reinsurer has never received data from the ceding company, a “MODCO liability ratio” will be developed by comparing the MODCO liabilities to the reinsurer’s total invested assets (Page 2, Line 12 of the blue blank, or its equivalent). The required capital for MODCO assumed is the reinsurer’s required capital as calculated prior to MODCO ceded and assumed adjustments multiplied by the “MODCO liability ratio.”

Adjustments for MODCO or Funds Withheld reinsurance agreements should be based on pre-tax factors.

Size Factor

Companies with MODCO or Funds Withheld reinsurance agreements should adjust the company’s year-end size factors according to the way the bonds are handled in the treaties. The assuming company includes the bonds that support its share of the liabilities; the ceding company includes the bonds that support its share of the liabilities. No adjustment is made for bonds purchased subsequent to June 30 of the valuation year and that solely support ceded liabilities.
Mortgages
The amount of RBC for mortgages is based upon the ceding company’s calculation for the mortgages, or portion of these mortgages, which support the ceded liabilities. Thus, the amount of RBC ceded is equal to the amount of RBC assumed.

Specific Instructions for Application of the Formula

MODCO OR FUNDS WITHHELD REINSURANCE AGREEMENTS
Reinsurance Ceded - Bonds C-1o
LR045

Column 4
Enter by reinsurer, the amount of C-1o RBC the insurance company has ceded that is attributable to bonds. The “total” should equal the total amount of the reduction in C-1o RBC shown on Line (19) of page LR002 Bonds.

MODCO OR FUNDS WITHHELD REINSURANCE AGREEMENTS
Reinsurance Assumed - Bonds C-1o
LR046

Column 4
Enter by ceding company, the amount of C-1o RBC the insurance company has assumed that is attributable to bonds. The “total” should equal the total amount of the increase in C-1o RBC shown on Line (20) of page LR002 Bonds.

MODCO OR FUNDS WITHHELD REINSURANCE AGREEMENTS
Reinsurance Ceded – All Other Assets C-0, C-1o And C-1cs
LR047

Column 4
Enter by reinsurer, the amount of C-0, C-1o And C-1cs RBC the company has ceded that is attributable to all assets except bonds. The “total” should equal the total amount of the reduction of C-0, C-1o And C-1cs RBC attributable to all assets except bonds for MODCO and funds withheld agreements.

MODCO OR FUNDS WITHHELD REINSURANCE AGREEMENTS
Reinsurance Assumed – All Other Assets C-0, C-1o And C-1cs
LR048

Column 4
Enter by ceding company, the amount of C-0, C-1o And C-1cs RBC the insurance company has assumed that is attributable to all assets except bonds. The “total” should equal the total amount of the increase in C-0, C-1o And C-1cs RBC attributable to all assets except bonds for MODCO and funds withheld agreements.

MODCO REINSURANCE AGREEMENTS
Reinsurance Ceded – Longevity C-2 Reserves
LRbdCeded

Column 4
Enter by reinsurer, the amount of reserves in scope for C-2b longevity risk per LRbd the insurance company holds for business ceded via MODCO reinsurance agreements.
Column 4
Enter by ceding company, the amount of reserves in scope for C-2b longevity risk per LRtbd the direct writer or ceding company holds for business assumed by the insurance company via MODCO reinsurance agreements.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call March 23, 2020. The following Working Group members participated: Philip Barlow, Chair (DC); Deborah Batista (CO); Wanchin Chou (CT); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT). Also participating was: Steve Drutz (WA).

1. **Adopted its Feb. 14 and 2019 Fall National Meeting Minutes**

   Mr. Ostlund made a motion, seconded by Mr. Boerner, to adopt the Working Group’s Feb. 14, 2020 (Attachment Four-D1) and Dec. 7, 2019 (see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Three) minutes. The motion passed unanimously.

2. **Exposed the Deletion of C-3 2019 Instruction for Public Comment**

   Mr. Barlow said he believes the deletion of those items in the C-3 instructions that were specific to 2019 are straightforward, but he suggested that the Working Group expose the changes to make sure they were done properly and completely. The Working Group agreed to expose the deletion of the 2019 specific instructions for a public comment period ending April 22.

3. **Discussed the Academy’s Bond Proposal**

   Mr. Barlow reminded Working Group members that this proposal has been discussed by the Investment Risk-Based Capital (E) Working Group for many years. He said there have been some questions raised by the industry and some state insurance regulators about the American Academy of Actuaries’ (Academy) proposal and a request for an additional review. He said he believes that there needs to be a resolution on this because the bond factors have not been updated since they were initially developed. He noted a real estate proposal that is related to this. He said he has been on the Investment Risk-Based Capital (E) Working Group and following this from the beginning, and he believes that the Academy has done what they were asked to do and developed a proposal that is in line with the original methodology. He said the Working Group would ultimately be asked to approve any changes, so he asked for Working Group members’ thoughts.

   Mr. Chou said Connecticut has been closely monitoring the discussions, and he would like to see a more enhanced study on this because the impact to the industry is quite significant.

   Mr. Tsang said he believes the questions raised are not about questioning the Academy’s factors but a desire to have another viewpoint to consider.

   While he recognizes that this is a significant change, Mr. Barlow said the Academy’s proposal has been presented with extensive documentation and exposed for comment by the Investment Risk-Based Capital (E) Working Group with those comments being reviewed and considered. He questioned whether it will significantly affect the primary purpose of risk-based capital (RBC), which is identifying weakly capitalized companies because the life insurance industry is very well capitalized. He said there is one area where he would favor making a non-actuarial adjustment to the Academy’s proposal and that is to the portfolio adjustment because he believes that it may adversely affect smaller insurance companies. He said he is not completely clear on what the Working Group would gain by additional work on the proposal that has been presented.

   Ms. Ahrens agreed and questioned what will come from an additional review with the Academy’s proposal being vetted for several years. While sympathetic to companies that will see higher C-1 charges, she said the reason the bonds were reviewed was due to companies seeking a higher yield in this interest rate environment, and it seems clear that the yield comes with risk.

   Mr. Barlow said the Working Group will schedule a conference call to devote more time to this discussion.

   Nancy Bennett (Academy) said the Academy will provide any information or presentation that the Working Group needs.
Paul S. Graham (American Council of Life Insurers—ACLI) said the industry still has significant concerns with the proposal, and it is still working on a request for proposal (RFP) with the intention to communicate with state insurance regulators to ensure that it yields information that is useful in making the final decision because it will have a significant impact.

4. **Heard an Update from the Academy C2 Work Group**

Chris Trost (Academy) provided a follow up from the update given at the 2019 Fall National Meeting where he discussed what the Academy C2 Work Group would change relative to the original work done. He said the work group’s evaluation of level risk was less than what came out of the original work. Based on the feedback that the work group received, he said the work group should be vetting emerging sustained mortality events, which it believed are better categorized as catastrophe risk, and this is what the work has been focused on. He said he just wanted to introduce this concept, and he indicated that it could be more fully discussed on a subsequent conference call.

Mr. Trost presented an update (Attachment Four-D2) that described the overall approach being taken, highlighted the inclusion of this new element of a sustained mortality increase from an emerging mortality risk, and noted the ongoing discussion of the correlation between the various risks. With respect to the current C-2 life mortality, he said the Work Group has been primarily focused on individual, but it has started work on group mortality. He discussed in more detail about the additional catastrophe component and product differentiation, and he presented the Work Group’s next steps.

5. **Heard an Update from the Academy C3 Life and Annuities Work Group**

Link Richardson (Academy) provided a brief overview of the work being done by the Academy’s C3 Life and Annuities Work Group (Attachment Four-D3). He discussed the request that the Work Group received and the high-level conceptual recommendations the Work Group has developed, and the desire is to get feedback before developing specific recommendations. Mr. Barlow said a conference call will be scheduled to have a more detailed discussion of this topic.

6. **Discussed Longevity Risk Correlation**

Mr. Barlow reminded the Working Group that it adopted a structural change to include the covariance adjustment and the guardrail with further discussion needed to determine what those factors will be before the end of June.

Ms. Ahrens noted the discussion on the bond proposal and the concern about the impact and the need to relook at that. She said she has been thinking about how to get a feel for the actual impact of adding the longevity factors at different correlations. She said one of the reasons the guardrail was included in what was recommended was a concern that there may be companies that actually get a reduction to the overall C-2 charge, and this needs to be more fully explored. She said the information needed to calculate the recommended longevity charge is not readily available in the current annual financial statement format, and trying to do an impact study is difficult to do. Trying to get that study done in the existing deadlines for RBC is going to be challenging, so she suggested that the Working Group could contemplate a different effective date or a field study based on companies using the 2019 information and making the needed adjustments. She said another alternative is to use the structure that has been adopted to capture the needed data for year-end 2020 to determine what the appropriate factors are.

7. **Received an Update on the Health Test Language Proposal**

Mr. Drutz said the Health Risk-Based Capital (E) Working Group formed the Health Test Ad Hoc Group that has been looking at possible changes to the health test, which helps determine what blank insurers file. The basis for the possible change to the health test is to ensure that health data written by life and property/casualty (P/C) companies is available in sufficient detail to help state insurance regulators make informed decisions. He said he believes that about 25% of health premium is reported on the life blank, and the detail provided on that blank is often not detailed enough to help in health-related analyses.

Mr. Drutz said the approach of the ad hoc group has been to look at possible changes to the health test itself, while also looking at possible blanks changes to capture more health data written by P/C and life blank filers and try to make the data already captured on those blanks consistent with the data captured on the health blank. He said the health test language changes were recently exposed, but work will likely now turn to the blanks themselves in more detail as changes in the blanks might affect how much state insurance regulators believe the health test language should be modified.
Mr. Drutz said the ad hoc group wants to ensure that state insurance regulators and interested parties are aware of the work being done, and he encouraged anyone interested to join the ad hoc group to help ensure that any proposed changes to the blanks or health test language have been thoroughly vetted to avoid any unintended consequences.

Mr. Drutz said the ad hoc group has pondered getting rid of the reserve ratio in the health test and changing the premium test threshold, but he is aware that by moving some life and possibly a few P/C companies to the health blank, state insurance regulators may lose useful data that is specific to those two blanks. He said the ad hoc group is trying to avoid that. He said he believes that the work the ad hoc group is doing is necessary but complicated, and having additional input from state insurance regulators and interested parties as the ad hoc group proceeds would be valuable to assure that it ends up with proposals that are well vetted and provides state insurance regulators with the data they need.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Feb. 14, 2020. The following Working Group members participated: Philip Barlow, Chair (DC); Perry Kupferman (CA); Deborah Batista (CO); Wanchin Chou (CT); Gilbert Moreau (FL); Vincent Tsang (IL); John Robinson (MN); William Leung (MO); Rhonda Ahrens (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).


Ms. Ahrens reminded the Working Group that there are two proposals with the American Academy of Actuaries’ (Academy) suggested factors for longevity exposed: one without a covariance adjustment and one with a covariance adjustment.

Mr. Barlow said the Working Group received several comment letters (Attachment Four-D1a). He provided those submitting comment letters the opportunity to speak on their comments.

Mr. Carmello said he understands the possible correlation between mortality and longevity, but the risk-based capital (RBC) formula is rather crude, and there are other places where possible correlations are not used. He said including the correlation in this instance would, for a number of companies, result in no charge for longevity risk, which defeats the purpose of this project. He said New York supports the version of the proposal without correlation.

Paul Navratil (Academy) presented the Academy’s comment letter. He said there had been some questions in the past about whether the proposed factors would change depending upon whether correlation is included, and he said they would not. He said the Academy does believe reflecting the correlation is important to achieve consistency across companies.

Brian Bayerle (American Council of Life Insurers—ACLI) presented the ACLI’s comment letter, noting the ACLI’s support for the Academy’s proposal with the covariance adjustment. He said the ACLI also recommends deferring implementation until the Academy’s work on new mortality factors is completed, and he suggested the possibility of including the longevity proposal on an informational basis for 2020 reporting.

Frederick Slater (Nationwide) presented Nationwide’s comment letter, indicating support for the version of the proposal, including covariance along with suggesting clarity with respect to scope regarding variable annuity living benefits.

Arthur Panighetti (Pacific Life) presented Pacific Life’s comment letter supporting the Academy’s proposal and echoing the ACLI’s support for the inclusion of covariance.

Sam Early (Principal) presented Principal’s comment letter expressing support for the proposal that includes a –33% correlation. He said any implementation of the longevity charge will require taking a position, either explicitly or implicitly, on what the correlation between the longevity charge and the mortality charge is.

Mr. Carmello asked whether the Academy’s proposal limits the covariance adjustment, so a company does not end up with a lower RBC requirement than before the longevity charge goes into effect if the Working Group goes with the correlation approach.

Mr. Barlow said his understanding is that there is nothing built into the proposal to do that, and depending on the correlation factor chosen, there could be companies whose authorized control level RBC could decrease.

Mr. Navratil said that the recommendation would, in theory, allow for a reduction in C-2 of around 4%–6% maximum, which the Academy believes is consistent with the offsets between the risks. He said the Academy also provided an alternative formula that would introduce guardrail factors that would floor the C-2 risk at the higher of the longevity or the mortality amount and prevent C-2 from ever going down.
Based on the comments received, Mr. Barlow suggested that the first decision the Working Group needs to make is whether to defer the proposal until the Academy’s work on potential mortality changes is complete. If the Working Group wants to move forward, he suggested that the Working Group could either adjust the covariance factor or put in something that prevents a negative C-2 amount. If the Working Group decides to adjust the factor, he suggested that the Working Group could move forward with the structural change needed and have a little more time to decide on the appropriate covariance factor.

Ms. Ahrens made a motion, seconded by Mr. Carmello, to adopt proposal 2019-13-L, the structural changes to incorporate a longevity risk charge as presented in the Academy’s Nov. 22, 2019, letter, which includes the covariance adjustment and the guardrail to be determined by the end of June, with the individual longevity schedule that was not included in that letter, along with suggested corrections to the annual financial statement references (see NAIC Proceedings – Summer 2020, Capital Adequacy (E) Task Force, Attachment One-B2). The motion passed unanimously.

2. Adopted Proposal 2020-03-L (C-3 Instructions and C-3 Guidance)

Ms. Hemphill said this issue has to do with the adoption of the Variable Annuities Framework and the timing of comparisons involved in the phase-in for reserves versus the phase-in for C-3 and the impact of voluntary reserves. She said there is a similar issue with smoothing. The modifications to the instructions will address this for year-end 2020, and the guidance document is to highlight the issue on smoothing for 2019.

Ms. Hemphill made a motion, seconded by Mr. Leung, to adopt proposal 2020-03-L, the C-3 instructional changes for year-end 2020 and the C-3 guidance document (see NAIC Proceedings – Summer 2020, Capital Adequacy (E) Task Force, Attachment Nine). The motion passed unanimously.

3. Discussed the Treatment of Alien Affiliates

Mr. Barlow asked Working Group members to consider two items with respect to the life RBC treatment of alien affiliates. The first has to do with a distinction between Canadian and other alien affiliates. He said there have not been any reported Canadian affiliates in 10 years, and he suggested eliminating that distinction. The second has to do with other alien affiliates and a change made in 2010 to exclude them from both the numerator and the denominator of the RBC calculation.

Mr. Barlow said the issues that gave rise to this change were that it was not really risk-based in that the affiliate having more capital negatively affected the RBC calculation and, to a lesser extent, the comparability between mutual and stock companies. With the work being done by the Group Capital Calculation (E) Working Group and the fact that there is more information now about these types of companies, he suggested that it would be good for the Working Group to review both of these. He asked Working Group members to start thinking about these items.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
January 23, 2020

Mr. Philip Barlow
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners

Via email: Dave Fleming (dfleming@naic.org)

Re: Exposure of proposed longevity risk charge

Dear Philip,

On behalf of the Longevity Risk Task Force of the American Academy of Actuaries,1 I am providing additional comments on the exposure of the longevity risk charge and risk-based capital (RBC) instructions update from the working group’s December 7, 2019, meeting. We want to reinforce our recommendation to add a longevity risk charge to the Life Risk-Based Capital formula (LRBC), and to express our support to include an explicit correlation factor less than 100% within the C-2 component.

The task force’s longevity factor recommendation was developed in line with the guidance from the Life Risk-Based Capital (E) Working Group to target a statistical safety level of 95th percentile associated with a longevity risk event that occurs over a 10-year period. The recommended longevity risk factors were calibrated to that target level. Given the close relationship between longevity risk (living longer than expected) and mortality risk (living shorter than expected), the Academy correlation recommendation (of -33%) was developed to maintain the 95th percentile capital target for the aggregate risk of uncertain future life span.

There are two different versions of the RBC worksheet and instructions included in the exposure. One includes a structure to allow for an explicit and transparent correlation between longevity and mortality risk with a correlation factor that can be specified. The second structure implicitly includes 100% correlation between longevity and mortality with no ability to adjust to a different correlation factor. We support the first structure that provides for an explicit correlation assumption and do not support the second, which keeps correlation implicit in the formula and restricted to a value of 100%.

Adding longevity risk and mortality risk with 100% correlation within LRBC would only represent a 95th percentile outcome for companies with concentrated exposure to either longevity

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
risk or mortality risk, while representing an outcome materially in excess of 95\textsuperscript{th} percentile for companies with exposure to both longevity and mortality risks. Using a 100\% correlation could reduce the usefulness of LRBC as a consistent tool to identify potentially weakly capitalized life insurers.

A 100\% correlation assumption would express the view that an adverse longevity outcome where annuitants are living longer than expected would, with 100\% certainty, occur concurrent with an equally adverse mortality outcome where insureds are dying sooner than expected. We do not believe this to be a plausible view of how longevity and mortality risk are related. Using a 100\% correlation would result in a total C-2 amount that exceeds the 95\textsuperscript{th} percentile objective.

While the task force understands that some regulators might not support a correlation assumption of -33\% based on the concern that it may overstate the diversification between mortality risk and longevity risk, we believe that positive 100\% correlation is unreasonable and inconsistent with the current RBC framework. The current framework clearly recognizes that the individual risk factors are not expected to all happen at the same time, and that is why a correlation adjustment across the various risk (C-0, C-1, etc.) is part of the current formula. We strongly believe that a similar approach should be applied for the longevity and mortality risk categories, because they are clearly not 100\% correlated (and, in our view, are at least partially negatively correlated).

I shared a summary of the correlation recommendation and rationale on behalf of the Longevity Risk Task Force at the NAIC Summer 2019 National Meeting and would gladly share additional detail or address questions at a future call if that would be useful to the working group in moving forward toward implementation of longevity risk within Life Risk-Based Capital.

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Should you have any questions or comments regarding this letter, please contact Ian Trepanier, life policy analyst at the Academy (trepanier@actuary.org).

Sincerely,

Paul Navratil, MAAA, FSA
Chairperson, Longevity Risk Task Force
American Academy of Actuaries
February 7, 2020

Mr. Philip Barlow  
Chair, NAIC Life Risk-Based Capital (E) Working Group (Life RBC)

Re: Longevity Risk Charge Proposal

Dear Philip:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to provide comments regarding the longevity risk charge proposal exposed for comment during the NAIC Fall Meeting. We appreciate all of the hard work of the American Academy of Actuaries Longevity Risk Task Force (Academy) to develop the factors and provide the rationale behind the assumptions and regulators’ thorough review of their work.

ACLI is supportive of the Academy recommendation regarding the longevity risk charge, contingent upon a reasonable correlation factor between the C-2 charges (mortality and longevity). We support both the recommendation on the factors themselves, as well as the recommended -33% covariance adjustment. We have the following comments regarding the exposure:

**A reasonable correlation adjustment is appropriate and necessary**

ACLI urges Life RBC to adopt the formula reflecting the correlation factor. As pointed out in our November 26\(^{th}\) letter, excluding the correlation factor in the RBC pages is equivalent to a +100% correlation. Given the generally inverse relationship between mortality and longevity risk, ACLI does not believe this to be a reasonable assumption. Such an additive view of the risks would overstate the capital needed for C-2 risks for companies with a balanced mix of mortality and longevity exposure. At the direction of the Longevity Risk (A/E) Subgroup, the Academy provided a recommendation of -33% for a correlation adjustment based on their analysis. We found their rationale for the -33% compelling, and as the Academy notes, it is in line with other jurisdictions (-25% for Canada and EU, -50% for Bermuda).

**Longevity Risk Charge should be paired with updated mortality factors**

ACLI recommends Life RBC delay implementation of the new longevity risk charge until the new mortality factors are adopted. This approach will allow the Longevity Risk Subgroup additional time to evaluate factors and methodology to include longevity reinsurance transactions. This approach would incorporate

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\(^1\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.
all C-2 changes for yearend 2021 reporting, assuming the mortality factors are approved in a timely manner. In the absence of deferred implementation, we would recommend making the first reporting of the longevity factors informational only; this approach will allow regulators to assess the industry impact and the effect of the correlation factor.

We look forward to discussing our comments on a future call.

Sincerely,

[Signature]

cc Dave Fleming, NAIC
February 7, 2020

Mr. Philip Barlow  
Chair, NAIC Life Risk Based Capital (E) Working Group (Life RBC)

Via email: Dave Fleming (dfleming@naic.org)

Re: RBC risk charge for longevity

Dear Philip,

Nationwide appreciates the opportunity to provide comments on the longevity risk charge proposal exposed for comment during the NAIC Fall Meeting. We appreciate the efforts of the American Academy of Actuaries Longevity Risk Task Force (LRTF) in developing the proposal and of the regulators in reviewing their work.

About Nationwide

Nationwide, a Fortune 100 company based in Columbus, Ohio, is one of the largest and strongest diversified insurance and financial services organizations in the United States. Nationwide is rated A+ by both A.M. Best and Standard & Poor’s. An industry leader in driving customer-focused innovation, Nationwide provides a full range of insurance and financial services products including auto, business, homeowners, farm and life insurance; public and private sector retirement plans, annuities and mutual funds; excess & surplus, specialty and surety; pet, motorcycle and boat insurance.

Nationwide supports the version of the Longevity C-2 proposal outlined in the November 22, 2019 letter from LRTF to the Longevity Risk (A/E) Subgroup. This version of the proposal allows for appropriate consideration of the covariance between longevity and mortality risk. We believe the LRTF’s proposal of a -33% correlation factor is well-supported and within the realm of assumptions used by other jurisdictions. However, if Life RBC is inclined to add conservatism to this assumption, the LRTF proposal allows the flexibility to substitute a more conservative factor.

Nationwide does not support the proposal that does not include a covariance adjustment. This version effectively assumes tail risks with respect to mortality and longevity are 100% correlated. Such an assumption does not reasonably take account of the generally inverse relationship between the two risks and would significantly overstate the amount of capital required to cover tail events for companies with a balanced mix of these risks.

Based on material presented by LRTF to the 2019 Spring NAIC meeting, Nationwide’s understanding of the intended scope of the longevity risk charge is that it excludes living benefit guarantees associated with variable annuities, even after the account value has been exhausted, as these would be captured in C3 Phase 2 testing. While the exposed instructions do not explicitly include such benefits in scope,
Nationwide suggests that specifically excluding VA living benefit guarantees from the scope would be useful in clarifying the intention.

Thank you for your consideration.

Sincerely,

Frederick W. Slater, MAAA, FSA
Senior Technical Directory, Nationwide Financial
February 10, 2020

Filed Electronically

Philip Barlow
Chair, NAIC Life Risk-Based Capital (E) Working Group

Re: Longevity Risk Charge Proposal

Philip:

Thank you for the opportunity to provide comments on the longevity risk charge proposal that was exposed for comment at the NAIC Fall Meeting in Austin. Pacific Life joins the ACLI in commending the quality work of the American Academy of Actuaries and the Longevity Risk (A/E) Subgroup in developing and supporting appropriate and reasonable factors to implement a new risk charge for longevity. With the ACLI we also support the Academy factors as well as an appropriate covariance adjustment, which the Academy recommends at -33%.

We strongly agree with the ACLI recommendation to adopt the formula that reflects the correlation factor. In addition to the reasons the ACLI cites, keeping the formula in Life RBC allows regulators the flexibility to monitor and adjust the correlation should future experience justify such a change. While a risk factor for longevity is currently prudent and appropriate, there is recent evidence of slowing improvement and even dis-improvement in mortality trends. Locking in a +100% correlation does is not necessary or appropriate, as ACLI also suggests.

As always, I am available for further comments or discussion

Sincerely,

Art Panighetti

Cc: Rhonda Ahrens, Chair Longevity Risk Subgroup
VIA EMAIL (philip.barlow@dc.gov)

February 5, 2020

Philip Barlow
Chair, NAIC Life Risk-Based Capital (E) Working Group
Associate Commissioner for Insurance
Department of Insurance, Securities and Banking
1050 First Street, NE, Suite 801
Washington, DC 20002

RE: Principal Life Insurance Company
Academy Proposal for Risk-Based Capital for Longevity Risk

Dear Mr. Barlow,

This letter is written on behalf of Principal Life Insurance Company (Principal) to provide comments on the American Academy of Actuaries Longevity Risk Working Group’s (Academy) proposal to add a longevity component to the C-2 factor within the Life RBC formula. We appreciate this opportunity to comment on the proposal. Principal is a top five payout annuity provider within the U.S. industry, with over $25B of reserves. We believe that payout products serve a critical need to retirees, providing income protection for life.

Principal encourages the Working Group to adopt the Academy proposal to include Longevity Risk within the RBC formula, including the Academy’s recommended -33% correlation between the new longevity risk charge and the mortality risk charge. Reflecting longevity risk has the potential to make the RBC formula more risk sensitive and more useful to regulators, provided it is designed appropriately.

Under consideration are a range of scenarios for correlation between mortality and longevity risk, including the Academy’s -33% recommendation, a 0% correlation, and a 100% correlation, which is embedded in one of the options exposed. The Academy extensively analyzed the correlation component of their recommendation. Through this work, the Academy determined that 100% correlation was inappropriate.

Principal agrees with the Academy and views a 100% correlation factor as being critically flawed. The 100% correlation scenario provides no recognition or incentive for companies to create a naturally hedged book of business. Adopting this version of the exposure would be unsupported by theory, observable results, and would be contrary to the work done by the Academy. It would also lead to a distorted impact on the RBC results of companies that issue both life insurance and payout annuity business.
Academy Proposal for Risk-Based Capital for Longevity Risk
Page 2

A 100% correlation implies simultaneous tail events occur on Life and Annuity blocks. This suggests a pandemic-like event only strikes life-insured participants while a critical life extending event only impacts a company’s annuitants. This is statistically improbable and implausible. A tail event for either a longevity risk or a mortality risk event would not discriminate towards either the annuitant block or the life block, creating a natural hedge.

In conclusion, Principal supports the Academy’s recommendation to include a charge for Longevity Risk in the RBC formula with a correlation factor of -33%. Thank you again for the opportunity to comment on the proposal.

Sincerely,

Sam Early, FSA, MAAA
Actuary
(515) 248-3104
early.sam@principal.com

Michelle Rosel, FSA, MAAA
Actuary
(515) 878-6454
roel.michelle@principal.com

cc: Via Email (rhonda.ahrens@nebraska.gov)
    Rhonda Ahrens
    Chair, Longevity Risk (A/E) Subgroup

cc: Via Email (dfleming@naic.org)
    Dave Fleming
    National Association of Insurance Commissioners

cc: Via Email (mike.yanacheak@iid.iow.gov)
    Mike Yanacheak
    Iowa Insurance Division
Via email:

Mr. Philip Barlow  
Chair, NAIC Life Risk-Based Capital (E) Working Group

Re: Exposure for incorporating Longevity Risk has an RBC charge the Life/Fraternal RBC formula

In attachment #1 of the exposure, the listed references in the Annual Statement Source column of the formula page are not formatted in the same manner as the rest of the formula. Statement references shown in this column are normally assumed to be for the General Accounts unless stated otherwise in the instructions or the line description. Additionally, the terms “blue book” and “green book” as references are not used anywhere else in the risk-based capital formula; not even on LR006 which specifically addresses Separate Accounts. The references in this column also indicate a “row” number. The correct term is “line.”

The line description for each of the four data lines already indicate if the general account or the separate account is being addressed. Therefore, it would seem logical that the reference listed in the Annual Statement Source column need only indicate the Exhibit, Column and Line number, although it might be a good idea to include a reference to the Separate Accounts in Line (4).

The following suggestion maintains the format normally used in the formula.

<table>
<thead>
<tr>
<th></th>
<th>General Account Life Contingent Annuity Reserves</th>
<th>Exhibit 5 Column 2 Line 0299999, in part†</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>General Account Life Contingent Supplemental Contract Reserves</td>
<td>Exhibit 5 Column 2 Line 0399999, in part‡</td>
</tr>
<tr>
<td>3</td>
<td>General Account Life Contingent Miscellaneous Reserves</td>
<td>Exhibit 5 Column 2 Line 0799999, in part‡</td>
</tr>
<tr>
<td>4</td>
<td>Separate Account (SA) Life Contingent Annuity Reserves</td>
<td>S/A Exhibit 3 Column 2 Line 0299999, in part‡</td>
</tr>
<tr>
<td>5</td>
<td>Total Life Contingent Annuity Reserves</td>
<td>Lines (1) + (2) + (3) + (4)</td>
</tr>
</tbody>
</table>

**Connie**

Connie Jasper Woodroof  
NAIC Liaison, Sapiens StatementPro

**Sapiens**
**Academy C-2 Mortality Work Group Update**

*Chris Trost, MAAA, FSA*

Chairperson, C-2 Work Group
American Academy of Actuaries

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**Agenda**

- Follow-up from December update at National Association of Insurance Commissioners (NAIC) Fall National meeting
  - Additional catastrophe component for an emerging sustained risk
  - Product differentiation
- Next steps

---

**C-2 Mortality Overall Approach**

- C-2 requirement covers mortality risk at the 95th percentile and is net of risk covered in statutory reserves
- C-2 requirement includes mortality risks related to:
  - Volatility risk—natural statistical deviations in experienced mortality
  - Level risk—error in base mortality assumption
  - Trend risk—adverse mortality trend
  - Catastrophe risk
  - Large temporary mortality increase from a severe event such as a pandemic or terrorism
- Sustained mortality increase from an emerging mortality risk
- Evaluate mortality risks using Monte Carlo simulation
- Express capital requirement using a factor-based approach (e.g., factor applied to Net Amount at Risk)

---

**Current C-2 Life Mortality Risk-Based Capital**

<table>
<thead>
<tr>
<th>Per $1000 of NAR</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>First $500M</td>
<td>2.25</td>
<td>1.75</td>
</tr>
<tr>
<td>Next $4.5B</td>
<td>1.46</td>
<td>1.16</td>
</tr>
<tr>
<td>Next $20B</td>
<td>1.17</td>
<td>0.87</td>
</tr>
<tr>
<td>$25B+</td>
<td>0.87</td>
<td>0.78</td>
</tr>
</tbody>
</table>
Additional Catastrophe Component for Emerging Risks

- Feedback from December NAIC meeting was that the LRBCWG should consider adding a component for an emerging mortality risk
- C-2 Work Group developed a second catastrophe component informed by historical health events impacting the US population e.g., AIDS and opioids
  - Component is intended to cover emerging risks that could materialize in the insured population
  - Conceptually, the component is expressed as a low annual probability of a sustained severe mortality increase (example approach provided in appendix)

Product Differentiation

- The work group is considering differentiating factors between products with near-term inforce pricing flexibility and those with minimal/no inforce pricing flexibility
- Higher factors are associated with products that have long-term guarantees
- Two options are under consideration
  1. Develop separate factors for product categories
  2. Blend the categories into one aggregate factor

Next Steps

- Follow-up call with LRBCWG to get more detailed feedback
- Finalize model and assumptions
  - Group life
  - Review size bands against current industry data
  - Review aggregate model output and peer review

Questions?

Additional Questions, contact:

Chris Trost, MAAA, FSA  Ryan Fleming, MAAA, FSA
Chairperson, C-2 Work Group  C-2 Work Group

Ian Trepanier
Life Policy Analyst
American Academy of Actuaries
trepanier@actuary.org
AIDS (1995) and opioids (2017) both peaked near a 2% increase to U.S. population mortality. Assumption for a 5% increase was derived by conservatively applying the increase in mortality at the worst age band in the worst year. Probability and magnitude are less than anticipated AIDS impact in early 1990s factor development (i.e., AIDS was a major concern at the time)

- However, additional component is greater than the actual mortality costs experienced in the insured population.
- Provides for the likelihood of a sustained event over a 40-year period.

### Appendix: Additional Catastrophe Component for Emerging Risks
(Expressed as a 2.5% annual probability of a 5% sustained mortality increase)

<table>
<thead>
<tr>
<th>Description</th>
<th>Source (CDC mortality statistics for U.S.)</th>
<th>Incr. to US Population Mortality</th>
<th>Mortality to US Population per 100K</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS mortality in peak year—1995, all ages</td>
<td>1.9%</td>
<td>16.4</td>
<td></td>
</tr>
<tr>
<td>AIDS mortality in peak year—1995, ages 35-44</td>
<td>5.0%</td>
<td>44.4</td>
<td></td>
</tr>
<tr>
<td>Estimated opioid mortality in peak year—2017, all ages</td>
<td>1.8%</td>
<td>15.8</td>
<td></td>
</tr>
<tr>
<td>Drug-induced mortality in peak year—2017, ages 35-44</td>
<td>4.7%</td>
<td>40.6</td>
<td></td>
</tr>
</tbody>
</table>

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C-3 Work Group Update

Link Richardson, MAIA, FSA
Chairperson, C-3 Work Group
American Academy of Actuaries

NAIC 2020 Spring National Meeting - Life Risk-Based Capital (E) Working Group

Discussion Outline

- 2015 C-3 Phase I (C-3 P1) Field Test Recap
- Highlights of changes since 2015
- Key remaining differences—C-3 P1 versus C-3 P2
- Scenario considerations
- High-level recommendations
- Analysis considerations

Discussion Topic

- The Academy C-3 Life and Annuities Work Group (C-3 WG) has a request from the NAIC Life Risk-Based Capital (E) Working Group (LRBC) to “Update the current C-3 Phase I or C-3 Phase II methodology to include Indexed Annuities.”
- The C-3 WG has developed high-level conceptual recommendations with respect to this request and would like to discuss them with the Life Risk-Based Capital Working Group (LRBC) before proceeding to develop the specifics of the recommendations.

C-3 Phase 1 Field Test Recap

- 2015 Field Test used 03/31/2014 models and scenarios, and essentially tested Phase 1 in the then-current C-3 Phase 2 framework
- Participation was made mandatory for large companies via Risk-Based Capital (RBC) Instructions, with results due in the February RBC filing
- Tested 200 “VM-20” interest rate scenarios
  - Key difference was Mean Reversion Point (MRP) of 4.00%, down from 6.55%
  - Resulting C-3 requirements were significantly higher, likely due to reinvestment effects for long-duration products, from lower MRP
- Also tested conditional full expectation (CTE) 90 metric, versus 92nd through 98th percentile (with boosted weight at 95%)
  - Change in metric made little difference to results
- C-3 Phase 1 use of expected defaults, and no Asset Valuation Reserve (AVR), was made explicit for C-3 Phase 2
C-3 Phase 2—Highlights of Changes since 2015 Field Test

- Interest rate scenarios now prescribed
- CTE 90 metric changed to 25% of CTE 98 minus CTE 70, from curve distribution, except for tax adjustment
- C-1 charges prescribed at CTE 70 level
- AWI only included if not used in cash flow testing (CFT)
- RBC Standard Scenario eliminated, but Reserve Additional Standard Projection Amount (ASP) doesn’t reduce RBC
- Working Reserve (WR) set to zero, instead of Cash Surplus value (CSV)
- Lower Error Factor allowed for implicit method of reflecting hedging
- Smoothing now applies to MRPs instead of CTE 98 – CTE 90
- SAP 108 allows hedge accounting for derivatives hedging US guarantees

C-3 Phase 1 Versus Updated Phase 2—Key Differences

- Minimum RBC is 50% of factor-based amount vs. implicit floor because reserves and RBC are from the same distribution
- ESG Mean Reversion Point (MRP) 6.55% vs. formulaic—currently 3.50%
- Capital requirement based on approximately CTE 90 vs. 25% of (CTE 98 minus CTE 70)
- C-1 charges at expected levels vs. CTE 70
- Surplus in projections based on reserves vs. WR of zero

Scenario Considerations

- No changes have been made for the MRPs. We currently have two MRPs—high one for C-3 F1 and a low one for F2 & C-3 F2
- A good solution is an MRP between these two, along with an update to increase the interest rate volatility. This recommendation could be provided as guidance to the development of the new ESG. It may be instructive to look at combined results for these two current scenario sets as a proxy for how that solution might look.
- The 2015 field test used 200 identical interest rate scenarios for all companies. Most companies ran 1,000 scenarios for C-3 F2. A two-dimensional stratification (interest rates and equity returns) was developed for 2015, but not used because Indebted Annuities were excluded.
- Use of the two-dimensional 200 scenario framework is recommended, and would allow for comparisons to both the current 50-scenario C-3 F1 framework and the typical 1,000 scenarios for C-3 F2.

High-Level Recommendations

- Repeat the 2015 C-3 Phase 3 field test, in 2020 for 1/1/2020 models, but using the updated C-3 Phase 2 framework and including various annuities, along with all products currently in scope for C-3 F1
- If the field test is mandatory for large companies, as the 2015 test was, change the timing to occur after year-end work is largely complete. Results could be due with the 1Q12 filing instead of February.
- Since the C-3 F1 framework now specifies interest rate scenarios as well as equity returns and hedging guidance, necessary adjustments to include Indebted Annuities should be minimal.
- The Total Asset Requirement (TAR) framework is suited to handling differing levels of reserve construction but is complicated by the change to 25% of CTE 98 minus CTE 70. Develop specific recommendations for treatment of reserves not equal to a CTE 70 basis. This type of field test could be performed before PM-22 updates are completed, even if PM-22 updates only apply to new business.
- Once new economic scenarios are available, a broader field test could be performed, including all products and frameworks to which the scenarios would apply, such as VMR, TAR, and C-3 testing.
Results Analysis Considerations

- Regulators and the Academy WG should develop a useful set of filing requirements and questions to facilitate and elicit participants’ comments on their own results. For example:
  - Results by model or product group would be helpful to analysis efforts.
  - Present values of ending surplus can be a useful indicator of the potential margin before deficiencies would develop, for scenarios where there is no deficiency.
  - Results with projected reserves, and with working reserves equal zero, can help with analysis of the significance of this choice.
  - The confidentiality provisions around RBC filings were relied upon in 2015, and would likely be suitable again. NAIC staff and regulators can perform work on summarization and aggregation of results.
  - If the High-Level Recommendations and Analysis Considerations are acceptable, the Academy C-3 WG can begin drafting of proposed RBC Instructions.

Questions?

- Link Richardson, MAAA, FSA
  Chairperson, C-3 Work Group
  American Academy of Actuaries

- Ian Trepanier
  Life Policy Analyst
  American Academy of Actuaries
  Trepanier@actuary.org
What RBC Pages Should Be Submitted?

For year-end 2020 life and fraternal risk-based capital (RBC), submit hard copies of pages LR001 through LR049 to any state that requests a hard copy in addition to the electronic filing. Starting with year-end 2007 RBC, a hardcopy was not required to be submitted to the NAIC. However, a portable document format (PDF) file representing the hard copy filing is part of the electronic filing.

If any actuarial certifications are required per the RBC instructions, those should be included as part of the hard copy filing. Starting with year-end 2008 RBC, the actuarial certifications were also part of the electronic RBC filing as PDF files, similar to the financial annual statement actuarial opinion.

Other pages, such as the mortgage and real estate worksheets, do not need to be submitted. However, they still need to be retained by the company as documentation.

Bond Designation Structure

The Capital Adequacy (E) Task Force adopted proposal 2019-16-CA to incorporate the 20 designation categories for bonds into the life and fraternal RBC formula to be used in conducting an impact analysis study for year-end 2020 reporting during its April 30, 2020 conference call. The 20 bond designation categories were incorporated into the Bonds page (LR002), Asset Concentration page (LR010) and Off Balance Sheet Collateral page (LR017).

Longevity Risk

As a result of the adoption of proposal 2019-13-L by the Capital Adequacy (E) Task Force on its April 30, 2020 conference call, changes developed by the Longevity Risk (E/A) Subgroup and recommended to the Life Risk-Based Capital (E) Working Group to implement the structure for a longevity risk charge were incorporated into the life RBC formula. On its June 30, 2020 conference call, the Task Force adopted the instructions with proposal 2020-06-L, which includes factors of zero for 2020. The structure adopted will provide information to be used in the ultimate determination of factors for 2021 reporting.

Capitation Tables

The Capital Adequacy (E) Task Force adopted proposal 2018-17-CA to capture the Capitation Tables electronically through the file submission of the life RBC formula during its June 28, 2019 conference call.

RBC Preamble

As a result of the adoption of proposal 2019-07-CA by the Capital Adequacy (E) Task Force at the 2019 Fall National Meeting, the Risk-Based Capital Preamble was added to the RBC instructions to provide a clear understanding of the purpose or RBC and goals of RBC as the Capital Adequacy (E) Task Force and RBC Working Groups review referrals and proposals.

Overview and Table of Contents

As a result of the adoption of proposal 2020-05-CA by the Capital Adequacy (E) Task Force during its June 30, 2020 conference call, the page iv instructions were modified to insert the word “Overview” in the page heading and the Table of Contents were modified to include only the page heading and delete references to the individual sections of the Overview.
RBC Forecasting and Instructions

The Life and Fraternal RBC forecasting spreadsheet calculates RBC using the same formula presented in the 2020 NAIC Life and Fraternal Risk-Based Capital Forecasting & Instructions for Companies, and is available to download from NAIC Account Manager. The 2020 Life and Fraternal Risk-Based Capital Forecasting & Instructions for Companies publication is available for purchase in hardcopy or electronic format through the NAIC Publications Department. This publication is available on or about Nov. 1 each year. The User Guide is no longer included in the Forecasting & Instructions.

**WARNING:** The RBC Forecasting Spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted and the RBC will not have been filed.
July 23, 2020

Philip A. Barlow, FSA, MAAA  
Chair, Life Risk-Based Capital (E) Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

Re: Progress Report for July 30, 2020 Working Group Meeting

Dear Mr. Barlow:

The Mortgage Bankers Associations (MBA)\(^1\) and the American Council of Life Insurers (ACLI),\(^2\) on behalf of our respective member insurers, respectfully submit to the Life Risk-Based Capital Working Group of the National Association of Insurance Commissioners (NAIC) the attached materials to support our report on the July 30, 2020 call, reporting on our progress following up on the Working Group’s July 10, 2020 call.

We appreciate the Working Group’s approval on that call of our requested reporting guidance on Contemporaneous Property Valuation, and we look forward to continuing to engage on reporting of 2020 Net Operating Income (NOI).

---

\(^1\) The Mortgage Bankers Association (MBA) is the national association representing the real estate finance industry, an industry that employs more than 280,000 people in virtually every community in the country. Its membership of over 2,300 companies includes all elements of real estate finance: mortgage companies, mortgage brokers, commercial banks, credit unions, thrifts, REITs, Wall Street conduits, 70 life insurance companies engaged in real estate finance, and others in the mortgage lending field. For additional information, visit MBA’s website: www.mba.org

\(^2\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States. Learn more at www.acl.com
We want to thank you and other regulators, and NAIC staff, for your considerable time and attention to this request. Please feel free to contact Bruce Oliver at boliver@mba.org or 202-557-2840 or Mike Monahan at mikemonahan@acli.com or 202-624-2324 for any additional information.

Sincerely,

Mike Flood

Paul S. Graham, III

Attachment: Supplement to June 8, 2020 Request for Risk-Based Capital Reporting Guidance

cc: Dave Fleming, NAIC Senior Insurance Reporting Analyst
I. BACKGROUND
A. The need for RBC guidance generally
Owners of properties that secure mortgage loans are experiencing temporary decreases in income, including rent income, from mandatory shutdowns and other governmental actions taken to flatten the COVID-19 pandemic curve. This is especially the case for properties in the retail and hospitality sectors.

RBC reporting standards were not designed with these circumstances in mind. Accordingly, the Financial Condition (E) Committee issued RBC guidance to adapt current RBC reporting standards to these unique circumstances. That guidance addresses RBC reporting treatments that would otherwise discourage or penalize reasonable and prudent temporary modifications of loans affected by the pandemic.

The E Committee delegated to the Life RBC Working Group the task of addressing further RBC reporting guidance, at a more detailed level, that may be appropriate to similarly address these unique circumstances.

Consistent with that delegation, the Life RBC Working Group has (1) extended the E Committee RBC Guidance to December 31, 2020 reporting, (2) adopted guidance on RBC treatment of construction loans paused under governmental directives, and (3) adopted guidance on reporting of Contemporary Property Values for 2020 RBC reporting.

The Working Group determined to defer consideration of a COVID-19-related adaptation of the reporting of 2020 Net Operating Income (NOI), which will affect 2021, 2022, and 2023 RBC reporting.

B. NOI and RBC reporting
NOI is the net of all operating income from a property, less all reasonably necessary operating expenses. Income for a property includes rents received, and operating expenses excludes principal and interest payments on loans.

For performing loans, the CM category is based on a matrix of Debt Service Coverage (DSC) and LTV. NOI affects RBC reporting because NOI is an element of DSC.

\[
DSC = \frac{\text{Net Operating Income (NOI)}}{\text{RBC Debt Service}}
\]

In 2013, regulators determined to dampen the direct impact of changes in NOI on RBC reporting by adopting a weighted-average approach to applying NOI values, as follows:

- 50% of preceding year NOI
- 30% of next preceding year NOI; and
- 20% of next preceding year NOI.

C. The need for RBC reporting guidance on 2020 NOI
NOI can provide insights into future credit risk where one can reasonably assume that future NOI will be similar to current NOI.

Given the unique nature of the COVID-19 pandemic, however, one cannot reasonably assume that 2021, 2022, and 2023 NOIs will be similar to 2020 NOI.

As a result, absent an adjustment to how 2020 NOI is reported at year end 2021, 2022, and 2023, RBC reporting would overstate the future credit risk impacts of temporary reductions in rent income that occur in 2020.
II. INDUSTRY 2020 NOI RECOMMENDATIONS

A. Revised Recommendation

For 2021, 2022, and 2023 RBC reporting:

- **Initial recommendation.** To prevent 2020 NOI values affected by temporary impacts of COVID-19 from overstating credit risk, industry initially recommended that, where a value of 2020 NOI is an input into the computation of the Rolling Average NOI, insurers should use the greater of:
  - 2020 NOI; or
  - [100% of] 2019 NOI.

- **Revised recommendation.** To address regulator feedback received in the June 30 WG conference call, industry revised its recommendation July 7 to reflect reductions in income in 2020, but with a floor.

  Specifically, industry recommends that, where a value of 2020 NOI is an input into the computation of the Rolling Average NOI, insurers should use the greater of:
  - 2020 NOI; or
  - 85% of 2019 NOI.

B. Why Revised Recommendation is Reasonable

- **Benchmark for 85%.** An NOI drop to 85% of a prior year's NOI is recognized as substantial by FHFA, which used a 15% drop in NOI (i.e., to 85% of the prior-year NOI) as a key “stress” assumption to calibrate multifamily credit risk in proposed GSE risk-based capital standards.

- **Consideration of historical data.** An NOI drop to 85% of a prior-year NOI represents roughly three times the historical worst four-quarter decline in NCREIF NOI values over the past 20 years, which includes the great financial crisis.

- **Non-performing loans are effectively excluded from recommendation.** A non-performing loan is classified in category CM6 or CM7, without regard to NOI. As a result, the recommended treatment of 2020 NOI would apply only to loans that are performing as of December 31, 2021, or a later reporting date.

- **2021 reductions in property valuation will be fully recognized.** The treatment of property valuations adopted by the WG on July 10 applies only for 2020 RBC reporting. As a result, 2021 reductions in property valuations (including those resulting from reduced NOI), will be fully reflected in LTVs for 2021 year-end RBC reporting.

C. Why Guidance is Necessary Now

While 2020 NOI is not incorporated into RBC reporting until year-end 2021, a lack of guidance on 2020 NOI RBC reporting has impacts now.

- **Evaluating new loans.** Insurers evaluating new loans as appropriate investments consider the return on capital as well as credit risk. Uncertainty as to RBC treatment of new loans impairs the ability to conduct that analysis. As a result, RBC considerations can prevent insurers from being competitive when seeking to make sound and appropriate mortgage investments.

  This impact would be most pronounced for loans on properties in states and regions that are hardest hit by actions to curb the COVID-19 pandemic.

- **Capital planning.** Regulators expect insurers to conduct robust capital planning, as do ratings agencies and investors and other stakeholders.

  A lack of clarity now as to impacts of 2020 NOIs on RBC reporting for 2021 and later years reduces insurers’ ability to account for their portfolios of mortgages in such capital planning.
III. PROGRESS REPORT

Industry actions following up on July 10 call

To provide the WG with additional information to support its reconsideration of the revised NOI recommendation, industry will:

A. Review and assess 2Q 2020 NOI information from various sources. This will include review and assessment of properties for which insurers receive quarterly NOI values, and any other similarly information that is available.

B. Consider market forecasts and projections from credible sources. See, e.g., MBA Commercial Real Estate Finance Forecast, by Jamie Woodwell; Reggie Booker (July 16, 2020) (excerpt below).

"For multifamily properties, much appears to depend on the federal government. Despite major disruptions in the labor market, the unemployment rate fell from 14% in April to 10% in June. If the economy rebounds, the apartment market should remain relatively balanced. This forecast anticipates continued federal support with a stimulus bill. The one-off checks and expanded unemployment insurance should support for displaced workers continue as the economy rebounds. This forecast anticipates continued federal support with a 'normal' (or 'GFC') - relatively light given the amount of labor market distress.

For office properties, the outcome will hinge on the tug-of-war between how dramatically companies embrace teleworking and shed office space on the one hand, and how companies resume their office space on the other. We anticipate that for most properties in most markets, the latter could largely mute the former, and that the greatest impact will come through shorter-term decision-making that maintains the leasing status quo. Looking across all property types, we expect the aggregate decline in NOI this recession could exceed that of the 2007 recession or GFC, but that impacts will be very different across different property types. The overall decline will also be concentrated in 2020."

* * *

Mike Flood    Paul S. Graham, III
SVP, CMF, Policy & Member Engagement   SVP, CMF, Policy & Member Engagement

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The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call July 30, 2020. The following Working Group members participated: Tom Botsko, Chair, and Dale Bruggeman (OH); Sheila Travis (AL); Mitchell Bronson, Rolf Kaumann and Eric Unger (CO); Wanchin Chou (CT); Robert Ridenour (FL); Judy Mottar (IL); Anna Krylova (NM); Sak-man Luk (NY); Will Davis (SC); Miriam Fisk (TX); and Randy Milquet (WI).

1. Adopted its June 12 and Feb. 3 Minutes

Mr. Botsko said the Working Group conducted an e-vote that concluded June 12 to adopt the updated Line 1 premium and reserve industry underwriting factors in the 2020 property/casualty (P/C) risk-based capital (RBC) formula.

The Working Group also met via conference call Feb. 3 in joint session with the Catastrophe Risk (E) Subgroup and took the following action: 1) adopted the Catastrophe Risk (E) Subgroup’s 2019 Fall National Meeting minutes; 2) adopted the Property and Casualty Risk-Based Capital (E) Working Group’s 2019 Fall National Meeting minutes; 3) adopted the Property and Casualty Risk-Based Capital (E) Working Group and Catastrophe Risk (E) Subgroup’s e-vote minutes; 4) adopted proposal 2018-19-P Vulnerable 6 or Unrated Risk Charge) and agreed to refer the Schedule F proposal to the Blanks (E) Working Group; 5) received referrals from the Statutory Accounting Principles (E) Working Group regarding Ref #2019-49: Retroactive Reinsurance Exception and Ref #2019-40: Reporting of Installment Fees and Expenses; and 6) received a referral from the Restructuring Mechanisms (E) Subgroup regarding the request to determine if changes should be made to the P/C formula to better assess companies in runoff.

Mr. Chou made a motion, seconded by Ms. Mottar, to adopt the Working Group’s June 12 minutes (Attachment Five-A) and Feb. 3 joint minutes with the Catastrophe Risk (E) Subgroup (Attachment Five-B). The motion passed unanimously.

2. Adopted the Report of the Catastrophe Risk (E) Subgroup

Mr. Botsko said the Catastrophe Risk (E) Subgroup met July 29 and took the following action: 1) adopted its Feb. 3 joint minutes with the Property and Casualty Risk-Based Capital (E) Working Group; 2) heard a presentation from Karen Clark & Company (KCC) on its catastrophe model. The presentation included the following topics: a) innovative risk metrics for identifying threats to solvency; b) how KCC partners with state insurance regulators; and c) an introduction to different KCC models; 3) discussed the possibility of allowing additional third-party commercial vendor models; and 4) discussed the internal catastrophe model evaluation process. The discussion included the following items: a) a definition of internal catastrophe model; b) NAIC guidance related to the use of “own models” for RBC catastrophe risk charges; and c) model validation and the Actuarial Standard of Practice (ASOP) No. 56.

Ms. Mottar made a motion, seconded by Mr. Chou, to adopt the report of the Catastrophe Risk (E) Subgroup (Attachment Five-C). The motion passed unanimously.

3. Adopted the 2020 P/C RBC Newsletter

Mr. Botsko said each year, NAIC staff incorporate all adopted current year proposals into the current year (RBC) formula. The 2020 changes have been incorporated into the P/C RBC newsletter.

Mr. Chou made a motion, seconded by Mr. Luk, to adopt the 2020 P/C RBC newsletter (Attachment Five-D). The motion passed unanimously.
4. **Discussed 2019 P/C RBC Statistics**

Mr. Botsko said the results of the 2019 P/C RBC report compiled by NAIC staff were fairly consistent with prior years. There were only 1.53% of the total companies that fell under the 200% RBC ratio, which is less than the historical failing percentage of around 2.3%. Overall, the asset risk has slightly increased overtime. It appears that a significant portion of the increase in R0 and R2 components. However, Mr. Botsko stated that the increase is concentrated on 15 insurers. These companies attribute to the 80.6% and 84.6% increase in R0 and R2, respectively (Attachment Five-E).

5. **Discussed the Possibility of Using the NAIC as a Centralized Location for Reinsurer Designations**

Charles A. Therriault (NAIC) said this project would be a substantial cost to the NAIC. He anticipated that it will be self-funded through some type of a fee structure that allows the NAIC to recoup its initial and ongoing costs from the industry (Attachment Five-F).

W. Scott Williamson (Reinsurance Association of America—RAA) said he believes that it should be a straightforward process. He said based on the Schedule F instructions, reporting companies are not permitted to list a reinsurer on Schedule F if it is not in the NAIC Electronic Listing of Companies. He recommended that the Working Group consider adding an equivalent reinsurer designation column in the NAIC Electronic Listing of Companies. He anticipated that the filing errors should be significantly reduced.

Mr. Botsko asked interested parties to document the concerns and share thoughts on the Working Group’s upcoming conference call.

6. **Discussed the R3 Credit Risk and Rcat Contingent Credit Risk Charges**

Mr. Felice said it is not clear that the entire 3% credit risk charge included in the Rcat risk factor is all operational risk. He suggested that by reducing the catastrophe credit risk charge to 3.8% from 4.8%, a 3% reduction in overall RBC would be achieved before operational risk if the Working Group decides to reduce the catastrophe credit risk charge to recognize the double counting issue.

Mr. Williamson said applying a 4.8% contingent credit risk factor, which is the same as the uncollateralized factor for the Secure 3 ratings category in the R3 charge, is far exceeding the targeted operational risk capital add-on charge. He recommended that the Working Group should consider eliminating the 3% operational risk cushion from the Rcat reinsurance contingent credit risk charge, as it causes a significant overstatement of RBC for catastrophe-exposed writers that utilize reinsurance to diversify their risk.

Mr. Botsko said two scenario testing was performed using 2019 P/C RBC data. He encouraged the interested parties to review the impact on both scenarios (Attachment Five-G) and provide thoughts to the Working Group during an upcoming conference call.

7. **Discussed Referrals from the Statutory Accounting Principles (E) Working Group**

a. **Ref #2019-49: Retroactive Reinsurance Exception**

Mr. Botsko said the Casualty Actuarial and Statistical (C) Task Force has organized a small group tasked with responding to the referral from the Statutory Accounting Principles (E) Working Group regarding Ref #2019-49: Retroactive Reinsurance Exceptions (Attachment Five-H) to clarify the accounting and reporting for retroactive reinsurance that meets the Statement of Statutory Accounting Principles (SSAP) No. 62R—Property Casualty Reinsurance exceptions to be accounted for as prospective reinsurance. Once a response is developed, both working groups will respond to the Statutory Accounting Principles (E) Working Group.

Ralph Blanchard (Travelers) commented that using a straight average across all companies will not materially distort the result if one company had erroneous data. However, using a weighted average approach could distort the industry experience adjustment if a large entity did a retroactive with prospective reinsurance treatment. He also pointed out that we would need to give consideration for those circumstances so there are no unintended consequences.
b. **Ref #2019-40: Reporting of Installment Fees and Expenses**

Mr. Botsko said the Casualty Actuarial and Statistical (C) Task Force submitted comments to the Statutory Accounting Principles (E) Working Group regarding Ref #2019-40: Reporting of Installment Fees and Expenses (Attachment Five-I) for the exposure draft of changes proposed to Footnote 1 of SSAP No. 53—*Property Casualty Contracts—Premiums* on Feb. 18.

Mr. Botsko stated that the Task Force supports the revisions proposed to Footnote 1 of SSAP No. 53 as detailed in the Statutory Accounting Principles (E) Working Group’s Ref #2019-40. He said the Working Group agreed with the Task Force decision in supporting clarification that ensures fees and charges associated with the transfer of risk are reported as premium and that fees and charges not associated with the transfer of risk are not reported as premium.

Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC) stated that a distinction should be made in the proposal for those fees that do affect premium and those that do not, such as insufficient funds fees.

8. **Forwarded the Request for Extension to the Restructuring Mechanisms (E) Subgroup**

Mr. Botsko said a survey result regarding the definition of runoff companies was received earlier. He encouraged all the interested parties to review it and provide comments during the upcoming conference call. He also said a request for extension was drafted, as he anticipated that the Working Group may not be able to come to a conclusion prior to the Fall National Meeting due to the current pandemic.

Mr. Milquet made a motion, seconded by Ms. Travis, to forward the request for extension (Attachment Five-J) to the Restructuring Mechanisms (E) Subgroup. The motion passed unanimously.

9. **Adopted its 2020 Working Agenda**

Mr. Botsko summarized the changes to the Working Group’s 2020 working agenda: 1) removed “Evaluate the AEP vs OEP factors” and “Evaluate the impact to RBC on: a) PreTax vs. After Tax; and b) Tax reform on Total Adjusted Capital” in the carry-over items; and 2) added “evaluate the RBC impact on two different retroactive reinsurance exception approaches,” “evaluate the RBC impact on the modification of the installment fees and expenses reporting guidance,” “evaluate if changes should be made to the P/C formula to better assess companies in runoff,” and “evaluate the underwriting risk line 1 factors in the P/C formula” in the new items section, respectively.

Mr. Chou made a motion, seconded by Mr. Luk, to adopt the Working Group’s 2020 working agenda (see *NAIC Proceedings – Summer 2020, Capital Adequacy (E) Task Force, Attachment Six*). The motion passed unanimously.

10. **Heard Updates on Current P/C RBC Projects from the Academy**

Lauren Cavanaugh (American Academy of Actuaries—Academy) said the Academy P/C RBC committee is continuing its work on reviewing the various components of the underwriting risk. She stated that the Academy is planning to release a report in the near future. The report will provide recommended updated line of business underwriting risk factors (Line 4 on PR017 and PR018). This will incorporate the Academy research from 2016 with additional data included. Ms. Cavanaugh also anticipated that another report, which is the investment income adjustment and loss/premium concentration factors report, will be released sometime next year.

11. **Discussed Line 1 Underwriting Risk Reserves and Premiums Methodology**

Mr. Botsko said that, prior to 2016, the line 1 of PR017 and PR018 are updated annually using the straight average approach for all lines of business. The Working Group noticed that results from this approach, especially for those lines with smaller populations, could be fluctuated or biased by different factors, such as intercompany pooling arrangements. In 2016, the Working Group adopted the approach of using weighted average approach on the smaller population, which is 500 or less companies. Mr. Botsko said that recently, some state insurance regulators asked the Working Group to determine the impact to the industry RBC result if the weighted average approach calculation were used across all lines.

Mr. Blanchard reiterated his comment in item #7a.
Mr. Botsko asked all the interested parties to review the analysis in the materials (Attachment Five-K) and provide comments during an upcoming conference call.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.

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Property and Casualty Risk-Based Capital (E) Working Group  
E-Vote  
June 12, 2020

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force conducted an e-vote that concluded June 12, 2020. The following Working Group members participated: Tom Botsko, Chair (OH); Richard Ford (AL); Mitchell Bronson (CO); Wanchin Chou (CT); Robert Ridenour (FL); Judy Mottar (IL); Anna Krylova (NM); Sak-man Luk (NY); Will Davis (SC); Miriam Fisk (TX); and Randy Milquet (WI).

1. **Adopted Proposal 2020-01-P (Underwriting Risk Line 1 Factors)**

The Working Group conducted an e-vote to consider adoption of the updated Line 1 premium and reserve industry underwriting factors in the 2020 P/C RBC formula.

Mr. Luk made a motion, seconded by Mr. Milquet, to adopt proposal 2020-01-P *(see NAIC Proceedings – Summer 2020, Capital Adequacy (E) Task Force, Attachment One-F)*. The motion passed unanimously.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.

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Property and Casualty Risk-Based Capital (E) Working Group and Catastrophe Risk (E) Subgroup
Conference Call
February 3, 2020

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call Feb. 3, 2020, in joint session with the Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force. The following Working Group members participated: Tom Botsko, Chair, and Dale Bruggeman (OH); Richard Ford (AL); Mitchell Bronson, Rolf Kaumann and Eric Unger (CO); Wanchin Chou (CT); Robert Ridenour (FL); Judy Mottar (IL); Anna Krylova (NM); Sak-man Luk (NY); Will Davis (SC); and Randy Milquet (WI). The following Subgroup members participated: Tom Botsko, Chair, and Dale Bruggeman (OH); Robert Ridenour, Vice Chair (FL); Kim Hudson and Laura Clements (CA); Mitchell Bronson, Rolf Kaumann and Eric Unger (CO); Wanchin Chou (CT); Judy Mottar (IL); Anna Krylova (NM); Sak-man Luk (NY); Andrew Schallhorn (OK); and Will Davis (SC). Also participating were: Julie Lederer (MO); and Steve Drutz (WA).

1. **Adopted the Subgroup’s 2019 Fall National Meeting Minutes**

Ms. Mottar made a motion, seconded by Mr. Chou, to adopt the Subgroup’s Dec. 6, 2019, minutes (*see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Four-B*). The motion passed unanimously.

2. **Adopted the Working Group’s 2019 Fall National Meeting Minutes**

Mr. Milquet made a motion, seconded by Ms. Mottar, to adopt the Working Group’s Dec. 8, 2019, minutes (*see NAIC Proceedings – Fall 2019, Capital Adequacy (E) Task Force, Attachment Four*). The motion passed unanimously.

3. **Adopted the Working Group and Subgroup’s Jan. 22 Minutes**

Mr. Botsko said the Working Group and the Subgroup conducted an e-vote to consider adoption of proposal 2019-14-CR (2019 U.S. and Non-U.S. Catastrophe Risk Event Lists).

Mr. Chou made a motion, seconded by Ms. Mottar, to adopt the Working Group and Subgroup’s Jan. 22 minutes (Attachment Five-B1). The motion passed unanimously.

4. **Adopted Proposal 2018-19-P (Vulnerable 6 or Unrated Risk Charge) and Agreed to Refer the Schedule F Proposal to the Blanks (E) Working Group**

Mr. Botsko said the purpose of this proposal is to modify the instructions to reflect that the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified and reciprocal reinsurance.

W. Scott Williamson (Reinsurance Association of America—RAA) said the RAA supports the proposal and the associated changes to the annual financial statement. He agreed with the Working Group approach to consider moving, over time, toward a charge that is more aligned with risk-indicated factors used by the rating agencies. He also recommended that the Working Group should consider applying different charges for: 1) captives and runoff reinsurers, as they may not obtain financial strength ratings; 2) reinsurer designation equivalent to categories 1 through 6 to reflect the most recent credit default experience and consistency with reinsurance recoverable credit risk factors in use by the rating agency capital models; and 3) lowering the cushion or margin for operational risk that is embedded in the credit risk factors.

Matthew B. Vece (American Property Casualty Insurance Association—APCIA) said he is concerned that this proposal inappropriately combines two groups with inherently different risk characteristics. He recommended an alternative approach to retain the current seven categories for the RBC R3 credit risk charge, with the last two categories being: 1) vulnerable 6; and 2) unrated (whether authorized, unauthorized, certified or reciprocal).

Mr. Williamson said the unrated category includes vulnerable reinsurers in addition to solvent reinsurers. He agreed with the current proposal that eliminates the NAIC 7 designation. If in the future, the Working Group defines a category for solvent runoff or other situations eligible for a capped factor, the NAIC 7 designation could be reactivated at that time.
Mr. Milquet asked if reclassifying NAIC 7 back to NAIC 6 creates more work for filing companies.

Mr. Williamson replied that it is necessary to take this action to ensure that future RBC filings are not populated with “legacy” NAIC 7 designations if and when a new definition is adopted.

Mr. Botsko said he understands the industry concerns. However, it was the Working Group’s intention to evaluate the data annually until reaching any agreed upon change to the factor and the structure. He recommended that the Working Group consider: 1) adopting proposal 2018-19-P for 2020 RBC filing; 2) forwarding the blanks proposal to the Blanks (E) Working Group for consideration; and 3) documenting the industry concerns in the working agenda for future discussion.

Mr. Milquet made a motion, seconded by Mr. Ridenour, to refer the Schedule F proposal to the Blanks (E) Working Group and adopt proposal 2018-19-P, subject to adoption of the Schedule F blanks proposal from the Blanks (E) Working Group (see NAIC Proceedings – Summer 2020, Capital Adequacy (E) Task Force, Attachment One-E). The motion passed unanimously.

5. Received Referrals from the Statutory Accounting Principles (E) Working Group

Mr. Botsko said the Working Group received two referrals from the Statutory Accounting Principles (E) Working Group.

Mr. Botsko said the first referral is regarding Ref #2019-49: Retroactive Reinsurance Exception. He said this agenda item addresses a request from the American Academy of Actuaries’ (Academy) Committee on Property and Liability Financial Reporting (COPLFR) Work Group to clarify both the accounting and reporting for retroactive contracts, which are accounted for prospectively. The COPLFR noted that there is diversity in the current practice due to lack of specific guidance. The clarifications requested include: 1) both the ceding entity and assuming entity, where both are members of the same group and are consolidated in the same combined annual statement; and 2) the reporting method to be used if the ceding entity and assuming entity are not in the same group.

Robin Marcotte (NAIC) said the Statutory Accounting Principles (E) Working Group is currently seeking: 1) input related to the RBC impacts; and 2) volunteers to assist with developing guidance. She encouraged volunteers to contact her.

Mr. Botsko said another referral is regarding Ref #2019-40: Reporting of Installment Fees and Expenses. Ms. Marcotte said the purpose of this exposure is to include a minor clarification of the current installment fee guidance in Statement of Statutory Accounting Principles (SSAP) No. 53—Property Casualty Contracts – Premiums and request input from the Working Group on the questions that are included in the referral regarding if incurred installment fee expenses should be allowed to be reported in other expenses. Excluding expenses from underwriting can have an impact on underwriting ratios.

Mr. Bruggeman encouraged members and interested parties to review this referral and share their thoughts during the Spring National Meeting.

Mr. Botsko said the Working Group will coordinate with the Casualty Actuarial and Statistical (C) Task Force to determine how to approach these referrals and provide findings during the Spring National Meeting.

6. Discussed Other Matters

Mr. Botsko said the Working Group just received another referral from the Restructuring Mechanisms (E) Subgroup. He stated that the purpose of the referral is requesting that the Working Group determine if changes should be made to the property/casualty formula to better assess companies in runoff. He encouraged interested parties to review the referral; the Working Group plans to have a more in-depth discussion at the Spring National Meeting.

Mr. Bruggeman said the survey included in the referral provided some example definitions of the runoff companies. He encouraged members and interested parties to review the survey and share their thoughts at the Spring National Meeting.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group and the Catastrophe Risk (E) Subgroup adjourned.

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Property and Casualty Risk-Based Capital (E) Working Group and Catastrophe Risk (E) Subgroup
E-Vote
January 22, 2020

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force conducted an e-vote with the Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force that concluded Jan. 22, 2020. The following Working Group members participated: Tom Botsko, Chair (OH); Mitchell Bronson (CO); Wanchin Chou (CT); Robert Ridenour (FL); Judy Mottar (IL); Anna Krylova (NM); Sak-man Luk (NY); Will Davis (SC); Miriam Fisk (TX); and Randy Milquet (WI). The following Subgroup members participated: Tom Botsko, Chair (OH); Robert Ridenour, Vice Chair (FL); Mitchell Bronson (CO); Wanchin Chou (CT); Judy Mottar (IL); Anna Krylova (NM); Sak-man Luk (NY); Andrew Schallhorn (OK); Will Davis (SC); and Miriam Fisk (TX).


The Working Group and the Subgroup conducted an e-vote to consider adoption of the updated 2019 U.S. and non-U.S. catastrophe event lists.

Mr. Bronson made a motion, seconded by Mr. Schallhorn, to adopt proposal 2019-14-CR (*see NAIC Proceedings – Summer 2020, Capital Adequacy (E) Task Force, Attachment One-A2*). The motion passed unanimously.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group and the Catastrophe Risk (E) Subgroup adjourned.

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The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met via conference call July 29, 2020. The following Subgroup members participated: Tom Botsko, Chair (OH); Robert Ridenour, Vice Chair (FL); Susan Bernard (CA); Mitchell Bronson and Eric Unger (CO); Wanchin Chou (CT); Judy Mottar (IL); Gordon Hay and Justin Schrader (NE); Anna Krylova (NM); Gloria Huberman and Sak-man Luk (NY); Cuc Nguyen (OK); Michael Wise (SC); and Miriam Fisk (TX).

1. **Adopted its Feb. 3 Minutes**

Mr. Botsko said the Catastrophe Risk (E) Subgroup met via conference call Feb. 3 in joint session with the Property and Casualty Risk-Based Capital (E) Working Group and took the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) adopted the Property and Casualty Risk-Based Capital (E) Working Group’s 2019 Fall National Meeting minutes; 3) adopted its Jan. 22 minutes; 4) adopted proposal 2018-19-P (vulnerable 6 or unrated risk charge) and agreed to refer the Schedule F proposal to the Blanks (E) Working Group; 5) received referrals from the Statutory Accounting Principles (E) Working Group regarding Ref #2019-49: Retroactive Reinsurance Exception and Ref #2019-40: Reporting of Installment Fees and Expenses; and 6) received a referral from the Restructuring Mechanisms (E) Subgroup regarding the request to determine if changes should be made to the property/casualty (P/C) formula to better assess companies in runoff.

Mr. Chou made a motion, seconded by Ms. Mottar, to adopt the Subgroup’s Feb. 3 minutes (see NAIC Proceedings – Summer 2020, Capital Adequacy (E) Task Force, Attachment Four-B). The motion passed unanimously.

2. **Heard a Presentation from Karen Clark & Company (KCC) on its Catastrophe Model**

Glen Daraskevich (Karen Clark & Company—KCC) said KCC is dedicated to delivering innovative approaches and new scientific tools for addressing current challenges in estimating and managing catastrophe risk. In addition to all the traditional metrics, Mr. Daraskevich said the KCC model provides: 1) additional risk metrics for underwriting and portfolio management; 2) unique sampling methodology enabling robust high-resolution (location level) loss analyses; 3) fully transparent model components; 4) built-in tools and high-resolution mapping for more efficient internal modeling process; and 5) more accurate model loss estimates. Joanne Yammine (KCC) stated that currently, the KCC model supports different major catastrophe perils such as earthquake, hurricane, coastal flood, inland flood, tornado/wind, wildfire, winter storm and hail, etc. (Attachment Five-C1)

Mr. Botsko encouraged interested parties to review the materials and provide their comments during the Subgroup’s next meeting.

3. **Discussed the Possibility of Allowing Additional Third-Party Commercial Vendor Models**

Mr. Botsko said the current risk-based capital (RBC) instructions clearly state that only five third-party commercial vendor catastrophe models were approved to calculate Rcat modeled losses. He stated that several modeling firms expressed their interest in becoming one of the approved models. He asked the interested parties to consider whether the Subgroup should allow any additional third-party commercial vendor models to be included in the approved model list. Comments and thoughts will be discussed during the Subgroup’s next meeting.

4. **Discussed the Internal Catastrophe Model Evaluation Process**

Mr. Chou said he believes that the definition of the internal catastrophe model should include: 1) internal catastrophe models for different natural perils; 2) vendor catastrophe models with certain adjustments; and 3) derivative models based on vendors’ catastrophe models. However, he said he thinks that the current NAIC RBC instructions do not cover the entire definition of the internal catastrophe model. Mr. Chou recommended that the Subgroup consider modifying the RBC instructions to cover the definition he mentioned. He also suggested that the Subgroup use the following as some of the possible references on modifying the current RBC instructions: 1) the Actuarial Standard of Practice (ASOP) No.56, *Modeling*, which provides
guidance to actuaries when performing actuarial services with respect to designing, developing, selecting, modifying, using, reviewing and evaluating models; 2) model validation from the company’s state of domicile; and 3) field exams. (Attachment Five-C2)

Mr. Botsko encouraged interested parties to consider the recommendation above and share comments and thoughts during the Subgroup’s next meeting.

5. Discussed Other Matters

Mr. Botsko said he plans to schedule a conference call in September to continue discussing all the outstanding issues.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
About Karen Clark & Company

- Established in 2006 by insurance industry veterans and pioneers in catastrophe risk management
- Karen Clark developed the first commercial hurricane model and launched the first catastrophe modeling company, AIR
- Vivek Basrur architected and led the development of AIR software technology, including CLAVE/L, CFFARADAR, and WinDrought (now PerilIndex)
- Senior staff have extensive experience in catastrophe model development and risk management
- KCC is dedicated to delivering innovative approaches and new scientific tools for addressing current challenges in estimating and managing catastrophe risk
- Characteristic Event methodology
- Physical models
- Live event technology
- KCC supports a diverse client base with consulting services and the RiskIntegrity® open modeling platform
- Top 10 U.S. P&I insurers
- Global reinsurance intermediaries
- Leading global reinsurers
- Cat Bond/ILS fund managers
- Regulators
- Academics

Opportunities for Improving Catastrophe Risk Management Practices

- More accurate and operational metrics for identifying threats to solvency
- Improved consistency and reliability in the average annual loss estimates used in ratemaking
- Direct access to the data and calculations underlying catastrophe models
- Open platform
- Transparent hazard and vulnerability components
- Embedded visualizations tools
- Innovative tools for delivering actionable information to decision makers
- Live event reporting
What's Different about Karen Clark & Company Models?

- Based on the same science and components as traditional models.
- Provides all the traditional metrics including PMLs, TVaRs, and AULs.
- Advancement: Additional risk metrics for underwriting and portfolio management.
- Advancement: Unique sampling methodology enabling robust high-resolution (location level) loss analysis.
- Advancement: Model components fully transparent.
- Advancement: Built-in tools and high resolution mapping for more efficient internal modeling process.
- Advancement: More accurate model loss estimates.

KCC's Unique Characteristic Events (CEs) Address These Questions

CEs Reveal Large Loss Potential Can Be Very Different Between Insurers with Similar PMLs

Why New Risk Metrics—EP Curves and PMLs Answer Some but Not All Important Questions

- 1% in 100 year PML
- 2% in 250 year PML

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Return Period Losses Calculated
CEs Illustrate How a 20 Year Event Can Cause a Loss Close to the 100 Year PML.

More Consistent and Accurate Location-level Loss Estimates is Critical for Ratemaking.

Ratemaking – Loss Cost Comparison – Miami, FL.

RiskInsight® is a Transparent and Open Model Which Allows Users to Independently Verify Model Assumptions and Better Understand Catastrophe Risk.
The CE Methodology Avoids Spatial Biases and “Blind Spots” Present in Traditional Random Sampling Methodologies

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Relative Wind Speed Changes Along the Coastline

Important CE Concept: Along the Coast the Event Changes to Keep the Hazard Probability the Same!
Unique CE Profile Delivers Clearer Insight into Tail Risk and Threats to Solvency

Enhances Pricing with More Consistent and Accurate Location-level Loss Estimates

- AALs based on uniform exposure on a 3 MW grid (open terrain)
- Logical relation to risk
- No spatial bias

KCC Live Event Tracking Provides Valuable Real-Time Data to Decision Makers

Developing a Complete and Spatially Unbiased Set of Potential Storms Across All Intensities
Introduction to KCC Models – KCC USEarthquake Reference Model

Evolution of USGS Hazard Maps

USGS Report Evolution: Improve Best Estimation and Better Handling of Uncertainty

KCC CEs are Based on USGS MFDs and Account for Location Uncertainty

- Select the CE Magnitude
- Use fault MFD from UCERF3 in CA
- Calculate the rupture area
- Calculate the rupture length
- Depending on model
- Assign the ruptures
KCC CEs Account for “Location Effect” by Generating Background Events on a Uniform Grid (Aligned with USGS)

CEs Enable High-Resolution, Location-Level Risk Metrics, and Avoid Surprise Losses

100 year Events:

RAA 2018 Vendor Model Comparison Session: California Earthquake

RAA 2018 Vendor Model Comparison Session: California EQEPCurves
Introduction to KCC Models – Additional KECUS Reference Models

Other Major US Perils Supported

Challenges with Traditional Statistical Approaches to Modeling - Historical Hail Reports

Issues with Reporting: Forecast Offices
KCC SCS Reference Model Leverages Physical Modeling for Hail Detection

- Reflectivity is measured in dBZ
- Radars scan at different tilt angles
- Base reflectivity is the lowest 0.5° tilt
- Composite reflectivity is the maximum reflectivity at any tilt
- Is combined with NWP to identify hail forming regions

Validation of KCC Simulated Hail Intensity with SPC Hail Reports and Claims Data

Simulated Hail Intensity Legend

SPC Reports
Hail Intensity
Hail Claims

KCC Employs a Composite Index to Capture the Physical Variables Driving Tornado and Straight-line Wind Behavior

- CAPE, SHEAR, and SRH are very useful, but SCS require many ingredients
- Composite Index – combines multiple parameters

Enhanced Significant Tornado Parameter

\[
\text{ESTP} = f(SRH, CAPE, SHEAR, LCL, CIN)
\]
KCC Physical Models Enable Daily Loss and Claims Estimates for Hail and Tornado/Wind

Hail Intensity Footprint Tornado/Wind Intensity Footprint

<table>
<thead>
<tr>
<th>State</th>
<th>Hail Claims</th>
<th>Tornado/Wind Claims</th>
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</thead>
<tbody>
<tr>
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<td>FL</td>
<td>6,789</td>
<td>987</td>
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</table>

Leveraging Real Time Losses

- Improve claims handling
- Notify insured of possible damage
- Detect possible fraudulent claims

Flood Reference Model - Modeling Inland Flooding

- Two major types of inland flooding are fluvial (riverine and pluvial) and surface flooding.
- Many areas in the US are susceptible to riverine flooding (major river floodplains, areas with high topography).
- Regions that are flat are more susceptible to surface flooding.

Flood Reference Model - What Makes Modeling Inland Flood Challenging?

- There is no single meteorological definition of an event occurring on a large spatial scale.
- Data on flood inundation is scarce, especially for surface flooding.
- Hazard occurs on a very small scale but over a large area.
How CEs Can Assist Rating Agencies and Regulators in Evaluating Threats to Surplus

How KCC Can Support Regulators

- More intuitive and operational CE metric for identifying threats to solvency
- Improved consistency and stability in the average annual loss estimates used in ratemaking
- Increased transparency and direct access to the data and calculations underlying catastrophe loss estimates
- Open platform
- Transitioned from loss estimates to community risk estimates
- Embedded visualization tools
- Innovative tools for delivering actionable information to decision makers
- Live event reporting
- Multiple impacts to the entire market

Landfall Point

Flood Reference Model – Cellular Automata Supports High Resolution Pluvial Flood Modeling

- Different methods have been applied to modeling pluvial flooding

1. Solving the shallow water equations (SWEs)
   - Bernoulli equation in single-coupling studies
   - Difficulty capturing flood inundation in large catchments
   - Non-continuous for large spatial scales and large spatial detail

2. Rapid Flood Model (RFM)
   - Faster in case than SWEs by orders of magnitude
   - Represents temporal evolution of flood
   - Requires substantial pre- and post-processing and tuning

3. Cellular Automata
   - Method is comparable to the SWE approach for flood flooding (e.g., Summerfield et al., 2003, Summerfield et al., 2004, and Summerfield et al., 2008)
   - Even more rapid than the RFM but more accurate than the SWE
   - Represents the physics of water flowing over topography

Flood Reference Model - Validation of the High-Resolution Footprints using Flood Reports

- Different methods have been applied to modeling pluvial flooding

1. Solving the shallow water equations (SWEs)
   - Bernoulli equation in single-coupling studies
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   - Represents the physics of water flowing over topography
Questions?
The Definition of Internal CAT Model

- Internal CAT Models – Natural Perils
- Vendor CAT Models with Adjustments
- Derivative Model Based on Vendor Models

NAIC Guidance Related to the Use of “Own Models” for RBC Catastrophe Risk Charges – PR027

The projected losses can be modeled using the following: NAIC approved third-party commercial reinsurance catastrophe models, GLA, EPIC, RMS, the Aon BestLoss Model, or the Florida Public Model for hurricane, as well as catastrophe models that are internally developed by the insurer or that are the result of adjustments made to the insurer’s reinsurance models to represent the insurer’s view of catastrophe risk differences (‘own models’).

To obtain permission to use the own model, the insurer must provide the domicile or host state insurance regulator with written evidence of each of the following:

1. The use of the own model is reasonable considering the insurer’s risk and complexity of the insurer’s catastrophe risk;
2. The own model is used for catastrophe risk management and capital assessment, and the capital allocations process and the model has been used for at least the last 2 years;
3. The peril included in the RBC Catastrophe Risk Charge have been validated by the insurer and that these perils include both US and global exposure, where applicable;
4. The own model has been developed using reasonable data and assumptions and that model results used in determining the RBC Catastrophe Risk Charge reflect exposure that is no other than 6 months;
NAIC Guidance Related to the Use of “Own Models” for RBC Catastrophe Risk Charges – PR027

5. The insurer has submitted to the NAIC and other parties with whom it has an agreement to develop and maintain a model that has been validated and a copy of the most recent validation report. The insurer is to be responsible for the relevant cost. For each period included in the RBC Reporting Year, the validation report shall include a description of the assumptions, results, and limitations of the validation, the individual qualifications of the validation, and the state of the validation. The model documentation and the model validation report must be made available at a minimum once every five years, or whenever the basis or scope of validation is changed, or whenever there is a material change in the insurer’s exposure to catastrophe risk.

6. The results of the model should be compared with the results produced by at least one of the following models: LCR, DIRO, DIRO, RBC, RBC, RBC, or the Dynamic Climate Model. The insurer must ensure that the comparison and an explanation of the differences between the results produced by the internal models and results produced by the external models.

7. If the model has been approved by the NAIC and/or the Regulatory Bodies, the insurer must submit the results of the validation to the NAIC and/or the Regulatory Bodies.

Model Validation and ASOP

• ASOP - 56
• Model Validation – State of Domicile
• Field Exams
• Other Thoughts – 2021/2022 Charges

Questions?
What RBC Pages Should Be Submitted?

For year-end 2020 property/casualty (P/C) risk-based capital (RBC), hardcopies of pages PR001 through PR035, as well as PR038 and PR039, should be submitted to any state that requests a hardcopy. Beginning with the year-end 2007 RBC, a hardcopy was not required to be submitted to the NAIC, but a portable document format (PDF) file representing the hardcopy filing is part of the electronic filing with the NAIC.

Capitation Tables

The Capital Adequacy (E) Task Force adopted proposal 2018-17-CA to capture the capitation table electronically through the file submission of the P/C RBC formula during its June 28, 2019, conference call.

RBC Preamble

As a result of the adoption of proposal 2019-07-CA by the Capital Adequacy (E) Task Force at the 2019 Fall National Meeting, the Risk-Based Capital Preamble was added to the RBC instruction to provide a clear understanding of the purpose of RBC and goals of RBC as the Task Force and Working Groups review referral and proposals.

Bond Designation Structure

The Capital Adequacy (E) Task Force adopted proposal 2019-16-CA to incorporate the 20 designation categories for bonds into the P/C RBC formula to be used in conducting an impact analysis study for year-end 2020 reporting during its April 30, 2020, conference call. The 20 bond designation categories were incorporated into the Bonds page (PR006), the Asset Concentration page (PR011) and the Off-Balance Sheet Security Lending Collateral and Schedule DL page (PR015).

Credit Risk

Vulnerable 6 or Unrated Risk Charge

As a result of the adoption of proposal 2018-19-P by the Capital Adequacy (E) Task Force during its June 30, 2020, conference call, the instruction was modified to reflect the factors for all uncollateralized reinsurance recoverable from unrated reinsurers be the same for authorized, unauthorized, certified and reciprocal reinsurance.

Clarification to Instructions Regarding Lloyd’s of London

As a result of the adoption of proposal 2019-11-P by the Capital Adequacy (E) Task Force at the 2019 Fall National Meeting, the instructions were changed to clarify the reinsurance recoverable from individual syndicates of Lloyd’s of London that are covered under the Lloyd’s Central Fund may utilize the lowest financial strength group rating received from an approved rating agency.

Elimination of PR038 Adjustment for Reinsurance Penalty for Affiliates Applicable to Schedule F

As a result of the adoption of proposal 2019-12-P by the Capital Adequacy (E) Task Force at the 2019 Fall National Meeting, the adjustment for Reinsurance Penalty for Affiliates Applicable to Schedule F in PR038 is no longer needed because the computation of RBC charge for reinsurance recoverable has been moved to the Annual Statement Schedule F, Part 3.

Overview and Table of Contents

As a result of the adoption of proposal 2020-05-CA by the Capital Adequacy (E) Task Force during its June 30, 2020, conference call, the page iv instructions were modified to insert the word “Overview” in the page heading, and the Table of Contents was modified to include only the page heading and delete references to the individual sections of the Overview.
New Industry Average Risk Factors – Annual Update

On its June 30, 2020, conference call, the Capital Adequacy (E) Task Force adopted the annual update of industry average development factors:

<table>
<thead>
<tr>
<th>PR017 Underwriting Risk – Reserves</th>
<th>PR018 Underwriting Risk – Net Written Premiums</th>
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<td>Line (1), Industry Average Loss and Expense Ratios</td>
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<td>(9)</td>
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<td>Auto Physical Damage</td>
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<td>REIN. P&amp;F Lines</td>
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<td>REIN. Liability</td>
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<td>PL</td>
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<td>(19)</td>
<td>Warranty</td>
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* Cat Lines
RBC Forecasting and Instructions

The P/C RBC forecasting spreadsheet calculates RBC using the same formula presented in the 2020 NAIC Property & Casualty Risk-Based Capital Report Including Overview & Instructions for Companies, and is available to download from NAIC Account Manager. The 2020 NAIC Property & Casualty Risk-Based Capital Report Including Overview & Instructions for Companies publication is available for purchase in hardcopy or electronic format through the NAIC Publications Department. This publication is available for purchase on or about Nov. 1 each year. The User Guide is no longer included in the RBC publications.

**WARNING:** The RBC forecasting spreadsheet CANNOT be used to meet the year-end RBC electronic filing requirement. RBC filing software from an annual financial statement software vendor should be used to create the electronic filing. If the forecasting worksheet is sent instead of an electronic filing, it will not be accepted, and the RBC will not have been filed.
### Summary: Aggregate P/C RBC Results By Year

#### AGGREGATED P&C RBC DATA

<table>
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<tr>
<th>Year</th>
<th># of Companies Filed RBC</th>
<th>% of RBC Companies</th>
<th>Grand Total of Cos at an Action Level</th>
<th>Trend Test</th>
<th>Company Action Level</th>
<th>Authorized Control Level</th>
<th>Mandatory Control Level</th>
<th>Total RRG's at an Action Level</th>
<th>Total COS at an Action Level Excluding RRG's</th>
<th>Total COS at an Action Level Excluding RRG's</th>
<th>% of Companies with RBC Ratio &gt; 10,000%</th>
<th>% of Companies with RBC Ratio &lt; 1000%</th>
<th>Total COS at an Action Level Excluding RRG's</th>
<th>Total COS at an Action Level Excluding RRG's</th>
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#### Capital Adequacy (E) Task Force

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<th># of Companies Filed RBC</th>
<th>% of RBC Companies</th>
<th>Total R0</th>
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<td>18,917</td>
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</table>

Source: NAIC Financial Database

© 2020 National Association of Insurance Commissioners
MEMORANDUM

To: Thomas Botsko, Chair, Property and Casualty Risk-Based Capital (E) Working Group
Members of the Property and Casualty Risk-Based Capital (E) Working Group

From: Charles Therriault, Director, NAIC Securities Valuation Office

Cc: Dan Daveline, Director, NAIC Financial Regulatory Services
Julie Gann, Assistant Director, NAIC Financial Regulatory Services
Eva Yeung, Sr. P/C RBC Analyst/Technical Lead, NAIC Financial Regulatory Services

Date: February 27, 2020

Re: Reinsurer financial strength ratings

The staff supporting the Property and Casualty Risk-Based Capital (E) Working Group inquired about the Security Valuation Office’s (SVO) access to financial strength ratings for reinsurers that are referenced in the Credit for Reinsurance Model Regulation (MDL-786). The SVO receives ratings data feeds from nine credit rating providers (CRP), nationally recognized statistical ratings organizations (NRSRO) that supply the NAIC with credit ratings data. This list of CRPs includes the four rating agencies identified as assigning acceptable financial strength ratings in MDL-786: Standard & Poor’s; Moody’s Investors Service; Fitch Ratings; and A.M. Best Company. The SVO receives issuer level financial strength ratings from these CRPs but that data is not currently stored within any NAIC system or database.

The NAIC uses credit rating data in its processes for investment securities but those ratings cannot be revealed to external parties outside of the NAIC, including NAIC members. This licensing restriction would also apply to any usage of the financial strength ratings for the Working Group. Similarly, external vendors sometimes report ratings, including financial strength ratings, within their applications and permit that information to be downloaded by a user into Microsoft’s Excel but there are often very strict licensing restrictions that limit the usage and redistribution of that ratings data by a user of the application that would prevent the NAIC from utilizing this data for any NAIC process.

The NAIC can initiate a project to utilize the data the SVO currently receives but does not store to create the reinsurer equivalent of an NAIC Designation; possibly, calling it a NAIC Reinsurer Designation. The SVO could administer such a process, as the only NAIC department licensed to access ratings data, and publish the results under its compilation instructions in a system like AVS+. The NAIC would be unable to share the actual financial strength ratings but there would be an NAIC measure of financial risk. This project would require support from the Working Group, the Capital Adequacy (E) Task Force and the Valuation of Securities (E) Task Force along with approval for funding through an NAIC fiscal request to the NAIC Executive Committee/Internal Administration (EX1) Subcommittee. It is likely that an NAIC technology project could easily require $300-500+...
thousand and there may be additional licensing costs from the rating agencies. A more detailed requirements
gathering, and cost estimate effort could be initiated if the Working Group receives approval to pursue this
project.

This would be a substantial cost to the NAIC and, given other NAIC priorities, it may be necessary for this project
to be self-funded through some type a fee structure that allows the NAIC to recoup its initial and ongoing costs
from the industry, as generally such self-funded projects are more likely to be approved by the NAIC Executive
Committee/Internal Administration (EX1) Subcommittee.
Based on the data, about half the companies that were flagged as significant CAT risk writers have an increase of greater than 10% (percent not points) in RBC ratio by eliminating the 3% credit risk load. About 9% of the remaining companies that write CAT risk also have an increase in RBC ratio of greater than 10%. In neither case does a company in action level move out of action level because of the change.

The 3% overall basic operational risk charge added to the formula last year was set at that level in recognition that there are other operational risk charges embedded in the RBC formulas. However, it did recognize specific operational charges in the LRBC formula (C-4a) and offset for those charges. Like C-4a, it is not clear that the entire 3% credit risk charge included in the RCAT risk factor is all op risk. Some reasonable portion should be retained for other risks such as contractual, dispute and legal risks. Therefore, I would say that the PRBCWG did decide to adjust the factor the members could consider reducing the load from 3% to something smaller in line with the following comments.

The notion of duplication of the op risk charge is based on duplication caused by the addition of a basic op risk charge that was added to all the RBC formulas. Therefore it seems that any reduction in RBC for duplication should be limited to the amount of the basic op risk charge as was done for Life RBC. Particularly for significant cat risk writers, changing the risk factor from 4.8% to 1.8% for cat risk (or for that matter even 2.8%) results in a much greater reduction to required RBC than simply eliminating the basic op risk charge. Going this route would seem to be akin to eliminating the business risk charge in the LRBC formula rather than essentially using the greater of the C-4a charge and the basic op risk charge. If the idea is to remove duplication, limiting the reduction in RBC to the amount of basic op risk would be the way to go for P/C. However, that would be more difficult to would into the P/C formula due to the cat risk credit risk charge being run through covariance.

As an alternative, in the aggregate a reduction in the Cat credit risk charge to 3.8% from 4.8% would achieve approximately a 3% reduction in overall RBC before op risk for the cohort of large cat writers (See chart below). A 3.9% factor would be just about equal to a 3% overall reduction.
## Contingent Credit Risk Analysis — Lou Felice

<table>
<thead>
<tr>
<th></th>
<th>Decrease in Current RBC Regmt After Cov before Basic Op Risk</th>
<th>Revised Basic Operational Risk</th>
<th>Decrease in RBC in Excess of Basic Op risk</th>
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<tbody>
<tr>
<td>Group of Top RCAT writers @1.8% Factor</td>
<td>146,265,287</td>
<td>41,966,186</td>
<td>(104,399,101)</td>
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<tr>
<td>Decrease in RBC as % of RBC After Cov before Op risk</td>
<td>9.50%</td>
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<tr>
<td>Group of Top RCAT writers @3.8% Factor</td>
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<td>7,037,682,309</td>
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<td>Decrease in RBC as % of RBC After Cov before Op risk</td>
<td>0.32%</td>
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<td>All other RCAT writers @3.8% Factor</td>
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<td>6,771,385,909</td>
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<tr>
<td>Decrease in RBC as % of RBC After Cov before Op risk</td>
<td>0.12%</td>
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Consideration of the Operational Risk Charge Components of RBC R3 & Rcat

Overview: The operational risk charge had been under development by the Operational Risk Subgroup since 2013, and the original proposal was to apply an explicit 3% operational risk factor to the greater of net premiums or net reserves, with a possible excessive growth risk component as well. Ultimately this “factor applied to net-proxies” approach was abandoned, and the existing excessive risk growth charge in R4 & R5 was retained. Beginning with 2018 year-end reporting, the Capital Adequacy Task Force implemented a 3% capital add-on charge, applied to overall RBC after covariance.

Part of the rationale for selecting 3% (which equates to a lower operational risk capital charge than in certain non-U.S. jurisdictions), was that many components of US RBC already implicitly contemplate operational risk.

However, contemporaneously with the development of the explicit operational risk “factor applied to net proxies” charge; the P&C RBC Working Group was developing an explicit operational risk charge applied to ceded reinsurance recoverable in RBC R3 credit risk. This was being done to ensure that the targeted 3% factor (being discussed by the Operational Risk Subgroup) would be applied to reinsurance; because a “net proxies” approach, by definition, would “net-out” ceded reinsurance.

When the “net proxies” approach was abandoned in favor of an after-covariance capital add-on, the explicit operational risk charge in R3 had already been incorporated into the credit risk factors applicable to reinsurance recoverable. This results in a double assessment of a charge for operational risk that gets applied to reinsurance recoverable.

This explicit operational risk charge is inadvertently being applied again in Rcat because the reinsurance contingent credit risk component of Rcat borrows from the R3 credit risk factor, which is primarily comprised of operational risk. Application of the 3% operational risk factor in Rcat is particularly burdensome because Rcat is calibrated at the 1-in-100-year modeled loss level.

R3 Reinsurance Credit Risk Charge: Beginning with 2018 year-end reporting, the Capital Adequacy Task Force implemented a new risk-based approach for assessing the credit risk charge applicable to reinsurance recoverable. This approach replaced the previous 10% factor that applied across the board to all reinsurance recoverable. The basis of this new charge borrowed from the asset credit risk factors for reinsurance recoverable used by Standard and Poor’s in their capital model. These factors are derived from historical credit default experience associated with different reinsurer financial strength rating categories. Table 1 below, demonstrates how the
current R3 factors were derived and how an explicit operational risk cushion was applied to mirror the “factor applied to net-proxies” approach.

Table 1—How the R3 Factors were Derived:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Secure 1</th>
<th>Secure 2</th>
<th>Secure 3</th>
<th>Secure 4</th>
<th>Secure 5</th>
<th>Vulnerable 6 or NR</th>
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<tbody>
<tr>
<td>1</td>
<td>S&amp;P Credit Risk Asset Factors Based on Historical Reinsurer Defaults</td>
<td>0.6%</td>
<td>1.1%</td>
<td>1.8%</td>
<td>1.8%</td>
<td>4.1%</td>
<td>14.9% to 50%</td>
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<tr>
<td>2</td>
<td>Adjusted S&amp;P Factors</td>
<td>0.6%</td>
<td>1.1%</td>
<td>1.8%</td>
<td>2.3%</td>
<td>4.1%</td>
<td>11.0%</td>
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<td>3</td>
<td>Explicit Factor for “Other Than Credit”/Reinsurance Operational Risk</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>4</td>
<td>R3 Factors for Uncollateralized Amounts (Item 2 + Item 3)</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.3%</td>
<td>7.1%</td>
<td>14.0%</td>
</tr>
<tr>
<td>5</td>
<td>Factor Credit for Collateral (MBTs, LOCs &amp; Other Trust Funds, etc.)</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.3%</td>
<td>2.1%</td>
<td>9.0%</td>
</tr>
<tr>
<td>6</td>
<td>R3 Factors for Collateralized Amounts (Item 4 - Item 5)</td>
<td>3.6%</td>
<td>4.1%</td>
<td>4.8%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

(See the Appendix for more detail on S&P’s methodology)

Some stakeholders have commented in the past that the previous 10% credit risk charge contemplated “other than credit risk” to address things like dispute risk and adverse reserve development. Therefore, there is a stated rationale for keeping some additional amount of operational risk cushion in R3.

However, other aspects of R3 and the Schedule F Penalty already address many of these same concerns. For instance, 20% penalties are assessed on amounts in dispute, reinsurance recoverable over 90 days past due, and reinsurance recoverable from slow paying reinsurers. After all the Schedule F penalties are applied, R3 further “stresses”, or grosses-up by 20%, the reinsurance recoverable before applying the credit risk charges to further account for dispute risk, commutation risk, and overreliance on reinsurance, etc.

Some stakeholders have noted that even if an explicit operational risk charge is being assessed, essentially twice; making a change to R3 would not be all that material to RBC overall. However, addressing this issue does not involve extensive project and time resources on the part of regulators or industry and is as simple as adjusting the explicit operational risk factor shown in Item 3 in the table above.

**R3 Proposal:** Consider eliminating or reducing the 3% operational risk cushion as it is redundant to the 20% stressing, the Schedule F Penalties, and the 3% capital add-on; which already address the various elements of operational risk related to reinsurance credit risk.
**Rcat Reinsurance Contingent Credit Risk Charge (RCCRC):** Beginning with 2017 year-end reporting, the Capital Adequacy Task Force implemented a new Catastrophe Risk Charge (Rcat) based on 1-in-100-year modeled losses, separately calculated for the hurricane and earthquake perils. Rcat is first applied to gross losses, but credit is given for modeled reinsurance recoverable. So, in practice, it is a net-of reinsurance charge. **There was never any intention to apply an explicit operational risk charge to Rcat. In fact, there is no element of Rcat that applies any operational risk charge to gross modeled losses.**

However, because Rcat contemplates modeled reinsurance recoverable, it was decided to include a reinsurance contingent credit risk charge component. Rcat borrows from the credit risk factor matrix shown in Table 1 above.

**How the RCCRC Factor was Derived:**

The contingent credit risk factor is 4.8%, which is the same as the uncollateralized factor for the Secure 3 ratings category in the R3 charge above. As a practical matter, catastrophe risk is not ceded to reinsurers with ratings below Secure 4 and the vast majority of CAT risk is ceded to reinsurers rated Secure 2 or 3.

About 63% of this 4.8% credit risk factor is attributable to another explicit, yet unintentional assessment of an operational risk charge on reinsurance recoverable; which again, was not the purpose of Rcat or the RCCRC. Stated another way, a 4.8% RCCRC is 2.66 times higher than the indicated credit risk.

Further, Rcat is different from other components of RBC because it is calibrated at a 1-in-100-year modeled loss level. Applying a 4.8% credit risk charge in R3 is akin to assessing the charge on an “average annual loss” type of balance. However, applying it in Rcat assesses the charge on a 1-in-100-year modeled balance. This calibration issue results in a disproportionate modeled reinsurance recoverable that can far exceed the targeted operational risk capital add-on charge.

**Table 2,** on the following page, shows the results of a NAIC staff analysis on the impact of the operational risk component of the RCCRC to a group of Florida market specialist (predominately writing hurricane exposed risks) relative to all others.

The analysis shows that “about half the companies that were flagged as significant CAT risk writers have an increase of greater than 10% (percent not points) in RBC ratio by eliminating the 3% credit risk load. About 9% of the remaining companies that write CAT risk also have an increase in RBC ratio of greater than 10%. In neither case does a company in action level move out of action level because of the change.”

Stated another way, the operational risk component of the RCCRC is producing after covariance capital requirements that are more than 3 times the capital add-on target of 3% after covariance for these Florida market specialists.
### Table 2: NAIC Staff Analysis of Op Risk in RCCRC for FL Specialists vs. All Writers

<table>
<thead>
<tr>
<th>Group of Top RCAT writers @ 1.8% Factor</th>
<th>Decrease in Current RBC Reqmt After Cov Before Basic Op Risk</th>
<th>Revised Basic Operational Risk</th>
<th>Decrease in RBC in Excess of Basic Op Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>146,265,287</td>
<td>41,866,186</td>
<td>-(104,399,101)</td>
</tr>
<tr>
<td>Decrease in RBC as % of RBC After Cov Before Op Risk</td>
<td>9.50%</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>-(8,659,021)</td>
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<tr>
<td>Decrease in RBC as % of RBC After Cov Before Op Risk</td>
<td>0.12%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rcat-RCCRC Proposal:** Consider completely, eliminating the 3% Operational Risk cushion from the RCCRC. Rcat was never intended to address operational risk. It is only being applied (inadvertently) with respect to the reinsurance component of the charge and is not applied at all in the modeled loss component. Further, the calibration of an explicit 3% operational risk charge to the reinsurance recoverable balances in Rcat is not at all comparable to R3 and causes significant overstatement of RBC for catastrophe-exposed writers that utilize reinsurance to diversify their risk.
Appendix

Standard and Poor’s Explanation of Asset Charge for Reinsurance Recoverable

Source: standardandpoors.com

Other Asset Credit Risk Charges

Reinsurance receivables plus reinsurance recoveries, less reinsurance deposits and LOCs

The risk inherent in reinsurance recoverable is often the largest asset-based risk for P/C companies; particularly those writing longer tailed lines of business. In that case, the primary company will estimate and record a reserve for notified outstanding claims and incurred but not reported claims and will offset any reinsurance arrangement that it believes will bear a portion of those claims. However, the reinsurer will not settle these potential obligations until the insurers have settled the gross claim, which may be a lengthy period. For this reason, Standard & Poor’s selected a single tenor of 10 years for nonlife insurance companies in computing the credit default factor. In the U.S., because this lag phenomenon in the life insurance sector is substantially reduced, a single tenor of one year was applied for life insurance companies.

Methodology for computing default factors. A single tenor of 10 years across the rating range for nonlife insurers and one year across the rating range for life insurers was selected. The factor applied to the recoverables from reinsurers will be subject to the specific reinsurer rating. To the extent that letters of credit from a financially secure financial institution or suitable trust assets are available to offset the recoverability risk, credit for up to 100% of the collateral could be used to offset the reinsurance recoverable credit risk charge. A surcharge of 20% on reinsurance recoverable balances related to asbestos and environmental pollution losses will be computed to reflect the prospective impact on capital due to disputed coverage. This surcharge will not apply to intragroup reinsurance recoverable where the reinsurer is highly rated.

<table>
<thead>
<tr>
<th>Reinsurance Credit Risk Factors</th>
<th>Reinsurance recoverable</th>
</tr>
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<tr>
<td></td>
<td>AAA</td>
</tr>
<tr>
<td>AAA rated reinsurer</td>
<td>0.8</td>
</tr>
<tr>
<td>AA rated reinsurer</td>
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</tr>
<tr>
<td>A rated reinsurer</td>
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</tr>
<tr>
<td>BBB rated reinsurer</td>
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</tr>
<tr>
<td>BB rated reinsurer</td>
<td>18.4</td>
</tr>
<tr>
<td>B rated reinsurer</td>
<td>34.1</td>
</tr>
<tr>
<td>CCC+ rated reinsurer</td>
<td>55.5</td>
</tr>
<tr>
<td>Nonrated reinsurer</td>
<td>40.7</td>
</tr>
<tr>
<td>Regulatory supervision</td>
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</table>
### 2019 P&C RBC - Comparison of Action Levels

**Current RBC Action Levels vs Alternative RBC Action Level**

Alternative RBC: a) 2% Reduction on Reinsurance Recoverable RBC Charge for Reinsurance Designation Equivalent 1 to 5 and 4% Increase on Uncollateralized Reinsurance Recoverable RBC charge for Designation Equivalent 7; and b) 2.5% Reduction on Catastrophe Contingent Credit Risk Charge

(Excluding Companies with Negative TAC)

<table>
<thead>
<tr>
<th></th>
<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
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<td>2019 RBC Action Level under Alternative RBC Formula</td>
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<td>17</td>
<td>2,418</td>
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(Companies with TAC Between $0 and $5 Million)

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(Companies with TAC Between $25 Million and $75 Million)

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<td>1</td>
<td>1</td>
<td>783</td>
<td>789</td>
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2019 P&C RBC - Comparison of Action Levels
Current RBC Action Levels vs Alternative RBC Action Level

Alternative RBC: a) 2% Reduction on Reinsurance Recoverable RBC Charge for Reinsurance Designation Equivalent 1 to 5 and 4% Increase on Uncollateralized Reinsurance Recoverable RBC charge for Designation Equivalent 7; and b) 2.5% Reduction on Catastrophe Contingent Credit Risk Charge

### (Companies with TAC Between $75 Million and $250 Million)

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<th>CAL</th>
<th>Trend Test</th>
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### (Companies with TAC Between $250 Million and $1 Billion)

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### (Companies with TAC Greater Than $1 Billion)

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</table>
Distributions of Percentage Change in 2019 RBC Ratios by Company Size under Alternative RBC Formula

Alternative RBC: a) 2% Reduction on Reinsurance Recoverable RBC Charge for Reinsurance Designation Equivalent 1 to 5 and 4% Increase on Uncollateralized Reinsurance Recoverable RBC charge for Designation Equivalent 7; and b) 2.5% Reduction on Catastrophe Contingent Credit Risk Charge

<table>
<thead>
<tr>
<th>RBC Ratio Change \ TAC Range</th>
<th>$0 to $5</th>
<th>$5 to $25</th>
<th>$25 to $75</th>
<th>$75 to $250</th>
<th>$250 to $1,000</th>
<th>Over $1,000</th>
<th>Total</th>
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<td>Less than -50%</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>-50% to -25%</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>-25% to -15%</td>
<td>1</td>
<td>1</td>
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<td>-15% to -5%</td>
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<td>-5% to 5%</td>
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<td>466</td>
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<td>232</td>
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<td>27</td>
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<td>15</td>
<td>22</td>
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<tr>
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<td>25</td>
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<td>25</td>
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<td>800</td>
<td>589</td>
<td>424</td>
<td>253</td>
<td>143</td>
<td>2,463</td>
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Comparison of 2019 RBC Charge under Alternative RBC Formula

Alternative RBC: a) 2% Reduction on Reinsurance Recoverable RBC Charge for Reinsurance Designation Equivalent 1 to 5 and 4% Increase on Uncollateralized Reinsurance Recoverable RBC charge for Designation Equivalent 7; and b) 2.5% Reduction on Catastrophe Contingent Credit Risk Charge

<table>
<thead>
<tr>
<th>TAC Range ($ Million)</th>
<th>$0 to $5</th>
<th>$5 to $25</th>
<th>$25 to $75</th>
<th>$75 to $250</th>
<th>$250 to $1,000</th>
<th>Over $1,000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>R3 - Current</td>
<td>40,657,812</td>
<td>227,414,773</td>
<td>642,691,617</td>
<td>1,455,147,905</td>
<td>1,902,090,313</td>
<td>5,015,693,293</td>
<td>9,283,695,713</td>
</tr>
<tr>
<td>Percentage Change</td>
<td>1.6%</td>
<td>-21.2%</td>
<td>-17.7%</td>
<td>-25.8%</td>
<td>-20.1%</td>
<td>-24.6%</td>
<td>-23.2%</td>
</tr>
<tr>
<td>R4 - Current</td>
<td>71,314,651</td>
<td>908,411,736</td>
<td>2,504,165,378</td>
<td>7,775,109,508</td>
<td>19,092,321,089</td>
<td>91,925,436,366</td>
<td>122,776,758,728</td>
</tr>
<tr>
<td>Percentage Change</td>
<td>-2.1%</td>
<td>-3.0%</td>
<td>-2.2%</td>
<td>-2.6%</td>
<td>-1.7%</td>
<td>-1.3%</td>
<td>-1.5%</td>
</tr>
<tr>
<td>R3 - Alternative</td>
<td>41,293,532</td>
<td>179,299,453</td>
<td>528,799,617</td>
<td>1,080,338,295</td>
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<td>3,781,627,573</td>
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<td>Percentage Change</td>
<td>-2.5%</td>
<td>-2.4%</td>
<td>-2.1%</td>
<td>-1.7%</td>
<td>-1.4%</td>
<td>-1.2%</td>
<td>-1.3%</td>
</tr>
<tr>
<td>R4 - Alternative</td>
<td>69,851,251</td>
<td>881,515,196</td>
<td>2,448,042,358</td>
<td>7,574,026,038</td>
<td>18,767,719,039</td>
<td>90,699,315,326</td>
<td>120,440,469,208</td>
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<td>Percentage Change</td>
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<td>-2.4%</td>
<td>-2.1%</td>
<td>-1.7%</td>
<td>-1.4%</td>
<td>-1.2%</td>
<td>-1.3%</td>
</tr>
<tr>
<td>RC - Current</td>
<td>5,064,514</td>
<td>316,769,245</td>
<td>1,152,242,745</td>
<td>2,463,497,426</td>
<td>5,753,797,112</td>
<td>43,954,785,122</td>
<td>53,646,156,164</td>
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<td>-19.8%</td>
<td>-23.0%</td>
<td>-13.7%</td>
<td>-6.9%</td>
<td>-4.0%</td>
<td>-4.0%</td>
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<tr>
<td>Percentage Change</td>
<td>-13.9%</td>
<td>-19.8%</td>
<td>-23.0%</td>
<td>-13.7%</td>
<td>-6.9%</td>
<td>-4.0%</td>
<td>-4.0%</td>
</tr>
<tr>
<td>Percentage Change</td>
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<td>-4.0%</td>
<td>-4.8%</td>
<td>-3.4%</td>
<td>-1.4%</td>
<td>-0.6%</td>
<td>-0.9%</td>
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</table>
### 2019 P&C RBC - Comparison of Action Levels

**Current RBC Action Levels vs Alternative RBC Action Level**

Alternative RBC: a) 1% Reduction on Reinsurance Recoverable RBC Charge for Reinsurance Designation Equivalent 1 to 5 and 4% Increase on Uncollateralized Reinsurance Recoverable RBC charge for Designation Equivalent 7; and b) 1% Reduction on Catastrophe Contingent Credit Risk Charge

(Excluding Companies with Negative TAC)

<table>
<thead>
<tr>
<th>2019 RBC Action Level under Current RBC Formula</th>
<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
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<tbody>
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<td></td>
<td>3</td>
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<td>RAL</td>
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<td>6</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>CAL</td>
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<td></td>
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<td>7</td>
<td>1</td>
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<td>2,422</td>
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<td>2</td>
<td>8</td>
<td>10</td>
<td>17</td>
<td>2,418</td>
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(Companies with TAC Between $0 and $5 Million)

<table>
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<th>2019 RBC Action Level under Current RBC Formula</th>
<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
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<td></td>
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<td></td>
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<td>CAL</td>
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<td>1</td>
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<tr>
<td>Trend Test</td>
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(Companies with TAC Between $5 Million and $25 Million)

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<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
</tr>
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<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>RAL</td>
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<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>CAL</td>
<td>1</td>
<td>6</td>
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<td></td>
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<td>3</td>
<td>6</td>
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<td>800</td>
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(Companies with TAC Between $25 Million and $75 Million)

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<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
</tr>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ACL</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RAL</td>
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<td></td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CAL</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Trend Test</td>
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<td></td>
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<td>1</td>
<td>1</td>
<td>3</td>
<td>583</td>
<td>589</td>
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### 2019 P&C RBC - Comparison of Action Levels

**Current RBC Action Levels vs Alternative RBC Action Level**

Alternative RBC: a) 1% Reduction on Reinsurance Recoverable RBC Charge for Reinsurance Designation Equivalent 1 to 5 and 4% Increase on Uncollateralized Reinsurance Recoverable RBC charge for Designation Equivalent 7; and b) 1% Reduction on Catastrophe Contingent Credit Risk Charge

(Companies with TAC Between $75 Million and $250 Million)

<table>
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<th>2019 RBC Action Level under Current RBC Formula</th>
<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
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(Companies with TAC Between $250 Million and $1 Billion)

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<th>2019 RBC Action Level under Current RBC Formula</th>
<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
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<th>Total</th>
</tr>
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<td>1</td>
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(Companies with TAC Greater Than $1 Billion)

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<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test No</td>
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</tr>
<tr>
<td>Action Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>143</td>
<td>143</td>
</tr>
</tbody>
</table>
Distributions of Percentage Change in 2019 RBC Ratios by Company Size under Alternative RBC Formula

Alternative RBC: a) 1% Reduction on Reinsurance Recoverable RBC Charge for Designation Equivalent 1 to 5 and 4% Increase on Uncollateralized Reinsurance Recoverable RBC charge for Designation Equivalent 7; and
b) 1% Reduction on Catastrophe Contingent Credit Risk Charge

<table>
<thead>
<tr>
<th>RBC Ratio Change \ TAC Range</th>
<th>$0 to $5</th>
<th>$5 to $25</th>
<th>$25 to $75</th>
<th>$75 to $250</th>
<th>$250 to $1,000</th>
<th>Over $1,000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than -50%</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>-50% to -25%</td>
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<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>-25% to -15%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
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<td>5</td>
</tr>
<tr>
<td>-15% to -5%</td>
<td>2</td>
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<td>0</td>
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<td>2</td>
<td>0</td>
<td>13</td>
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<td>-5% to 5%</td>
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<td>508</td>
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<td>246</td>
<td>142</td>
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<td>44</td>
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<td>1</td>
<td>125</td>
</tr>
<tr>
<td>15% to 25%</td>
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<td>29</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>69</td>
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<td>25% to 50%</td>
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<tr>
<td>Greater than 50%</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>254</td>
<td>800</td>
<td>589</td>
<td>424</td>
<td>253</td>
<td>143</td>
<td>2,463</td>
</tr>
</tbody>
</table>

Comparison of 2019 RBC Charge under Alternative RBC Formula

Alternative RBC: a) 1% Reduction on Reinsurance Recoverable RBC Charge for Designation Equivalent 1 to 5 and 4% Increase on Uncollateralized Reinsurance Recoverable RBC charge for Designation Equivalent 7; and
b) 1% Reduction on Catastrophe Contingent Credit Risk Charge

<table>
<thead>
<tr>
<th>TAC Range ($ Million)</th>
<th>$0 to $5</th>
<th>$5 to $25</th>
<th>$25 to $75</th>
<th>$75 to $250</th>
<th>$250 to $1,000</th>
<th>Over $1,000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>R3 - Current</td>
<td>40,657,812</td>
<td>227,414,773</td>
<td>642,691,617</td>
<td>1,455,147,905</td>
<td>1,902,090,313</td>
<td>5,015,693,293</td>
<td>9,283,695,713</td>
</tr>
<tr>
<td>R3 - Alternative</td>
<td>43,761,192</td>
<td>207,363,223</td>
<td>605,711,667</td>
<td>1,287,302,150</td>
<td>1,726,752,908</td>
<td>4,424,261,963</td>
<td>8,295,153,103</td>
</tr>
<tr>
<td>Percentage Change</td>
<td>7.6%</td>
<td>-8.8%</td>
<td>-5.8%</td>
<td>-11.5%</td>
<td>-9.2%</td>
<td>-11.8%</td>
<td>-10.6%</td>
</tr>
<tr>
<td>R4 - Current</td>
<td>71,314,651</td>
<td>908,411,736</td>
<td>2,504,165,378</td>
<td>7,775,109,508</td>
<td>19,092,312,089</td>
<td>91,925,436,366</td>
<td>122,776,758,728</td>
</tr>
<tr>
<td>R4 - Alternative</td>
<td>71,685,611</td>
<td>895,894,536</td>
<td>2,478,333,358</td>
<td>7,678,865,123</td>
<td>18,934,687,974</td>
<td>91,337,200,716</td>
<td>121,395,667,318</td>
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<td>-0.7%</td>
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<tr>
<td>Rcat - Current</td>
<td>5,064,514</td>
<td>316,769,245</td>
<td>1,152,242,745</td>
<td>2,463,497,426</td>
<td>5,753,797,112</td>
<td>43,954,785,122</td>
<td>53,646,156,164</td>
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<tr>
<td>Rcat - Alternative</td>
<td>4,782,889</td>
<td>293,701,197</td>
<td>1,046,268,627</td>
<td>2,328,811,999</td>
<td>5,595,320,599</td>
<td>43,528,302,594</td>
<td>52,797,187,904</td>
</tr>
<tr>
<td>Percentage Change</td>
<td>-5.6%</td>
<td>-7.3%</td>
<td>-9.2%</td>
<td>-5.5%</td>
<td>-2.8%</td>
<td>-1.0%</td>
<td>-1.6%</td>
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<tr>
<td>RBC After Covariance (incl. Oper Risk) - Alternative</td>
<td>190,593,202</td>
<td>1,986,219,767</td>
<td>5,323,930,140</td>
<td>14,556,136,834</td>
<td>35,669,112,661</td>
<td>282,210,554,439</td>
<td>339,936,007,043</td>
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<tr>
<td>Percentage Change</td>
<td>1.5%</td>
<td>-1.6%</td>
<td>-1.7%</td>
<td>-1.5%</td>
<td>-0.7%</td>
<td>-0.3%</td>
<td>-0.4%</td>
</tr>
</tbody>
</table>
TO: Phil Vigliaturo, chair representative of Steve Kelley, Chair, (MN), of the Casualty Actuarial and Statistical (C) Task Force  
Tom Botsko, OH), Chair of the Property and Casualty Risk Based Capital Working Group  
FROM: Dale Bruggeman (OH), Chair of the Statutory Accounting Principles (E) Working Group  
DATE: January 7, 2020  
RE: Ref #2019-49: Retroactive Reinsurance Exception

This referral has been provided to notify the Casualty Actuarial and Statistical (C) Task Force of a current Statutory Accounting Principles (E) Working Group agenda item to allow for ongoing coordination. This agenda item is to address a request from the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries Working Group. The request, which was also received by the Task Force, was to clarify the accounting and reporting for retroactive reinsurance which meets the SSAP No. 62R—Property and Casualty Reinsurance exceptions to be accounted for as prospective reinsurance. The comment deadline for the public exposure is January 31, 2020, but the Working Group is primarily notifying the Task Force of the project and requesting volunteers.

During the 2019 Fall National Meeting, the Statutory Accounting Principles (E) Working Group exposed agenda item 2019-49: Retroactive Reinsurance Exception which includes a request for comments and for industry and regulator volunteers to assist with developing guidance. The goal is to clarify both the accounting and reporting for retroactive contracts which are accounted for prospectively, including:

- Both the ceding entity and assuming entity, where both are members of the same group and are consolidated in the same Combined Annual Statement.  
- The reporting method to be used if the ceding entity and assuming entity are not in the same group.

Comments are specially requested regarding the preferred approaches to reporting and the advantages and disadvantages to each approach being used, including both the Schedule P (and related loss analysis) and risk-based capital impacts.

Because the items under discussion can have impact on information reported in Schedule P, the Working Group directed notification of the exposure to seek your input. Please contact, Robin Marcotte, NAIC staff Rmarcotte@naic.org of the Statutory Accounting Principles (E) Working Group with any questions or volunteers.

Cc: Julie Gann, Robin Marcotte, Fatima Sediqzad, Jake Stultz, Jim Pinegar, Kris DeFrain, Eva Yeung; Jane Barr
February 27, 2020

Dale Bruggeman, Chair
Statutory Accounting Principles (E) Working Group
National Association of Insurance Commissioners

Via email

Dear Mr. Bruggeman:

I am writing on behalf of the American Academy of Actuaries\(^1\) Committee on Property and Liability Financial Reporting (COPLFR). We are following up on previous correspondence regarding Schedule P Instructions for Retroactive Reinsurance between Affiliates and Non-Affiliates.

COPLFR appreciates that the Statutory Accounting Principles Working Group (SAPWG) is looking into certain inconsistencies that were identified in our May 21, 2019, letter to you. In July, Julie Lederer, acting in her capacity as a member of the Casualty Actuarial and Statistical (C) Task Force, posed several questions about specific details in our initial comment letter. Her comments and COPLFR’s replies are presented here.

**Julie Lederer’s Comment**

1. I’m not sure what Allianz/Allianz Re agreement the letter is referring to. The letter suggests that this agreement was enacted in 2015 and that the accounting changed between year-ends 2015 and 2016, but Allianz Re’s 2018 MD&A (which is said to be included as an attachment to COPLFR’s letter but is not) suggests that the agreements between Allianz and Allianz Re weren’t enacted until 2016. Allianz Re did assume retroactive business from a different entity, Fireman’s Fund, in 2015:

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
a. There’s hardly any workers comp data in Allianz’s 2015 Schedule P. There’s a lot of WC data at year-end 2016, which appears to be due to the addition of Firemen’s Fund to the pooling agreement.

b. When I compare Allianz Re’s 2015 and 2016 Schedule Ps, I don’t see major changes. There is significant assumed premium reported in CY 2015 in both statements, and both statements show assumed reserves only for AYs 2012 and prior. I think this is related to Allianz Re’s transaction with FFIC (as mentioned in the MD&A above), not with Allianz.

COPLFR’s Response

The May 21, 2019, COPLFR letter is referring to the July 1, 2015, reinsurance agreement between FFIC and Allianz Reinsurance America (“Allianz Re”), where Allianz Re agreed to reinsure certain workers’ compensation (WC) and construction defect liabilities. The 2015 Schedule P, Part 1 of Allianz Re (page 4 of the May 21 letter PDF) shows $1.1 billion of 2015 accident year direct and assumed WC earned premium, presumably this Loss Portfolio Transfer. The 2016 Schedule P of Allianz Global Risk US Ins Co. (“Allianz or FFIC”) (page 7 of the May 21 letter PDF) shows $1.1 billion of 2015 accident year WC ceded earned premium, about equal to the assumptions of the Allianz Re premium discussed in the prior sentence. Allianz Global Risk US is synonymous with FFIC, as we understand it.

In our May 21, 2019, letter, we did state that “Initially, as of December 31, 2015, Allianz included all of the ceded losses in accident year (‘AY’) 2015.” We did only include the 2016 Allianz Schedule P; it would have been clearer to include the 2015 Allianz Schedule P as well, which we have attached as page 15 of the May 21 letter PDF (Attachment A). We agree with the comment in a. above that the additional data is due to the addition of Fireman’s Fund in the pooling agreement. Similarly, for b., we only show Allianz Re’s 2015 Schedule P.; we should additionally obtain Allianz Re’s 2016 Schedule P. We would not expect much change from the 2015 to 2016 Schedule P. Finally, our comments were not intended to suggest that the agreement between Allianz and Allianz Re was not enacted until 2016. We did, however, want to point out that as of Dec. 31, 2015, Allianz included all of the ceded losses in AY 2015, and in the following year, as of Dec. 31, 2016, Allianz recorded the ceded losses across the subject AYs 2012 and prior, as shown in Schedule P, Part 2 of Allianz (see page 8 of the PDF).

Julie Lederer’s Comment

2. I believe some of the attachments noted in the letter are missing:
   a. The letter includes Allianz Re’s 2015 Schedule P and Allianz’s 2016 Schedule P, but the text of the letter suggests that Allianz’s 2015 and 2016 Schedule Ps are included.
Regardless, it’s pretty hard to compare Allianz’s 2015 and 2016 Schedule Ps anyway, since Fireman’s Fund was added to the intercompany pool in 2016 and the historical AYs in Allianz’s 2016 Schedule P were adjusted accordingly.

When I compare Allianz Re’s 2015 and 2016 Schedule Ps, I don’t see major changes. The assumed premium is reported in CY 2015 in both statements, and both statements show assumed reserves only for AYs 2012 and prior.

Attachment A1SAO (Allianz Re’s 2018 SAO) is missing. I looked up the SAO myself and found this passage, which is rather vague, doesn’t name the counterparties, and doesn’t discuss the accounting for the agreements:

- The Company entered into several significant reinsurance arrangements during calendar years 2015 – 2018, some of which serve to mitigate the risk factors discussed above.
  1. Effective January 1, 2015, the Company entered into a reinsurance agreement whereby the Company assumed and agreed to reissue certain A&E reserves. Effective July 1, 2015, the Company further assumed and agreed to reissue certain WC and CD reserves.
  2. Effective January 1, 2016, the Company entered into a reinsurance agreement by which the Company ceded 50% of the Company’s carried A&E, WC, and CD liabilities acquired in 2015.
  Additionally, effective January 1, 2016, the Company entered into reinsurance agreements whereby the Company assumed and agreed to reissue certain Professional Healthcare Liabilities and certain A&E, GL-Excess and WC Liabilities. Effective July 1, 2016, the Company entered into another reinsurance agreement by which the Company assumed and agreed to reissue certain GL-Excess exposure.

Attachment A2MDA (Allianz Re’s 2018 MD&A) is missing. I looked this up myself and included a relevant passage above in item #1.

COPLFR’s Response

The attachments were in the Academy’s submission to the CASTF and were in the CASTF materials for a call in June, but apparently were omitted by NAIC staff in materials provided for subsequent calls and referrals.

We too consider the excerpt you provided to be vague. To help clarify the issue, we are attaching MD&As from 2015 and 2016 that include Fireman’s Fund Insurance Company in their scope (attachments B and C). One of the difficulties in tracking this issue is the series of actions taken by Allianz since 2015.

Julie Lederer’s Comment

3. GEICO’s Note 21, included as an attachment, is useful, but it’s not clear what we should take away from GEICO’s 2014 Schedule P alone. It might have been useful to attach the 2013 Schedule P as well. By comparing the 2013 and 2014 Schedule Ps, it’s clear that GEICO made significant cessions in 2014 and that these were spread among older AYs.

COPLFR’s Response

Our takeaway from GEICO’s 2014 Schedule P alone is that Schedule P, Part 2 (page 13 of the PDF) shows $3.3 billion of decreased development. This is a distortion as we understand it and is supported by the 2013 and 2014 comparison noted above. That distortion would carry over to the RBC filings of the respective entities (based on our understanding of the RBC formula and...
related instructions). Industry Schedule P data can also be distorted based on what is and is not included in industry totals based on the data scrubbing performed.

We believe that this additional information clarifies our original comments and will help SAPWG to move forward with its own analysis. If you have additional questions, contact Marc Rosenberg, the Academy’s senior casualty policy analyst, at 202-785-7865 or rosenberg@actuary.org.

Sincerely,

Kathy Odomirok, MAAA, FCAS
Chairperson, COPLFR
American Academy of Actuaries

3 attachments
TO: Phil Vigliaturo, chair representative of Steve Kelley, Chair, (MN), of the Casualty Actuarial and Statistical (C) Task Force  
Tom Botsko, Chair, (OH) Property and Casualty Risk-Based Capital (E) Working Group  
FROM: Dale Bruggeman (OH), Chair of the Statutory Accounting Principles (E) Working Group  
DATE: January 7, 2020  
RE: Ref #2019-40: Reporting of Installment Fees and Expenses  

This referral has been provided to notify the Casualty Actuarial and Statistical (C) Task Force and the Property and Casualty Risk-Based Capital (E) Working Group of a current Statutory Accounting Principles (E) Working Group exposure to allow for comments. The comment deadline for the public exposure is January 31, 2020, but the Working Group can provide additional time if needed.  

During the 2019 Fall National Meeting, the Statutory Accounting Principles (E) Working Group exposed agenda item 2019-40: Reporting of Installment Fees and Expenses. The exposure included a minor clarification noting that the current installment fee guidance in SSAP No. 53—Property and Casualty Contracts - Premium, which allows installment fees which meet the criteria to be excluded from premium and reported as other income, is to be narrowly applied. This clarification is being added because the Working Group was made aware of some writers (particularly non-standard writers) who were attempting to use the language to exclude a material portion of fees from premium.  

In addition, the Working Group requested input on whether to develop guidance that allows for different reporting on related installment fee expenses. Both the exposed language and the questions for exposure are excerpted on the following pages.  

Because the items under discussion can have impact on the loss ratios and information reported in Schedule P, the Working Group directed notification of the exposure to seek your input. Please contact NAIC staff of the Statutory Accounting Principles (E) Working Group with any questions.  

Cc: Julie Gann, Robin Marcotte, Fatima Sediqzad, Jake Stultz, Jim Pinegar, Kris DeFrain, Eva Yeung; Jane Barr
Issue 1 - Exposed the following revisions to the existing footnote in SSAP No. 53:

6. Written premiums for all other contracts shall be recorded as of the effective date of the contract. Upon recording written premium, a liability, the unearned premium reserve, shall be established to reflect the amount of premium for the portion of the insurance coverage that has not yet expired. Flat fee service charges on installment premiums1 (fees charged to policyholders who pay premiums on an installment basis rather than in full at inception of contract) are reported in the Other Income section of the Underwriting and Investment Exhibit as Finance and Service Charges. Flat fee service charges on installment premiums, which do not meet the requirements outlined in footnote 1 (e.g., policy may be cancelled for non-payment of fee or fee is refundable), shall be recorded as written premium on the effective date of the contract and subject to the unearned premium guidelines included in paragraph 8.

1 If the policyholder elects to pay an installment rather than the full amount or the full remaining balance, the policyholder is traditionally charged a flat fee service charge on the subsequent billing cycle(s). The amount charged is primarily intended to compensate the insurer for the additional administrative costs associated with processing more frequent billings and has no relationship to the amount of insurance coverage provided, the period of coverage, or the lost investment income associated with receiving the premium over a period of time rather than in a lump sum. As described, there is no underwriting risk associated with this service charge. If a policyholder does not pay the service charge, the policy is not cancelled (unlike non-payment of premium), but instead the policy is converted back to an annual pay plan. If a policyholder cancels coverage, the premium is returned but the service charge is not, as the service charge is not a part of premium. Note that this footnote on flat fee service charges on installment premium is intentionally narrow and specific and this guidance should not be applied to other fees or service charges. Clarification reporting of installment fees in of finance and service charges as other income should not be construed as having any bearing on whether such charges are subject to premium taxation, which remains an issue of state law and regulation.

Issue 2 – Exposed a request for regarding if incurred installment fee expenses should be allowed to be reported in other expenses?

As background note the following:

- SSAP No. 53 allows for installment fee income that meets specified criteria to be excluded from premium and reported as other income with finance and service charges, however it does not separately address the related installment fee expenses incurred by the reporting entity.
- The annual statement instructions provide that the expenses that are most commonly associated with installment expense such as postage printing and stationery are reported in underwriting expenses. These expenses and their related revenue are typically immaterial for most property and casualty products but are material for some nonstandard product writers. Having a mismatch between underwriting revenue / underwriting expenses and other revenue / other expenses can affect a reporting entity’s combined ratio as the combined ratio considers the losses, loss adjusting expenses and underwriting expenses.
- From a purely conceptual basis, it might be more consistent if the installment fee expenses are reported in other expenses. This is because it is a theoretical mismatch in the annual statement to report the installment fees in other revenue and have the related expenses in underwriting expenses. While this might be better theoretical match to have both the revenue and expense in the same category, NAIC staff notes that not having “other expenses” in the property and casualty income statement seems to be an intentional choice as there are no “other expense” reporting lines. Therefore an “other expense” would have to be reported as a contra revenue.
- If incurred installment fee expenses were to be reported in other expenses, a reporting location would need to be determined as there is not an annual statement line to accommodate such reporting. If it was reported, it would most like have to be report as a contra amount in “Aggregate Write-Ins for Miscellaneous Income” (not in underwriting expenses) as netting it in Finance and service charges would not provide transparency. Further, if reported, limitations would need to be determined – i.e. expenses not to exceed installment fee revenue.
Ultimately adoption of any such guidance would also require updates to the existing annual statement instructions.

Questions exposed:

a. Should the Working Group develop guidance to allow installment fee expenses associated with fees that are reported in other income according to the criteria in SSAP No. 53 be permitted reported in or as an expense in “Other Income?”

b. If included in Other Income, should the expense be classified as a contra revenue in or “Aggregate Write-Ins for Miscellaneous Income”?

c. Installment fees and expenses are often immaterial for property and casualty except for nonstandard writers. Comments are also requested on allowing diversity in reporting installment fee expenses (that is optional to report as other expense category of contra other revenue Aggregate Write-Ins for Miscellaneous Income,” particularly for immaterial amounts.
TO: Dale Bruggeman (OH), Chair of the Statutory Accounting Principles (E) Working Group
FROM: Tom Botsko, OH), Chair of the Property and Casualty Risk Based Capital Working Group
DATE: March 22, 2020
RE: Ref #2019-40: Reporting of Installment Fees and Expenses

Thank you for the opportunity to comment on the Statutory Accounting Principles (E) Working Group’s (“SAPWG”) exposure draft of changes proposed to Footnote 1 of SSAP No. 53 - Property Casualty Contracts–Premiums.

As you know, the Property and Casualty Risk Based Capital Working Group (P&C RBC WG) exists under the National Association of Insurance Commissioners (NAIC) Capital Adequacy Task Force and ultimately the Financial Condition (E) Committee. The Task Force’s mission is to evaluate and recommend appropriate refinements to capital requirements for all types of insurers. The Property and Casualty Risk Based Capital Working Group supports the Task Force from the Property and Casualty Risk Based Capital perspective. One of the charges for the Working Group is monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the Accounting Practices and Procedures Manual to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives. Our members include the state insurance regulators tasked with reviewing and maintaining the Property and Casualty Risk Based Capital formula in accordance with monitoring minimum capital requirements. As such, we have interest in the SAPWG’s proposed changes to Footnote 1 of SSAP No. 53 - Property Casualty Contracts–Premiums.

As noted in Footnote 1 of SSAP No. 53, an installment fee “has no relationship to the amount of insurance coverage provided, the period of coverage, or the lost investment income associated with receiving the premium over a period of time rather than in a lump sum” and “there is no underwriting risk” associated with an installment fee. As such, an installment fee is not related to the transfer of risk and should not be reported as premium. In addition, there may be other fees that may need to be considered as not related to the transfer of risk. These include, but not limited to Non-Sufficient Funds or Late Fees. However, there are other charges and fees that are related to the transfer of risk and that should be reported as premium, such as a policy fee. The members of P&C RBC WG support clarification that ensures fees and charges associated with the transfer of risk are reported as premium and that fees and charges not associated with the transfer of risk will not be reported as premium. This will help ensure that the minimum capital requirement appropriately reflects the risk of the company.

For these reasons, the members of P&C RBC WG support the revisions proposed to Footnote 1 of SSAP No. 53 as detailed in SAPWG’s Ref# 2019-40. We are also open to your recommendations for additional reporting categories for these fees.

Please contact, Eva Yeung, NAIC staff eyeung@naic.org of the Property and Casualty Risk-Based Capital (E) Working Group with any questions.

Cc: Julie Gann, Robin Marcotte, Fatima Sediqzad, Jake Stultz, Jim Pinegar, Eva Yeung

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MEMORANDUM

TO: Thomas Botsko (OH)
Chair of the Property Casualty Risk-Based Capital (E) Working Group

FROM: David Smith & Doug Stolte (VA)
Co-Chairs of the Restructuring Mechanisms (E) Subgroup

DATE: January 29, 2020

RE: Request for Input

The Financial Condition (E) Committee formed the Restructuring Mechanisms (E) Working Group and Restructuring Mechanisms (E) Subgroup in early 2019. The Subgroup has determined that its priority in addressing its charges is to develop best practices as it relates to reviewing and considering such transactions for approval. While the Subgroup intends to leverage existing practices used by international regulators and other practices proposed in the past for liability-based restructuring, addressing this priority charge is expected to take some time. Among other things, the Subgroup is also charged with the following:

Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff. Complete by the 2020 Fall National Meeting.

In order to be responsive to the RBC charge noted above, the Subgroup requests your Working Group to take the lead in addressing this charge. More specifically, as the subject matter experts of the Property Casualty RBC formula, you are best equipped to determine if changes should be made to the formula to better assess companies in runoff. As the issues and positions are identified, we ask that P&C RBC also to take the lead in coordinating with other RBC working groups including Life and Health.

We note that the above charge is for companies in run-off rather than for blocks of business only in run-off. The subgroup’s survey of states asked questions regarding the definition of run-off. These responses are shared with the Working Group on the following page for discussion.

As noted above, our charge has a due date of the 2020 Fall National Meeting; therefore to the extent you are unable to come to a conclusion prior to that date, please notify us and include in such a notification a more appropriate date under which you could make such a determination. From there, the Subgroup will request an extension based upon your suggestion.

Please contact me or NAIC staff for this project, Robin Marcotte rmarcotte@naic.org, if you have any questions.

Cc: Dan Daveline, Eva Yeung; Jane Barr

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1. Does your state have a definition for “Runoff Companies”?

   a. Yes – 4 states
   b. No – 29 states however, 4 provided responses.

<table>
<thead>
<tr>
<th>State</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Yes (none was provided). Comment in RBC it discusses running off or run off but not definition.</td>
</tr>
<tr>
<td>2.</td>
<td>Yes. There is no formal definition. It is understood to mean companies that, voluntary or not, have ceased writing premium except for mandatory renewals required by regulation in various states.</td>
</tr>
<tr>
<td>3.</td>
<td>Yes. Licensed companies that are no longer writing business and have no plans to write in the future.</td>
</tr>
<tr>
<td>4.</td>
<td>Yes. Under the state’s laws &quot;Run-off insurer&quot; means an insurer that: (i) Is domiciled in the state; (ii) Has liabilities under policies for property and casualty lines of business; (iii) Has ceased underwriting new business; and (iv) Is only renewing ongoing business to the extent required by law or by contract. However, for purposes of the Restructuring Mechanism Subgroup, we believe the following definition is appropriate to define &quot;Runoff Companies&quot; in general: &quot;Companies that are no longer actively writing new insurance business or collecting premiums except where required to in accordance with contractual or regulatory obligations, and whose sole material business is the management of an existing or assumed group of insurance policies or contracts through their termination.&quot;</td>
</tr>
<tr>
<td>5.</td>
<td>No. However, in practice, a run-off company services only existing business, does not write new business, and has no intent to acquire or engage in the business of run-off by acquiring other run-off blocks of business</td>
</tr>
<tr>
<td>6.</td>
<td>No. The state’s insurance law does not define “runoff companies;” however, the state applies a general concept of “runoff companies” to include an insurer that writes no new premium or has had no new policyholders for several years leading to claims administration only.</td>
</tr>
<tr>
<td>7.</td>
<td>No. This concept is something we plan to institute internally in 2019. The details have yet to be determined.</td>
</tr>
<tr>
<td>8.</td>
<td>No. There is no formal definition for &quot;Runoff Companies&quot; in the statutes or regulations.</td>
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</tbody>
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1 State numbers are just for the responses and state 1 in a chart may be a different state in the next chart.
1) What is the definition for “Runoff Companies” in your state? (please review the 2nd page of the attachment for reference)

CT does not have a definition for ‘Runoff Companies”. However, in practice, a run-off company services only existing business, does not write new business, and has no intent to acquire or engage in the business of run-off by acquiring other run-off blocks of business.

Colorado does not define Run-off companies officially.

There is no formal definition in Florida Statutes or Florida Administrative Code. A company in run-off can mean the company is no longer writing new business in all lines of insurance but continues to collect premiums, pay claims, and only servicing existing business to the extent required by statute.

SC doesn’t have a definition of “runoff company”. we generally understand it to mean a licensed company that is no longer writing premium and has no plans to write.

There is no formal definition for "Runoff Companies" in our statutes or regulations. (this response was also previously submitted to the restructuring mechanisms group’s survey)

There is none in Wisconsin that I am aware of.

2) How to identify the “Runoff Companies” by the available Annual Statement data?

No annual statement data specifically indicated that, but the five-year historical data, Schedule P and Schedule T might provide useful reference.

Lack of new business (underwriting).

- Decline in capital and surplus;
- Decrease in premiums written;
- Decrease in operating expenses because of cost-cutting measures
- Increase in loss ratio;
- Lack of income;
- Commutations of reinsurance agreements

$0 direct and assumed written premium for a certain number of years? Maybe a combination of having [some number of consecutive years of] $0 direct and assumed written premium, plus [net?] LLAE reserves have decreased to a certain percentage of what it was as of the last year-end where the company had non-zero written premium?

Domestics - Would know due to interaction with companies. Non-domestics, largely the MD&A after seeing minimal, no, or negative premium and large development.
Runoff Survey – PC RBC

3) Once the Working Group identifies a “Runoff Company”, where should the Runoff indicator be reported? (Annual Statement or RBC Report?)

I would suggest that the Runoff indicator to be reported in both annual statement and RBC reports. The Department asks for a quarterly liquidity report. On a case-by-case basis we may enter into a Stipulation and Consent Order which may contain certain reserving requirements.

The Annual Statement (interrogatories?)

Annual Statement

I don’t have good answers right now.

I am not sure of the value of the Run-Off indicator being in a company’s RBC report. This would be considered confidential. How would the ceding companies to this reinsurer know for completion of PR012.

4) Should the RBC formula be adjusted for the “Runoff Companies”?

Yes, they are different from the ongoing companies. The RBC formula in underwriting risk charges for written premium (R5) will not be relevant to the ‘Runoff companies’, and the other risk charges (R0-R4) need to be adjusted properly to reflect their differences in business operations.

No

No. The Office believes an insurer writing no business and running-off its existing business should be allowed to continue its run-off. This is usually done through a consent order order approving the run-off plan. The company may be required to maintain a specified minimum surplus amount and a minimum net reserve to surplus ratio or any other requirements deemed necessary for a solvent run-off.

I don’t have good answers right now.

The charge should be relevant to the financial condition of a reinsurer and not their operational status. Reinsurers without an NRSRO rating and an RBC of 300% or more could have a 10% risk factor (the general old factor), whereas reinsurers who do not meet RBC of 300% should use 14% or a higher. It may be reasonable to use 200% and don’t meet the trend test, however companies in run-off, especially with adverse development trigger would trigger the trend test due to their combined ratio. This becomes an issue for reinsurers who do not report RBC which would be a concern in and of itself.

5) How to reflect the appropriate risk of a given “Runoff Companies” relative to an ongoing companies?

- They are not having the new written premium or earned premium in the future.
- The accuracy of their reserving especially long tail lines probably should be individually modeled instead of using aggregate triangles.
- The understanding of the acquisition and transaction details, and
- The market and industry operational and liquidity risks.
- The Runoff companies might have two separate categories. One without new business in their own business, and the others are specialized in assuming runoff business from other companies. These two require different strategies and expertise.

I will have to defer to more informed members of the group.

Liquidity risk factor. Assets and income must be maintained to cover the claims and administrative costs; however, run-off companies only source of income may be their investment income. There is always the possibility of not being able to collect loss payments from the reinsurers.
Runoff Survey – PC RBC

I don’t have good answers right now.

See the response above.

I am concerned about who would have the responsibility of identifying run-off status. This is a status of the reinsurer which would be used by the ceding insurer. It would be more consistent if this was a status given to the reinsurer by its state of domicile which is reported in the financial statements and the ceding insurers could use. The definition of run-off could be determined by the restructuring working group. However, the definition should be more difficult than flipping a switch to change.
TO: David Smith & Doug Stolte (VA)  
Co-Chairs of the Restructuring Mechanisms (E) Subgroup  
FROM: Tom Botsko, OH), Chair of the Property and Casualty Risk Based Capital Working Group  
DATE: July 30, 2020  
RE: Request for Extension  

The Property and Casualty Risk-Based Capital (E) Working Group is responding to the request from the Restructuring Mechanisms (E) Working group for taking the lead in addressing the charges of: 1) considering the need to make changes to the Property and Casualty RBC formula to better assess the minimum surplus requirements for companies in runoff; and 2) coordinating with other RBC working groups as the issues and positions are identified.

As noted in the request memo, the due date of the charge is 2020 Fall National Meeting. At this time, the Working Group requests an extension until the 2021 Fall National Meeting in order to have the necessary time to review the definition of the Property and Casualty companies in run-off to better address the issues when determining future factor changes to the Vulnerable 6 or Unauthorized Unrated category in R3 component of the Risk-Based Capital Formula. The Working Group anticipated that this issue would require extensive discussions to make determination in the future.

The Working Group appreciates this opportunity to take the lead to address these charges. Please contact, Eva Yeung, NAIC staff eyeung@naic.org of the Property and Casualty Risk-Based Capital (E) Working Group with any questions.

Cc: Eva Yeung; Robin Marcotte; Dan Daveline.
## 2019 P&C RBC - Comparison of Action Levels

**Current RBC Action Levels vs RBC Action Level with Weighted Average Line 1 Factors for PR017 and PR018**

### All RBC Filers (excluding Companies with Negative TAC)

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### 2019 P&C RBC - Comparison of Action Levels

**Current RBC Action Levels vs RBC Action Level with Weighted Average Line 1 Factors for PR017 and PR018**

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Percentage Change in 2019 R4 and R5 Charges by Company Size under Alternative RBC Formula

Alternative RBC Formula: Line 1 of PR017 and PR018 evaluated using Weighted Average for all RBC Lines

(Excluding Companies with TAC Less Than $0)

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<td>401</td>
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<td>3</td>
<td>17</td>
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<tr>
<td>15% to 25%</td>
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<td>5</td>
<td>4</td>
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<td>6</td>
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<tr>
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<td>0</td>
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<td>805</td>
<td>593</td>
<td>427</td>
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### Percentage Change in 2019 R5 Charges under Alternative RBC Formula

Alternative RBC Formula: Line 1 of PR017 and PR018 evaluated using Weighted Average for all RBC Lines
(Excluding Companies with TAC Less Than $0)

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<tr>
<th>% Change in R4</th>
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<th>Personal</th>
<th>MM</th>
<th>Prof Reim</th>
<th>Other</th>
<th>Total</th>
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<td>-15% to -5%</td>
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<td>-5% to 5%</td>
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<td>557</td>
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<th>MM</th>
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</table>
### Comparison of 2019 RBC Charge under Alternative RBC Formula

Alternative RBC Formula: Line 1 of PR017 and PR018 evaluated using Weighted Average for all RBC Lines

<table>
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<th>TAC Range ($ Million)</th>
<th>$0 - $5M</th>
<th>$5M - $25M</th>
<th>$25M - $75M</th>
<th>$75M - $250M</th>
<th>$250M - $1B</th>
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<tbody>
<tr>
<td>R3 - Current</td>
<td>41,660,425</td>
<td>227,878,006</td>
<td>646,417,755</td>
<td>1,463,408,161</td>
<td>1,924,780,342</td>
<td>5,015,891,571</td>
<td>9,320,076,260</td>
</tr>
<tr>
<td>Percentage Change</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>R3 - Alternative</td>
<td>41,660,425</td>
<td>227,878,006</td>
<td>646,417,755</td>
<td>1,463,408,161</td>
<td>1,924,780,342</td>
<td>5,015,891,571</td>
<td>9,320,076,260</td>
</tr>
<tr>
<td>Percentage Change</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>R4 - Current</td>
<td>73,348,952</td>
<td>912,362,532</td>
<td>2,519,497,668</td>
<td>7,861,358,031</td>
<td>19,263,431,722</td>
<td>91,925,674,644</td>
<td>122,553,790,437</td>
</tr>
<tr>
<td>Percentage Change</td>
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<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>R4 - Alternative</td>
<td>73,486,817</td>
<td>913,617,963</td>
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<td>7,854,310,359</td>
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<td>91,913,765,662</td>
<td>122,513,790,437</td>
</tr>
<tr>
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<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>R5 - Current</td>
<td>101,168,395</td>
<td>1,005,953,282</td>
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<td>74,711,962,027</td>
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<td>-3.2%</td>
<td>-5.2%</td>
<td>-6.2%</td>
<td>-5.9%</td>
<td>-5.8%</td>
<td>-5.8%</td>
</tr>
<tr>
<td>R5 - Alternative</td>
<td>98,820,741</td>
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<td>12,095,584,191</td>
<td>48,779,588,779</td>
<td>70,349,999,584</td>
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<tr>
<td>Percentage Change</td>
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<td>-3.2%</td>
<td>-5.2%</td>
<td>-6.2%</td>
<td>-5.9%</td>
<td>-5.8%</td>
<td>-5.8%</td>
</tr>
</tbody>
</table>

### Company Type

<table>
<thead>
<tr>
<th>Company Type</th>
<th>Commercial</th>
<th>Personal</th>
<th>MM</th>
<th>Prof Rein</th>
<th>Other</th>
<th>Total</th>
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<tbody>
<tr>
<td>R3 - Current</td>
<td>7,346,229,398</td>
<td>1,466,758,726</td>
<td>229,985,097</td>
<td>97,323,338</td>
<td>179,779,701</td>
<td>9,320,076,260</td>
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<tr>
<td>R3 - Alternative</td>
<td>7,346,229,398</td>
<td>1,466,758,726</td>
<td>229,985,097</td>
<td>97,323,338</td>
<td>179,779,701</td>
<td>9,320,076,260</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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<tr>
<td>R4 - Current</td>
<td>90,687,462,079</td>
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<td>-1.5%</td>
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<td>-0.5%</td>
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<td>14,698,596,084</td>
<td>35,967,264,314</td>
<td>122,513,790,437</td>
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<td>Percentage Change</td>
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<td>-1.0%</td>
<td>-1.3%</td>
<td>-1.5%</td>
<td>-1.2%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>R5 - Current</td>
<td>40,371,137,598</td>
<td>3,714,879,187</td>
<td>30,254,362,688</td>
<td>669,687,603</td>
<td>75,131,883</td>
<td>70,349,999,584</td>
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<tr>
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<td>-3.8%</td>
<td>-0.3%</td>
<td>-1.8%</td>
<td>8.9%</td>
<td>-5.8%</td>
</tr>
<tr>
<td>R5 - Alternative</td>
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<td>75,131,883</td>
<td>70,349,999,584</td>
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<tr>
<td>Percentage Change</td>
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<td>-3.8%</td>
<td>-0.3%</td>
<td>-1.8%</td>
<td>8.9%</td>
<td>-5.8%</td>
</tr>
</tbody>
</table>

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Attachment Five - K

10-1337

NAIC Proceedings – Summer 2020
### Comparisons of PR017 Line 1 Factors between Current RBC Formula and RBC formula with Weighted Average PR017 Line 1 Factors for all RBC Lines

#### PR017 Official Line 1 Factors

| Year of filing | HF  | PPA  | CA   | WC   | CMP | MPL OCURRENCE | MPL CLMS MADE | SL | OL | FIDELITY/SURETY | SPECIAL PROPERTY | AUTO PHYSICAL DAMAGE | OTHER (CREDIT A&H) | FINANCIAL/MORTGAGE | GUARANTY | INTL | REIN PROPERTY & FINANCIAL LINES | REIN LIABILITY | PL | WARRANTY |
|----------------|-----|------|------|------|-----|----------------|----------------|----|----|-----------------|-------------------|---------------------|-------------------|-----------------|------|----------------|-----------------|------|---------|
| 2015           | 0.962 | 1.002 | 0.987 | 0.961 | 0.936 | 0.946 | 0.905 | 0.924 | 0.914 | 0.902 | 0.981 | 1.016 | 1.011 | 0.991 | 1.021 | 1.041 | 1.165 | 1.350 | 1.092 | 0.938 | 1.072 | 0.994 |
| 2016           | 0.972 | 1.002 | 1.015 | 0.971 | 0.942 | 0.841 | 0.822 | 0.916 | 0.929 | 1.029 | 0.973 | 0.985 | 0.986 | 0.853 | 0.853 | 0.887 | 0.814 | 0.996 | 0.996 | 0.997 | 0.977 |
| 2017           | 0.968 | 1.012 | 1.038 | 0.971 | 0.960 | 0.964 | 0.926 | 0.962 | 1.016 | 0.962 | 1.001 | 0.937 | 0.973 | 0.973 | 0.973 | 0.974 | 0.914 | 0.914 | 0.914 | 0.914 | 0.914 |
| 2018           | 0.989 | 1.022 | 1.060 | 0.962 | 0.960 | 0.871 | 0.866 | 0.933 | 0.966 | 0.996 | 0.971 | 1.070 | 0.976 | 0.870 | 0.870 | 0.887 | 0.814 | 0.949 | 0.949 | 0.927 | 1.015 |
| 2019           | 0.980 | 1.020 | 1.067 | 0.965 | 0.962 | 0.844 | 0.907 | 0.936 | 0.971 | 0.990 | 0.972 | 0.996 | 0.973 | 0.769 | 0.769 | 1.037 | 0.972 | 0.950 | 0.913 | 1.017 |

#### PR017 All Weighted Line 1 Factors

| Year of filing | HF  | PPA  | CA   | WC   | CMP | MPL OCURRENCE | MPL CLMS MADE | SL | OL | FIDELITY/SURETY | SPECIAL PROPERTY | AUTO PHYSICAL DAMAGE | OTHER (CREDIT A&H) | FINANCIAL/MORTGAGE | GUARANTY | INTL | REIN PROPERTY & FINANCIAL LINES | REIN LIABILITY | PL | WARRANTY |
|----------------|-----|------|------|------|-----|----------------|----------------|----|----|-----------------|-------------------|---------------------|-------------------|-----------------|------|----------------|-----------------|------|---------|
| 2015           | 0.977 | 0.973 | 0.948 | 0.946 | 0.956 | 0.946 | 0.905 | 0.924 | 0.914 | 0.902 | 0.981 | 1.016 | 1.011 | 0.991 | 1.021 | 1.041 | 1.165 | 1.350 | 1.075 | 0.938 | 1.072 | 0.995 |
| 2016           | 0.979 | 0.980 | 1.022 | 0.972 | 0.956 | 0.841 | 0.822 | 0.916 | 0.929 | 1.029 | 0.973 | 0.985 | 0.986 | 0.853 | 0.853 | 0.887 | 0.814 | 0.996 | 0.996 | 0.997 | 0.977 |
| 2017           | 0.979 | 0.987 | 1.047 | 0.963 | 0.971 | 0.868 | 0.854 | 0.926 | 0.956 | 0.986 | 0.971 | 1.070 | 0.976 | 0.870 | 0.870 | 0.887 | 0.814 | 0.949 | 0.949 | 0.927 | 0.999 |
| 2018           | 0.983 | 0.982 | 1.005 | 0.984 | 0.978 | 0.871 | 0.866 | 0.933 | 0.966 | 0.996 | 0.971 | 0.976 | 0.870 | 0.870 | 0.870 | 0.887 | 0.814 | 0.949 | 0.949 | 0.927 | 1.015 |
| 2019           | 0.981 | 0.994 | 1.062 | 0.952 | 0.987 | 0.864 | 0.907 | 0.936 | 0.984 | 0.996 | 0.971 | 0.973 | 0.769 | 0.769 | 1.037 | 0.972 | 0.950 | 0.913 | 1.017 |

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Comparisons of PR018 Line 1 Factors between Current RBC Formula and RBC formula with Weighted Average PR018 Line 1 Factors for all RBC Lines

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<th>CMP</th>
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<th>AUTO PHYSICAL DAMAGE</th>
<th>OTHER (CREDIT ASSET)</th>
<th>FINANCIAL/GUARANTY</th>
<th>INTL</th>
<th>REN PROXY &amp; FINANCIAL LINES</th>
<th>FINANCIAL LIABILITY PL</th>
<th>REN LIABILITY</th>
<th>PL</th>
<th>WARRANTY</th>
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<td>0.618</td>
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<td>0.694</td>
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<tr>
<td>2017</td>
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<td>0.716</td>
<td>0.751</td>
<td>0.647</td>
<td>0.772</td>
<td>0.667</td>
<td>0.629</td>
<td>0.480</td>
<td>0.555</td>
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<td>0.670</td>
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<tr>
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<td>0.704</td>
<td>1.096</td>
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<td>0.666</td>
<td>0.671</td>
<td>0.702</td>
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<td>0.815</td>
<td>0.727</td>
<td>0.728</td>
<td>0.656</td>
<td>0.749</td>
<td>0.671</td>
<td>0.568</td>
<td>0.599</td>
<td>0.654</td>
<td>0.732</td>
<td>0.811</td>
<td>0.798</td>
<td>0.522</td>
<td>0.679</td>
<td>0.696</td>
<td>0.695</td>
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</table>

Remarks: PR018 Official Line 1 Factors are PR018 Line 1 Factors officially adopted in the RBC filings. For those lines subject to straight average calculation under current RBC formula, PR018 Recalculated Line 1 Factors are the industrywide straight average LLAE ratios computed using populations recently pulled. For those lines subject to straight average calculation under current RBC formula, PR018 All Weighted Line 1 Factors are the industrywide weighted average LLAE ratios computed using populations recently pulled. Line 1 Factors stay the same for those lines subject to weighted average calculation under current RBC formula.

- Evaluation using straight average
- Evaluation using weighted average
## Ongoing Items – Life RBC

<table>
<thead>
<tr>
<th>#</th>
<th>Owner</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Life RBC</td>
<td>Ongoing</td>
<td>Make technical corrections to Life RBC instructions, blank and/or methods to</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>WG</td>
<td>Ongoing</td>
<td>provide for consistent treatment among asset types and among the various</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>components of the RBC calculations for a single asset type.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Life RBC</td>
<td>2020 or later</td>
<td>Evaluate the overall effectiveness of the C-3 Phase II and AG-43</td>
<td>CATF</td>
<td>Being addressed by the Variable Annuities Capital and Reserve (E/A)</td>
</tr>
<tr>
<td></td>
<td>WG</td>
<td></td>
<td>methodologies by conducting an in-depth analysis of the models, modeling</td>
<td></td>
<td>Subgroup</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>assumptions, processes, supporting documentation and results of a sample of</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>companies writing variable annuities with guarantees and to make</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>recommendations to the Capital Adequacy Task Force or Life Actuarial Task</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Force on any changes to the methodologies to improve their overall effectiveness.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Develop and recommend changes to C-3 Phase II and AG-43 that</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>implement, for 2018 adoption, the Variable Annuities Framework for Change.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Monitor the impact of changes to the variable annuities reserve</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>framework and risk-based capital (RBC) calculation and determine if</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>additional revisions need to be made.</td>
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<td></td>
<td></td>
<td></td>
<td>2. Develop and recommend appropriate changes including those to improve</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>accuracy and clarity of variable annuity (VA) capital and reserve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Life RBC</td>
<td>2020 or later</td>
<td>Provide recommendations for recognizing longevity risk in statutory reserves and/or</td>
<td>New Jersey</td>
<td>Being addressed by the Longevity (E/A) Subgroup</td>
</tr>
<tr>
<td></td>
<td>WG</td>
<td></td>
<td>RBC, as appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Life RBC</td>
<td>2020 or later</td>
<td>Update the current C-3 Phase I or C-3 Phase II methodology to include indexed</td>
<td>AAA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WG</td>
<td></td>
<td>annuities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Life RBC</td>
<td>2020 or later</td>
<td>Develop guidance, for inclusion in the proposed NAIC contingent deferred annuity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>WG</td>
<td></td>
<td>(CDA) guidelines, for states as to how current regulations governing risk-based</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>capital requirements, including C-3 Phase II, should be applied to</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>contingent deferred annuities (CDAs). Recommend a process for reviewing capital</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>adequacy for insurers issuing CDAs and prepare clarifying guidance, if necessary,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>due to different nomenclature then used with regard to CDAs. The development of</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>this guidance does not preclude the Working Group from reviewing CDAs as part of</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>any ongoing or future charges where applicable and is made with the understanding</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>that this guidance could change as a result of such a review.</td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>Life RBC</td>
<td>2020</td>
<td>Review and evaluate company submissions for the RBC Shortfall schedule and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>WG</td>
<td></td>
<td>corresponding adjustment to Total Adjusted Capital.</td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>Life RBC</td>
<td>2020</td>
<td>Review and evaluate company submissions for the Primary Security Shortfall</td>
<td></td>
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<tr>
<td></td>
<td>WG</td>
<td></td>
<td>schedule and corresponding adjustment to Authorized Control Level.</td>
<td></td>
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<tr>
<td>8</td>
<td>Life RBC</td>
<td>2020</td>
<td>Continue consideration impacts and modifications necessary due to the Federal</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>WG</td>
<td></td>
<td>Tax Cuts and Jobs Act and develop guidance for users of RBC on those impacts.</td>
<td>3/24/2018</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Life RBC</td>
<td>2020</td>
<td>Determine if any adjustment is needed to the XXX/AXXX RBC Shortfall</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>WG</td>
<td></td>
<td>calculation to address surplus notes issued by captives.</td>
<td>11/1/2017</td>
<td>Referal from the Reinsurance (E) Task Force</td>
</tr>
<tr>
<td>10</td>
<td>Life RBC</td>
<td>2019</td>
<td>Address changes needed due to elimination of the e fraternal annual statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>WG</td>
<td></td>
<td>blank.</td>
<td>9/1/2018</td>
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### Working Agenda Items for Calendar Year 2020

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<tr>
<td>10</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2020</td>
<td>Determine if any adjustment is needed due to the changes made to the Life and Health Guaranty Association Model Act, Model #520</td>
<td></td>
<td></td>
<td>9/1/2018</td>
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<tr>
<td>11</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2020</td>
<td>Determine if any adjustment is needed to the reinsurance credit risk in light of changes related to collateral and the changes made to the property RBC formula.</td>
<td></td>
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<td>9/1/2018</td>
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#### New Items – Life

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<tr>
<td>12</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Discuss and determine the bond factors for the 20 designations.</td>
<td>Referral from Investment RBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Discuss and determine the need to adjust the real estate factors.</td>
<td>Referral from Investment RBC</td>
<td></td>
<td></td>
</tr>
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</table>

#### Carry-Over Items Currently Being Addressed – P&C RBC

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>14</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>Year-end 2020</td>
<td>Continue development of RBC formula revisions to include a risk charge based on catastrophe model output.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>a) Evaluate other catastrophe risks for possible inclusion in the charge</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- determine whether to recommend developing charges for any additional perils, and which perils or perils those should be.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>Evaluate a) the current growth risk methodology whether it is adequately reflects both operational risk and underwriting risk; b) the premium and reserve based growth risk factors either as a stand-alone task or in conjunction with the ongoing underwriting risk factor review with consideration of the operational risk component of excessive growth; c) whether the application of the growth factors to NET proxies adequately accounts for growth risk that is ceded to reinsurers that do not trigger growth risk in their own right.</td>
<td>Refer from Operational Risk Subgroup</td>
<td>1) Sent a referral to the Academy on 6/14/18 conference call.</td>
<td>1/25/2018</td>
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<table>
<thead>
<tr>
<th>#</th>
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<th>Priority</th>
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<tbody>
<tr>
<td>16</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2020 Summer Meeting or later</td>
<td>Continue development of RBC formula revisions based on the Covered Agreement: a) consider eliminating the different treatment of uncollateralized reinsurance recoverable from authorized versus unauthorized, unrated reinsurers; b) consider whether the factor for uncollateralized, unrated reinsurers, runoff and captive companies should be adjusted; c) Evaluate the possibility of using NAIC as a centralized location for reinsurance designations.</td>
<td>Tax impact on RBC was not material.</td>
<td></td>
<td>1/25/2018</td>
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<thead>
<tr>
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<tr>
<td>17</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2021 Summer Meeting or later</td>
<td>Evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to P/C RBC Affiliated Investments</td>
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<tr>
<td>18</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2021 Summer Meeting or later</td>
<td>Continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as appropriate.</td>
<td></td>
<td></td>
<td>6/10/2019</td>
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### New Items – P&C RBC

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<tr>
<td>19</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>Evaluate the possibility of allowing additional third party models to calculate the cat model losses</td>
<td></td>
<td></td>
<td>12/6/2019</td>
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</table>
## Capital Adequacy (E) Task Force

### Working Agenda Items for Calendar Year 2020

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<tr>
<td>20</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2020</td>
<td>Evaluate the RBC impact on two different retroactive reinsurance exception approaches</td>
<td>1/7/20 - received a referral from the SAPWG</td>
<td>1/9/2020</td>
<td>1/9/2020</td>
</tr>
<tr>
<td>21</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2020</td>
<td>Evaluate the RBC impact on the modification of the installment fees and expenses reporting guidance</td>
<td>1/7/20 - received a referral from the SAPWG</td>
<td>1/9/2020</td>
<td>1/9/2020</td>
</tr>
<tr>
<td>22</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2021 Spring Meeting</td>
<td>Evaluate if changes should be made to the P/C formula to better assess companies in runoff</td>
<td>1/29/20 - received a referral from the Restructuring Mechanisms (E) WG</td>
<td>2/3/2020</td>
<td>2/3/2020</td>
</tr>
<tr>
<td>23</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2021 Spring Meeting</td>
<td>Evaluate the Underwriting Risk Line 1 Factors in the P/C formula.</td>
<td></td>
<td>7/30/2020</td>
<td></td>
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</tbody>
</table>

### Ongoing Items – Health RBC

| 25     | Health RBC WG      | 3             | Year-end 2021 RBC or later | Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula: - Development of the state reinsurance programs; - Association Health Plans; - Cross-border sales | HRBCWG                        | Discus and monitor the development of federal level programs and the potential impact on the HRBC formula. | 1/1/2018 |

### Carry-Over Items Currently being Addressed – Health RBC

| 26     | Health RBC WG      | 3             | Year-End 2023 RBC or Later | Consider changes for stop-loss insurance or reinsurance. | AAA Report at Dec. 2006 Meeting | (Based on Academy report expected to be received at YE-2016) 2016-17-CA |                      |
| 27     | Health RBC WG      | 2             | Year-end 2023 RBC or Later | Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula. | HRBCWG                        | Adopted 2016-06-H Rejected 2019-04-H |                      |
| 28     | Health RBC WG      | 1             | Year-end 2022 or later     | Establish an Ad Hoc Group to review the Health Test and annual statement changes for reporting health business in the Life and P/C Blanks | HRBCWG                        | Evaluate the applicability of the current Health Test in the Annual Statement instructions in today’s health insurance market. Discuss ways to gather additional information for health business reported in other blanks. | 8/4/2018 |
| 29     | Health RBC WG      | 1             | Year-end 2020 RBC or Later | Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b. | HRBCWG                        | Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 & 1 to 2a and 2b. | 12/3/2018 |
## Working Agenda Items for Calendar Year 2020

### Priority Levels
- **Priority 1** – High priority
- **Priority 2** – Medium priority
- **Priority 3** – Low priority

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<tbody>
<tr>
<td>30</td>
<td>Health RBC WG</td>
<td>Priority 1</td>
<td>Year-end 2020 or later</td>
<td>Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.</td>
<td>HRBCWG</td>
<td>Review if changes are required to the Health RBC Formula.</td>
<td>4/7/2019</td>
</tr>
<tr>
<td>31</td>
<td>Health RBC WG</td>
<td>Priority 1</td>
<td>2021 Spring Meeting</td>
<td>Review and consider the formula for the MAX function in Line 17 of the Excessive Growth Charge.</td>
<td>HRBCWG</td>
<td>2020-04-H</td>
<td>4/3/2020</td>
</tr>
<tr>
<td>32</td>
<td>Health RBC WG</td>
<td>Priority 1</td>
<td>Year-End 2021 or later</td>
<td>Consider impact of COVID-19 and pandemic risk in the Health RBC formula.</td>
<td>HRBCWG</td>
<td></td>
<td>7/30/2020</td>
</tr>
<tr>
<td>33</td>
<td>CADTF</td>
<td>Priority 1</td>
<td>2020</td>
<td>Consideration given to 20 designations for bonds in all RBC formulas so that an impact analysis can be provided on 2020 year-end data to determine the bond RBC factors. The Task Force will need to discuss and determine whether Hybrids are included with the new bond’s structure.</td>
<td>HRBCWG-Dec 2019</td>
<td>An Academy report issued in 2015 and updated 2017 report recommended an increase in the number of designations. Ultimately, the WG members agreed that the number of designations should be increased to 20. In 2017/2018, the PRBC and HRBC (E) Working Groups began discussion of the change to 20 designations. In 2019 both working groups concurred with the LRBC WG position that the number of designations should be increased to 19 in their respective formulas Proposal # 2019 – 16CA</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>CADTF</td>
<td>Priority 2</td>
<td>2022</td>
<td>Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016</td>
<td>Ad Hoc Group</td>
<td>Ad Hoc group will provide periodic updates on their progress.</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>CADTF</td>
<td>Priority 3</td>
<td>2021 or Later</td>
<td>NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks Equity investments that have an underlying bond characteristic should have a lower RBC charge? Similar to existing guidance for SVO-identified ETFs reported on Schedule D-1, are treated as bonds.</td>
<td>Referral from SAPWG 8/13/2018</td>
<td>10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>10/8/2018</td>
</tr>
<tr>
<td>37</td>
<td>CADTF</td>
<td>Priority 3</td>
<td>2021 or Later</td>
<td>Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are unwound by a debt structure.</td>
<td>Referral from SAPWG April 16, 2019</td>
<td>10/9/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factor.</td>
<td>8/4/2019</td>
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<tbody>
<tr>
<td>38</td>
<td>CADTF</td>
<td>3</td>
<td>2021 or Later</td>
<td>Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2</td>
<td>Referral from VOSTF 9/2/2018</td>
<td>Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day comment period ending 11/8/19 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>11/16/2018</td>
</tr>
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</table>

### Carry-Over Items Currently Being Addressed – Task Force

<table>
<thead>
<tr>
<th>#</th>
<th>Owner</th>
<th>Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
<th>Date Added to Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>XXX/AXXX Captive Reinsurance RBC Shortfall</td>
<td>Referral from Reinsurance Task Force / RITF</td>
<td>Referred to Life RBC WG for consideration and comment</td>
<td>11/1/2017</td>
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<tr>
<td>40</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>Payout Annuities for RBC</td>
<td>Referral from Allstate and IL DOI</td>
<td>Referred to Life RBC WG for consideration and comment</td>
<td>3/25/2018</td>
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<tr>
<td>41</td>
<td>CADTF</td>
<td>2</td>
<td>2020 or Later</td>
<td>Guaranty Association Assessment Risk</td>
<td>Referral from Receivernship and Insolvency (E) Task Force 5/1/2018</td>
<td>Referred to the LiE RBC WG and Health RBC WG for consideration and comment.</td>
<td>6/30/2018</td>
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### Investment Risk-Based Capital Working Group

#### Carry-Over Items Currently Being Addressed – Investment RBC

<table>
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<th>Working Agenda Item</th>
<th>Source</th>
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<tbody>
<tr>
<td>42</td>
<td>Investments at RBC WG</td>
<td>1</td>
<td>2020 or later</td>
<td>The Solvency Modernization Initiative (EX) Task Force and the Capital Adequacy (E) Task Force have been discussing reform of the RBC formulae for life, property/casualty and health insurers. The Working Group recommends a comprehensive review of RBC, including a review of whether all RBC formulae should have greater granularity.</td>
<td>Referral from Rating Agency WG Referral March 2010</td>
<td>Comprehensive review to be discussed at the Capital Adequacy (E) Task Force. Disband the Investment Risk-Based Capital (E) Working Group effective Aug. 5, 2020</td>
<td></td>
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</table>

#### Carry-Over Items not Currently Being Addressed – Investment RBC

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<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
<th>Date Added to Agenda</th>
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</thead>
<tbody>
<tr>
<td>43</td>
<td>Investments at RBC WG</td>
<td>2</td>
<td>Year-End 2021</td>
<td>Consideration should be given to recalibrate the RBC formulae to require different levels of capital for municipal, corporate and structured securities.</td>
<td>Referral from Rating Agency WG Referral March 2010</td>
<td>Comprehensive review to be discussed at the Capital Adequacy (E) Task Force. Disband the Investment Risk-Based Capital (E) Working Group effective Aug. 5, 2020</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Owner</td>
<td>Priority</td>
<td>Expected Completion Date</td>
<td>Working Agenda Item</td>
<td>Source</td>
<td>Comments</td>
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<td>---------------------</td>
<td>--------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Investment RBC WG</td>
<td>1</td>
<td>Year-End 2021</td>
<td>Ensure that the RBC formulae, for all business types, for common stock and bonds are consistent with respect to statistical safety levels, modeling assumptions, where appropriate.</td>
<td>CADTF</td>
<td>Consolidated with items #42, 43 and 44 from the 2015 Working Agenda. Comprehensive review to be discussed at the Capital Adequacy (E) Task Force. Disband the Investment Risk-Based Capital (E) Working Group effective Aug. 5, 2020.</td>
<td>2/10/2015</td>
</tr>
<tr>
<td>45</td>
<td>Investment RBC WG</td>
<td>2</td>
<td>Year-End 2021</td>
<td>Consider modifications for investment risk to capture more than credit risk to place less reliance on the rating agencies. Consider modifications to better identify liquidity and asset concentration.</td>
<td>Rating Agency WG</td>
<td>Comprehensive review to be discussed at the Capital Adequacy (E) Task Force. Disband the Investment Risk-Based Capital (E) Working Group effective Aug. 5, 2020.</td>
<td>4/6/2021</td>
</tr>
<tr>
<td>46</td>
<td>Investment RBC WG</td>
<td>2</td>
<td>Year-End 2021</td>
<td>The asset valuation reserve (AVR) establishes a reserve to offset potential credit-related investment losses on all invested asset categories. Similar to RBC, consideration should be given to making complementary adjustments to AVR to be consistent with changes to RBC.</td>
<td>CADTF</td>
<td>Consolidated with item #42, 43 and 44 from the 2015 Working Agenda. Comprehensive review to be discussed at the Capital Adequacy (E) Task Force. Disband the Investment Risk-Based Capital (E) Working Group effective Aug. 5, 2020.</td>
<td>2/10/2015</td>
</tr>
</tbody>
</table>

W:\QA\CADTF\Working Agenda 2020 as of 08-05-2020.xls
Delete the ACA Fee Sensitivity Test from each formula.

The purpose of the proposal is to delete the ACA Fee Sensitivity test from each formula as a result of the repeal of the ACA HIT tax for 2021. The SAP Working Group is also drafting a Form A to remove the disclosures of the ACA fee in 2021.
## CALCULATION OF TOTAL ADJUSTED CAPITAL (XR025)

<table>
<thead>
<tr>
<th>Company Amounts</th>
<th>Annual Statement Source</th>
<th>(1) Amount</th>
<th>(2) Factor</th>
<th>(3) Adjusted Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Capital and Surplus</td>
<td>Page 3, Col 3, Line 33</td>
<td>$0</td>
<td>1.000</td>
<td></td>
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</tbody>
</table>

### Subsidiary Adjustments

| (2) AVR - Life Subsidiaries | Affiliate's statement § | 1.000 |
| (3) Dividend Liability - Life Subsidiaries | Affiliate's statement | 0.500 |
| (4) Tabular Discounts - P&C Subsidiaries | Affiliate's statement | -1.000 |
| (5) Non-Tabular Discounts - P&C Subsidiaries | Affiliate's statement | -1.000 |

(6) Total Adjusted Capital, Post-deferred Tax

### Sensitivity Test:

| (7) DTA Value for Company | Page 2, Col 3, Line 18.2 | 1.000 |
| (8) DTL Value for Company | Page 3, Col 3, Line 10.2 | 1.000 |
| (9) DTA Value for Insurance Subsidiaries | Company Records | 1.000 |
| (10) DTL Value for Insurance Subsidiaries | Company Records | 1.000 |

(11) Total Adjusted Capital, Pre-deferred Tax (sensitivity) \[ L(6) - L(7) + L(8) - L(9) + L(10) \]

### Ex DTA ACL RBC Ratio Sensitivity Test

| (12) Deferred Tax Asset | Page 2 Column 3 Line 18.2 | 1.000 |
| (13) Total Adjusted Capital Less Deferred Tax Asset | Line (6) less Line (12) |      |
| (14) Authorized Control Level RBC | XR026 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4) |      |
| (15) Ex DTA ACL RBC Ratio | Line (13) / Line (14) | 0.000% |

### ACA Fee RBC Ratio Sensitivity Test

| (16) ACA Fee (Data Year Amount to be Paid in the Fee Year) Note 22B | 1.000 | $0 |
| (17) Total Adjusted Capital Less ACA Fee | Line (6) less Line (16) | $0 |
| (18) Authorized Control Level RBC | XR026 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4) | $0 |
| (19) ACA Fee RBC Ratio | Line (17) / Line (18) | 0.000% |

---

§ The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

Denotes items that must be manually entered on filing software.
CALCULATION OF TOTAL ADJUSTED CAPITAL (LR033)
( Including Total Adjusted Capital Tax Sensitivity Test )

<table>
<thead>
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<th>(1)</th>
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</thead>
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<td><strong>Company Amounts</strong></td>
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</tr>
<tr>
<td>(1)</td>
<td>Capital and Surplus</td>
</tr>
<tr>
<td>(2)</td>
<td>Asset Valuation Reserve</td>
</tr>
<tr>
<td>(3)</td>
<td>Dividends Apportioned for Payment</td>
</tr>
<tr>
<td>(4)</td>
<td>Dividends Not Yet Apportioned</td>
</tr>
<tr>
<td>(5)</td>
<td>Hedging Fair Value Adjustment</td>
</tr>
</tbody>
</table>

| **Life Subsidiary/Company Amounts** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (6) | Asset Valuation Reserve | Subsidiaries' Annual Statement Page 3 Column 1 Line 24.01 | X | 1.000 | = |
| (7) | Dividend Liability | Subsidiaries' Annual Statement Page 3 Column 1 Line 6.1 + Line 6.2 | X | 0.500 | = |

| **Property and Casualty and Other Non-U.S. Affiliated Amounts** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (8) | Non-Tabular discount and/or Alien Insurance Subsidiaries: Other | Included in Subsidiaries' Annual Statement Page 3 Column 1 Line 1 + 3 | X | 1.000 | = |

| **Total Adjusted Capital Before Capital Notes** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (9) | Total Adjusted Capital Before Capital Notes | Sum of Lines (1) through (7), less Line (8) | | | |

| **Credit for Capital Notes** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (10.1) | Surplus Notes | Page 3 Column 1 Line 32 | | | |
| (10.2) | Limitation on Capital Notes | 0.5 x [Line (9) - Line (10.1)] - Line (10.1), but not less than 0 | | | |
| (10.3) | Capital Notes Before Limitation | LR032 Capital Notes Before Limitation Column (4) Line (18) | | | |
| (10.4) | Credit for Capital Notes | Lesser of Column (1) Line (10.2) or Line (10.3) | | | |

| **XXX/AXXX Reinsurance RBC Shortfall** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (11) | XXX/AXXX Reinsurance RBC Shortfall | LR037 XXX/AXXX Captive Reinsurance Consolidated Exhibit Column (10) Line (10) | | | |

| **Total Adjusted Capital** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (12) | Total Adjusted Capital | Line (9) + Line (10.8) - Line (11) | | | |

| **Tax Sensitivity Test** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (13) | Deferred Tax Asset (DTA) Value | Page 2 Column 3 Line 18.2 | X | 1.000 | = |
| (14) | Deferred Tax Liability (DTL) Value | Page 3 Column 1 Line 15.2 | X | 1.000 | = |

| **Subsidiary Amounts** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (15) | Deferred Tax Asset (DTA) Value | Company Records | X | 1.000 | = |
| (16) | Deferred Tax Liability (DTL) Value | Company Records | X | 1.000 | = |

| **Tax Sensitivity Test: Total Adjusted Capital** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |

| **Ex DTA ACL RBC Ratio Sensitivity Test** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (18) | Ex DTA ACL RBC Ratio | Page 2 Column 3 Line 18.2 | X | 1.000 | = |
| (19) | Ex DTA ACL RBC Ratio | Line (12) - Line (10) | | | |

| **Authorized Control Level RBC** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (20) | Authorized Control Level RBC | LR034 Risk-Based Capital Level of Action Line (4) | X | 1.000 | = |

| **Ex DTA ACL RBC Ratio** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (21) | Ex DTA ACL RBC Ratio | Line (19) / Line (20) | | 0.000% |

- **ACA Fee RBC Ratio Sensitivity Test**

| (22) | ACA Fee (Data Year Amount to be Paid in the Fee Year) | Note 72B | X | 1.000 | = |

| **Total Adjusted Capital Less ACA Fee** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (23) | Total Adjusted Capital Less ACA Fee | Line (12) - Line (21) | | | |

| **Authorized Control Level RBC** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (24) | Authorized Control Level RBC | LR034 Risk-Based Capital Level of Action Line (4) | | | |

| **ACA Fee RBC Ratio** | **Annual Statement Source** | **Statement Value** | **Factor** | **Adjusted Capital** |
| (25) | ACA Fee RBC Ratio | Line (23) / Line (24) | | 0.000% |

† Including subsidiaries owned by holding companies.
‡ Multiply statement value by percent of ownership.
§ The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

Denotes items that must be manually entered on the filing software.
### CALCULATION OF TOTAL ADJUSTED CAPITAL  PR029

<table>
<thead>
<tr>
<th>Annual Statement Reference</th>
<th>Statement Value*</th>
<th>Factor</th>
<th>Adjusted Capital</th>
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<tbody>
<tr>
<td>(1) Capital and Surplus</td>
<td>P3 C1 L37</td>
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<td>0</td>
</tr>
<tr>
<td>(2) Non-Tabular Discount - Losses</td>
<td>Sch P Pt-Sum C32 L12</td>
<td>0.000</td>
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<tr>
<td>(3) Non-Tabular Discount - Expense</td>
<td>Sch P Pt-Sum C33 L12</td>
<td>0.000</td>
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<tr>
<td>(4) Discount on Medical Loss Reserves Reported as Tabular in Schedule P</td>
<td>Company Records</td>
<td>0.000</td>
<td>0</td>
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<tr>
<td>(5) Discount on Medical Expense Reserves Reported as Tabular in Schedule P</td>
<td>Company Records</td>
<td>0.000</td>
<td>0</td>
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<tr>
<td>(6) P&amp;C Subs Non-Tabular Discount - Losses</td>
<td>Subs' Sch P Pt1-Sum C32 L12</td>
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<td>0</td>
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<tr>
<td>(7) P&amp;C Subs Non-Tabular Discount - Expense</td>
<td>Subs' Sch P Pt1-Sum C33 L12</td>
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<tr>
<td>(8) P&amp;C Subs Discount on Medical Loss Reserves Reported as Tabular in Schedule P</td>
<td>Subs' Company Records</td>
<td>0.000</td>
<td>0</td>
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<tr>
<td>(9) P&amp;C Subs Discount on Medical Expense Reserves Reported as Tabular in Schedule P</td>
<td>Subs' Company Records</td>
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<td>(10) AVR - Life Subs §</td>
<td>Subs' P3 C1 L24.01 §</td>
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<td>(11) Dividend Liability - Life Subs</td>
<td>Subs' P3 C1 L6.1 + L6.2</td>
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<td>(12) Total Adjusted Capital Before Capital Notes</td>
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#### Credit for Capital Notes

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<tbody>
<tr>
<td>(13.1)</td>
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<td>Page 3 Column 1 Line 33</td>
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<td>(13.2)</td>
<td>Limitation on Capital Notes</td>
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<td>(13.3)</td>
<td>Capital Notes Before Limitation</td>
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<td>Credit for Capital Notes</td>
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<td>(14)</td>
<td>Total Adjusted Capital (Post-Deferred Tax)</td>
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#### Sensitivity Test:

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<tbody>
<tr>
<td>(15)</td>
<td>Deferred Tax Assets</td>
<td>Page 2 Column 3 Line 18.2</td>
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<tr>
<td>(15.1)</td>
<td>Deferred Tax Liabilities</td>
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<td>(16)</td>
<td>Deferred Tax Assets for Subsidiary</td>
<td>Company Record</td>
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<tr>
<td>(16.1)</td>
<td>Deferred Tax Liabilities for Subsidiary</td>
<td>Company Record</td>
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<tr>
<td>(17)</td>
<td>Total Adjusted Capital For Sensitivity Test</td>
<td>Line (14) - Line (15)*(15.1)+Line (16)+(16.1)</td>
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#### Ex DTA ACL RBC Ratio

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<th>Description</th>
<th>Calculation</th>
<th>Factor</th>
<th>Adjusted Capital</th>
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</thead>
<tbody>
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<td>(19)</td>
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<td>0.000</td>
</tr>
<tr>
<td>(20)</td>
<td>Authorized Control Level RBC</td>
<td>PR034 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)</td>
<td>0.000</td>
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<tr>
<td>(21)</td>
<td>Ex DTA ACL RBC Ratio</td>
<td>Line (19)/Line (20)</td>
<td>0.000%</td>
<td>0.000%</td>
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#### ACA Fee RBC Ratio

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Calculation</th>
<th>Factor</th>
<th>Adjusted Capital</th>
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</thead>
<tbody>
<tr>
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<td>Notes to Financial Statements Form 21B</td>
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<tr>
<td>(23)</td>
<td>Total Adjusted Capital Less ACA Fee</td>
<td>Line (14) - Line (22)</td>
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<tr>
<td>(24)</td>
<td>Authorized Control Level RBC</td>
<td>PR034 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)</td>
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<td>(25)</td>
<td>ACA Fee RBC Ratio</td>
<td>Line (23)/Line (24)</td>
<td>0.000%</td>
<td>0.000%</td>
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</table>

* Report amounts in this column as whole dollars.

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

Notes to Financial Statements Item 22B

<table>
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<tr>
<th>Line</th>
<th>Description</th>
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<tbody>
<tr>
<td>(26)</td>
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<td>Notes to Financial Statements Form 21B</td>
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<td>0.000</td>
</tr>
<tr>
<td>(27)</td>
<td>Total Adjusted Capital Less ACA Fee</td>
<td>Line (14) - Line (26)</td>
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<td>0.000</td>
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<tr>
<td>(28)</td>
<td>Authorized Control Level RBC</td>
<td>PR034 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)</td>
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<td>0.000</td>
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<tr>
<td>(29)</td>
<td>ACA Fee RBC Ratio</td>
<td>Line (27)/Line (28)</td>
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<td>0.000%</td>
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</tbody>
</table>

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Draft: 7/31/20
Adopted by the Executive (EX) Committee and Plenary, Dec. xx, 2020
Adopted by the Financial Condition (E) Committee, Dec. xx, 2020
Adopted by the Capital Adequacy (E) Task Force, Aug. 5, 2020

2021 Proposed Charges

CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Capital Adequacy (E) Task Force will:
   A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
   C. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the risk-based capital (RBC) formulas and delivering those recommendations to the Capital Adequacy (E) Task Force.
   D. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the risk-based capital (RBC) formulas and delivering those recommendations to the Capital Adequacy (E) Task Force.
   E. 

2. The Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group and Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Evaluate refinements to the existing NAIC risk-based capital (RBC) formulas implemented in prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C) and health RBC formulas to the Financial Condition (E) Committee by June.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 in the year of the change, and adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting or conference call. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by April 30 and results in an amended change may be considered by July 30 for those exceptions where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members present, no later than June 30 for the current reporting year.
   C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised Accounting Practices and Procedures Manual (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
   D. Review the effectiveness of the NAIC’s RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the summer and fall national meetings.

3. The Investment Risk-Based Capital (E) Working Group will:
   A. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the risk-based capital (RBC) formulas and delivering those recommendations to the Capital Adequacy (E) Task Force.
4. The **Variable Annuities Capital and Reserve (E/A) Subgroup**, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation, and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.

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

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

NAIC Support Staff: Jane Barr
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Capital Adequacy (E) Task Force  
[ ] Health RBC (E) Working Group  
[ X ] Life RBC (E) Working Group

[ ] Catastrophe Risk (E) Subgroup  
[ ] Investment RBC (E) Working Group  
[ ] Operational Risk (E) Subgroup

[ ] C3 Phase II/ AG43 (E/A) Subgroup  
[ ] P/C RBC (E) Working Group  
[ ] Longevity Risk (A/E) Subgroup

DATE: 6/6/19

CONTACT PERSON: Dave Fleming

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ON BEHALF OF: Life Risk-Based Capital (E) Working Group

NAME: Philip Barlow, Chair

TITLE: Associate Commissioner of Insurance

AFFILIATION: District of Columbia

ADDRESS: 1050 First Street, NE Suite 801
Washington, DC 20002

FOR NAIC USE ONLY

Agenda Item # 2020-03-L (MOD)

Year 2020

DISPOSITION

[ X ] ADOPTED 2/14/20

[ ] REJECTED

[ ] DEFERRED TO

[ ] REFERRED TO OTHER NAIC GROUP

[ X ] EXPOSED 1/13/20

[ ] OTHER (SPECIFY)

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

[ ] Health RBC Blanks  
[ ] Property/Casualty RBC Blanks  
[ x ] Life and Fraternal RBC Instructions

[ ] Health RBC Instructions  
[ ] Property/Casualty RBC Instructions  
[ ] Life and Fraternal RBC Blanks

[ ] OTHER ____________________________

DESCRIPTION OF CHANGE(S)

This proposal modifies the C-3 RBC instructions for 2020 and creates guidance for 2019 reporting. It also includes the deletion of instructions specific to 2019 which are not applicable for 2020 and beyond.

REASON OR JUSTIFICATION FOR CHANGE **

This proposal incorporates changes into the C-3 RBC instructions for 2020 to address an issue with the phase in of the new Variable Annuities Framework and guidance for a related issue with smoothing due to the treatment of voluntary reserves.

Additional Staff Comments:

• 1-13-20: Proposal was exposed for comments (DBF)
• 2-14-20: Proposal was exposed for comments adopted (DBF)
• 3-23-20: 2019 specific instruction deletion approved by Working Group and exposed for comment with no comments received. (DBF)

** This section must be completed on all forms.
INTEREST RATE RISK AND MARKET RISK
LR027

Overview

The amount reported on Line (35) and Line (37) is calculated using the 7-step process defined below. This calculation applies to all policies and contracts that have been valued following the requirements of AG-43 or VM-21. For contracts whose reserve was determined using the Alternative Methodology (VM-21 Section 7) see step 3 while all other contracts follow steps 1 and 2, then all contracts follow steps 4 - 7.

Step 1 CTE98: The first step is to determine CTE98 by applying the one of the two methodologies described in paragraph A below.

Step 2 C-3 RBC: using the formulas in paragraph B, determine the C-3 RBC amount based on the amount calculated in step (1). Floor this amount at $0.

Step 3 Determine the C-3 RBC using the Alternative Methodology for any business subject to that requirements as described in paragraph C.

Step 4 As described in paragraph D below, the C-3 RBC amount is the sum of the amounts determined in steps 2 and 3 above, but not less than zero. The Total Asset Requirement is the Reserve based on the requirements of VM-21 prior to the application of any phase-in, plus the C-3 RBC amount.

Step 5: For a company that has elected a Phase-in for reserves following VM-21 Section 2.B., the C-3 RBC amount is to be phased-in over the same time period following the requirements in paragraph E below.

Step 6 Apply the smoothing rules (if applicable) to the C-3 RBC amount in step (4) or (5) as applicable.

Step 7 Divide the amount from Step 4, 5, or 6 (as appropriate) by (1-enacted maximum federal corporate income tax rate). Split this amount into an interest rate risk portion and a market risk portion, as described in paragraph G.

The interest rate portion of the risk should be included in Line (35) and the market risk portion in Line (37).

The C-3 RBC is calculated as follows:

A. CTE (98) is calculated as follows: Except for policies and contracts subject to the Alternative Methodology (See C. below), apply the CTE methodology described in NAIC Valuation Manual VM-21 and calculate the CTE (98) as the numerical average of the 2 percent largest values of the Scenario Reserves, as defined by Section 4 of VM-21. In performing this calculation, the process and methods used to calculate the Scenario Reserves use the requirements of VM-21 and should be the same as used for the reserve calculations. The effect of Federal Income Tax should be handled following one of the following two methods

1. If using the Macro Tax Adjustment (MTA): The modeled cash flows will ignore the effect of Federal Income Tax. As a result, for each individual scenario, the numerical value of the scenario reserve used in this calculation should be identical to that for the same scenario in the Aggregate Reserve calculation under VM-21. Federal Income Tax is reflected later in the formula in paragraph B.1.

2. If using Specific Tax Recognition (STR): At the option of the company, CTE After-Tax (98) (CTEAT (98)) may be calculated using an approach in which the effect of Federal Income Tax is reflected in the projection of Accumulated Deficiencies, as defined in Section 4.A. of VM-21, when calculating the Scenario Reserve for each
scenario. To reflect the effect of Federal Income Tax, the company should find a reasonable and consistent basis for approximating the evolution of tax reserves in the projection, taking into account restrictions around the size of the tax reserves (e.g., that tax reserve must equal or exceed the cash surrender value for a given contract). The Accumulated Deficiency at the end of each projection year should also be discounted at a rate that reflects the projected after-tax discount rates in that year. In addition, the company should add the Tax Adjustment as described below to the calculated CTEAT (98) value.

3. A company that has elected to calculate CTEAT (98) using STR may not switch back to using MTA in the projection of Accumulated Deficiencies without prominently disclosing that change in the certification and supporting memorandum. The company should also disclose the methodology adopted, and the rationale for its adoption, in the documentation required by paragraph J below.

4. Application of the Tax Adjustment: Under the U.S. IRC, the tax reserve is defined. It can never exceed the statutory reserve nor be less than the cash surrender value. If a company is using STR and if the company’s actual tax reserves exceed the projected tax reserves at the beginning of the projection, a tax adjustment is required. The CTEAT (98) must be increased on an approximate basis to correct for the understatement of modeled tax expense. The additional taxable income at the time of claim will be realized over the projection and will be approximated using the duration to worst, i.e., the duration producing the lowest present value for each scenario. The method of developing the approximate tax adjustment is described below.

The increase to CTEAT (98) may be approximated as the corporate tax rate times f times the difference between the company’s actual tax reserves and projected tax reserves at the start of the projections. For this calculation, f is calculated as follows: For the scenarios reflected in calculating CTE (98), the scenario reserve is determined and its associated projection duration is tabulated. At each such duration, the ratio of the number of contracts in force (or covered lives for group contracts) to the number of contracts in force (or covered lives) at the start of the modeling projection is calculated. The average ratio is then calculated over all CTE (98) scenarios and f is one minus this average ratio. If the Alternative Method is used, f is approximated as 0.5.

B. Determination of RBC amount using stochastic modeling:

1. If using the MTA: Calculate the RBC Requirement by the following formula in which the statutory reserve is the actual reserve reported in the Annual Statement. In the second term – i.e., the difference between statutory reserves and tax reserves multiplied by the Federal Income Tax Rate – may not exceed the portion of the company’s non-admitted deferred tax assets attributable to the same portfolio of contracts to which VM-21 is applied in calculating statutory reserves:

\[ 0.25 \times \left( (\text{CTE (98)} + \text{Additional Standard Projection Amount} - \text{Statutory Reserve}) \times (1 - \text{Federal Income Tax Rate}) - (\text{Statutory Reserve} - \text{Tax Reserve}) \times \text{Federal Income Tax Rate} \right) \]

2. If the company elects to use the STR: the C-3 RBC is determined by the following formula:

\[ 0.25 \times (\text{CTEAT (98)} + \text{Additional Standard Projection Amount} - \text{Statutory Reserve}) \]

The Additional Standard Projection Amount is calculated using the methodology outlined in Section 6 of VM-21.

C. Determination of C-3 RBC using Alternative Methodology: This calculation applies to all policies and contracts that have been valued following the requirements of AG-43 or VM-21, for which the reserve was determined using the Alternative Methodology (VM-21 Section 7). The C-3 RBC amount is determined by applying the methodology as defined in Appendix 2 to these instructions.
D. The C-3 RBC amount is the sum of the amounts determined in paragraphs B and C above, but not less than zero. The TAR is defined as the Reserve determined according to VM-21 plus the C-3 RBC amount. All values are prior to any consideration of Phase-in allowances for either reserve or C-3 RBC, or any C-3 RBC smoothing allowance. The RBC values are post-tax.

E. Phase in: A company that has elected to phase-in the effect of the new reserve requirements following VM-21 Section 2.B. shall phase in the effect on C-3 RBC over the same time period, using the following steps:
1. Begin with the C-3 RBC amount from step 7 for Dec. 31, 2019 LR027 Line (37) instructions for all business within the scope of the Variable Annuities modeling requirements as of 12/31/19. Add to this any voluntary reserves which were subtracted from TAR when the C-3 RBC amount reported for 2019 was determined. Also add to this the amount of C-3 RBC computed in the same manner as the 2019 value for any reinsurance ceded that is expected to be recaptured in 2020 and in the scope of the Variable Annuities modeling requirements. This amount is 2019 RBC
2. Determine the C-3 RBC amount as of 12/31/19 using paragraphs A, B, C, and D for the same inforce business as in 1. Exclude any voluntary reserves in these calculations. Labeled as 2019 RBC New.
3. Determine the phase-in amount (PIA) as the excess of 2019RBC New over 2019RBC
4. For 12/31/2020, compute the C-3 RBC following paragraphs A – D above, then subtract PIA times (2/3)
5. For 12/31/2021, compute the C-3 RBC following paragraphs A – D above, then subtract PIA times (1/3)

Guidance Note: For a company that has adopted a Phase-in for reserves longer than 3 years, adjust the above formula to reflect the actual period with uniform amortization amounts during that period.

Guidance Note: An adjustment is made for voluntary reserves. Voluntary reserve means any reserve that is not required by AG-43, VM-21 and/or a state in which the company is doing business and was subtracted from TAR in 2019 to determine the RBC.

F. Smoothing of C-3 RBC amount
A company should decide whether or not to smooth the C-3 RBC calculated in paragraph D or E above to determine the amount in Line (37). For any business reinsured under a coinsurance agreement that complies with all applicable reinsurance reserve credit “transfer of risk” requirements, the ceding company shall reduce the reserve in proportion to the business ceded while the assuming company shall use a reserve consistent with the business assumed.

A company may choose to smooth the C-3 RBC calculated in paragraph D or E above. A company is required to get approval from its domestic regulator prior to changing its decision about smoothiing from the prior year. In addition, a company that has elected to smooth the risk-based capital is required to get approval from its domestic regulator prior to smoothing if it has experienced a material change in its Clearly Defined Hedging Strategy from the prior year. For this purpose, a company’s Clearly Defined Hedging Strategy is considered to have experienced a material change if any of the items outlined in VM-21 Section 1.D.2 in the current year differs from that in the prior year.

To implement smoothing, use the following steps. If a company does not qualify to smooth or a decision has been made not to smooth, go to paragraph G.
1. Determine the C-3 RBC amount calculated in paragraph D or E above
2. Determine the aggregate reserve for the contracts covered by the Variable Annuity Stochastic modeling requirements.
3. Determine the ratio of the C-3 RBC / reserve for current year.
4. Determine the C-3 RBC as actually reported for the prior year Lines (35) plus (37) and adjust that amount to a post-tax amount by multiplying by (1 - enacted maximum federal corporate income tax rate). Restate the amount to remove the effect of any voluntary reserves held in prior years that materially differ in amount from the voluntary reserves held in the current year.
5. Determine the aggregate reserve for the contracts in scope of these requirements for the prior year-end. Restate the aggregate reserve to remove any voluntary reserves held for the prior year-end that materially differ in amount from the voluntary reserves held as of the current year-end.
6. Determine the ratio of the C-3 RBC / reserve for prior year.
7. Determine a ratio as 0.4*(6) plus 0.6*(3) {40% prior year ratio and 60% current year ratio}.
8. Determine the risk-based capital for current year as the product of (7) and (2) (adjust (2) to be actual 12/31 reserve).

G. The amount determined in paragraphs D., E., or F. above for the contracts shall be divided by (1 - enacted maximum federal corporate income tax rate) to arrive at a pre-tax amount. This pre-tax amount shall be split into a component for interest rate risk and a component for market risk. Neither component may be less than zero. The provision for the interest rate risk, if any, is to be reported in Line (35). The market risk component is reported in Line (37).

The amount reported in Line (37) is to be combined with the C-1cs component for covariance purposes.

H. The way grouping (of funds and of contracts), sampling, number of scenarios, and simplification methods are handled is the responsibility of the company. However, all these methods are subject to Actuarial Standards of Practice, supporting documentation and justification, and should be identical to those used in calculating the company's statutory reserves following VM-21.

I. Certification of the work done to set the C-3 RBC amount for Variable Annuities and Similar products are the same as are required for reserves as part of VM-31. The certification should specify that the actuary is not opining on the adequacy of the company's surplus or its future financial condition.

The certification(s) should be submitted by hard copy with any state requiring an RBC hard copy.

J. An actuarial memorandum should be constructed documenting the methodology and assumptions upon which the required capital for the variable annuities and similar products is determined. Since the starting point for the C-3 RBC calculation is the cash flow modeling used for the reserves, the documentation requirements for reserves (VM-31) should be followed for the C-3 RBC. The reserve report may be incorporated by reference, with this C-3 RBC memorandum focused on identifying differences and items unique to the C-3 RBC process, or at the company's option, the documentation of C-3 RBC may be merged into the VA Report with the differences for C-3 RBC discussed in a separate section of the Memorandum as outlined in VM-31.

These differences that would need to be identified either in the RBC Actuarial Memorandum or the VA Report will typically include:
* the basis for considering federal income tax,
* whether or not smoothing was applied, and the effect of that smoothing,
* whether or not a phase in was used, and the impact on the reported values,
* If the company elects to calculate CTEAT (98) using STR whereby the effect of Federal Income Tax is reflected in the projection of Accumulated Deficiencies, the company should still disclose in the memorandum the Total Asset Requirement and C-3 RBC that would be obtained if the company had elected to use the MTA method.
* Documentation of the alternative methodology calculations, if applicable, and
* Documentation of how the C-3 RBC values were allocated to the interest and market risk components.

This actuarial memorandum will be confidential and available to regulators upon request.
The lines on the alternative calculations page will not be required for 2019 or later.

The total of all annual statement reserves representing exposure to C–3 risk on Line (36) should equal the following:

Exhibit 5, Column 2, Line 0199999
- Page 2, Column 3, Line 6
+ Exhibit 5, Column 2, Line 0299999
+ Exhibit 5, Column 2, Line 0399999
+ Exhibit 7, Column 1, Line 14
+ Separate Accounts Page 3, Column 3, Line 1 plus Line 2 after deducting (a) funds in unitized separate accounts with no underlying guaranteed minimum return and no uninsured guaranteed living benefits; (b) non-indexed separate accounts that are not cash flow tested with guarantees less than 4 percent; (c) non-cash-flow-tested experience-rated pension reserves/liabilities; and (d) guaranteed indexed separate accounts using a Class II investment strategy.
- Non policyholder reserves reported on Exhibit 7
+ Exhibit 5, Column 2, Line 0799997
+ Schedule S, Part 1, Section 1, Column 12
- Schedule S, Part 3, Section 1, Column 14
During the Life Risk-Based Capital (E) Working Group’s discussion at the Fall National Meeting, an issue was raised with respect to voluntary reserves and smoothing that may impact those companies that choose to early adopt for 2019. To highlight and address this issue, the Working Group exposed proposed modifications to the 2020 RBC instructions for comment. Additionally, as indicated, the Working Group is also now exposing the following recommendation for 2019 reporting for comment:

For insurers that meet the following three criteria:

1. Are early adopting the revised methodology for variable annuity reserves and C-3 RBC;
2. Held voluntary reserves in 2018 and intend to reduce or eliminate voluntary reserves in 2019;
3. Are currently smoothing or intend to request permission to smooth for 2019;

It is recommended those insurers do not smooth for 2019. Those insurers may then choose to begin smoothing in 2020. The smoothing instructions have been proposed to be revised for 2020 and the impact of the change will be a discontinuity in the C-3 RBC amount between 2019 and 2020 for those companies meeting the criteria identified above. A change in smoothing does require approval from the state of domicile.
INTEREST RATE RISK AND MARKET RISK
LR027

The following instructions for the Interest Rate Risk and Market Risk will remain effective independent of the status of the sunset provision, Section 8, of Actuarial Guideline XLVIII (AG 48) in a particular state or jurisdiction. This instruction will be considered for change once the amendment referenced in AG 48, Section 8, regarding credit for reinsurance, is adopted by the NAIC.

Detail Eliminated To Conserve Space

Cash Flow Modeling for C-3 RBC Requirements for Variable Annuities and Similar Products:

Instructions for 2019:

2019 is a transition year to a new modeling framework. A company must follow one of two options to develop the C-3 RBC amount:

A. If the company has elected to apply the requirements of VM-21 from the 2020 version of the NAIC valuation manual to determine reserves for the Variable Annuities for 12/31/19, the company shall follow the instructions beginning on page 16 labeled “Instructions for 2020 and Later” for determining the C-3 RBC requirement on the Variable Annuities and similar contracts, but may not apply the phase-in provisions of paragraph E on page 18. Otherwise,

B. The company shall follow the nine-step process below through page 15.

Overview (2019)

The amount reported on Line (37) is calculated using a nine-step process. As in Step 3 of the Single Scenario C-3 Measurement Considerations section of Appendix 1a – Cash Flow Testing for C-3 RBC Methodology, existing AVR-related assets should not be included in the initial assets used in the C-3 modeling unless AVR has been excluded from TAC due to its use in the asset adequacy analysis supporting reserves. AVR-related assets may be included with C-3 testing to the extent that the AVR has been used in the cash flow testing and is therefore excluded from TAC, and that portion of the AVR-related assets relates to the business being tested. These assets are available for future credit loss deviations over and above expected credit losses. These deviations are covered by C-1 risk capital. Similarly, future AVR contributions should not be modeled. However, the expected credit losses should be in the C-3 modeling. (Deviations from expected are covered by both the AVR and C-1 risk capital and should not be modeled).

IMR assets should be used for C-3 modeling. If negative cash flows are handled by selling assets, then appropriate modeling of contributions to and amortization of the IMR need to be reflected in the modeling.
The first step is determined by applying the methodology described in the report “Recommended Approach for Setting Risk-Based Capital Requirements for Variable Annuities and Similar Products Presented by the American Academy of Actuaries’ Life Capital Adequacy Subcommittee to the National Association of Insurance Commissioners’ Capital Adequacy Task Force (June 2005)” to calculate the total asset requirement. Although Appendix 2 in the Report notes path-dependent models under a different set of initialization parameters might produce scenarios that do not satisfy all the calibration points shown in Table 1, to be in compliance with the requirements in this first step, the actual scenarios used for diversified U.S. equity funds must meet the calibration criteria. The scenarios need not strictly satisfy all calibration points in Table 1 of Appendix 2, but the actuary should be satisfied that any differences do not materially reduce the resulting capital requirements. See the Preamble to the Accounting Practices and Procedures Manual for an explanation of materiality. Include the Tax Adjustment as described in the report using the enacted maximum federal corporate income tax rate. If using the Alternative Method for GMDB Risks, use 1 minus the enacted maximum federal corporate income tax rate in place of the 65% adjustment contained in paragraph 4 (page 55) and the enacted maximum federal corporate income tax rate in place of the 35% Income Tax Rate shown in Table 8-9 (page 78). The discount rate in Table 8-9 should also be adjusted for the appropriate enacted maximum federal corporate income tax rate.

The second step is to reduce the amount calculated in (1) above by the interest rate portion of the risk (i.e., only the separate account market risk is included in this step).

The third step is to calculate the Standard Scenario Amount.

Take the greater of the amounts from steps (2) and (3).

Apply the smoothing and transition rules (if applicable) to the amount in step (4).

Add the general account interest rate portion of the risk to the amount in step (5).

Subtract the reported statutory reserves for the business subject to the Report from the amount calculated in step (6). Floor this amount at $0.

Divide the result from step (7) by (1 - enacted maximum federal corporate income tax rate) to arrive at a pre-tax amount.

Split the result from step (8) into an interest rate risk portion and a market risk portion. Note that the interest rate portion may not equal the interest rate portion of the risk used in steps (2) and (6) above even after adjusting these to a pre-tax basis. The interest rate portion of the risk should be included in Line (35) and the market risk portion in Line (37).

The lines on the alternative calculations page will not be required for 2019.

Calculation of the Total Asset Requirement

The method of calculating the Total Asset Requirement is explained in detail in the AAA’s June 2005 report, referenced above. In summary, it is as follows:

A—Aggregate the results of running stochastic scenarios using prudent best estimate assumptions (the more reliable the underlying data is, the smaller the need for margins for conservatism) and calibrated fund performance distribution functions. If utilizing prepackaged scenarios as outlined in the American Academy of Actuaries’ report, Construction and Use of Pre-Packaged Scenarios to Support the Determination of Regulatory Risk-Based Capital Requirements for Variable Annuities and Similar Products, Jan. 13, 2006, the Enhanced C-3 Phase I Interest Rate Generator should be used in generating any interest rate scenarios or regenerating pre-packaged fund scenarios for funds that include the impact of bond yields. Details concerning the Enhanced C-3 Phase I Interest Rate Generator can be found on the American Academy of Actuaries webpage at the following address http://www.actuary.org/pdf/life/c3supp_jan06.pdf. The Enhanced C-3 Phase I Interest Rate Generator, with its ability to use the yield curve as of the run date and to regenerate pre-packaged fund returns using interest rate scenarios based on the current yield curve replaces the usage of the March 2005 pre-packaged scenarios.
B. Calculate required capital for each scenario by calculating accumulated statutory surplus, including the effect of federal income taxes at the enacted maximum federal corporate income tax rate, for each calendar year end and its present value. The negative of the lowest of these present values is the asset requirement for that scenario. These values are recorded for each scenario and the scenarios are then sorted on this measure. For this purpose, statutory surplus is modeled as if the statutory reserve were equal to the working reserve.

C. The Total Asset Requirement is set at the 90 Conditional Tail Expectation by taking the average of the worst 10 percent of all the scenarios’ asset requirements (capital plus starting reserve). Risk-based capital is calculated as the excess of the Total Asset Requirement above the statutory reserves. For products with no guaranteed living benefit, or just a guaranteed death benefit, an alternative method is allowed, as described in the AAA report.

D. Risk-based capital is calculated as the excess of the Total Asset Requirement above the statutory reserves. Except for the effect of the Standard Scenario and the Smoothing and Transition Rules (see below), this RBC is to be combined with the C-1cs component for covariance purposes.

E. A provision for the interest rate risk of the guaranteed fixed fund option, if any, is to be calculated and combined with the current C-3 component of the formula.

F. The way grouping (of funds and of contracts), sampling, number of scenarios, and simplification methods are handled is the responsibility of the actuary. However, all these methods are subject to Actuarial Standards of Practice, supporting documentation and justification.

G. Certification of the work done to set the RBC level will be required to be submitted with the RBC filing. Refer to Appendices 10 and 11 of the AAA LCAS C-3 Phase II RBC Report (June 2005) for further details of the certification requirements. The certification should specify that the actuary is not opining on the adequacy of the company’s surplus or its future financial condition. The actuary will also note any material change in the model or assumptions from that used previously and the impact of such changes (excluding changes due to a change in these NAIC instructions). Changes will require regulatory disclosure and may be subject to regulatory review and approval. Additionally, if hedging is reflected in the stochastic modeling, additional certifications are required from an actuary and financial officer of the company.

The certification(s) should be submitted by hard copy with any state requiring an RBC hard copy.

H. An actuarial memorandum should be constructed documenting the methodology and assumptions upon which the required capital is determined. The memorandum should also include sensitivity tests that the actuary feels appropriate, given the composition of their block of business (i.e., identifying the key assumptions that, if changed, produce the largest changes in the RBC amount). This memorandum will be confidential and available to regulators upon request.

Application of the Tax Adjustment

Tax Adjustment: Under the U.S. IRC, the tax reserve is defined. It can never exceed the statutory reserve nor be less than the cash surrender value. If tax reserves assumed in the projection are set equal to Working Reserves and if tax reserves actually exceed Working Reserves at the beginning of the projection, a tax adjustment is required.

A tax adjustment is not required in the following situations:

- Tax reserves are projected directly, that is, it is not assumed that projected tax reserves are equal to Working Reserves, whether these are cash values or other approximations.
- Tax reserves at the beginning of the projection period are equal to Working Reserves.
- Tax reserves at the beginning of the projection period are lower than Working Reserves. This situation is only possible for contracts without cash surrender values and when these contracts are significant enough to dominate other contracts where tax reserves exceed Working Reserves. In this case the modeled tax results are overstated each year for reserves in the projection, as well as the projected tax results reversed at the time of claim.
If a tax adjustment is required, the Total Asset Requirement (TAR) must be increased on an approximate basis to correct for the understatement of modeled tax expense. The additional taxable income at the time of claim will be realized over the projection and will be measured approximately using the duration to worst, i.e., the duration producing the lowest present value for each scenario. The method of developing the approximate tax adjustment is described below.

The increase to TAR may be approximated as the corporate tax rate times \( t \) times the difference between tax reserves and Working Reserves at the start of the projections. For this calculation, \( t \) is calculated as follows: For the scenarios reflected in calculating 90 CTE, the lowest of these present values of accumulated statutory surplus is determined for each calendar year end and its associated projection duration is tabulated. At each such duration, the ratio of the number of contracts in force (or covered lives for group contracts) to the number of contracts in force (or covered lives) at the start of the modeling projection is calculated. The average ratio is then calculated, over all 90 CTE scenarios, and \( f \) is one minus this average ratio. If instead, RBC is determined under the standard scenario method then \( f \) is based on the ratio at the worst duration under that scenario. If the Alternative Method is used, \( f \) is approximated as 0.8.

Calculation of the Standard Scenario Amount

Standard Scenario for C-3 Phase II Risk Based Capital (RBC) Determination

1. Overview

   A) Application to Determine RBC:

   A Standard Scenario Amount shall be determined for all of the contracts under the scope described in the June 2005 report, “Recommended Approach for Setting Risk-Based Capital Requirements for Variable Annuities and Similar Products”. If the Standard Scenario Amount is greater than the Total Asset Requirement less any amount included in the TAR but attributable to and allocated to C-3 (Interest Rate Risk) otherwise determined based on the Report, then the Total Asset Requirement before tax adjustment used to determine C-3 Phase II (Market Risk) RBC shall be the Standard Scenario Amount.

   The Standard Scenario Amount shall be the sum of the following:

   1. For contracts for which RBC is based on the Alternative Methodology applied without a model office using 100 percent of the MGDB mortality table, the Standard Scenario Amount shall be the sum of the total asset requirement before tax adjustment from the Alternative Methodology applied to such contracts.

   2. For contracts without guaranteed death benefits for which RBC is based on the Alternative Methodology applied without a model office, the Standard Scenario Amount shall be the sum of the total asset requirements before tax adjustment from the Alternative Methodology applied to such contracts.

   3. For contracts under the scope of the Report other than contracts for which paragraphs 1 and 2 apply, the Standard Scenario Amount is determined by use of The Standard Scenario Method described in Section III. The Standard Scenario Method requires a single projection of account values based on specified returns on the assets supporting the account values. On the valuation date an initial drop is applied to the account values based on the supporting assets. Subsequently, account values are projected at the rate earned on supporting assets less a margin. Additionally, the projection includes the cash flows for certain contract provisions, including any guaranteed living and death benefits using the assumptions in Section III. Thus, the calculation of the Standard Scenario Amount will reflect the greatest present value of the accumulated projected cost of guaranteed benefits less the accumulated projected revenue produced by the margins in accordance with Subsection III (D).

B) The Standard Scenario Amount under the Standard Scenario Method

The Standard Scenario Amount for all contracts subject to the Standard Scenario Method is determined as of the valuation date under the Standard Scenario Method described in Section III based on a rate, \( DR \). \( DR \) is the annual effective equivalent of the 10-year constant maturity treasury rate reported by the Federal Reserve for the month of valuation plus 50 basis points. However, \( DR \) shall not be less than 3 percent or more than 9 percent. If the 10-year constant maturity treasury rate is no longer available, then a substitute rate determined by the National Association of Insurance Commissioners shall be used. The accumulation rate, \( AR \), is the product of \( DR \) and one minus the tax rate defined in paragraph III(D)(10).
No modification is allowed from the requirements in Section III unless the Domiciliary Commissioner approves such modification as necessary to produce a reasonable result.

C) Illustrative Application of the Standard Scenario Method to a Projection, Model Office and Contract by Contract

To provide information on the significance of aggregation, a determination of the Standard Scenario Amount based on paragraphs III(B)(1) and III(B)(2) is required for each contract subject to paragraph I(A)(3). The sum of all such Standard Scenario Amounts is described as row B in Table A. In addition, if the Conditional Tail Expectation Amount in the Report is determined based on a projection of an inforce prior to the statement date and/or by the use of a model office, which is a grouping of contracts into representative cells, then additional determinations of the Standard Scenario Amount shall be performed on the prior inforce and/or model office. The calculations are for illustrative purposes to assist in validating the reasonableness of the projection and/or model office and to determine the significance of aggregation.

Table A identifies the Standard Scenario Amounts required by this section. The Standard Scenario Amounts required are based on how the Conditional Tail Expectation projection or Alternative Methodology is applied. For completeness, the table also includes the Standard Scenario Amount required by paragraph I(A)(3). The amounts in Table A should be included as part of the certifying actuary’s annual supporting memorandum specified in paragraph (H) of the “Calculation of the Total Asset Requirement” section of the RBC instructions.

- Standard Scenario Amounts in rows A and B in Table A are required of all companies subject to paragraph I(A)(3). No additional Standard Scenario Amounts are required if a company’s stochastic or alternative methodology result is calculated on the statement date using individual contracts (i.e., without a model office).
- A company that uses a model office as of the statement date to determine its stochastic or alternative methodology result must provide the Standard Scenario Amount for the model office. This is row C.
- A company that uses an aggregation by duration of contract by contract projection of a prior inforce to determine its stochastic or alternative methodology with result PS and then projects requirements to the statement date with result S must provide the Standard Scenario Amount for the prior inforce, row D.
- A company that uses a model office of a prior inforce to determine its stochastic or alternative methodology requirements with result PM and then projects requirements to the statement date with result S must provide the Standard Scenario Amount for the model office on the prior inforce date, row E.
Table A

<table>
<thead>
<tr>
<th>Standard Scenario Amounts</th>
<th>Validation Measures</th>
<th>Model Office Projection</th>
<th>Projection of Prior Inforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Aggregate valuation on the statement date on inforce contracts required in I(A)(3)</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>B. Seriatim valuation on the statement date on inforce contracts</td>
<td>None: Compare to A</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>C. Aggregate valuation on the statement date on the model office</td>
<td>If not material to model office validation: A/C</td>
<td>A/C compare to 1.00</td>
<td>None</td>
</tr>
<tr>
<td>D. Aggregate valuation on a prior inforce date on prior inforce contracts</td>
<td>If not material to projection validation</td>
<td>None</td>
<td>A/D – S/PS Compare to 0</td>
</tr>
<tr>
<td>E. Aggregate valuation on a prior inforce date of a model office</td>
<td>If not material to model office or projection validation</td>
<td>(A/E – S/PM) compare to 0</td>
<td></td>
</tr>
</tbody>
</table>

Modification of the requirements in Section III when applied to a prior inforce or a model office is permitted if such modification facilitates validating the projection of inforce or the model office. All such modifications should be documented. No modification is allowed for row B as of the statement date unless the Domiciliary Commissioner approved such modification as necessary to produce a reasonable result under the corresponding amount in row A.

II) Basic Adjusted Reserve

For purposes of determining the Standard Scenario Amount for Risk-Based Capital, the Basic Adjusted Reserve for a contract shall be the Working Reserve, as described in the Report, as of the valuation date.

III) Standard Scenario Amount – Application of the Standard Scenario Method

A) General

Where not inconsistent with the guidance given here, the process and methods used to determine results under the Standard Scenario Method shall be the same as required in the calculation under the modeling methodology required by the Report. Any additional assumptions needed to apply the Standard Scenario Method to the inforce shall be explicitly documented.
B) Results for the Standard Scenario Method.

The Standard Scenario Amount is equal to (1) + (2) – (3) where:

1) Is the sum of the Basic Adjusted Reserve as described in Section II for all contracts for which the Standard Scenario Amount is being determined,

2) Is zero or if greater the aggregate greatest present value for all contracts measured as of the end of each projection year of the negative of the Accumulated Net Revenue described below using the assumptions described in Subsection III(D) and a discount rate equal to the Accumulation Rate, AR. The Accumulated Net Revenue at the end of a projection year equals (i) + (ii) – (iii) where:

(i) Is the Accumulated Net Revenue at the end of the prior projection year accumulated at the rate AR to the end of the current projection year. The Accumulated Net Revenue at the beginning of the projection (i.e., time 0) is zero.

(ii) Are the margins generated during the projection year on account values as defined in paragraph III(D)(1) multiplied by one minus the tax rate and accumulated at rate AR to the end of current projection year, and

(iii) Are the contract benefits paid in excess of account value applied plus the Individual reinsurance premiums (ceded less assumed) less the Individual reinsurance benefits (ceded less assumed) payable or receivable during the projection year multiplied by one minus the tax rate and accumulated at rate AR to the end of current projection year. Individual reinsurance is defined in paragraph III(D)(2).

3) Is the value of approved hedges and Aggregate reinsurance as described in paragraph III(E)(2). Aggregate reinsurance is defined in paragraph III(D)(2).

C) The actuary shall determine the projected reinsurance premiums and benefits reflecting all treaty limitations and assuming any options in the treaty to the other party are exercised to decrease the value of reinsurance to the reporting company (e.g., options to increase premiums or terminate coverage). The positive value of any reinsurance treaty that is not guaranteed to the insurer or its successor shall be excluded from the value of reinsurance. The commissioner may require the exclusion of any portion of the value of reinsurance if the terms of the reinsurance treaties are too restrictive (e.g., time or amount limits on benefits correlate to the Standard Scenario Method).

D) Assumptions for Paragraph III (B) (2) Margins and Account Values.

1) Margins on Account Values. The bases for return assumptions on assets supporting account values are shown in Table I. The initial returns shall be applied to the account values assigned to each asset class on the valuation date as immediate drops, resulting in the Account Values at time 0. The “Year 1” and “Year 2+” returns are gross annual effective rates of return and are used (along with other decrements and/or increases) to produce the Account Values as of the end of each projection year. For purposes of this section, money market funds shall be considered part of the Bond class.

The Fixed Fund rate is the greater of the minimum rate guaranteed in the contract or 3.5 percent but not greater than the current rates being credited to Fixed Funds on the valuation date.

Account Values shall be accumulated after the initial drop using the rates from Table 1 with appropriate reductions applied to the supporting assets. The appropriate reductions for account values supported by assets in the Equity, Bond or Balance Classes are all fund and contract charges according to the provisions of the funds and contracts. The appropriate reduction for Account Values supported by Fixed Funds is zero.
The margins on Account Values are defined as follows:

a) During the Surrender Charge Period:
   i. 0.10% of Account Value; plus
   ii. The maximum of:
      - 0.20% of Account Value; or
      - Explicit and optional contract charges for guaranteed living and death benefits.

b) After the Surrender Charge Period:
   i. The amount determined in (a) above; plus
   ii. The lesser of:
      - 0.65% of Account Values; and
      - 50% of the excess, if any, of all contract charges over (a) above.

However, on fixed funds after the surrender charge period, a margin of up to the amount in (a) above plus 0.4% may be used.

Table 1

<table>
<thead>
<tr>
<th>Class</th>
<th>Initial</th>
<th>Year 1</th>
<th>Year 2+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity Class</td>
<td>-20%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Bond Class</td>
<td>0%</td>
<td>0%</td>
<td>4.85%</td>
</tr>
<tr>
<td>Balanced Class</td>
<td>-1.7%</td>
<td>0%</td>
<td>1.74%</td>
</tr>
<tr>
<td>Fixed Separate Accounts and General Account</td>
<td>Fixed Fund Rate</td>
<td>Fixed Fund Rate</td>
<td></td>
</tr>
</tbody>
</table>

3) Reinsurance Credit: Individual reinsurance is defined as reinsurance where the total premiums for and benefits of the reinsurance can be determined by applying the terms of the reinsurance to each contract covered without reference to the premiums or benefits of any other contract covered and summing the results over all contracts covered. Reinsurance that is not individual reinsurance is Aggregate reinsurance.

Individual reinsurance premiums projected to be payable on ceded risk and receivable on assumed risk shall be included in subparagraph III(B)(2)(iii). Similarly, Individual reinsurance benefits projected to be receivable on ceded risk and payable on assumed risk shall be included in subparagraph III(B)(2)(iii). No Aggregate reinsurance shall be included in subparagraph III(B)(2)(ii).
3) Lapses, Partial Withdrawals, and Moneyness. Partial withdrawals elected as guaranteed living benefits or required contractually (e.g., a contract operating under an automatic withdrawal provision on the valuation date) are to be included in subparagraph III(B)(2)(iii). No other partial withdrawals, including free partial withdrawals, are to be included. All lapse rates shall be applied as full contract surrenders.

A contract is in the money (ITM) if it includes a guaranteed living benefit and at any time the portion of the future projected account value under the Standard Scenario Method required to obtain the benefit would be less than the value of the guaranteed benefit at the time of exercise or payment. If the projected account value is 90 percent of the value of the guaranteed benefit at the time of exercise or payment, the contract is said to be 10 percent in the money. If the income from applying the projected account value to guaranteed purchase rates exceeds the income from applying the projected benefit base to GMIB purchase rates for the same type of annuity, then there is no GMIB cost and the GMIB is not in the money. A contract not in the money is out of the money (OTM). If a contract has multiple living benefit guarantees then the contract is ITM to the extent that any of the living benefit guarantees are ITM. Lapses shall be at the annual effective rates given in Table II.

<table>
<thead>
<tr>
<th>Table II – Lapse Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Death Benefit Only Contracts</td>
</tr>
<tr>
<td>All Guaranteed Living Benefits OTM</td>
</tr>
<tr>
<td>ITM&lt;10%</td>
</tr>
<tr>
<td>10%≤ITM&lt;20%</td>
</tr>
<tr>
<td>20%≤ITM</td>
</tr>
<tr>
<td>Any Guaranteed Account Balance Benefits ITM</td>
</tr>
<tr>
<td>Any Other Guaranteed Living Benefits ITM</td>
</tr>
</tbody>
</table>

4) Account Transfers and Future Deposits. No transfers between funds shall be assumed to determine the greatest present value amount required under paragraph III(B)(2) unless required by the contract (e.g., transfers from a dollar cost averaging fund or contractual rights given to the insurer to implement a contractually specified portfolio management strategy or a contract operating under an automatic re-balancing option). When transfers must be modeled, to the extent not inconsistent with contract language, the allocation of transfers to funds must be in proportion to the contract’s current allocation to funds.

Margins generated during a projection year on funds supporting account values are transferred to the Accumulation of Net Revenue at year-end and are subsequently accumulated at the Accumulation Rate. Assets for each class supporting account values are to be reduced in proportion to the amount held in each asset class at the time of transfer of margins or any portion of Account Value applied to the payment of benefits.

No future deposits shall be assumed unless required by the terms of the contract to prevent contract or guaranteed benefit lapse, in which case they must be modeled. When future deposits must be modeled, to the extent not inconsistent with contract language, the allocation of the deposit to funds must be in proportion to the contract’s current allocation to funds.

5) Mortality. Mortality at 80 percent of the 1994 MGDB tables through age 95 increasing by 1 percent each year to 100 percent of the 1994 MGDB table at age 115 shall be assumed in the projection used to determine the greatest present value amount required under paragraph III(B)(2).
6) Projection Frequency. The projection used to determine the greatest present value amount required under paragraph III(B)(2) shall be calculated using an annual or more frequent time step, such as quarterly. For time steps more frequent than annual, assets supporting Account Values at the start of each projection year may be retained in such funds until year-end (i.e., pre-tax margin earned during the year will earn the fund rates instead of the Discount Rate until year-end) or removed after each time step. However, the same approach shall be applied for all years. Subsequent to each projection year-end, Accumulated Net Revenues for the year shall earn the Accumulation Rate. Similarly, projected benefits, lapses, elections, and other contract activity can be assumed to occur annually or at the end of each time step, but the approach shall be consistent for all years.

7) Surrender Charge Period. If the surrender charge for the contract is determined based on individual contributions or deposits to the contracts, the surrender charge amortization period may be estimated for projection purposes. Such estimated period shall not be less than the remaining duration based on the normal amortization pattern for the remaining total contract charge assuming it resulted from a single deposit, plus one year.

8) Contract Holder Election Rates. Contract holder election rates to determine amounts in subparagraph III(B)(2)(iii) shall be 15 percent per annum for any elective ITM benefit except guaranteed withdrawal benefits, but only to the extent such election does not terminate a more valuable benefit subject to election. Guaranteed Minimum Death Benefits are not benefit subject to election. Exception: Contract holder election rates shall be 100 percent at the last opportunity to elect an ITM benefit, but only to the extent the such election does not terminate a more valuable benefit subject to election. A benefit is more valuable if it is more ITM in absolute dollars using the definition of ITM in paragraph III(D)(3).

For guaranteed minimum withdrawal benefits, a partial withdrawal equal to the applicable percentage in Table III applied to the contract’s maximum allowable partial withdrawal shall be assumed in subparagraph III(B)(2)(iii). However, if the contract’s minimum allowable partial withdrawal exceeds the partial withdrawal from applying the rate in Table III to the contract’s maximum allowable partial withdrawal, then the contract’s minimum allowable partial withdrawal shall be assumed in subparagraph III(B)(2)(iii).

### Table III—Guaranteed Withdrawal Assumptions

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Less than 50</th>
<th>50 to 59</th>
<th>60 or Greater</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Withdrawals do not reduce other elective guarantees that are in the money</td>
<td>50%</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>With Withdrawals reduce elective guarantees that are in the money</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
</tr>
</tbody>
</table>

9) GMIB. For subparagraph III(B)(2)(iii), GMIB cost at the time of election shall be the excess, if positive, of the reserve required for the projected annuitization stream over the available account value. If the reserve required is less than the account value, the GMIB cost shall be zero. The reserve required shall be determined using the Annuity 2000 Mortality Table and a valuation interest rate equal to the Discount Rate. If more than one annuity option is available, choose the option with a reserve closest to the reserve for a life annuity with 10 years of certain payments.

10) Indices. If an interest index is required to determine projected benefits or reinsurance obligations, the index must assume interest rates have not changed since the last reported rates before the valuation date. If an equity index is required, the index shall be consistent with the last reported index before the valuation date, the initial drop in equity returns, and the subsequent equity returns in the standard scenario projection up to the time the index is used. The sources of information and how the information is used to determine indexes shall be documented and, to the extent possible, consistent from year to year.

11) Taxes. All taxes shall be based on the enacted maximum federal corporate income tax rate.

E) Assumptions for use in paragraph III (B) (3).
1) The Value of Aggregate Reinsurance. The value of Aggregate reinsurance is the discounted value, at rate AR, of the excess of: a) the benefit payments from the reinsurance, over b) the reinsurance premiums, where (a) and (b) are determined under the assumptions described in Subsection III(D).

2) The Value of Approved Hedges. The value of approved hedges shall be calculated separately from the calculation in paragraph III(B)(2). The value of approved hedges is the difference between: a) the discounted value at rate AR of the after-tax cash flows from the approved hedges; less b) their statement values on the valuation date.

To be an approved hedge, a derivative or other investment has to be an actual asset held on the valuation date, be designated as a hedge for one or more contracts subject to the Standard Scenario, and be part of a clearly defined hedging strategy as described in the Report. If the approved hedge also supports contracts not subject to the Standard Scenario, then only that portion of the hedge designated for contracts subject to the Standard Scenario shall be included in the value of approved hedges. Approved hedges must be held in accordance with an investment policy that has been implemented for at least six months, and has been approved by the Board of Directors or a subcommittee of Board members. A copy of the investment policy and the resolution approving the policy shall be maintained with the documentation of the Standard Scenario and available on request. Approved hedges must be held in accordance with a written investment strategy developed by management to implement the Board’s investment policy. A copy of the investment strategy on the valuation date, the most recent investment strategy presented to the Board if different and the most recent written report on the effectiveness of the strategy shall be maintained with the documentation of the Standard Scenario and available on request.

The commissioner may require the exclusion of any portion of the value of approved hedges upon a finding that the company’s documentation, controls, measurement, execution of strategy, or historical results are not adequate to support a future expectation of risk reduction commensurate with the value of approved hedges.

The item being hedged, the contract guarantees, and the approved hedges are assumed to be accounted for at the average present value of the tail scenarios. The value of approved hedges for the standard scenario is the difference between an estimate of this “tail value” and the “fair value” of approved hedges. For this valuation to be consistent with the statement value of approved hedges, the statement value of approved hedges will need to be held at fair value with the immediate recognition of gains and losses. Accordingly, it is assumed that approved hedges are not subject to the IMR or the equity component of the AVR. Approved hedges need not satisfy SSAP No. 86. In particular, as gains and losses of approved hedges are recognized immediately, approved hedges need not satisfy the requirements for hedge accounting of fair value hedges.

It is the combination of hedges and liabilities that determine which scenarios are the tail scenarios. In particular, scenarios where the hedging is least effective are likely to be tail scenarios and liabilities that are a left tail risk could in combination with hedges become a right tail risk.

The cash flow projection for approved hedges that expire in less than one year from the valuation date should be based on holding the hedges to their expiration. For hedges with an expiration of more than one year, the value of hedges should be based on liquidation of the hedges one year from the valuation date. Where applicable, the liquidation value of hedges shall be consistent with Black-Scholes pricing, a risk-free rate of DR, annual volatility implicit as of the valuation date in the statement value of the hedges under Black-Scholes pricing and a risk-free rate of DR and the assumed returns in the Standard Scenario from the valuation date to the date of liquidation.

There is no credit in the Standard Scenario for dynamic hedging beyond the credit that results from hedges actually held on the valuation date. There is no credit for hedges actually held on the valuation date that are not approved hedges as the commitment to maintain the level of risk reduction derived from such hedges is not adequate.

3) Retention of Components. For the Standard Scenario Amounts on the statement date the company should have available to the Commissioner the following values:
   a) For runs A and B as defined in I(C) by contract and in aggregate the amounts determined in III(E)(1) and III(E)(2);
   b) For run A the aggregate amounts determined in III(E)(1) and III(E)(2).

Smoothing and Transition Rules
1. Determine the Total Asset Requirement as the greater of that produced by the “Recommended Approach for Setting Risk-Based Capital Requirements for Variable Annuities and Similar Products” presented by the American Academy of Actuaries’ Life Capital Adequacy Subcommittee to the National Association of Insurance Commissioner’s Capital Adequacy Task Force (June 2005) for the definition of this phrase) or some or all of its business, a decision should be made whether or not to smooth the TAR. In all cases, where ‘cash value’ is to be used, the values used must be computed on a consistent basis for each block of business at successive year-ends. For deferred annuities with a cash value option, direct writers will use the cash value. For deferred annuities with no cash value option, or for reinsurance assumed through a treaty other than coinsurance, use the policy holder account value of the underlying contract. For payout annuities, or other annuities with no account value or cash value, use the amount as defined for variable payout annuities in the definition of Working Reserve. For any property insurance, use the policy holder account value of the underlying contract. For any business reinsured under a coinsurance agreement that complies with all applicable reinsurance reserve credit “transfer of risk” requirements, the ceding company shall reduce the value in proportion to the business ceded while the assuming company shall use an amount consistent with the business assumed.

A company who reported an amount in Line (37) last year may choose to smooth the Total Asset Requirement. A company is required to get approval from its domestic regulator prior to changing its decision about smoothing from the prior year. To implement smoothing, use the following steps. If a company does not qualify to smooth or a decision has been made not to smooth, go to the step “Reduction for Reported Statutory Reserves.”

Instructions—2007 and Later

1. Determine the Total Asset Requirement as the greater of that produced by the “Recommended Approach for Setting Risk-Based Capital Requirements for Variable Annuities and Similar Products” presented by the American Academy of Actuaries’ Life Capital Adequacy Subcommittee to the National Association of Insurance Commissioner’s Capital Adequacy Task Force (June 2005) or the value produced by the “Standard Scenario” as outlined above.

2. Determine the aggregate cash value for the contracts covered by the Stochastic modeling requirements.

3. Determine the ratio of TAR / CV for current year.

4. Determine the Total Asset Requirement as actually reported for the prior year Line (37).

5. Determine the aggregate cash value for the same contracts for the prior year-end.

6. Determine the ratio of TAR / CV for prior year.

7. Determine a ratio as 0.4*(6) plus 0.6*(3) {40% prior year ratio and 60% current year ratio}.

8. Determine TAR for current year as the product of (7) and (2) {adjust (2) to be actual 12/31 cash value}.

Reduction for Reported Statutory Reserves

The amount of the TAR (post Federal Income Tax) determined using the instructions for the applicable year is reduced by the reserve, net of reinsurance, for the business subject to this instruction reported in the current statutory annual statement.

Allocation of Results to Line (35) and Line (37)

See step (9) located in the overview section at the beginning of the instructions for this line.
Cash Flow Modeling for the C-3 RBC Requirements for Variable Annuities and Similar Products: Instructions for 2020 & Later

Drafting Note: in the material that follows, Oliver Wyman’s proposed instructions are modified to present a more understandable requirement, but the only changes to actual requirements are for: C. Alternative Methodology, E. Phase-in, F. Smoothing, and I. Format of documentation.
EXAMINATION OVERSIGHT (E) TASK FORCE

The Examination Oversight (E) Task Force did not meet at the Summer National Meeting.
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force Aug. 7, 2020, Minutes

Receivership and Insolvency (E) Task Force March 4, 2020, and Jan. 8, 2020, Minutes (Attachment One) ...................................................... 10-1374

Comments Regarding Key Provisions of Receivership and Guaranty Fund Laws All States Should Consider Enacting (Attachment One-A) ...................................................... 10-1378

Memorandum to the Financial Condition (E) Committee Regarding Request for NAIC Model Law Development for the Insurance Holding Company Regulatory Act (#440) and the Insurance Holding Company Model Regulation (#450), Jan. 8, 2020 (Attachment One-B) ....................... 10-1388


Receivership Large Deductible Workers’ Compensation (E) Working Group March 2, 2020, Minutes (Attachment Three) ...................................................... 10-1408

Memorandum from NAIC Staff Regarding Guideline: Alternative to Section 712 of the Insurer Receivership Model Act (#555), Dec. 2, 2019 (Attachment Three-A) ............................................. 10-1409


National Conference of Insurance Guaranty Funds (NCIGF) Letter Regarding Section 712 Guideline (Attachment Three-C) ...................................................... 10-1415

Summary of Proposed Maine Revisions to Section 712 Guideline (Attachment Three-D) ...................................................... 10-1417

Maine Alternative Proposal to Section 712 Guideline, Jan. 6, 2020 (Attachment Three-E) ...................................................... 10-1420

Summary of Key Provisions of Receivership and Guaranty Fund Laws All States Should Consider Enacting, Aug. 4, 2020, Draft (Attachment Four) ...................................................... 10-1429
The Receivership and Insolvency (E) Task Force met via conference call Aug. 7, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by James Kennedy (TX); Karima M. Woods, Vice Chair (DC); Alan McClain represented by Steve Uhrynowycz (AR); Ricardo Lara represented by Joe Holloway (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Toma Wilkerson (FL); Doug Ommen represented by Kim Cross (IA); Robert H. Muriel represented by Kevin Baldwin (IL); Vicki Schmidt represented by Chut Tee (KS); Sharon P. Clark represented by Rodney Hugle (KY); Gary Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by James Gerber (MI); Chlora Lindley-Myers represented by Debbie Doggett and Shelley Forrest (MO); Bruce R. Ramge represented by Lindsay Crawford (NE); Glen Mulready represented by Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer and Matt Gendron (RI); Raymond G. Farmer represented by Ryan Basnett (SC); Hodgen Mainda represented by Patrick Merkel (TN); and Todd E. Kiser represented by Jake Garn (UT).

1. **Adopted its March 4, Jan. 8, and 2019 Fall National Meeting Minutes**

Ms. Cross made a motion, seconded by Ms. Wilson, to adopt the Task Force’s March 4, Jan. 8 (Attachment One), and 2019 Fall National Meeting (see NAIC Proceedings – Fall 2019, Receivership and Insolvency (E) Task Force) minutes. The motion passed unanimously.

2. **Adopted Revisions to the Receiver’s Handbook for Insurance Company Insolvencies**

Ms. Slaymaker made a motion, seconded by Mr. Baldwin, to adopt the Receiver’s Handbook for Insurance Company Insolvencies for federal taxes and federal releases (Attachment Two). The motion passed unanimously.


Ms. Wilson said the Receivership Financial Analysis (E) Working Group met Aug. 4 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings to discuss the status of individual receiverships and related issues. Ms. Wilson made a motion, seconded by Ms. Wilkerson, to adopt the Working Group’s report. The motion passed unanimously.

4. **Adopted the Report of the Receivership Large Deductible Workers’ Compensation (E) Working Group**

Ms. Slaymaker said the Receivership Large Deductible Workers’ Compensation (E) Working Group met March 2 and took the following action: 1) received comments on a draft model guideline that provides alternative language for the Insurer Receivership Model Act Section 712—Administration of Loss Reimbursement Policies; and 2) formed a drafting group to address comments received. The drafting group and the Working Group will reconvene after the national meeting. Ms. Slaymaker made a motion, seconded by Mr. Wake, to adopt the Working Group’s report, including its March 2 minutes (Attachment Three). The motion passed unanimously.

5. **Exposed Key Provisions of Receivership and Guaranty Fund Laws**

Mr. Kennedy discussed the Task Force’s response to the Macroprudential Initiative (MPI). The Task Force received comments on key provisions of receivership and guaranty fund laws that states should consider adopting into their laws, particularly with respect to receiverships of insurers operating in multiple states. The Task Force discussed the comments on its March 4 conference call. He said the key provisions identified in comments will be exposed for a 30-day public comment period ending Sept. 8 for state insurance regulators and interested parties to provide additional feedback for each provision (Attachment Four). The Task Force requests comments on each key provision as follows: 1) if it is critical for all states to have in receivership and guaranty fund law in a receivership affecting multiple states; 2) if it should be considered for a limited scope accreditation standard; 3) if other methods should be used to encourage its adoption; and 4) if there are impediments to its adoption.
6. **Heard a Presentation on Cyber Claims in Receivership**

Roger H. Schmelzer (National Conference of Insurance Guaranty Funds—NCIGF), Chad Anderson (Western Guaranty Fund Services—WGFS), and Tim Schotke (Illinois Insurance Guaranty Fund—IIGF) gave a presentation on the NCIGF’s white paper, *Insurance Resolution: Preparing for Cyber Claims*, which is located on the NCIGF’s webpage.

Mr. Schotke said there is more risk in cyberinsurance due to lack of pricing and loss experience. He said cyberinsurance is operationally very different from any other business that guaranty funds deal with, such as indemnity provisions and in-kind services; therefore, receivers need to be prepared. There may be tasks that receivers are not prepared to provide, such as restoring system and forensic work. Mr. Anderson said these policies are complicated and inconsistent and there is little standardization. He said guaranty associations are aiming to be prepared for potential issues in the future. He said guaranty associations are looking for state insurance regulators and receivers to acknowledge potential issues with cyber claims in a receivership and engage in early communication with guaranty funds when an insurer that writes cyber policies becomes troubled. Guaranty associations are looking to put together a group of experts as contacts, if needed, such as forensic experts. Guaranty associations will also be internally evaluating potential claims or other issues. Mr. Schmelzer said guaranty associations are open and eager to work in advance with state insurance regulators and receivers on potential issues with a receivership of cyberinsurance.

7. **Heard an Update on International Resolution Activities**

Mr. Kennedy reported that the International Association of Insurance Supervisors (IAIS) Resolution Working Group (ReWG) met via conference call in April 2020 to continue development of the *Application Paper on Resolution Planning*. The ReWG expects to finalize the draft of the application paper at a conference call in September 2020. The draft paper is expected to be exposed for consultation in November 2020.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
The Receivership and Insolvency (E) Task Force met via conference call March 4, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by James Kennedy (TX); Karima M. Woods, Vice Chair, represented by N. Kevin Brown (DC); Lori K. Wing-Heier represented by David Phifer (AK); Allen W. Kerr represented by Steve Uhrynowycz (AR); Ricardo Lara represented by David Wilson (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jon Arsenault (CT); David Altmaier represented by Toma Wilkerson (FL); Doug Ommen represented by Karen Cross (IA); Robert H. Muriel represented by Kevin Baldwin (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); Gary Anderson represented by Christopher Joyce (MA); Chlora Lindley-Myers (MO); Matthew Rosendale represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Lindsay Crawford (NE); Glen Muleady represented by Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Raymond G. Farmer represented by Geoffrey Bonham (SC); Hodgen Mainda represented by Nikita Hampton (TN); and Todd E. Kiser represented by Jake Garn (UT).

1. Discussed Comments on Key Provisions of Receivership and Guaranty Fund Laws

Mr. Kennedy said that as part of the Task Force’s response to the Macroprudential Initiative (MPI), during its conference call on Jan. 8, the Task Force requested comments on key provisions of receivership and guaranty fund laws that states should consider adopting into their laws, particularly with respect to receiverships of insurers operating in multiple states.

Mr. Kennedy summarized the comments received from Missouri, Pennsylvania, Texas, the American Council of Life Insurers (ACLI), the National Conference of Insurance Guaranty Funds (NCIGF), and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) (Attachment One-A).

Barbara Cox (NCIGF) said she disagrees with the comment from Pennsylvania that all states should have uniform property/casualty (P/C) guaranty fund limits as there may be local variation between states—for example, home values. The claim cap in one state may not be appropriate in another state, so some difference in claim caps is probably appropriate for P/C business. Ms. McDonald said the Pennsylvania comment was regarding medical malpractice insurance.

Bill O’Sullivan (NOLHGA) said on the life side, there has been good success in states updating their laws to adopt the provisions of Life and Health Insurance Guaranty Association Model Act (#520). He said 28 states have adopted the 2017 revisions to the Model #520, and another nine states are expected to propose revisions in 2020. He said NOLHGA would have concerns if Model #520 were further revised as it may create delays in states adopting the 2017 revisions. He said NOLHGA has not identified any significant issues that would require amendments to Model #520. He said NOLHGA has not discussed consideration of changes to accreditation standards. He said it would be complicated to identify the standards and to compare them to states’ laws.

Wayne Mehlman (ACLI) said an ad hoc committee of the ACLI has had these comments under consideration. He said the comments address holistic improvements to the system rather than specific provisions. Ms. Wilkerson asked for clarification on ACLI’s comment related to timing of orders of liquidation. Mr. Mehlman said the intent was to address the length of time a rehabilitation order can continue as the administrative expenses of receivership consume resources before liquidation. Mr. Kennedy said Texas had a provision that imposed a deadline for closing a rehabilitation, but it created many legal problems, was unworkable and was repealed. He said there may be other ways to address the issue other than time limits in state statutes.

Mr. Kennedy said NAIC staff would circulate a list of the items identified in the comment letters to all members, interested state insurance regulators and interested parties and request feedback on each item: 1) agree or disagree to include the item in a response to the Financial Stability (EX) Task Force that this provision(s) is critical for states to have in law for a multi-jurisdiction receivership as it addresses financial stability concerns in resolution; and 2) agree or disagree that this provision(s) is critical for states to have in law for a multi-jurisdiction receivership and should be considered in further discussions regarding a possible update to accreditation standards. He requested responses by March 13.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
The Receivership and Insolvency (E) Task Force met via conference call Jan. 8, 2020. The following Task Force members participated: Kent Sullivan, Chair, represented by James Kennedy (TX); Stephen C. Taylor, Vice Chair, represented by N. Kevin Brown (DC); Allen W. Kerr represented by Steve Uhrynowycz (AR); Ricardo Lara represented by Joe Holloway and David Wilson (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jon Arsenault (CT); David Altmaier represented by Toma Wilkerson (FL); Doug Ommen represented by Carrie Mears and Kim Cross (IA); Robert H. Muriel represented by Kevin Baldwin (IL); Vicki Schmidt represented by Paige Blevins (KS); Gary Anderson represented by Christopher Joyce (MA); Chlora Lindley-Myers represented by John Rehagen (MO); Matthew Rosendale represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge represented by Justin Schrader and Lindsay Crawford (NE); Glen Mulready represented by Donna Wilson (OK); Jessica Altman represented by Laura Lyon Slaymaker (PA); Raymond G. Farmer represented by Lee Hill (SC); Hodgen Mainda represented by Bill Huddleston (TN); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); and Mike Kreidler represented by Ron Pastuch (WA).

1. **Adopted a Referral to the Financial Condition (E) Committee**

Mr. Kennedy said at the 2019 Fall National Meeting, the Task Force discussed requesting that the Financial Condition (E) Committee consider opening the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) to consider revisions to address issues with the continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company, specifically agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

Iain Nasatir (Pachulski Stang Ziehl & Jones) asked if the Task Force had considered if such changes to Model #440 would conflict with federal laws, such as the McCarran-Ferguson Act or the federal bankruptcy law. Mr. Kennedy said that future discussions will include potential conflicts with other laws.

Mr. Kaumann made a motion, seconded by Mr. Hill, to adopt the referral to the Financial Condition (E) Committee (Attachment One-B). The motion passed unanimously.

2. **Requested Comments on Key Provisions of Receivership and Guaranty Fund Laws**

Mr. Kennedy said that as part of the Macroprudential Initiative (MPI), a recommendation was adopted by the Task Force to consider methods to encourage states to adopt provisions in receivership and guaranty fund laws that promote effectiveness and consistency, particularly with respect to receiverships of insurers operating in multiple states.

Mr. Kennedy requested that Task Force members, interested state insurance regulators, and interested parties submit suggestions for a list of key provisions that states should have in their laws to promote effectiveness and consistency in receiverships affecting multiple states. Comments should be submitted to Jane Koenigsman (NAIC) by Feb. 7, 2020.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

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Draft: 1/14/20

Receivership and Insolvency (E) Task Force
Conference Call
January 8, 2020
MISSOURI COMMENTS

Sent: Friday, February 7, 2020 2:49 PM
Subject: Comments on Key Provisions of Receivership Laws

You requested suggestions for a list of key provisions that states should have in its laws to promote effectiveness and consistency in receiverships impacting multiple states. I suggest that states consider adding provisions relating to the following:

1. **Conflicts of Law.** Please see the Insurer Receivership Model Act (MDL-555), Section 102. Conflicts of Law. “This Act, Title [XXX], and the state insurance guaranty association acts constitute this state’s insurer receivership laws, and these laws shall be construed together in a manner that is consistent. In the event of a conflict between the insurer receivership laws and the provisions of any other law, the insurer receivership laws shall prevail.”

2. **Police and Regulatory Exception to Stay.** The Bankruptcy Code includes certain exceptions to the automatic stay, including an exception for a governmental unit to enforce such governmental unit’s police or regulatory power. See 11 U.S.C. §362(b)(4). States should consider including such an exception to receivership statutes relating to injunctions and orders. Section 108 of the MDL-555 relates to Injunctions and Orders. Including an exception to the stay provision would confirm for states that an action by an insurance department, while exercising its regulatory powers against a license of an insurance company in a receivership case pending in a different state, is not stayed by the commencement of a receivership proceeding.

Please let me know if you would like additional information about the foregoing.

Best regards,

Shelley L. Forrest
Receivership Counsel
Missouri Department of Commerce and Insurance
Suggestions from Pennsylvania focus on three different areas where we feel there is a lack of effectiveness and consistency in receiverships that impact multiple states. The biggest inconsistency is the recognition of stays and the failure to give full faith and credit when lawsuits are pending in states that are not the domestic state. Obviously in Pennsylvania we view the Warrantech issue and over the cap payments to claimants to be a large issue. Lastly the Model Act 520 did a lot to change inconstancies on the life and health side but we view the varying property and casualty GA limits across the country as an issue and something to possibly be addressed.

If there is anything else you need from me do not hesitate to reach out.

Best,

Crystal McDonald

Crystal D. McDonald, Esquire | Project Director
Insurance Department | Office of Liquidations, Rehabilitations and Special Funds
Insurer Receivership Model Act Key Provisions

Article X. Interstate Relations

Article X was drafted to resolve issues that arise in receiverships impacting multiple states. The enactment of these provisions would enhance the efficiency and effectiveness of receiverships.

Section 1001 provides for an ancillary conservation of foreign insurers. The adoption of this section would avoid unnecessary ancillary receiverships. In some cases, ancillary receiverships can increase the costs of administration while providing little or no benefit to policyholders.

Section 1002 deals with domiciliary receivers in other states, and addresses two important issues:

- It ensures that other states’ receivership statutes and court orders are given full faith and credit. This promotes a uniform application of laws and orders in receivership proceedings. It also avoids any criteria for determining whether another state qualifies as a “reciprocal state”, which is inconsistent in existing statutes. In 2017, the NAIC Financial Condition Committee encouraged states to enact laws according full faith and credit to stays and injunctions entered in other states’ receivership proceedings. This recommendation also suggested that states consider adopting the stay provisions of the more recent NAIC models (See IRMA §108).

- It provides for the disposition of deposits held for an insurer placed in receivership, and ensures that they are available to the receivership estate or guaranty associations, as applicable. This can avoid a situation where deposits languish due to statutory ambiguities or inconsistencies.

Section 102. Conflicts of Law

This section provides that the Insurer Receivership Act and state insurance guaranty association acts shall prevail in the event of a conflict with other laws. This is an important principle, as these laws must control over general laws governing insurers.

Section 502. Continuance of Coverage

This section governs the continuation of coverage under policies when a liquidation order is entered. Section 502 D specifies that insurance policies or annuities covered by a life and health insurance guaranty association continue in force after the entry of a liquidation order. This provision is critical in a liquidation of a life or health insurer, as it ensures that such policies are not automatically terminated as a result of a liquidation order. Section 502 B also permits the Liquidator, with court approval, to set the date on which policies not covered by a life and health insurance guaranty association are canceled. This gives the Liquidator flexibility to deal with situations where the default 30-day period might not be appropriate.

Section 801. Priority of Distribution

The priority scheme governing the distribution of assets must comport with the Supreme Court’s decision in United States Department of Treasury v. Fabe.

Guideline for Implementation of State Orderly Liquidation Authority

The NAIC Receiver’s Handbook for Insurance Company Insolvencies addresses the implementation of a receivership in the event of a proceeding under Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Title II). It includes a guideline for initiating a receivership in connection with a proceeding under Title II. A receivership act should include
TEXAS COMMENTS

authority similar to the guideline to ensure that expeditious action can be taken if there is a proceeding under Title II.
Wayne Mehlman
Senior Counsel

February 7, 2020

James Kennedy, Chair
Receivership and Insolvency (E) Task Force
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108

RE: List of Key Provisions to Promote Effectiveness and Consistency
in State Receivership and Guaranty Association Laws

Dear Chairman Kennedy:

The American Council of Life Insurers ("ACLI")\(^1\) appreciates this opportunity to respond to the Task Force’s request for a list of key provisions that states should adopt in its receivership and guaranty association laws in order to promote effectiveness and consistency, particularly with regard to multi-state receiverships.

The ACLI believes that both the state receivership and guaranty association systems have operated very efficiently and effectively since their inception and that there is a high degree of consistency among the states, particularly with regard to state guaranty association laws.

That being said, there is always room for improvement, which is why we are recommending a list of potential improvements. We are not, however, seeking to “open up” either the receivership or guaranty association models to revisions or additional provisions, though we are suggesting some amendments to the Insurance Holding Company System Regulatory Act which the Task Force is currently looking to revise.

Instead, we are seeking more holistic ways of improving the overall receivership and guaranty association systems and related state laws, including those pertaining to the timing, administration and costs of rehabilitations and liquidations, as well as to the judiciary and the NAIC.

\(^1\) The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States. Learn more at www.acli.com.

American Council of Life Insurers
101 Constitution Avenue, NW, Washington, DC 20001-2133
(202) 624-2135  waynemehlman@acli.com
Below is a list of our suggested improvements:

- Encourage all states to adopt the NAIC’s recently-revised *Life and Health Insurance Guaranty Association Model Act*

- Create a NAIC accreditation standard that would require states to adopt, in a “functionally consistent” manner, the *Life and Health Insurance Guaranty Association Model Act*

- Align our receivership and guaranty association laws as they relate to life and health reinsurance

- Promote least-cost resolution at the administrative level and in the early stages of judicial proceedings

- Limit how long a receivership proceeding can be left open (since administration expenses can consume considerable resources)

- Address the timing of orders of liquidations

- Limit judicial discretion regarding a regulator’s petition for rehabilitation or liquidation

- Create a designated receivership court in every state

- Provide standardized judicial education on the receivership process

- Strengthen the NAIC’s Financial Analysis Working Group (FAWG) and Receivership Financial Analysis Working Group (R-FAWG)

- Create a NAIC “SWAT” team of receivership experts

- Continue to address modifications to Section 7 of the *Insurance Holding Company System Regulatory Act* that would assure the continuation of inter-affiliate services where receiverships impact multiple states

- Create crisis management groups for supervisory colleges within Section 7 of the *Insurance Holding Company System Regulatory Act* and/or guidance such as the Receivers’ Handbook

Thanks again for this opportunity to comment. If you have any questions, feel free to contact me at waynemehlman@acli.com or 202-624-2135.

Sincerely,

Wayne Mehlman
Senior Counsel, Insurance Regulation
February 7, 2020

James Kennedy
Chairman, Receivership and Insolvency Task Force
National Association of Insurance Commissioners
1100 Walnut Street
Kansas City, MO 64106-2197

Subject: Response to Request for Comment on Key Provisions for Insolvency Laws

Dear James:

Thank you for inviting comments on Key Provisions for Insolvency Laws. In response NCIGF offers the following:

The NCIGF is undertaking a multi-year effort to implement various revisions to property and casualty guaranty fund acts. This effort will focus on the following areas:

1) Modernization as needed of state laws. A small minority of states need updates to provisions in their laws such as the base for calculation of member assessments, claim bar dates and other matters. We plan to identify areas where an update may be needed and offer suggestions to fund managers and their boards in this regard.

2) Statutory changes to accommodate transactions under Insurance Business Transfer and corporate division statutes. We have advised the Restructuring Mechanisms Working Group that we have concerns that under current state guaranty fund laws certain claimants involved in these transactions may not be covered in the event of the insolvency of a new entity. NCIGF recently adopted a policy stating that coverage should remain in place for those claimants who would have had guaranty fund coverage before the transaction. Conversely, the policy states that guaranty fund coverage should not be created for such claims that would not have been covered claims before the transaction. We are in the process of developing statutory language to achieve this result and will suggest to local managers that the changes be implemented as needed and assist them in tailoring our template language to their local statutes.

3) Specific statutory changes if needed to permit guaranty funds to assess for administrative costs that are not tied to the volume of insolvency activity. As you are aware the guaranty funds are often called upon to “ramp up” very quickly to address new liquidations. To achieve this “always ready” status it is important that a minimal cadre of experienced staff be available to handle short-notice influx of claims and that physical guaranty fund facilities be maintained. Some
states may need specific statutory changes to address this need and we will be assisting our members in this regard.

4) Statutory changes as needed to prevent “orphan claims” scenarios. In a minority of states non-standard language, usually related to residency requirements, is on the books. This could create a claim denial of a claim the system is intended to cover. We plan to work with those states, again a minority, in which such problem could arise.

With regard to liquidation acts, as you know, the NCIGF for some time has promoted specific liquidation act language to address large deductibles. The NAIC’s IRMA model has such a provision and recently the large deductible working group has exposed an alternative approach as a “guideline” for states to consider. This alternative approach calls for the asset to be remitted in full to the guaranty funds and not be treated as a general asset of the estate. The NCIGF supports the alternative approach proposed by the Large Deductible Working Group with some technical tweaks that will be offered in our comments. The Large Deductible Working Group has concluded, and we agree, that large deductible business, in an insurance liquidation, is best managed when there is a statute in place.

Thank you for considering our comments. We would be happy to answer any questions the RITF may have.

Very truly yours,

Barbara F. Cox
Attorney at Law
Barbara F. Cox, LLC
February 7, 2020

James Kennedy, Chair
Receivership and Insolvency Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Jane M. Koenigsman, Life/Health Financial Analysis Manager
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197


Dear Mr. Kennedy and Ms. Koenigsman:

We understand that the NAIC’s Receivership and Insolvency Task Force is requesting comments from Interested Regulators and Interested Parties concerning efforts to encourage state adoption of provisions in receivership and guaranty association laws that promote effectiveness and consistency in multi-state insurer insolvencies, in furtherance of recommendations made related to the NAIC’s Macro Prudential Initiative. We understand further that the Task Force intends to develop a list of “key” receivership and guaranty fund provisions to recommend for adoption in the states. We appreciate the opportunity to have input in this process.

The Life and Health Insurance Guaranty Association system has already achieved a high degree of statutory consistency with the NAIC’s Life and Health Insurance Guaranty Association Model Act (“Model Act”). To date, there are 46 states that are substantially consistent with the key provisions of the Model Act, as it existed prior to the recently adopted 2017 amendments.¹

As you know, the process for amending the Model Act in 2017 was very thorough and resulted in extensive changes to reflect the Guaranty System’s most recent insolvency experience dealing with long term care insurance. Since the NAIC’s adoption of the 2017 amendments, there has been a successful effort to seek enactment of those amendments across the country. To date, 27

¹ The key provisions deal with coverage limits, triggering, the definitions of insolvent and impaired insurer, non-resident coverage, coverage of citizens living abroad, payee coverage for structured settlement annuities, non-guaranteed products, interest rate adjustments, equity indexed products, Medicare Part C and D products and reinsurance.
states have substantially adopted the 2017 amendments, and there are continuing efforts to update the guaranty association laws in the balance of the states, including bills introduced or soon to be introduced for 2020 legislative sessions.

Given that the Model Act was recently updated in 2017, and given that there already is a high level of conformity between state law and the Model Act, we believe that the focus of current efforts should be on supporting the adoption of the 2017 amendments in the remaining states rather than reopening discussions about the Model Act. We would be concerned that such discussions, in particular if they resulted in additional changes to the Model Act, could distract and disrupt efforts to adopt the 2017 amendments in the remaining states.

Again, we thank you for this opportunity to comment, and we would be happy to answer any questions that you may have concerning our comments.

Sincerely,

Peter G. Gallanis
President

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2 Of these 27 states, one state, Utah, has adopted a 75 25 split between life and health insurers for purposes of allocating the costs of long-term care assessments.
To:  Financial Condition (E) Committee  
From:  Receivership and Insolvency (E) Task Force  
Date:  January 8, 2020  
RE:  Model Law Request for Insurance Holding Company System Regulatory Act (#440) and  
Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

The Receivership and Insolvency (E) Task Force requests the Committee consider opening the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to consider revisions to address issues with continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company, specifically agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

The Task Force is cognizant of other unrelated revisions being considered for Models 440 and 450 under an existing open Model Law Request and understands the sensitivity of the timing of that work. Work related to the continuation of essential services is not intended to delay or impede any other revisions; however, the Task Force feels it may be efficient to conduct its review and drafting concurrently with that work.

Background and Rationale

In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Financial Stability Board’s (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

- The Insurance Holding Company System Model Act (#440) requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The Insurance

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Holding Company System Model Regulation (#450), Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.

- The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

One potential solution is to revise the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.

The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450
The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed draft Models 440 and 450 revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450. Consistency with any revisions to Model 440

Any questions about this memorandum may be directed to NAIC staff, Jane Koenigsman (jkoenigsman@naic.org), 816-783-8145).
Chapter 3 – Accounting and Financial Analysis

CHAPTER 3 – ACCOUNTING AND FINANCIAL ANALYSIS

***********TEXT NOT SHOWN TO CONSERVE SPACE***********

VIII. TAX ISSUES

In virtually every receivership federal tax issues must be considered. The insurer cannot be discharged or liquidated without the filing of federal income tax returns. In addition, consideration should be given to the payment of federal corporate income and other taxes. The receiver can be held personally liable for the payment of certain unpaid taxes if specific procedures are not followed.

Because of the complexity of federal income taxation issues, the potential personal liability of the Receiver and the additional complexities associated with receiverships, and the significant impact on the estate from items such as forgiveness of debt, alternative minimum tax, Phase III tax triggering for life companies, consolidation rules and other matters, the receiver should hire individuals with expertise in these areas. Such experts could include independent CPAs or counsel with experience in such matters. Furthermore, because of the continuously evolving nature of federal income taxation issues, many of the issues addressed in this chapter may have changed. This is a reason that the receiver should hire individuals that will be as up-to-date as possible in these areas, and why receivers should seek updated guidance on tax matters (both federal income and state premium tax issues) in reference to the issues addressed in this Handbook.

The receiver should ascertain the insurer’s tax status as part of the takeover procedure, in addition to securing copies of tax returns and company tax payment records. Foremost, the receiver should learn whether all tax returns due have been filed and any amounts owing have been paid. In addition, the receiver should learn whether the insurer was part of a consolidated group filing or party to any tax sharing or similar contractual agreements. The receiver should also obtain and carefully review and understand the provisions of any tax sharing agreements between the insurer and any related parties. In almost all receiverships, the receiver takes over the insurer, but not necessarily its holding company or other affiliated group with which the insurer may be consolidated for tax purposes. In addition, the insurer may own non-regulated subsidiaries that are taxed differently from the insurer.

Prior years’ returns and any correspondence with the IRS also should be reviewed. Discussion may be held with any outside CPAs or counsel who may have been involved in filing the returns or in handling any disputes with the IRS. The receiver should be alert to any contingencies that may exist for payment of taxes, penalties and interest resulting from failure to file on time, failure to pay tax due on the return, inappropriate treatment of income or deductions on the return, etc. Contingency reserves recorded on the balance sheet of the insurer or its parent should be reviewed and analyzed for purposes of determining tax positions taken by the company which are not “more likely than not.” The receiver should consider these contingencies when allocating distributable assets of the estate in light of the priority generally alleged by the federal government and accorded by the applicable priority statute (see Chapter 9—Legal Considerations).

The receiver may request an “Account Transcript” from the IRS for the receivership entity. The transcript, available by type of tax (Form 1120, Form 941, etc.) and year, may be obtained by filing form 4506-T, Request for Transcript of Tax Return. An account transcript typically contains information on tax payments (amounts and dates) and filing of returns (dates).

Income taxation of insurers is somewhat different from conventional corporations, with additional provisions that are applicable to life insurers contained in Part I of Subchapter L of the Internal Revenue Code (“IRC”) and specific provisions applicable to other insurance companies contained in Part II of Subchapter L of the IRC, and taxation of life insurers differs to some extent from taxation of property and casualty insurers. To further confuse the issue, mutual life insurers are subject to tax adjustments not applicable to stock life insurers.
Even though an insurer may have substantial statutory losses, it is possible that based on its taxable income, federal income taxes will be due. See discussion in this chapter of deferred income that may be taxed when a company loses its status as a life insurance company for federal tax purposes. There also exists the possibility that the insurer is entitled to recover prior years’ taxes because of the existence of capital losses, operating losses or tax credits. Operating losses, which can be carried back two years and forward 20 years by property and casualty insurers. Prior to 2018, life insurers were allowed to carry back ordinary losses for 3 years and carry forward losses for 15 years. No carryback is allowed for operating losses of insurers other than property and casualty insurers for taxable years after December 31, 2017, but these insurers are allowed indefinite carryforwards which are limited to 80% of taxable income in each year to which the operating loss is carried. All insurers are allowed to carry back capital losses 3 years and forward up to 5 years to offset capital gains and tax credit carrybacks vary depending upon the type of credit, so you should always check with a tax advisor. The insurer may also have made estimated tax payments that can be recovered. An insurer may also be entitled to a tax recovery because of its inclusion in a consolidated tax filing where its losses were used to set off taxable income from affiliated entities. Tax recovery due to tax sharing agreements will not be recoverable from the IRS but must be recovered from affiliated entities. Therefore, income tax recoverable may not be collectible and, as such, should not be booked. In addition, under Section 848 of the Internal Revenue Code, an insurer must capitalize its estimated acquisition expenses, which are then amortizable (deductible) over the ensuing 10-year period for amounts capitalized prior to through Dec. 31, 2017 and over a 15-year period for amounts capitalized after December 31, 2017.(five years for smaller companies).

The receiver should be aware that IRC Section 6511(a) places a deadline by which claims for credit or refund of taxes must be made. In many instances, this deadline will be three years from the due date of the return for which the claim for refund is being made. However, if the claim for refund results from the carryback of a net operating losses to the preceding tax years, the deadline will be three years from the due date of the return which generated the net operating loss. Due to the critical nature of properly determining these deadlines, the receiver should consider consulting independent CPAs or counsel with experience with these matters.

In addition to federal corporate income taxes, the receiver also has to be concerned about state corporate income taxes, federal and state payroll taxes, premium taxes, real estate taxes, federal excise taxes, state franchise and excise taxes, sales taxes, and personal property taxes, along with myriad reporting and filing requirements. The receiver will also need to file final tax returns upon the closing of the receivership estate.

A. Notice

Within 10 days from the date a receiver is appointed, Form 56 (Notice Concerning Fiduciary Relationship) must be filed with the IRS. A certified copy of the court appointment should be attached. This form should be filed for all forms of receivership. The receiver should specify that he is to receive notice concerning income, excise, sales and property, and payroll tax matters. The list of tax forms should include Form 1120L (for life companies) or Form 1120PC (for property and casualty companies), Form 941 (quarterly payroll tax returns), Form 940 (Federal Unemployment Compensation Tax), and Form 720 (Federal Quarterly Excise Tax Return). If the insurer owns subsidiaries, the receiver should also file a Form 56 notice for each subsidiary.

In addition to the federal filing, many states have similar notice requirements. Even without a specific requirement, sending similar notice to the taxing authorities of those states and foreign countries where the insurer did business or had employees should be considered.

Form 56 is not to be used to update the last known address of the receivership entity. The receiver should file form 8822, Change of Address, with the IRS.

B. Income Taxes

Under Section 1.6012-3(b)(4) of the Federal Income Tax Regulations, a receiver or trustee who, by order of a court of competent jurisdiction, by operation of law or otherwise, has possession of or holds title to
Chapter 3 – Accounting and Financial Analysis

all, or substantially all, the property or business of a corporation, must file a return in the same manner and form as the corporation.

The due date for filing federal corporate income tax returns for insurance companies is the 15th day of the fourth month (generally March April 15) of the following year following the year end of the company. [For years beginning prior to 2016, the due date was the 15th day of the third month (generally March 15) of the year following the year end of the company.] A six-month extension to October 15 can be obtained for the filing of the return, if the extension form is sent to the IRS prior to the March April 15 deadline. This extension, however, is only for the filing of the return and not for the payment of tax liabilities. The March April 15 deadline is applicable to calendar-year companies only. There may be certain non-insurance companies under the receiver’s authority that have fiscal year-ends.

Once an affiliated group of corporations files a consolidated return, it must continue to do so as long as the group remains in existence. Therefore, consolidated returns must continue to be filed with the insurer’s subsidiaries. In addition, the IRS has ruled under PLR 9246031 that an insurer in liquidation under state law is required to be included in its common parent’s consolidated federal income tax return. The receiver may request approval from the IRS to file separate returns. This permission may be granted on a case-by-case basis for good cause shown. Pursuant to the consolidated return regulations (1.1502-75), the parent of the affiliated group must request deconsolidation for good cause. A deconsolidation may weaken the IRS’s position; as such, the granting of a deconsolidation is not guaranteed.

Following is a list of various insurance or insurance-related entities and the Federal Income Tax Form that should be filed:

<table>
<thead>
<tr>
<th>Type of Insurer (Based on Business Written)</th>
<th>Federal Income Tax Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property/Casualty</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Life</td>
<td>1120-L</td>
</tr>
<tr>
<td>HMO</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Staff Model HMO</td>
<td>1120</td>
</tr>
<tr>
<td>501(c)(15)(A) - tax exempt</td>
<td>990</td>
</tr>
<tr>
<td>Title</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Blue Cross/Blue Shield</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Health</td>
<td>1120-PC</td>
</tr>
<tr>
<td>Health w/ noncancellable and/or Guaranteed renewable contracts</td>
<td>1120-L</td>
</tr>
</tbody>
</table>

For a company to be considered an “insurance company,” at least half of its business during the taxable year must be the issuing of insurance or annuity contracts or the reinsuring of risks underwritten by insurance companies.

For a company to be considered a “life insurance company,” it must be engaged in the business of issuing life insurance and annuity contracts (either separately or combined with accident and health insurance), or noncancellable and/or guaranteed renewable contracts of health and accident insurance. Also, its life insurance reserves plus unearned premiums—and unpaid premiums on unpaid losses and on noncancellable life, accident, or health policies not included in life reserves—must make up 50 percent or more of its total reserves.

In certain special situations, managed care organizations may qualify for tax exempt status; if so, they would file Form 990.
1. Life Insurance Companies

Life insurers (whether stock, mutual or mutual benefit) that meet certain reserve requirements file Form 1120-L. If a life insurer does not meet the reserve requirements, then it must file Form 1120-PC. If a stock life insurer loses its life insurance tax status because its life insurance reserves fall below the minimum requirement, then taxes that were deferred in earlier years may now become due.

In Revenue Procedure 2018-31, Section 26.03 provides for an automatic accounting method change when there’s a change in qualification as a life insurance company as defined in Internal Revenue Code (“IRC”) Section 816(a). This happens when, under prior federal law, a portion of the income earned by a life insurer was considered to belong to the policyholders and was excluded from income. It was segregated and carried on the tax return in an account called “policyholder surplus.” Upon loss of life insurance company tax status, or certain other events, all or a portion of the “policyholder surplus” account may be taxed. This is referred to as “Phase III tax liability” and can be a material amount for some life insurers. Phase III tax liability also can result from losses exceeding prior years’ accumulated taxable income and reduction of premium volume or reserves or loss of insurance company status.

Phase III tax may be a liability which arises prior to the receivership or during the administration of the estate. This may have a significant impact on the statute of limitations for assessment of the tax as well as the priority of the claim for payment of the tax relative to creditors and policyholders. The existence of net operating losses may be unavailable in reducing or avoiding a Phase III tax liability.

For taxable years ending before January 1, 2018, life insurers with less than $500 million in assets are entitled to a small life insurer deduction of 60 percent of their “life insurance company taxable income.” This deduction is available for income up to $3 million and then is gradually phased out on income from $3 million to $15 million. Alternative minimum tax should be considered in calculating the benefit of the small company deduction. For taxable years after December 31, 2017, the small life insurer company deduction is repealed, and the alternative minimum tax for corporations is repealed as well.

2. Non-Life Insurance Companies

Non-life insurers (stock and mutual) file Form 1120-PC. Non-life companies generally are taxed on their statutory income with certain modifications, including the discounting of loss reserves and the non-deductibility of 20% of the increase of the unearned premium reserves. The non-deductible 20% of the unearned premium reserve (UPR) gives the taxpayer a tax benefit when the UPR is reduced but the effect of the reversal of the 80% deductible portion has a greater impact and may create taxable income. As previously stated, the receiver should consult their tax consultant regarding the ramifications of these issues.

Non-life insurers whose written premiums for the year do not exceed $42.2 million (an amount which is inflation-adjusted for each taxable year beginning after 2015) may elect to be taxed only on investment income under Code Section 831(b). The premium limits are based upon the premiums of a “controlled group” of corporations as defined by Code Section 1563(a), with the exception that more than 50% is the definition of control. The fact that an insurer is in receivership does not remove it from a “controlled group.” The company also must meet certain diversification requirements with regard to premiums and owners as prescribed in IRC Section 831(b)(2)(B)). Taxation on investment income may not be advantageous to companies that are currently generating or utilizing net operating losses, as the company may lose the benefit of those losses. IRC Section 831(b)(3) prescribes limitations on the use of net operating losses for insurance companies taxed only on investment income.

Prior to January 1, 2005, small non-life insurers with less than $350,000 of premium income could qualify to be exempt from income tax under Code Section 501(c)(15). Many receivers took advantage
of this provision to exempt liquidation estates from federal income taxation. In 2004, Section 501(c)(15) was amended to provide tax exempt status only to those non-life insurers with gross receipts less than $600,000, and then only if more than 50% of the gross receipts were from premiums. Since most companies in liquidation have virtually zero premium income after the first couple of years of the liquidation, and since most have annual income exceeding the $600,000 cap, this amendment to Code Section 501(c)(15) generally eliminated its applicability to insurance receiverships.

The impact upon insurance companies in receivership was considered as Code Section 501(c)(15) was being amended in 2004, and the applicability of the exemption to insurance companies in receivership was specifically extended through calendar year 2007. However, as of January 1, 2008, any insurers in liquidation that may have previously been qualified for exemption under the pre-2005 provisions of Code Section 501(c)(15) became ineligible for such exemption and are subject to federal income tax from that time forward unless they met the new requirements.

3. Special Relief

Under Revenue Procedure 84-59, the receiver may apply to the District Director of Internal Revenue for relief from the filing requirements under limited circumstances. In order to request this relief, the insurer has to have ceased operations and no longer have assets or income.

4. Prompt Audit

The receiver may request that a prompt determination be made under Revenue Procedure 2006-2426-23 whether the income tax return is being selected for examination by the IRS or is accepted as filed. The receiver will be discharged from any liability upon payment of the tax shown on the return if the IRS does not notify the receiver within 60 days after the request that the return has been selected for examination, or if the IRS does not complete the examination and notify the receiver of any tax due within 180 days after the request. This procedure enables the receiver to proceed with the receivership, or enhances the possible sale of the insurer, by resolving contingencies relating to taxes due for prior periods. The prompt audit provisions specifically apply to bankruptcy proceedings, not state liquidations. Certain IRS offices have approved applying the provisions to state liquidations; however, the approval is not automatic. When this is the case, a request for prompt assessment should be made under I.R.C. §6501(d). This will reduce the statute of limitations for assessment to 18 months. The request contemplates a corporate dissolution in 18 months and requires the submission of Form 4810 to the IRS.

5. Carrybacks

An insurer often becomes financially troubled because it incurred operating and/or other losses. Such losses may be deductible for income tax purposes. A review may be made of the deductibility of such losses to determine if the losses were deducted in the correct fiscal year and may be carried back to recover previously paid income taxes. If the losses were not deducted in the correct years, prior years’ income tax returns may have to be amended. Net operating losses can be carried back for two years, and capital losses can be carried back for three years.

Under the Tax Cuts and Jobs Act of 2017 (TCJA) net operating losses of non-life insurance companies can still be carried back two years and carried forward 20 years (Internal Revenue Code Section 172(b)(1)(C)). However, there is no carryback for life insurance company net operating losses arising in 2018 and later years and an unlimited carry forward period (Internal Revenue Code Section 172(b)(1)(A)). Operational losses of life insurers arising in 2017 and earlier are carried back three years and forward fifteen years. A non-life insurance company can use the full amount of its net
operating losses to offset taxable income (Internal Revenue Code Section 172(f)). A life insurance company is limited to an 80% net operating loss deduction against taxable income (Internal Revenue Code Section 172(a)(2)).

An example of a restructuring technique used in the liquidation of Reliance Insurance Company to address significant net operating loss carryovers is available in Exhibit 3-4.

6. Carryovers

To the extent that there is a discharge of indebtedness, any net operating loss carryover may be reduced by the amount of the discharge, which may trigger alternative minimum tax liabilities. A company could have alternative minimum tax, even if there are net operating losses available to offset the income, because of the 90% limitation for alternative minimum tax net operating losses. If guaranty funds or other creditors are entitled to future funds, there may not have been a complete discharge.

Net operating losses are allowed an indefinite carryover period in taxable years beginning after December 31, 2017. The net operating loss deduction is limited to 80 percent of taxable income (without regard to the deduction) for losses arising in taxable years beginning after December 31, 2017. Therefore, even when there are net operating loss carryovers available, discharge of indebtedness could still result in income tax liabilities due because of the carryover taxable income limitations.

C. Premium Taxes

If the insurer is in rehabilitation, the receiver may be required to continue paying state and municipal premium taxes. Insurers are usually required to pay premium taxes that are calculated as a percent of direct premiums written. Many state and local tax authorities require insurers to pay estimated premium taxes. In many cases, a financially troubled insurer may experience a decrease in premium volume, or policies in force may be canceled. This may result in a reduction in premiums written and the related premium taxes. A review may be made to determine whether the insurer is entitled to premium tax refunds. It may then be necessary to refile the most recent returns to reflect the reduction in premium income. In addition, the receiver may attempt recovery of any prepaid or estimated premium taxes. If premium taxes are owed in a liquidation many states may relegate premium tax claims to a lower or general creditor status.

D. Payroll Taxes

Insurers are required to withhold federal income tax and social security tax (as well as state and local income taxes) from the wages and salaries of their employees. All of these taxes are considered “trust fund taxes” and must be remitted periodically to the various taxing authorities. The receiver should promptly ascertain that all payroll tax payments have been remitted by the insurer. If the receiver finds that taxes have not been paid, the Special Procedures Office of the IRS should be notified. In this way, the taxes or 100% penalty can be assessed against the former officers or persons with the responsibility for paying the taxes. The receiver may be asked to complete Form 4180 or Form 4181, which are questionnaires relating to the payment of “trust fund taxes.”

If the receiver fails to follow these procedures and funds that could have been used to pay “trust fund liabilities” are used for other purposes, the receiver may be held personally liable. The receiver should make certain that any plan filed with the court for the distribution of assets provides for the payment of these outstanding federal tax liabilities.
Many states have similar laws relating to withheld payroll taxes, and the receiver should be aware of the responsibilities imposed by these laws. The receiver should continue to file W-2s, as well as Forms 940 and 941, for employees of the insolvent insurer.

E. Other Taxes and Assessments

1. Real Estate and Corporate Personal Property Taxes

The receiver should ascertain whether all real estate tax payments have been made, including those that the insurer has been collecting on mortgages it holds or services. The tax collector should be notified of the receivership proceeding and instructed to send any notices to the receiver.

2. Guaranty Fund Assessments

State guaranty funds periodically assess insurers to cover their administrative and claim costs. If the insurer is operating under supervision or rehabilitation, it may still be liable for guaranty fund assessments. If the insurer is in liquidation, the funds will typically waive payment of the assessment upon notice of the insolvency.

3. Excise Taxes

Some insurers are required to remit excise taxes to the IRS because of foreign reinsurance premiums. These taxes are also considered “trust fund taxes,” and the same care should be afforded these taxes as is given to withheld payroll taxes.

4. Commissions and Other Payments

At year-end, insurers are required to file Forms W-2 and/or 1099 for all commissions and other payments to an individual or partnership in excess of $600 during the year. In addition, the receiver is required to prepare Forms 1099 and send the forms to policyholders of life companies while business is still being serviced by the insolvent insurer. In addition, if the insurer has received interest from mortgages, the receiver is required to prepare and provide Form 1098 to the payer. If more than 250 1099 forms are to be issued, the filing is required to be done electronically. However, relief from this electronic filing may be secured upon request to the IRS. The receiver should be able to demonstrate that an electronic filing would place an undue hardship on the insolvent insurer. The IRS can assess penalties for both the failure to issue the forms to agents and the failure to file the forms with the IRS. If the receiver has not already sought relief and the estate is assessed, the IRS may waive the assessment upon request. Additionally, most states and some localities have filing requirements.

5. Franchise Taxes

Several states have franchise taxes. The tax basis can be the net worth of the insurer, the assets of the insurer, the number of shares of authorized stock or the amount of paid-in capital. The failure to file and pay these taxes may result in the cancellation of the insurer’s corporate certificate of authority.

6. Other State Taxes and Licenses

Insurers are subject to numerous state taxes and assessments, including: workers’ compensation; second injury funds; firemen’s and policemen’s pension funds; medical disaster funds; major medical insurance funds; arson, fire and fraud prevention funds; fire marshal tax; insurance department administrative assessments; “Fair Plan” assessments; and motor vehicle insurance funds. In addition, many localities have licenses and taxes unique to insurers. Comprehensive summaries are published...
by several insurers groups, including the Property Casualty Insurers Association of America (PCI), the American Insurance Association (AIA) and the American Council of Life Insurers (ACLI). The receiver should also ascertain if the insurer has any responsibility for filing informational returns and/or paying other state or local taxes such as sales and use taxes, water and sewer taxes, business and occupational privilege licenses, and taxes for employment training funds. Before paying these taxes, consideration should be given to the importance or lack of importance of maintaining state corporate certificates of authority and/or licenses.

All taxes should be reviewed to determine how any liability should be included in the priority scheme. The receiver should consider whether the certificate of authority or licenses have value before they are allowed to expire or be cancelled.

IX. INVESTMENTS

F. Other Considerations

The insurer may be the owner of various tangible and intangible assets that may not be apparent on its statutory balance sheet. The receiver should try to identify and value all possible assets of the insurer, including the insurance licenses, the value of the shell of the company, assets that have been previously written off, and any assets that are listed in Schedule X of the annual statement.

1. Pension and Deferred Compensation Plans

The insurer’s employee benefits may include participation in either a defined-benefit or defined-contribution pension plan. The plan may require or allow that a percentage of the assets of the plan be invested in shares of the insurer. It is not uncommon for the trustees of the plan to be officers of the insurer. Also, the plan administrator may be the insurer itself or an outside financial institution. The regulatory action will create several uncertainties in relation to the plan. The receiver should be familiar with the provisions of the plan and whether a complete liquidation and distribution is required. The provisions of the pension plan agreement and the Employee Retirement Income Security Act of 1974 (ERISA) may clarify some of these issues. It is recommended that the receiver retain the services of a consultant CPA firm to audit and provide independent opinion regarding compliance with IRS and ERISA requisites.

If the insurer is insolvent and the plan is heavily invested in shares of the insurer, then the plan may be insolvent also. The administrator, therefore, may need to liquidate the plan. If the pension plan is solvent, the administrator must continue with its duties. If the insurer is the plan administrator, the receiver may become the plan administrator by succession. If the plan administrator is a third party, the receiver may wish to evaluate the propriety of changing administrators.

The insurer may have hidden equity in other employee benefit plans. A saving plan that requires the insurer to partially match amounts contributed by the employees may be such a plan. The plan agreement will detail the operation of the plan and when the insurer’s contributions vest to the employees. The plan should have provisions for possible employee termination on a voluntary or involuntary basis. Depending upon the terms of the plan, the receiver may recover contributions that have not vested to the employees, or amend terms, for example, to eliminate employer matching of contributions.

Pension considerations may be further complicated if an employee benefit plan is established to cover the employees of a parent holding company and its many subsidiaries, of which the receiver has
authority only for one or more insurer subsidiaries. The desire of the receiver to terminate the plan and attach excess assets (or reduce additional exposure to underfunding) may be mitigated by excise tax issues on termination, ERISA and other considerations.

It should be noted that under some state liquidation priority statutes, amounts and priorities due employees may be limited. Compensation and benefits due officers and directors may also be excluded in their entirety.

*************TEXT NOT SHOWN TO CONSERVE SPACE**********************

3. Structured Settlements

In the insolvency of an annuity insurer, special consideration should be given to any single premium immediate annuities that were issued to form the basis of funding periodic or lump sum payments in personal injury settlements, commonly known as “structured settlement annuities.”

These annuities are normally issued to qualified assignment (QA) companies in order to comport with numerous IRS Tax Codes (primarily 104(a)(2)) and various Revenue Ruling in order to preserve the tax benefit to the beneficiary or payee. However, some older annuities (prior to 1986), although not issued to a QA company, may nonetheless enjoy the same tax benefits. Generally, periodic payments are excludable from the recipient’s gross income only if the payee is not the legal or constructive owner of the annuity and does not have the current economic benefit of the sum required to purchase the periodic payments.

When these blocks of business are resolved in the insolvency context (typically through assumption reinsurance), extreme care must be taken to ensure that the resolution does not compromise the tax benefits to the payees. It is strongly recommended that competent and experienced tax counsel be retained to guide the receiver through this potentially complicated process.
**Example: Restructuring Transaction**

When placed into liquidation, Reliance was part of a three-tiered holding company structure, whereby 100% of the stock of Reliance was owned by Reliance Financial Services Corp (“RFS”). RFS, in turn, was wholly-owned by Reliance Group Holdings, Inc. (“RGH”).[1] In 2003, a settlement agreement was entered into between Reliance, RFS, and RGH whereby, among other things, the parties created a new consolidated tax group for federal income tax purposes with RFS as the common parent and with Reliance as a member.

In 2015, after collection of certain assets, RFS desired to terminate its existence and dissolve. Because Reliance is part of the consolidated tax group, the dissolution of RFS could have led to a change in ownership of Reliance which, under §382 of the Internal Revenue Code of 1986, as amended (“Code”), could have adversely affected the significant net operating loss carryovers (“NOLs”)[2] held by Reliance which may be used to offset future net income, thereby reducing tax liabilities. Therefore, Reliance and its advisors developed a restructuring plan and a transaction which was approved by this Court and executed as of December 31, 2016.

The transaction resulted in an ownership change of Reliance which qualified for the bankruptcy exception under §382(l)(5) of the Code. Pursuant to the plan, all of the issued Reliance common shares are now owned by 4 GAs (“Participating GAs”) who paid Reliance policyholder claims and who received Reliance stock in exchange for the partial cancellation of such indebtedness. Each Participating GA has entered into a shareholder’s agreement which restricts the sale, transfer, pledge or assignment of the shares, and each shareholder executed a revocable proxy granting the right to vote all the shares to the Pennsylvania Insurance Commissioner as Liquidator. The Participating GAs will receive no preference as to their claims against Reliance due to their new ownership status.

Furthermore, the Reliance stock issued to the Participating GAs provides them with no additional viable claim against Reliance as assets will be insufficient for distributions to any creditors below priority class (b), much less priority class (i) shareholders. Furthermore, the Reliance stock issued to the Participating GAs provides them with no additional viable claim against Reliance as assets will be insufficient for distributions to class (i) creditors (shareholders).

The transaction received a favorable private letter ruling on August 24, 2016 from the Internal Revenue Service holding that the Participating GAs would be treated as receiving the Reliance stock in their capacity as creditors of Reliance for purposes of the Code. The plan preserved the substantial NOLs for the benefit of the Reliance estate and allows Reliance to control its own future regarding tax positions and negotiations with the Internal Revenue Service. As a result of the restructuring, Reliance will become its own tax filer and will no longer be part of a consolidated tax group.[3]

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[1] RGH and RFS jointly filed for bankruptcy in 2001 and the RGH and RFS reorganization plan was approved in 2005 with RGH converting into a liquidating trust and RFS converting into Reorganized RFS Corporation.

[2] As a result of the large losses suffered by Reliance during the final years of its independent operations and during its liquidation, in excess of $4 billion of NOLs were accumulated through 2014. Approximately $1.5 billion of that $4 billion was utilized in the 2015 consolidated tax return.

[3] For additional details, see the Liquidator’s Application for Approval of Restructuring Proposal filed with the Court on October 7, 2016, which is document # 3745 on the www.reliancedocuments website.
III. CONSIDERATIONS PRIOR TO CLOSURE OF A LIQUIDATION

B. Tax Issues to be Considered Prior to Closure

1. General

Generally, federal and state tax returns should be filed by the liquidator throughout the liquidation. The final returns will be filed as of December 31 of the year during which final distributions are paid. As set forth above, the expenses that will be incurred to prepare the returns should be prepaid, as the actual filings will occur in the year subsequent to closure.

With each of the federal tax returns filed during the liquidation, the liquidator may consider the submission of a written application requesting a Prompt Audit and Determination under Revenue Procedure 76-23 2006-24 to the IRS. Generally, this will expedite the entire process and end the statute of limitations for the returns. Technically, this procedure only applies to companies in a bankruptcy proceeding (Title 11), but in the past the IRS has extended it to insurers in receivership. If this procedure is not extended to an insurer in receivership, however, the IRS has taken the position that Revenue Procedures 76-23 and 81-17 do not apply to insurance companies in receivership. This position requires insurance company receivers to file federal income tax returns in the normal course of business as if the insolvent insurer were a perpetual concern, with no mechanism to sever the statute of limitations period. As it stands, this is an impediment to closure of an estate that must be dealt with by receivers on a case by case basis through closing agreements with the IRS.

For more information regarding tax issues, refer to Chapter 3—Accounting and Financial Analysis. It is strongly recommended that the receiver consult and retain a tax expert for all tax related issues.

2. Phase III Tax of Life Insurance Companies

Any life insurance company that was a stock life insurance company before 1984 potentially has a balance in a Policyholder Surplus Account (as defined in Section 815 of the Internal Revenue Code). The balance represents previously deferred income, which is potentially subject to recapture at some point prior to closure of the estate, producing a tax liability without an increase in the ability to pay.

Some estates have recently filed returns taking the position that the recapture event does not occur in the course of an insolvency proceeding. One theory is based on an assertion that the legislative history of Section 815 provides ample evidence of a Congressional intent not to impose the Phase III tax when a Policyholder Surplus Account is eliminated due to events occurring in a liquidation. This theory seems enhanced by the obvious statutory reliance on regulatory accounting principles, under which the real surplus of the company has been obliterated by losses.

Another theory that has been advanced is that, as a result of the changes made by the Tax Reform Act of 1984, a literal interpretation of the statute allows the recapture to be offset by operating losses, clearly a benefit not previously allowable.
While these techniques for achieving a non-taxable (or partially sheltered) elimination of the Policyholder Surplus Account seem quite credible, the IRS has opposed their use in some cases. Nevertheless, on November 8, 1994, in *Monat Capital Corporation v United States*, 869 F. Supp. 1513 (D. Kansas 1994), the federal district court in Kansas ruled that in the case of an insolvent life insurance company where no shareholder will receive any distribution from the Policyholder Surplus Account, the account should not be restored to taxpayers’ income. Accordingly, these theories should be explored with tax counsel and, if any such position is taken on a tax return, it is recommended that adequate disclosure be made in the return to maximize protection against the imposition of the 20% penalty under Section 6662 of the Internal Revenue Code. Of course, absolute immunity from penalties can only be secured by taking this position and claiming a refund of Phase III tax paid in an amended return, which can be filed immediately after the original return has been filed. These issues must be addressed prior to closure.

3. Internal Revenue Codes Relative to Insurance Contracts and Distributions

Tax implications and/or consequences of assumption transactions, 1035 exchanges or other such transfer of policyholder liabilities or payout of policyholder benefits is also an area of concern and consideration by the receiver. In response to insurer insolvencies, the IRS has addressed several issues affecting such taxation and tax implications. Such rulings have addressed issues such as funding in “steps,”1 tax free exchanges,2 multiple contract issues3 and contract dates and testing for compliance,4 to name a few, and specifically relate to Internal Revenue Codes 72 and 7702.

Section 72 of the IRC, “Annuities; Certain Proceeds of endowment and life insurance contracts,” specifically subsection (s), references required distributions where the holder of an annuity dies before the entire interest is distributed. The rules in Section 72 govern the income taxation of all amounts received under annuity contracts and living proceeds from life insurance policies and endowment contracts. Section 72 also covers the tax treatment of policy dividends and forms of premium returns.

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1 (Rev. Rul.) 92-43, 1992-1 CB 288. The IRS will allow a valid exchange where funds come into the contract or policy in a series of transactions if the insurer issuing the contract or policy to be exchanged is subject to a “rehabilitation, conservatorship or similar state proceeding.” Funds may be transferred in this “serial” manner if: (1) the old policy or contract is issued by an insurer subject to a “rehabilitation, conservatorship, insolvency or similar state proceeding” at the time of the cash distribution; (2) the policy owner withdraws the full amount of the cash distribution to which he is entitled under the terms of the state proceeding; (3) the exchange would otherwise qualify for Section 1035 treatment; and (4) the policy owner transfers the funds received from the old contract to a single new contract issued by another insurer not later than 60 days after receipt or, if later, September 13, 1992. If the amount transferred is not the full amount to which the policy owner is ultimately entitled, the policy owner must assign his right to any subsequent distributions to the issuer of the new contract for investment in that contract. Revenue Proc. (Rev. Proc.) 92-44, 1992-1 CB 875, as modified by Rev. Proc. 92-44A, 1992-1 CB 876; (Let. Rul.) 9335054.

2 If a non-qualified annuity contract is exchanged under Section 1035 within the scope of Rev. Rul. 92-43 (i.e., as part of a rehabilitation proceeding), the annuity received will retain the attributes of the annuity for which it was exchanged for purposes of determining when amounts are to be considered invested and for computing the taxability of any withdrawals.

3 An annuity that is received as part of a Section 1035 exchange that was undertaken as part of a troubled insurer’s rehabilitation process under Rev. Rul. 92-43 is considered to have been entered into for purposes of the multiple contract rule on the date that the new contract is issued. The newly-received contract is not “grandfathered” back to the issue date of the original annuity for this purpose. Let. Rul. 9442030.

4 The IRS, in response to insurer insolvency proceedings, stated that modification of an annuity, life insurance, or endowment contract after Dec. 31, 1990, that is necessitated by the insurer’s insolvency will not affect the date on which such contract was issued, entered into or purchased for purposes of IRC Section 72, 101(f) 264, 7702 and 7702A and also as not resulting in retesting or the start of a new test period under §§7702(f)(7)(B)(i) and 7702A(c). Rev. Proc. 92-57, 1992-2 CB 410; Let. Rul. 9239026. See also Let. Rul. 9305013. The date is not affected by assumption reinsurance transactions entered into by the insurer provided that the terms and conditions of the policies, other than the insurer, do not change. Let. Ruls. 9323022, 9305013. The IRS also concluded that where a nonqualified annuity is exchanged for another via Section 1035 as part of a troubled insurer’s rehabilitation process under Rev. Rul. 92-43, the annuity received in the exchange will be treated as issued, entered into, or purchased as of the date of the exchange except as provided in IRC Sections 72(e)(5) and 72(q)(2)(F). Let. Rul. 9442030.
Chapter 10 – Closing Estates

IRC Section 7702 relates to the definition of a life insurance contract. For purposes of this section, the term “life insurance contract” means any contract that is a life insurance contract under the applicable law, but only if such contract meets the cash value accumulation test as defined in Section 7702(b), or meets the guideline premium requirements of Section 7702(c) and falls within the cash value corridor of Section 7702(d).

a. Cash Value Accumulation Test

Generally, a contract meets the cash value accumulation test if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits under the contract.

b. Guideline Premium Requirement and Cash Value Corridor

With respect to the guideline premium, a contract generally meets this requirement if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of such time. Guideline premium limitation means, as of any date, the greater of the guideline single premium or the sum of the guideline level premiums to such date. Guideline single premium means the premium at issue with respect to future benefits under the contract. Guideline level premium means the level annual amount, payable over a period not ending before the insured attains age 95, computed on the same basis as the guideline single premium.

A contract generally falls within the cash value corridor if the death benefit under the contract at any time is not less than the applicable percentage of the cash surrender value.

As with any tax issue, the implications of all Internal Revenue Codes to a particular liquidation proceeding and that proceeding’s specific transactions should be explored with tax counsel.

4. Collection of Tax

Under Section 801 of IRMA, claims of the federal government are assigned a Class 5 priority and claims of state or local government are assigned a Class 8 priority, unless the claims represent losses incurred under policies of insurance (Class 3 or 4 claims). Thus, tax liabilities not properly characterized as an expense of receivership administration (Class 1) rank behind any claims for guaranty fund administrative expenses (Class 2) and all claims of policyholders (Class 3 or 4), including guaranty funds. Conversely, under the federal “super-priority” statute, 31 U.S.C. § 3713, claims of the federal government (in cases not covered by the bankruptcy code) are given first priority. The Supreme Court of the United States has resolved this conflict in United States Department of the Treasury, et al v. Fabe, 508 U.S., 491, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993). The Court held that the Ohio priority of distribution statute was not pre-empted by the federal statute to the extent that the Ohio law protects policyholders, because to that extent it constitutes a law enacted “for the purpose of regulating the business of insurance.” Since the court also viewed administrative expenses as incurred in the process of protecting policyholders, administrative expenses also were ranked ahead of federal claims.

More recently, the 1st U.S. Circuit Court of Appeals has ruled that the federal government does not automatically have priority over other creditors, including state guaranty funds, in insurer liquidations. The 1st Circuit panel’s ruling in Ruthardt vs. United States of America (see Chapter 9—Legal Considerations, section on Federal Government Claims) affirmed a Massachusetts district court’s decision. In this litigation, the federal government challenged two aspects of the Massachusetts liquidation statute. First, the government argued that the liquidation priority provision...
in the statute is preempted by federal law to the extent it provides for payment of guaranty association claims ahead of claims of the federal government. The federal government also argued that the state’s statutory bar date for filing claims against the insolvent insurer’s estate does not apply to claims of the federal government. The federal district court ruled that the provision affording priority to guaranty association claims under the Massachusetts statute is a provision enacted for the purpose of regulating the business of insurance and is therefore shielded from federal pre-emption in accordance with the McCarran-Ferguson Act. With respect to the claims bar date, the district court concluded that it was bound by a controlling 1993 First Circuit decision finding that the benefits provided to policyholders by a state’s claim bar date were too tenuous for that provision to constitute the regulation of the business of insurance subject to the McCarran-Ferguson protections. The Court of Appeals affirmed on both issues.

Generally, taxes are, at most, an expense of administration if the taxes arise during the period of administration (as distinguished from unpaid taxes for periods ending before commencement of liquidation) and are incurred by the estate, i.e., imposed on income from which the estate derived some benefit. While the matter has not yet been tested in court, it is likely that the Phase III tax would not be treated as an expense of administration, since the income upon which it was imposed was obviously earned, collected and dissipated before the liquidation commenced. Decisions regarding the payment of computed taxes should only be made after consultation with legal counsel.

5. Filing of Tax Returns

The entry of an order of liquidation does not terminate the existence of the insurer for tax purposes, regardless of the impact the order may have under state law. The taxable entity remains in existence until the liquidation is complete, i.e., all the assets have been distributed. Accordingly, the liquidator must attend to the continued filing of tax returns during the liquidation proceeding, which may include several taxable years. Therefore, the liquidator should recognize the need to undertake tax planning.

As set forth above, it is possible that over the period of administration, an insolvent insurer may lose its status as an insurance company or become exempt from taxation altogether. Since these classifications are based on a testing of the company’s activities and reserve characteristics, as activities cease, premium diminishes and insurance obligations are ceded under assumption reinsurance arrangements, the company may begin to fail these tests. The liquidator should anticipate the occurrence of this, and plan for the attendant consequences (reserve restoration, Phase III tax, etc.).

If the insurance company placed in liquidation is the common parent of a group that has been filing consolidated returns, the receiver may have to continue filing on that basis. If the company was a subsidiary in a consolidated group, it is arguable that an order of liquidation should cause a termination of membership in the group. It should be noted that the only apparent pronouncement in this area is a 1985 private ruling (LTR 8544018) in which the IRS held that continued inclusion in a consolidated group is required of an insurer throughout the period of administration. However, among the consequences of entering an order of liquidation are the facts that the liquidator is given the power to exercise all shareholder rights (Section 504A(16) of IRMA), the receiver may contemporaneously dissolve the corporate existence under state law (Section 503) and the shareholders, in their capacity as owners, become creditors of the estate (Section 501). Any one of these conditions, and certainly all of them in combination, would seem to indicate that the parent company no longer has any stock ownership interest in the insurer, much less any voting rights. Furthermore, considering that this is a permanent stockholder displacement rather than a mere suspension of rights, the ruling seems rather questionable. In this situation, tax counsel should be consulted. When dealing with tax sharing agreements and consolidated tax returns, the need for termination of any prior agreements should
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quickly be assessed. Termination of these agreements could prevent a parent of a subsidiary insurance company from taking away tax benefits that rightfully belong to the estate.

The liquidator needs to also be aware of the tax consequences for a member of a consolidated group upon its ceasing to be a member. It will have two short-period years, one ending on the day it leaves the group that will be included in the group’s consolidated return, and one beginning on the next day and ending at the insurer’s normal year-end that will require a separate return. Even though the insurer might be included in the group’s consolidated return for a small portion of the year, it will be jointly and severally exposed to the group’s consolidated tax for the entire year, which tax could be increased by the recognition of an excess loss account (i.e., negative basis) that the group might have in the stock of the insurer. If gains of the insurer on prior transactions with other members were deferred, the gains must be recognized in the consolidated return upon the member’s departure. The tax thereon can come back to the insurer, either through joint and several liability or under a tax allocation agreement of the group. Any estimated tax payments made by the group during the year must be allocated. Operating losses sustained by the insurer in subsequent periods that can be carried back to prior consolidated returns will produce refunds that will be made to the common parent of the group.

Affiliates’ use of losses within a consolidated return presents a difficult issue regarding the estate’s ability to recover any portion of the benefit. If the group had entered into a tax allocation agreement, the estate’s benefit would be determined pursuant to that agreement. However, absent a written agreement, as a matter of equity, courts seem to allocate tax benefits according to which entities paid the tax being recovered, or whose income is being offset (thus giving value to the loss). Note that the rules contained in the Department of the Treasury’s regulations regarding allocations of consolidated tax are effective only for determining income tax consequences and do not, in and of themselves, create a contractual right of any member to receive any tax payments from another member.

Accordingly, a loss of the insurer, which can only be used against income of other members in the current year or another year and producing a refund of consolidated tax paid in by other members, is not likely to provide a material benefit for the insurer. If a refund potential exists, the liquidator might consider taking the position that inclusion in a consolidated return by a subsidiary insurer is no longer permitted or required (pursuant to the discussion above), thereby perhaps developing some leverage in negotiating a tax allocation agreement.

6. Net Operating Losses

An insurer placed under a liquidation order will ordinarily have incurred large operating losses, some of which may have been realized prior to the receivership and remain eligible for carryover to periods ending after the receivership began, and some of which may be realized during the receivership and may be carried back to earlier periods. Operating losses incurred by life insurers may no longer be carried back for taxable years beginning after December 31, 2017. Net operating loss deductions (“NOLs”) are limited to 80 percent of taxable income (without regard to the deduction) for losses arising in taxable years beginning after December 31, 2017. Carryovers to other years are adjusted to take accounting of this limitation and may be carried forward indefinitely. Property and casualty insurers may carry back losses 2 years and forward 20 years. The 80 percent limitation on use of NOLs does not apply to a property and casualty insurance company.

Under general rules, loss carryovers expire if not used within a certain period of time. It may be, therefore, necessary for the liquidator to project the probable timing of income realization, particularly for property and casualty insurers where loss carryovers expire if not used within a
The major item of income realization which may be debt cancellation income when advances from guaranty funds, for example, are forgiven at closing.

The general rules for carryback and carryover of losses are modified if there is a change in the status of the insurer before January 1, 2018. A loss of a life insurance company may only be carried back to a year in which it qualified as a life insurance company if the loss occurs prior to January 1, 2018. For years beginning after December 31, 2017, life insurance companies are allowed the NOL deduction under section 172. A similar rule exists for property and casualty companies. As to loss carryovers, a change in character does not result in denial of the carryover, but the amount of loss from the earlier year may not exceed the amount it would have been if the insurer had the same character in all relevant years as it has in the year to which the loss is carried.

Loss carryforwards generally become severely restricted upon a substantial change in the ownership of the stock of a corporation. However, the rules requiring this result should not apply in these cases. If the IRS takes the position that the entry of an order of liquidation does not affect stock ownership (as, for example, in LTR 8544018), then the rules are not invoked. Conversely, if the entry of the order, in fact, does represent a complete change in ownership, then the exception for “Title 11 or similar case,” e.g., bankruptcy or receivership, should be available (see 26 U.S.C. § 382(l)(5)).

The liquidator should consider techniques having the effect of accelerating income, such as the sale of appreciated property, reserve adjustments or reinsurance transactions. If the insurer can remain in a profitable consolidated group with which it has a tax allocation agreement, benefits can be realized without regard to extraordinary transactions.

7. Federal Claims and Releases

a. Communicating with the Department of Justice.

Contact with the Department of Justice ("DOJ") at the inception of a receivership estate is critical to obtaining a prompt release of personal liability of the Receiver under 31. U.S.C. 3713(b) (the “3713 Release”) to facilitate estate distributions to policyholders, claimants against policyholders, guaranty associations and other creditors. DOJ has historically identified a single Assistant U.S. Attorney as gatekeeper between the receiver and all federal agencies, except for the Internal Revenue Service, that may have claims against the receivership estate. Receivers may want to limit the number of people communicating with the DOJ to reduce the possibility of mixed messages, or messages going to the wrong person. Additionally it is recommended that Receivers follow the checklist provided by the DOJ when submitting documents. Contact the NAIC’s office in DC if you need assistance to identify the current DOJ receivership contact.

b. Identifying potential federal claims, particularly long tail claims.

The Receiver’s initial goal should be to identify potential federal claims from the insurer’s claim and corporate files. Federal claims that are classified at the policyholder priority level as claims under an insurance policy or against an insured under an insurance policy should be reviewed and adjusted as soon as possible and their resolution and adjudication should be summarized for the DOJ in connection with the 3713 Release request. In addition to potential federal claims identified by the receiver, DOJ will typically request the receiver to identify all former policyholders of the insurer, including policy periods and limits of coverage so that federal agencies can perform their own search of potential claims against the insurer. An example of claims with a federal agency as a claimant are claims identified as having an environmental exposure.
c. Classification and handling of federal claims.

Pursuant to United States Dept. of Treas. v. Fabe, 508 U.S. 491 (1993), state law may prioritize payment of administrative expenses and policyholder claims, including claims by third parties against policyholders and claims by guaranty associations, ahead of claims of all other general unsecured creditors, provided that the priority of federal claims immediately follows that of policyholders and precedes all other creditor classes. Claims of federal agencies under a policy of insurance or against a policyholder, however, are entitled to policyholder priority treatment.

d. Facilitating the process of obtaining a federal release.

All federal claims that are prioritized at the policyholder priority level should be identified and resolved before applying to the DOJ for a 3713 Release. The process of interacting with the DOJ, including the DOJ’s survey of federal agencies for potential federal claims can take several years. Long-tail claims, such as claims involving environmental liability and coverage, as well as the number of policy years that the insurer provided coverage for long-tail exposures, is likely to increase the amount of time needed to resolve the potential federal claims and obtain the 3713 Release.

A best practice is to provide the DOJ with very detailed information on policies and claim information in order to avoid prolonging the process unnecessarily and lead to a long series of back-and-forth requests and production of additional data. For example, include a list of all policyholders unless the lines of business were limited to medical insurance. It may be helpful to segregate the various lines of business as the Environmental Protection Agency (EPA) is more interested in general liability lines as opposed to workers compensation exposures. If the company uses specific policy prefixes for different lines of business, a listing of the policy prefix definitions should be submitted with the list of policies. DOJ resources are usually limited, so key to successfully receiving the Release, it is helpful to keep the lines of communication open, not press for immediate results, consider routine follow-ups with the DOJ such as scheduled monthly status calls.

e. Impact of federal release on receivership closure.

Obtaining the 3713 Release is essential to protecting the receiver against the personal liability imposed under 31 U.S.C. s.3713, and accordingly impacts the receiver’s ability to make final distributions of estate assets and close the estate. The foregoing practices should be commenced at the outset of the receivership and pursued with diligence throughout the life of the estate to ensure that the ultimate discharge of the estate is not prolonged.

7. Closing Agreement

The liquidator may want to consider utilizing a closing agreement pursuant to Revenue Procedure 2019-98-1, IRS Procedures for providing advice to taxpayers in the form of letter rulings, closing agreements, determination letters and information letters, and orally on issues Issuing Rulings, Determination Letters, and Information Letters, and for Entering Into Closing Agreements on Specific Issues Uu nder the Jurisdiction of the Associate Chief Counsels (DomesticCorporate), (Employee Benefits and Exempt Organizations), (Financial Institutions & Products), (Income Tax & Accounting), (International), (Passthroughs & Special Industries), (Procedure and Administration) and (Enforcement Litigation). The closing agreement is a final agreement between the IRS and the taxpayer on a specific issue or liability and is entered into under the authority in §7121. The closing agreement would provide for a final determination to be made by the IRS with respect to tax returns filed on
behalf of the insolvent company for specific years and would be final and conclusive except in the event of fraud, malfeasance or misrepresentation of material fact.

Additionally, retaining a Taxpayer Advocate’s opinion is a possible best practice to address potential tax liability after receivership closure. Because the Taxpayer Advocate is associated with the IRS, this type of opinion could create an obstacle for tax authorities if they decide to revisit a tax return.
The Receivership Large Deductible Workers’ Compensation (E) Working Group of the Receivership and Insolvency (E) Task Force met via conference call March 2, 2020. The following Working Group members participated: Donna Wilson, Co-Chair (OK); Laura Lyon Slaymaker, Co-Chair (PA); Steve Uhrynowycz (AR); Toma Wilkerson (FL); Kevin Baldwin (IL); Robert Wake (ME); John Rehagen (MO); Tom Green (NE); Mark Jordan (NM); and James Kennedy (TX).

1. Reviewed the Exposure of a Memorandum Regarding Model #555

Ms. Wilson presented an overview of the memorandum (Attachment Three-A) from NAIC staff regarding a guideline for an alternative to Section 712 of the *Insurer Receivership Model Act* (#555) (Attachment Three-B) that was exposed until Jan. 31, 2020.

2. Considered Comment Letters from the Exposure of a Model #555 Guideline

Ms. Slaymaker informed the Working Group that two comment letters had been received during the comment period from Mr. Wake and Barbara F. Cox (National Conference on Insurance Guaranty Funds—NCIGF) (Attachment Three-C). Mr. Wake presented a summary (Attachment Three-D) of the original comment letter (Attachment Three-E) submitted to the Working Group. Based on Mr. Wake’s comments, the Working Group agreed to form an ad hoc drafting group consisting of Mr. Wake, Mr. Kennedy, Ms. Wilkerson, Ms. Wilson, Ms. Cox and Rowe W. Snider (Locke Lord LLP) to develop revisions based on the comments received from Maine and NCIGF.

Having no further business, the Receivership Large Deductible Workers’ Compensation (E) Working Group adjourned.
MEMORANDUM

TO: Receivership Large Deductible Workers’ Compensation (E) Working Group

FROM: NAIC Staff

DATE: December 2, 2019

RE: Guideline: Alternative to Section 712 of Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies

Executive Summary

Having the necessary statutory authority specific to large deductible workers’ compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation.

NAIC staff has been asked to draft the attached Guideline: Alternative to Section 712 of Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies as alternative language to Section 712 of Model #555.

Guideline v. Model Law

The NAIC model law development process helps provide uniformity while balancing the needs of insurers operating in multiple jurisdictions with the unique nature of state judicial, legislative and regulatory frameworks. In 2007, the NAIC changed the way model laws and model regulations were developed. The criteria for development of a model law or regulation now involve a two-pronged test. First, the subject matter of the model law or regulation must call for a minimum national standard or require uniformity among the states. The second part of the test is the NAIC members must be committed to dedicating significant regulator and NAIC staff resources to educating, communicating and supporting the adoption of the model law or regulation.

When issues arise where a proposed model law does not meet the two-pronged test, a group can proceed to develop a guideline to address the regulatory issue. Guidelines are not considered to be equivalent to model laws of the NAIC. They are considered regulatory best practices. While Section 712 of Model #555 is a model law, it is the opinion of NAIC staff that the alternative language to Section 712 should be drafted as a guideline, because it does not meet the two-pronged test to be a model law.

2016 Workers’ Compensation Large Deductible Study

Section 712 of Model #555 was originally adopted in 2007 separately from the other provisions of Model #555. After discussion and consideration of recent workers’ compensation insurer insolvencies, the growth of the large
deductible market and the increased number of workers affected by large deductibles, the NAIC/IAIABC Joint (C) Working Group was charged in 2015 to provide an update to the 2006 Workers’ Compensation Large Deductible Study. The 2016 Workers’ Compensation Large Deductible Study provides the following discussion on the use, business practices and potential risks of large deductible policies in workers’ compensation:

**Current State of the Law**

In most states, there is little guidance governing the rights and obligations of the parties when an insurance company with a large deductible portfolio becomes insolvent. One approach to the problem could be called the “secured claim” approach, which places the highest importance on the principle that claims within the deductible are primarily the obligation of the policyholder. Under this approach, deductible reimbursements are earmarked to pay those claims, and any collateral posted by or on behalf of the policyholder is held to ensure that those claims are paid. Accordingly, when the guaranty association takes on the responsibility of paying a claim within the deductible, it earns the benefit of the reimbursement due from the policyholder, and the right to draw on the collateral if necessary, or to initiate a draw by the receiver, for the benefit of the guaranty fund. [Note: this is the approach of the NCIGF Model].

Another approach could be called the “reinsurance” approach, which places the highest importance on the principle that the insurer’s obligation to pay all covered claims and the policyholder’s obligation to reimburse the insurer are unconditional and that each is independent of the other. Under this approach, deductible reimbursements are a general asset of the estate so that large deductible policies and guaranteed cost policies are essentially identical from the guaranty fund’s perspective, and the guaranty fund only benefits from the deductible reimbursements in proportion to its share as a creditor of the estate. The NAIC has largely taken the second approach. Under the Insurer Receivership Model Act (Model #555), Section 712—Administration of Loss Reimbursement Policies, the receiver has the right to collect all deductible reimbursements, drawing on collateral as necessary. All such payments are general assets of the estate. Any reimbursements paid to the guaranty association are treated as early access distributions and offset from future recoveries from the estate. However, the receiver also has the option to enter into an agreement under which the policyholder takes on responsibility for claims within the deductible, directly or through a TPA, and any such claims remain off the books of both the estate and the guaranty fund. It should be noted that no state has enacted the reinsurance approach embodied in Model #555. The NCIGF approach, on the other hand, has had some success in state legislatures, as the paragraph below demonstrates. Further, some states may have concerns about the impact of the Model #555 approach on statutory deposit requirements in California.

[Update: Eleven states currently have statutes in place: California, Florida, Illinois, Indiana, Michigan, Missouri, New Jersey, Pennsylvania, Texas, West Virginia and Utah.] Most of these states follow the NCIGF approach and have amended their insurance liquidation acts to clarify the following when to secure competing claims such as deductible amounts owed the insurer and retroactive premium balances: 1) the ownership of the deductible reimbursements or collateral drawdowns; 2) claims-handling matters; 3) collection responsibility; and 4) allocation of collateral.

**Variations on NCIGF Model**

Some states have adopted variations from the NCIGF model that may be considered by states when they are considering adding such language. For example, Illinois, Michigan, and Pennsylvania adopted laws that provide for a three percent administrative fee for the receiver. The following is example language the Working Group included in the Guideline in section F:

The Commissioner as receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements as provided pursuant to [insert state priority of claim statute].
Another variation noted by the Working Group was that California law includes a variation in the threshold amount for the deductible. The Working Group edited section A(1)(b) to reflect a reference to each states’ definition of large deductible.

See ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (#555) “ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES”
GUIDELINE: ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (#555)
“ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES”

Drafting Note: Having the necessary statutory authority specific to large deductible workers’ compensation policies in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted: 1) Section 712 of the NAIC Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies; and 2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation. Generally, both approaches provide for the collection of reimbursements, resolve disputes over who gets the reimbursements and ensure that the claimants are paid. The provisions in each of the two options generally complement each other, except for conflicting provisions regarding the issue of the ultimate ownership of, and entitlement to, the deductible recoveries and collateral as between the estate and the guaranty fund. The issue is whether the guaranty funds, on behalf of the claimants, are entitled to any deductible reimbursements or whether they are a general estate asset that is shared pro rata by the guaranty funds and the uncovered claimants.

Alternative Model Section 712. Administration of Large Deductible Policies and Insured Collateral

This section shall apply to workers’ compensation large deductible policies issued by an insurer subject to delinquency proceedings under this chapter; however, this section shall not apply to first party claims, or to claims funded by a guaranty association net of the deductible unless paragraph B. of this section applies. Large deductible policies shall be administered in accordance with their terms, except to the extent such terms conflict with this section.

A. Definitions. For purposes of this section:

(1) “Large deductible policy” means any combination of one or more workers compensation policies and endorsements issued to an insured, and contracts or security agreements entered into between an insured and the insurer in which the insured has agreed with the insurer to:
(a) Pay directly the initial portion of any claim under the policy up to a specified dollar amount, or the expenses related to any claim; or
(b) Reimburse the insurer for its payment of any claim or related expenses under the policy up to the specified dollar amount of the deductible.

The term “large deductible policy” also includes policies which contain an aggregate limit on the insured’s liability for all deductible claims in addition to a per claim deductible limit. The primary purpose and distinguishing characteristic of a large deductible policy is the shifting of a portion of the ultimate financial responsibility under the large deductible policy to pay claims from the insurer to the insured, even though the obligation to initially pay claims may remain with the insurer. A large deductible shall include [any policy with a deductible of fifty thousand dollars or greater] [Alternative: inset state specific citation for the definition of large deductible].

Large deductible policies do not include policies, endorsements or agreements which provide that the initial portion of any covered claim shall be self-insured and further that the insurer shall have no payment obligation within the self-insured retention. Large deductible policies also do not include policies that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements, except to the extent such arrangements or agreements assume, secure, or pay the policyholder’s large deductible obligations.

(2) “Deductible claim” means any claim, including a claim for loss and defense and cost containment expense (unless such expenses are excluded), under a large deductible policy that is within the deductible.

(3) “Collateral” means any cash, letters of credit, surety bond, or any other form of security posted by the insured, or by a captive insurer or reinsurer, to secure the insured’s obligation under the large deductible policy to pay deductible claims or to reimburse the insurer for deductible claim payments. Collateral may also secure an insured’s obligation to reimburse or pay to the insurer as may be required for other secured obligations.

(4) “Commercially Reasonable” means, to act in good faith using prevailing industry practices and making all reasonable efforts considering the facts and circumstances of the matter.
“Other secured obligations” means obligations of an insured to an insurer other than those under a large deductible policy, such as those under a reinsurance agreement or other agreement involving retrospective premium obligations the performance of which is secured by collateral that also secures an insured’s obligations under a large deductible policy.

B. Handling of Large Deductible Claims.

Unless otherwise agreed by the responsible guaranty association, all large deductible claims, which are also “covered claims” as defined by the applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim, pursuant to an agreement by the guaranty fund or otherwise, the insured’s funding or payment of a deductible claim will extinguish the obligations, if any, of the receiver and/or any guaranty association to pay such claim. No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s funding or payment of a deductible claim.

C. Deductible claims paid by a guaranty association.

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the net amount of the reimbursement, and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under [cite to early access statute].

To the extent that a guaranty association pays a deductible claim that is not reimbursed either from collateral or by insured payments, or incurred expenses in connection with large deductible policies that are not reimbursed under this section, the guaranty association shall be entitled to assert a claim for those amounts in the delinquency proceeding.

Nothing in this subsection limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association’s related expenses, such as those provided for pursuant to [insert cite to guaranty association net worth provision], or existing under similar laws of other states.

D. Collections

(1) The receiver shall have the obligation to collect reimbursements owed for deductible claims as provided for herein and shall take all commercially reasonable actions to collect such reimbursements. The receiver shall promptly bill insureds for reimbursement of deductible claims:

(a) Paid by the insurer prior to the commencement of delinquency proceedings;

(b) Paid by a guaranty association upon receipt by the receiver of notice from a guaranty association of reimbursable payments; or

(c) Paid or allowed by the receiver.

(2) If the insured does not make payment within the time specified in the large deductible policy, or within sixty (60) days after the date of billing if no time is specified, the receiver shall take all commercially reasonable actions to collect any reimbursements owed.

(3) Neither the insolvency of the insurer, nor its inability to perform any of its obligations under the large deductible policy, shall be a defense to the insured’s reimbursement obligation under the large deductible policy.

(4) Except for gross negligence, an allegation of improper handling or payment of a deductible claim by the insurer, the receiver and/or any guaranty association shall not be a defense to the insured’s reimbursement obligations under the large deductible policy.
E. Collateral.

(1) Subject to the provisions of this subsection, the receiver shall utilize collateral, when available, to secure the insured’s obligation to fund or reimburse deductible claims or other secured obligations or other payment obligations. A guaranty association shall be entitled to collateral as provided for in this subsection to the extent needed to reimburse a guaranty association for the payment of a deductible claim. Any distributions made to a guaranty association pursuant to this subsection shall not be treated as distributions under [Insert state insurance liquidation priority distribution statute] or as early access payments under [Insert state early access statute].

(2) All claims against the collateral shall be paid in the order received and no claim of the receiver, including those described in this Subsection, shall supersede any other claim against the collateral as described in Subsection (4) of this Section.

(3) The receiver shall draw down collateral to the extent necessary in the event that the insured fails to:
   (a) Perform its funding or payment obligations under any large deductible policy;
   (b) Pay deductible claim reimbursements within the time specified in the large deductible policy or within sixty (60) days after the date of the billing if no time is specified;
   (c) Pay amounts due the estate for pre-liquidation obligations
   (d) Timely fund any other secured obligation; or
   (e) Timely pay expenses.

(4) Claims that are validly asserted against the collateral shall be satisfied in the order in which such claims are received by the receiver.

(5) Excess collateral may be returned to the insured as determined by the receiver after a periodic review of claims paid, outstanding case reserves and a factor for incurred but not reported claims.

E. Administrative Fees.

(1) The Commissioner as receiver is entitled to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements as provided pursuant to [insert state priority of claim statute].
Laura Slaymaker, Co-Chairman, Large Deductible Working Group
Donna Wilson, Co-Chairman, Large Deductible Working Group
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Dear Ms. Slaymaker and Ms. Wilson:

Thank you for the opportunity to comment on the proposed draft guideline regarding large deductible treatment in liquidation. We applaud your efforts to make this process more efficient and cost effective in liquidation by proposing this draft guideline. As does the Working Group, NCIGF believes that clear statutory guidance is the best way for a state to manage large deductible claims in liquidation.

As you know, the NCIGF supports the alternative approach, GUIDELINE: ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (§555) “ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES” as attached to the memo forwarded for comment. The memo notes that some variation of this approach, which calls for the deductible collections and collateral draw downs to be remitted in full to the guaranty associations to the extent of their claim payments, has been adopted in eleven states. At this point, there are actually twelve states that have adopted this approach – Louisiana now has a provision which is effective January 1, 2020.

Regarding the specific language of the alternative we suggest the following revision to make the guideline more clearly reflect its intent.

The alternative is very close in language to the NCIGF Model Deductible statute. This statute reads in paragraph C:

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement, and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under[cite to early access statute].
The proposed NAIC Guideline Paragraph C reads as follows:

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the net amount of the reimbursement, and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under [cite to early access statute].

We believe the rephrased portion of this paragraph was meant to reference the second paragraph E in the draft guideline. (It is likely meant to be paragraph F.) This paragraph allows the receiver to deduct reasonable expenses from collected or drawn down amounts. We would suggest the following modification to paragraph C of the draft guideline to better reflect the intent:

To the extent a guaranty association pays any deductible claim for which the insurer would have been entitled to reimbursement from the insured, a guaranty association shall be entitled to the full amount of the reimbursement, and available collateral as provided for under this section to the extent necessary to reimburse the guaranty association less any expenses reasonably incurred by the receiver in accordance with paragraph F of this section. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under [cite to priority distribution statute] or as early access payments under [cite to early access statute].

Thank you for considering our comments. We look forward to discussing them with you and we are available to answer any questions the Working Group may have.

Very truly yours,

Barbara F. Cox
Attorney at Law
Barbara F. Cox, LLC
Summary of Proposed Maine Revisions to Section 712 Guideline

General Structure: The NCIGF Model is a stand-alone Model Act, which makes sense from NCIGF’s perspective, since they don’t have a comprehensive model receivership law. However, once our work product is ultimately enacted in the states that choose to adopt it, it ought to go in the state’s comprehensive receivership law. Where this issue fits in the NAIC Model Law scheme is IRMA § 712. Furthermore, we aren’t changing the existing Section 712 at all, except to prepare a parallel version for states that choose to grant injured workers (and through them the guaranty funds) a property interest in the employer payment stream. Because we need to address the same issues either way, and the Alternative Section 712 can be drafted as a set of discrete amendments to the existing Model, I think we should go that route, which preserves the structure of the existing Model Law and makes clearer what is different under the Guideline and what is the same.

The D-Word: One big difference between the exposure draft and the existing IRMA language is editorial rather than substantive. The exposure draft refers to “large deductible” policies, while IRMA calls them “loss reimbursement” policies. “Large deductible” has one obvious advantage—that’s what everyone calls them in real life. If we were writing from a clean slate, that might sway me, but there are three reasons I prefer “loss reimbursement,” even though it’s a made-up term that nobody uses outside IRMA. The first is that we’re not proposing to use it outside IRMA—all other things being equal, if we’re drafting an alternate version of IRMA § 712, I think we should avoid unnecessary deviations. The second is that even though it’s supposed to be entirely a stylistic difference, it can have unintended legal consequences in practice—we’ve already seen that some courts have looked at the word “deductible” in a policy and applied laws that were clearly intended to apply only to true deductibles where the insurer has no obligation to pay below the deductible, even to the point of overriding the state’s strong public policy that injured workers should always have guaranty fund coverage. Finally, if we use the term “large deductible,” we either have to say “not only didn’t we really mean ‘deductible,’ we didn’t really mean ‘large’ either!” or (as in the exposure draft), we have to make an arbitrary decision how large is “large” enough? That would only make sense if there’s a reason for treating employer reimbursements (and the collateral that secures them) differently depending on the claim attachment point, and I haven’t heard anyone suggest such a reason. I did add a drafting note discussing this issue, which includes some language from the exposure draft that makes more sense as an explanatory note than as a defining criterion. (If it’s a “distinguishing characteristic” as a matter of law, does that mean people will have the right to dispute the law’s applicability to a particular case by litigating the “primary purpose” of the specific policy that’s at issue in that case?)

Decision Point – do we limit the Guideline to Workers’ Comp? I think this might have been a discussion worth having if we were reopening IRMA itself, but if we’re going to have two versions of Section 712 for states to choose from, does it make sense to limit one of them to workers’ compensation but not the other?

Net Reimbursement: As the NCIGF observed, the exposure draft refers to the “net amount of the reimbursement” but doesn’t say net of what. NCIGF and I both concluded that this refers to the provision allowing “reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements” to be deducted “from the collateral or from the deductible reimbursements.” This is a place where I prefer the existing IRMA language. Subsection 712(G) expressly authorizes the receiver to recover these costs “through billings to the insured or from loss reimbursement collateral” – deducting these amounts from the guaranty fund
reimbursements should be a last resort, only if the collateral is insufficient to cover both the guaranty fund reimbursements and the collection costs, and the deficiency cannot be recovered from the insured.

**Other Secured Obligations:** They exist, so the law needs to address them – and even to honor them when that doesn’t come at more deserving parties’ expense – but commingled collateral should be disfavored, and I don’t think we should take the exposure draft’s approach of giving workers’ compensation claims and collateral-diluting side deals equal priority when there isn’t enough collateral to go around.

**Claims of the Receiver:** The exposure draft says “no claim of the receiver, including those described in this Subsection, shall supersede any other claim against the collateral as described in Subsection (4) of this Section.” My proposal says, instead, that the priority (regardless of who is making the claim) should be (1) uncovered policy claims (if any) secured by the same collateral; (2) reimbursements for covered claims, whether paid by the guaranty fund or by the receiver; (3) other secured obligations; and (4) return of excess collateral with strict guardrails.

**Gross negligence:** Both the exposure draft and existing Section 712 include language barring allegations of improper handling or payment of a claim as a defense against the employer’s obligation to reimburse the claim. The exposure draft makes an exception for gross negligence. This is worth discussing, but it has nothing to do with the issues that motivated the Guideline, so my comments suggest that if we did agree to propose a gross negligence exception, it ought to be done in a drafting note that makes clear that this is an optional provision states could consider whether they follow the Guideline approach or the existing IRMA approach.

**“No Charge of Any Kind”:** In addition to the language providing that any claim payment made by the insurer extinguishes both the estate’s and the guaranty fund’s liability for that claim or the relevant portion of that claim, the exposure draft includes the sentence “No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s funding or payment of a deductible claim.” What is the problem this additional language is trying to solve? What kind of charge might be made, in what circumstances, in the absence of this sentence?

**Miscellaneous Issues If We Stay with the Exposure Draft’s Format:** All the issues below are moot if we go with my draft, but if we revert to the exposure draft, I think we should make changes to address the following additional issues flagged in my balloon comments (numbered as in the handout): (2) Why are “claims funded by a guaranty association net of the deductible” exempt from this section? (6) The exposure draft exempts policies with aggregate-only deductibles – was this intended? (10) The exposure draft makes an exception to the reinsurance exception for reinsurance “arrangements or agreements [that] assume, secure, or pay the policyholder’s large deductible obligations” - does this encourage sham coverage with side agreements saying it will only be used as security even though the contract by its terms is absolute? (14) The right to opt out of the entire section by agreement with the guaranty association seems overbroad, especially if it purports to delegate powers that ought to be exercised only by the receiver; (16) I think self-pay agreements with employers should be under the ultimate control of the receiver, not the guaranty fund; (19 & 39) Especially since “the policy” is defined to include side agreements, the exposure draft’s deference to the policy terms seems overbroad and should be subject to the receiver’s usual powers to abrogate or modify executory contracts – this is a particularly serious problem where the exposure draft requires the receiver to honor any self-pay agreements the
insurer entered into before it was taken down (even if they’re a contributing cause of the insolvency); (34) the exposure draft defines “commercially reasonable” for purposes of Section 712, but the term is used multiple times elsewhere in IRMA – is it intended to have a different meaning there? (35) The exposure draft provides that “the insurer’s” inability to perform its contractual obligations isn’t a defense to the employer’s reimbursement obligations (and therefore must be pursued, if at all, in some collateral action) – should we clarify that this is the insurer’s “or receiver’s” inability to perform? (46) The exposure draft gives the receiver the obligation to make all commercially reasonable efforts to obtain reimbursement, but doesn’t give the guaranty fund any remedy if the receiver fails to do it – I think we should include the existing Model’s language allowing the guaranty fund to go after the employer “on the same basis as the receiver, and with the same rights and remedies including without limitation the right to recover reasonable costs of collection from the insured”; (52) The exposure draft has language clarifying that the guaranty fund’s reimbursement rights under this section don’t limit any rights that might exist under other applicable laws – in particular the guaranty fund’s right to reimbursement by high-net-worth employers under the pay-and-recover clause – do we need express language clarifying that the aggregate reimbursement can’t exceed the amount paid? (So that you can’t, for example, draw collateral to pay the worker and collect a high-net-worth reimbursement for the same claim)
Maine alternative proposal, January 6, 2020. I think that if we’re presenting an alternative to Section 712, without proposing amendments, we should avoid unnecessary inconsistencies between the two versions. In particular, I think it confuses the issue to have one version call these policies “large deductible” policies and the other version call them “loss reimbursement policies.” There are pros and cons to both approaches, and I don’t think they have anything to do with the substantive differences between existing IRMA § 712 and the Guideline alternative. Accordingly, the draft I’m proposing is marked up against the existing language (with explanatory balloon comments in the margin), except for the drafting note at the top, which is marked up against the exposure draft.

GUIDELINE: ALTERNATIVE TO SECTION 712 OF INSURER RECEIVERSHIP MODEL ACT (#555) “ADMINISTRATION OF LOSS REIMBURSEMENT POLICIES”

Drafting Note: Having the necessary statutory authority specific to so-called “large deductible” workers’ compensation products in receiverships is key to the successful resolution of these insurers. There are currently two statutory authority options available, and there are differences across states as to which authority has been adopted:
1) Section 712 of the NAIC Insurer Receivership Model Act (#555), Administration of Loss Reimbursement Policies; and
2) the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Collateral. Both provide statutory guidance that articulates the respective rights and responsibilities of the various parties, which greatly enhance a state’s ability to manage complex large deductible programs in liquidation. Generally, both approaches provide for the collection of reimbursements, resolve disputes over who gets the reimbursements and ensure that the claimants are paid. The provisions in each of the two options are generally consistent with one another, except for conflicting provisions regarding the issue of the ultimate ownership of, and entitlement to, the deductible recoveries and collateral as between the estate and the guaranty fund. The issue is whether the guaranty funds, on behalf of the claimants, are entitled to any deductible reimbursements or whether they are a general estate asset that is shared pro rata by the guaranty funds and the uncovered claimants.

Alternative Section 712. Administration of Loss Reimbursement Policies

A. For purposes of this section:

(1) “Loss reimbursement policy” means any combination of one or more policies, endorsements, contracts or security agreements in which:

(a) The insured has agreed with the insurer to: (i) Pay directly any portion of a loss or loss adjustment expense owed by the insurer under the policy up to a specified dollar amount; or (ii) Reimburse the insurer for its payment of loss and loss adjustment expense under the policy up to a specified dollar amount; and

(b) Under which the insurer remains liable for payment of loss and loss adjustment expense under the policy regardless of whether the insured has met its obligations. A loss reimbursement policy may provide for a specific dollar amount of loss reimbursement applicable to each claim, an aggregate dollar amount applicable to all claims under the policy, or both.

Drafting Note: The primary purpose of a loss reimbursement policy is the shifting of a portion of the ultimate financial responsibility to pay claims from the insurer to the insured, even though the initial obligation to pay claims may remain with the insurer. Because the payment of the entire amount of each claim remains the unconditional obligation of the insurer, the insured’s loss reimbursement obligation should not be treated as a “deductible” for

Commented [RAW1]: The exposure draft leaves out the expletive in the first line of Paragraph A(1). It should be restored if we retain the restriction to workers’ compensation. (Even if we don’t—see next comment—I have no problem with keeping the word “deductible” which references to workers’ comp or the term “large deductible” in the drafting note, since that provides useful background on the context and purpose.

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Commented [RAW2]: The exposure draft makes this section inapplicable to “claims funded by a guaranty association net of the deductible unless paragraph B of this section applies.” I don’t understand the purpose of this exclusion, and I don’t see a need for it. Paragraph B of the exposure draft is what does apply when the insured self-pays the claim within the deductible. And even if, God forbid, the state in its wisdom decides injured workers deserve no guaranty fund protection if they were foolish enough to work for employers that might default on their loss reimbursement obligations, the provisions for the receiver collecting reimbursements should still apply, and the provisions for paying the GA aren’t relevant because in that scenario the claim within the deductible isn’t a “covered claim.”

Commented [RAW3]: If we were to apply this Guideline only to deductibles above a certain threshold, as the exposure draft proposes, then I would agree that the term needs to be changed to “large deductible” policies—and the definition should be changed accordingly, similar to the change proposed in the exposure draft. But why? What law would then apply to “small and mid-size” deductibles?

Commented [RAW4]: Should the scope be limited to workers’ compensation? Or more broadly, to P&C policies? I think that’s an IRMA question rather than a question specific to the Guideline proposal, so I don’t see any compelling reason for the scope of the Guideline to be different from the scope of the existing provision.

Commented [RAW5]: However, if the consensus is that we want the two different versions of IRMA § 712 to have different scopes (or if down the road we want to amend both versions), then change “one or more policies” to “one or more workers’ compensation policies.”

Commented [RAW6]: This seems much clearer than the “also applies” clause in the exposure draft. As written, the exposure draft would not apply to a policy with a billion-dollar aggregate deductible and no specific coverage below it, which if I recall correctly was one of the examples that touched off this latest round of review.

Commented [RAW7]: The first sentence is taken from the exposure draft, which has it in the body of the definition, but it seems more suitable to a drafting note. The exposure draft also says this is a “distinguishing characteristic” of large deductible policies, but contradicts this by explicitly enumerating three other types of policies that share this...

[1]
purposes of any applicable exclusion from guaranty association coverage, even though these policies are commonly referred to as “large deductible” policies.

(2) “Loss reimbursement” means any payment made by the insured to or on behalf of the insurer for loss or loss adjustment expense pursuant to the terms of a loss reimbursement policy, to the extent that the insurer is responsible for payment regardless of whether the insured has met its obligations. Loss reimbursement includes any voluntary or involuntary application of loss reimbursement collateral to the loss reimbursement obligations of the insured. Loss reimbursement does not include:

(a) Payments made by the insured pursuant to a deductible arrangement under which the insurer has no obligation to pay or advance the amount of the deductible on behalf of the insured or a self-insurance arrangement under which the insurer has no payment obligation for the obligation of the self-insured;

(b) Retrospectively rated premium payments; or

(c) Reinsurance claim payments made by a captive reinsurer or other reinsurer affiliated with or funded by the insured or affiliated with the insurer.

(3) “Loss reimbursement claim” means any claim on a loss reimbursement policy that has been made against the estate, or that was previously paid by the insurer, to the extent that it is subject to an insured’s loss reimbursement obligation. A loss reimbursement claim includes any loss adjustment expenses that are subject to reimbursement by the terms of the policy.

(4) “Loss reimbursement collateral” means any cash, letters of credit, surety bond or any other form of security provided by the insured to secure its loss reimbursement obligations, regardless of whether the collateral is held by, for the benefit of, or assigned to the insurer, and regardless of whether the collateral also secures other obligations of the insured.

(5) “Uncovered loss reimbursement claim” means a loss reimbursement claim that is not defined as a covered claim under the relevant guaranty association statute.

(6) “Other secured obligations” means any obligations, such as reinsurance or retrospective premium obligations, that are payable by the insured to the insurer and which are secured by collateral that also secures a loss reimbursement obligation.

B. Administration of Loss Reimbursement Claims.

(1) Except as otherwise provided in this section, all loss reimbursement claims that are also “covered claims” under an applicable guaranty association law, including those that may have been funded by an insured before liquidation, shall be turned over to the guaranty association for administration and payment as provided in the guaranty association law.
(2) Unless otherwise prohibited by law, the receiver, with notice to all affected guaranty associations, may enter into agreements allowing an insured to fund or pay loss reimbursement claims, directly or through a third-party administrator:

(a) If the insurer previously allowed the insured to fund or pay loss reimbursement claims directly or through a third-party administrator, the arrangement is subject to assumption or rejection by the receiver as an executory contract under Section 114.

(b) This paragraph does not preclude a guaranty association that is responsible for payment of a loss reimbursement claim from entering into an agreement with an insured, or a third-party administrator selected by an insured, to administer or pay loss reimbursement claims on behalf of the guaranty association.

(3) The insured’s payment of a loss reimbursement claim in whole or part, including any payment made by a third-party administrator on behalf of the insured, shall extinguish the obligation, if any, of the receiver or any guaranty association to pay that claim or that portion of the claim. Acceptance of the insured’s payment by a claimant in full or final settlement of a claim shall bar the assertion of that claim in the delinquency proceeding or the guaranty association claims process.

(4) An agreement entered into or reaffirmed under this subsection may be terminated in the manner specified in the agreement.

C. Any loss reimbursements owed by an insured shall be administered as follows:

(1) The receiver shall bill an insured for reimbursement of a loss reimbursement claim when:

(a) the insured paid the claim prior to the commencement of delinquency proceedings;

(b) the receiver is notified that a guaranty association has paid a loss reimbursement claim;

(c) the receiver has paid a loss reimbursement claim; or

(d) a loss reimbursement claim is allowed in liquidation proceedings.

(2) If the receiver is reimbursed by or on behalf of the insured, or obtains reimbursement by drawing collateral, for all or part of a loss reimbursement claim that a guaranty association has paid or is obligated to pay, the receiver shall remit such funds to the guaranty association, net of any reasonable and actual collection costs the receiver was unable to recover from the insured, to the extent necessary to reimburse the guaranty association. Reimbursements paid to the guaranty association pursuant to this subsection shall not be treated as distributions under Section 802 or early access payments under Section 803. The extent to which the guaranty association is not fully reimbursed for its claim payments and its loss reimbursement claim payments shall be rebated to the insured.

Commented [RAW16]: The exposure draft gives this power to the guaranty association. I think it has to be the receiver when it’s a global agreement for the entire policy.

Commented [RAW17]: Doesn’t affect the meaning, but emphasizes that the decision needs to be made on a policy-by-policy basis.

Commented [RAW18]: IRMA’s punctuation is inconsistent – when “third-party” is used as an adjective, IRMA hyphenates it 6 times and leaves out the hyphen. ... [2]

Commented [RAW19]: Existing Section 712, as wr. ... [6]

Commented [RAW20]: Something to discuss – not ... [7]

Commented [RAW21]: I think this is a helpful ... [8]

Commented [RAW22]: Exposure draft omits refer ... [9]

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Commented [RAW24]: The exposure draft is more ... [11]

Commented [RAW25]: The deleted half of this para ... [12]

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Commented [RAW27]: A version of this clause ap ... [14]

Commented [RAW28]: The exposure draft phrase ... [16]

Commented [RAW29]: This paragraph, and the de ... [17]

Commented [RAW30]: The exposure draft says “in ... [18]

Commented [RAW31R30]: Note also that the exp ... [19]

Commented [RAW32]: The exposure draft has ... [21]
reasonable and actual expenses, it shall be entitled to assert a claim for those amounts in the delinquency proceeding.

(3) If the insured does not make payment within the time specified in the loss reimbursement policy, or within sixty (60) days after receipt of the billing if no time is specified, the receiver has the obligation to take all commercially reasonable actions necessary to collect any reimbursements owed.

(4) The insolvency of the insurer, the insurer’s or receiver’s inability to perform any of the insurer’s obligations under the loss reimbursement policy, or any allegation of improper handling or payment of a loss reimbursement claim by the receiver and/or any guaranty association shall not be a defense to the insured’s reimbursement obligation under the loss reimbursement policy.

D. Any collateral held under a loss reimbursement policy issued by an insurer subject to a delinquency proceeding under this Act shall be maintained and administered in accordance with the loss reimbursement policy except where the loss reimbursement policy conflicts with this section.

E. If the loss reimbursement collateral, when combined with loss reimbursement payments that have been made by the insured, is insufficient to reimburse loss reimbursement claims already paid by the insurer, the receiver and guaranty associations, and to discharge all currently and past due loss reimbursement claims and other secured obligations, then the collateral shall be applied first to fully meet any uncovered loss reimbursement claims whose reimbursement is secured by the collateral, then to all reimbursements due to guaranty associations under paragraph (C)(2) or for covered claims that have been paid directly by the receiver, and finally to any other secured obligations.

(1) Claims of the same type shall be paid in the order filed with the receiver.

(2) Excess collateral may be returned to the insured only if the receiver determines, after a periodic review of claims paid, that the collateral is sufficient, with a confidence level of at least 95%, to discharge both outstanding case reserves and incurred but not reported claims.

F. If the receiver declines to seek or is unsuccessful in obtaining reimbursement from the insured for a loss reimbursement claim and there is no available collateral, a guaranty association may, after notice to the receiver, seek to collect reimbursement due from the insured on the same basis as the receiver, and with the same rights and remedies including without limitation the right to recover reasonable costs of collection from the insured. The guaranty association shall report any amounts so collected from each insured to the receiver. The receiver shall provide the guaranty association with available information needed to collect a reimbursement due from the insured. Whenever a guaranty association undertakes to collect reimbursements from an insured, it shall notify all other guaranty associations that have paid loss reimbursement claims on behalf of the same insured. Amounts collected by a guaranty association pursuant to this paragraph shall be treated in accordance with subparagraph C(2), The expenses incurred by a guaranty association in pursuing reimbursement shall not be permitted as a claim in the delinquency proceeding at

Deleted: (3) Any loss reimbursement paid to the receiver that is allocable to a claim paid by a guaranty association shall be immediately distributed to that guaranty association as an early access payment in accordance with Section 803; provided, however, that notwithstanding the provisions of Section 803, receivership court approval shall not be required for early access distributions made pursuant to this section.

Commented [RAW32]: No change from original.

Commented [RAW33]: Existing Section 712 says “receiver’s,” exposure draft says “insurer’s.” If I had to pick between the two, I’d go with “receiver’s,” because the insurer’s insolvency is already listed separately and other types of “inability” are more likely to be post-receivership issues.

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Commented [RAW34]: The exposure draft includes a definition of this term. However, it’s used multiple times in other provisions of IRMA, and shouldn’t have a separate definition for purposes of this section. Perhaps a drafting note suggesting that states consider defining the term if it doesn’t already have an established meaning under state law?

Commented [RAW35]: The exposure draft makes an exception for gross negligence. This is worth discussing.

Commented [RAW36]: The exposure draft goes in 2022.

Commented [RAW37]: The applicable contractual definitions are referenced for the first time in the exposure draft here.

Commented [RAW38]: The applicable contractual definitions are referenced for the first time in the exposure draft here.

Commented [RAW39]: The exposure draft is broad.

Commented [RAW40]: Should there be any reference to the contractual definitions?

Commented [RAW41]: This is a substantive difference.

Commented [RAW42]: I think we ought to consider...

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Commented [RAW43]: The exposure draft says “in,” original says “as in accordance with.”

Commented [RAW44]: This is in the exposure draft.

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Commented [RAW45]: This is an important addition.

Commented [RAW46]: I’m surprised this has no
discussion around it.

Commented [RAW47]: Is this the only trigger, or is there a
backup?

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Commented [RAW48]: The phrase “as in accordance with” is
already in the exposure draft.

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any priority, except as agreed by the receiver at or before the time the expenses are incurred; however, a guaranty association may net the expenses incurred in collecting any reimbursement against that reimbursement.

G. The receiver is entitled to recover through billings to the insured or from loss reimbursement collateral all reasonable expenses that the receiver or guaranty associations incur in fulfilling their responsibilities under this Section. All such deductions or charges shall be in addition to the insured’s obligation to reimburse claims and related expenses and shall not diminish the rights of claimants or guaranty associations.

H. Nothing in this section limits any rights of the receiver or a guaranty association that may otherwise exist under applicable law to obtain reimbursement from insureds for claims payments made by the guaranty association under policies of the insurer or for the guaranty association’s related expenses, such as those provided for pursuant to [insert cite to guaranty association net worth provision], or existing under similar laws of other states, provided that the guaranty association’s aggregate reimbursement attributable to any claim or expense payment may not exceed the actual amount paid.

J. [OPTIONAL] The provisions of this section shall be applied in all receiverships pending at the time of enactment.

Drafting Note: Attention should be drawn to whether Section 712 is adopted with IRMA or as a stand-alone. If it is adopted with IRMA, then the provisions in Section 111 of IRMA may apply. States may wish for this particular section to not apply retroactively even if electing to have the rest of IRMA so applied, or may wish to apply Section 712 retroactively while having the rest of IRMA applying prospectively.
The first sentence is taken from the exposure draft, which has it in the body of the definition, but it seems more suitable to a drafting note. The exposure draft also says this is a “distinguishing characteristic” of large deductible policies, but contradicts this by explicitly enumerating three other types of policies that share this characteristic: smaller deductibles, retros, and captive reinsurance.

IRMA’s punctuation is inconsistent – when “third-party” is used as an adjective, IRMA hyphenates it 6 times and leaves out the hyphen 14 times. Even the three references to TPAs within Section 712 are inconsistent. So I went with what I consider the correct form.

Existing Section 712, as written, seems to require the receiver to keep any pre-receivership self-pay arrangement in place, even if it’s unwritten and undesirable. This is even more problematic in the framework of the existing Model than it is for our Guideline, since under the existing Model, self-pay arrangements operate to diminish the estate.

Something to discuss – not sure whether it’s an appropriate addition. Global agreements are the receiver’s call, but maybe there’s a place for separate agreements with individual GAs if there’s no global agreement?

I think this is a helpful clarification, though it was omitted from the exposure draft. It avoids any ambiguity regarding a single workers’ compensation “claim” encompassing a series of periodic “claims” against the estate, and also addresses the situation where the money runs out in the middle of a single payment.

Exposure draft omits reference to TPAs. Not strictly necessary, but I think it’s a helpful clarification.

The exposure draft’s counterpart to this paragraph includes the sentence “No charge of any kind shall be made against the receiver or a guaranty association on the basis of an insured’s funding or payment of a deductible claim.” Maybe I’m just burned out as I try to wrap this up, but I’m baffled by this sentence. What is the problem it’s trying to solve? What kind of charge might be made, in what circumstances, in the absence of this sentence?

The exposure draft is more forceful, but “shall have the obligation to” and “shall” actually mean the same thing, and the rights and duties of the receiver and GA seem to be a better fit in Paragraph (4) below.
The deleted half of this paragraph is one of the awkward features of existing Section 712 – what happens when the employer is required to reimburse the same claim under both a large deductible agreement and a net worth “pay and recover” law? It’s been deleted because the Guideline approach eliminates the conflict so there’s no need to resolve it – the guaranty association is entitled to the reimbursement either way.

Since the sentence that follows is deleted, these subparagraphs don’t need to be numbered inline.

A version of this clause appears in both the existing Model and the exposure draft, but how can the mere allowance of a claim trigger an obligation to “reimburse” a claim that hasn’t been paid? Should this be limited to cases where the insurer has the contractual right to bill the employer as soon as the claim is accepted? Are there such contracts?

The exposure draft phrases reimbursements by the insured and draws on collateral as though they were two different things. But as far as we’re concerned, it all comes from the insured, one way or another. If a surety or guarantor has collection issues with the insured, that’s their problem, not ours.

This paragraph, and the deletion of existing paragraph (3), are the heart of the difference between the Guideline approach and the approach taken by the existing IRMA language. This draft is generally based on the first two paragraphs of Subsection C of the exposure draft, but I tried to clarify certain points. For example, the exposure draft says the GA “shall be entitled to recover” but doesn’t say from whom.

The exposure draft says “net amount of the reimbursement,” but doesn’t explain “net of what?” in this paragraph. That seems to be the point of the second Subsection E of the exposure draft, but I prefer existing Subsection G which makes those costs the responsibility of the insured if possible.

Note also that the exposure draft has two “Subsection E”s – if we keep the exposure draft’s organization, the second of those, “Administrative Fees,” should be F. It also consists in its entirety of a single numbered paragraph (1), with no paragraph (2), so the internal numbering seems superfluous.

The exposure draft has placeholder language, which would make sense in a stand-alone law, but I think it’s understood, when a state only adopts IRMA (or any other Model) in part, that internal cross-references might need to be changed to reference some other law. (For that matter, even when IRMA is adopted intact the internal cross-references might need to change to match the state’s own numbering scheme.)
The exposure draft makes an exception for gross negligence. This is worth discussing (we’re talking here about allegations that the insurer paid meritless claims because it wasn’t the insurer’s own money on the line), but is there a good reason for the two versions to be inconsistent here? If we agree to propose a gross negligence exception, consider doing it as a drafting note suggesting that states might want to consider such an exception, whichever version of Section 712 they adopt.

The exposure draft goes into more detail about the triggers for draws on collateral. Is that material necessary? I don’t see it as a substantive difference from the existing language, nor as a clarification that patches a hole that’s created any actual problems.

The applicable contractual provisions might not be in the policy itself, but I think that’s taken care of by the definition of “loss reimbursement policy.”

The exposure draft is broader, saying the entire policy applies unless there’s a conflict with this section. To the extent that it does more than restate the obvious, it doesn’t seem appropriate, since it seems to say the contract trumps all other sections of the receivership law, including all discretionary powers of the receiver therein, except Section 712. Seems particularly dangerous since the policy is defined to include all applicable side agreements.

Should there be any reference to Section 710 here, which addresses collateral more generally? Note that the race-to-file provision we’re proposing is different from the pro rata distribution called for by Subsection 710(B), but that ambiguously worded subsection seems to be intended to apply only to surety bond collateral.

This is a substantive difference between the exposure draft and the existing IRMA language where I strongly prefer the existing language. “Other secured obligations” that weaken the collateral should be disfavored and should not be entitled to compete on equal terms in the race to access the collateral.

I think we ought to consider giving uncovered secured claims – if they exist – priority over the Gas. If we don’t do this, however, we should as noted earlier delete the definition of “uncovered loss reimbursement claims because the term isn’t used.

The exposure draft says “no claim of the receiver, including those described in this Subsection, shall supersede any other claim against the collateral as described in Subsection (4) of this Section.” This seems wrong for three reasons. One is that it contradicts the other provisions in the exposure draft expressly allowing the receiver to net out actual and reasonable collection expenses. The other is that I don’t understand why claims of the same type should be treated differently depending on which responsible party happened to be on the spot to make the initial payment. Finally, if we keep the provision protecting uncovered loss reimbursement claimants, this is based on paying them out of the collateral and loss reimbursements as secured claimants, not paying them in full out of general estate assets and making the receiver go to the tail of the line for reimbursement.

This is in the exposure draft but not in the existing IRMA. Not sure why – is that because it doesn’t matter as much if they’re merely Early Access Distributions and not final payments?
This is an important addition made by the exposure draft, but I don’t think the exposure draft is strong enough. Even the 95th confidence level has, by definition, one chance in 20 of being inadequate. I omitted the reference to “a factor for” IBNR because I was afraid it might encourage reliance on rules of thumb which are often insufficient.

I’m surprised this has no counterpart in the exposure draft. The receiver has the obligation to pursue prompt and diligent collection of reimbursements, but what’s the remedy if the receiver doesn’t successfully get them?

Is this the only trigger, or should the receiver have the authority to delegate the authority to collect reimbursements and administer collateral to one or more Gas by agreement? (Or does that power already exist, to whatever extent it might be useful, when the law is silent?)

The phrase “as in accordance with” in existing IRMA looks like a typo. Should be either “in accordance with” or (but only in the existing version, not the Guideline alternative, of course!) “as early access payments in accordance with”
<table>
<thead>
<tr>
<th>Key Provisions Identified in Comments</th>
<th>Related Model Section</th>
<th>Is it critical to a multi-jurisdictional receivership? (Y/N)</th>
<th>Should it be considered as an accreditation standard? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflicts of Law:</td>
<td>§ 102</td>
<td></td>
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<tr>
<td>- The receivership act and insurance guaranty association acts prevail if there is a conflict with other laws, which ensures that these laws control over general laws.</td>
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<tr>
<td>Stays &amp; Injunctions</td>
<td>§ 108</td>
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<tr>
<td>- Provides automatic stay of actions against receivership estate and insureds.</td>
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<tr>
<td>Continuation of Coverage for life and health policies:</td>
<td>§ 502</td>
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<tr>
<td>- Governs the continuation of policies when a liquidation order is entered.</td>
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<tr>
<td>Priority of Distribution:</td>
<td>§ 801</td>
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<tr>
<td>- Priority scheme for distribution of assets must comport with the Supreme Court’s decision in United States Department of Treasury v. Fobe.</td>
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<tr>
<td>Ancillary Conservation of Foreign Insurers:</td>
<td>§ 1002</td>
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<td>- Limits scope of ancillary receiverships.</td>
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<tr>
<td>Domiciliary Receivers in Other States:</td>
<td>§ 1001</td>
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<tr>
<td>- Other states’ receivership laws and are given full faith and credit, which promotes the consistent application of laws and orders and avoids conflicting reciprocity standards.</td>
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<tr>
<td>Treatment of Large Deductible Workers Compensation policies:</td>
<td>§ 712 or pending alternate guideline</td>
<td></td>
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<tr>
<td>- Procedures govern parties’ rights regarding large deductible policies in liquidation.</td>
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<tr>
<td>Designated court for receivership proceedings:</td>
<td>§ 105 K</td>
<td></td>
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<tr>
<td>- Court may order that one judge hears all matters in a delinquency proceeding.</td>
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<tr>
<td>Limitation on judicial discretion regarding a receivership petition:</td>
<td>§ 205, § 208</td>
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<tr>
<td>- Court must enter judgment on petition within 15 days of conclusion of the evidence.</td>
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<tr>
<td>Timing of Proceedings:</td>
<td>§ 105 L, § 403</td>
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<tr>
<td><strong>Question:</strong> If not an update to accreditation standards, what other options do you propose for encouraging states to adopt these provisions into law?</td>
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<td>[insert response]</td>
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### Other Comments Received

<table>
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<tr>
<th>Additional Feedback?</th>
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<tbody>
<tr>
<td>Create accreditation standard requiring adoption of Life and Health Insurance Guaranty Association Model Act in a “functionally consistent” manner.</td>
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<td>Promote cost effective resolution in early stages of receivership proceedings.</td>
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<td>Provide standardized judicial education on the receivership process.</td>
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<tr>
<td>Strengthen the NAIC’s Financial Analysis Working Group (FAWG) and Receivership Financial Analysis Working Group (R-FAWG).</td>
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<td>Create NAIC “SWAT” team of receivership experts.</td>
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<tr>
<td>Revise Section 7 of the Insurance Holding Company System Regulatory Act to ensure the continuation of inter-affiliate services in receiverships.</td>
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<td>Create crisis management groups for supervisory colleges within Section 7 of the Insurance Holding Company System Regulatory Act and/or guidance such as the Receivers’ Handbook.</td>
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<tr>
<td>Develop statutory changes to accommodate transactions under Insurance Business Transfer and corporate division statutes.</td>
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<tr>
<td>Develop statutory changes (if needed) to permit guaranty funds to assess for administrative costs that are not tied to the volume of insolvency activity.</td>
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<tr>
<td>Develop statutory changes as needed to prevent “orphan claims” scenarios.</td>
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</tbody>
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NAIC Proceedings – Summer 2020

REINSURANCE (E) TASK FORCE

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Reinsurance (E) Task Force June 9, 2020, Minutes (Attachment One)........................................ 10-1435
Reinsurance (E) Task Force March 11, 2020, Minutes (Attachment One-A).............................. 10-1437

Memorandum to the Financial Regulation Standards and Accreditation (F) Committee
Regarding 2011 and 2019 Revisions to Credit for Reinsurance Model Law (#785)
and Credit for Reinsurance Model Regulation (#786) – Applicability to Risk Retention Groups (RRGs), Feb. 12, 2020 (Attachment One-A1) ................................................................. 10-1440

Memorandum from NAIC Staff Regarding Comparison of Term and Universal Life Insurance
Reserve Financing Model Regulation (#787) and Actuarial Guideline XLVIII—Actuarial
Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be
Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model
Regulation (AG 48), Feb. 5, 2020 (Attachment One-A2) ............................................................. 10-1445

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(Attachment One-A3) ..................................................................................................................... 10-1463

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(Attachment One-B1) ..................................................................................................................... 10-1473

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Uniform Checklist for Reciprocal Jurisdiction Reinsurers, May 4, 2020, Draft (Attachment One-D) 10-1492

Comment Letters Received Regarding the Uniform Checklist for Reciprocal Jurisdiction Reinsurers
and the Uniform Application Checklist for Certified Reinsurers (Attachment One-E) ................. 10-1498

Uniform Checklist for Reciprocal Jurisdiction Reinsurers, June 9, 2020, Draft (Attachment One-F) 10-1502

Reinsurance (E) Task Force 2021 Proposed Charges (Attachment Two) ......................................... 10-1508

Maps Showing the Implementation of the 2019 Revisions to Model #785 and Model #786
(Attachment Three) ..................................................................................................................... 10-1510
The Reinsurance (E) Task Force met via conference call Aug. 6, 2020. The following Task Force members participated: Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Raymond G. Farmer, Vice Chair, represented by Ryan Basnett (SC); Lori K. Wing-Heier represented by David Abreo (AL); Elizabeth Perri (AS); Ricardo Lara represented by Monica Macaluso (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Kathy Belfi (CT); David Altmair represented by Carolyn Morgan and Virginia Christy (FL); Doug Ommen represented by Carrie Mears and Kim Cross (IA); Dean L. Cameron represented by Nathan Faragher (ID); Robert H. Muriel represented by Susan Berry (IL); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by John Tirado (NJ); Barbara D. Richardson represented by Perter Rao and Gennady Stolyarov (NV); Linda A. Lacewell represented by Mona Bhalla (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Kent Sullivan represented by Jamie Walker (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by David Smith and Doug Stolte (VA); Michael S. Pieciak represented by David Provost (VT); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted its June 9 Minutes**

Mr. Rehagen stated that the Task Force met June 9 and took the following action: 1) adopted its March 11, Jan. 29, and Dec. 8, 2019, minutes; 2) discussed whether Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48) should be considered to be “substantially similar” to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) for purposes of accreditation; and 3) adopted the new Uniform Checklist for Reciprocal Jurisdiction Reinsurers and revisions to the Uniform Application Checklist for Certified Reinsurers.

Ms. Belfi made a motion, seconded by Mr. Milquet, to adopt the Task Force’s June 9 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its 2021 Proposed Charges**

Mr. Rehagen stated that the proposed 2021 charges include minor revisions to the 2020 charges, and the charges related to the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) had been incorporated during the prior year.

Ms. Macaluso made a motion, seconded by Mr. Eft, to adopt the 2021 proposed charges of the Task Force, the Reinsurance Financial Analysis (E) Working Group, and the Qualified Jurisdiction (E) Working Group (Attachment Two). The motion passed unanimously.


Mr. Kaumann provided the report of the Working Group. He stated that the Working Group met March 11 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to adopt the new Uniform Checklist for Reciprocal Jurisdiction Reinsurers and revisions to the Uniform Application Checklist for Certified Reinsurers.

Mr. Kaumann stated that the Working Group monitors 33 certified reinsurers that have been recommended for passporting, and the reviews of these certified reinsurers must be completed before year end. He stated that the Working Group will begin discussions to determine the best and most effective approaches for the financial solvency surveillance of the reciprocal jurisdiction reinsurers in the next several months.
Mr. Kaumann made a motion, seconded by Mr. Wake, to adopt the report of the Reinsurance Financial Analysis (E) Working Group. The motion passed unanimously.

4. Adopted the Report of the Qualified Jurisdiction (E) Working Group

Mr. Wake stated that the Working Group has not met during 2020. He stated that during the fall of 2019, the Working Group completed several projects related to the 2019 revisions to Model #785 and Model #786, and he noted that the Working Group also completed the re-reviews of the qualified jurisdictions that were due prior to Jan. 1, 2020, and the initial reviews of the reciprocal jurisdictions that are not subject to covered agreements.

Mr. Wake stated that the Working Group has been approached by three countries that have shown interest in becoming qualified jurisdictions. He stated that the Working Group intends to perform the initial reviews of these countries over the next several months. He noted that the Working Group stands ready to assist with any issues.

Dan Schelp (NAIC) stated that the Working Group has committed to updating the Process for Evaluating Qualified and Reciprocal Jurisdictions to include a process for termination of a qualified jurisdiction or reciprocal jurisdiction.

Mr. Wake made a motion, seconded by Mr. Kaumann, to adopt the report of the Qualified Jurisdiction (E) Working Group. The motion passed unanimously.

5. Received a Status Report on the States’ Implementation of the 2019 Revisions to Model #785 and Model #786

Mr. Rehagen stated that as of July 7, 11 U.S. jurisdictions have adopted the 2019 revisions to Model #785, and 17 jurisdictions have action under consideration. He noted that Virginia has adopted the revisions to Model #786, and Kentucky, Pennsylvania, and West Virginia currently have action under consideration. He stated that the maps showing the adoption of the 2019 revisions to Model #785 and Model #786 were included in the meeting materials (Attachment Three).

Mr. Rehagen stated that the 2019 revisions to the models must be adopted by the states prior to Sept. 1, 2022, which is when the revisions are expected to become an accreditation standard. He noted that Sept. 1, 2022, is also the date at which the Federal Insurance Office (FIO) must complete its federal preemption reviews under the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement). He noted that the COVID-19 pandemic has slowed the adoption process, and several state legislatures have temporarily closed or have primarily focused on the pandemic. He stated that the Task Force will provide support to the states to meet this deadline, and it will communicate with the U.S. Department of the Treasury (Treasury Department) and the FIO, as necessary. He noted that there have not been any specific conversations with either the FIO or the European Union (EU) about extending this deadline, but there have been some preliminary discussions with the FIO on the status of state adoptions.

Mr. Rehagen stated that the SMI Dashboard is updated regularly to show the current adoptions of several model laws and regulations, and it can be found on the Financial Condition (E) Committee’s webpage. He noted that Mr. Schelp and Jake Stultz (NAIC) can answer any technical questions during the legislative process, and Holly Weatherford (NAIC), Legislative Counsel, is working directly with the states on the adoption of the 2019 revisions to Model #785 and Model #786.

Karalee C. Morell (Reinsurance Association of America—RAA) stated that there has been a significant amount of work completed by the state legislatures, but the process has been slowed by COVID-19. She noted that several states had to stop all legislative activity earlier in early 2020, and she noted that with the potential risk of a second wave of COVID-19, the states must plan around any potential further legislative recesses in the next few months. She stated that the EU Covered Agreement effective dates are not flexible. She noted that the RAA can assist the state legislatures during the adoption process.

Mr. Kaumann asked if the RAA has talking points that they can provide to the states. Ms. Morell stated that she can provide the RAA talking points directly to anybody that requests them. Mr. Schelp noted that the NAIC has a legislative packet with talking points and other information that has been distributed to the state legislative liaisons, and NAIC staff can resend those to any states that need them during the legislative process.

Having no further business, the Reinsurance (E) Task Force adjourned.
The Reinsurance (E) Task Force met via conference call June 9, 2020. The following Task Force members participated: Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Raymond G. Farmer, Vice Chair, represented by Daniel Morris (SC); Lori K. Wing-Heier represented by David Phifer (AK); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Monica Macaluso and Kim Hudson (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Kathy Belfi and Jim Jakielo (CT); Trinidad Navarro represented by Dave Lonchar (DE); David Altmaier represented by Carolyn Morgan (FL); John F. King (GA); Doug Ommen represented by Carrie Mears (IA); Dean L. Cameron represented by Nathan Faragher (ID); Robert H. Muriel represented by Eric Moser (IL); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by Christopher Joyce (MA); Eric A. Cioppa, represented by Robert Wake (ME); Matthew Rosendale represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfried represented by Matt Fischer (ND); Bruce R. Ramge represented by Lindsay Crawford and Justin Schrader (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by John Tirado (NJ); Barbara D. Richardson represented by Joel Bengo (NV); Linda A. Lacewell represented by Michael Campanelli (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Andrew Schallhorn (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Kent Sullivan represented by Jamie Walker and Mike Boerner (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by David Smith and Doug Stolte (VA); and Mark Afable represented by Randy Milquet (WI).

1. Adopted its March 11, Jan. 29, and 2019 Fall National Meeting Minutes

Mr. Rehagen stated that the Task Force met March 11, Jan. 29, and Dec. 8, 2019. During its March 11 meeting, the Task Force: 1) adopted a recommendation that the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) be an accreditation standard for risk retention groups (RRGs); and 2) discussed whether Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48) should be considered to be “substantially similar” to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) for purposes of accreditation. During its Jan. 29 meeting, the Task Force adopted technical revisions to Model #787.

Mr. Eft made a motion, seconded by Ms. Obusek, to adopt the Task Force’s March 11 (Attachment One-A), Jan. 29 (Attachment One-B) and Dec. 8, 2019 (see NAIC Proceedings – Fall 2019, Reinsurance (E) Task Force) minutes. The motion passed unanimously.

2. Discussed Whether Compliance with AG 48 Should be Considered “Substantially Similar” to Model #787 for Accreditation Purposes

Mr. Rehagen stated that the Task Force discussed whether compliance with AG 48 should be considered “substantially similar” to Model #787 for accreditation purposes on its March 11 conference call. He stated that the Task Force exposed a memorandum (See NAIC Proceedings – Summer 2020, Reinsurance (E) Task Force, Attachment One-A2) on Feb. 5 for a 21-day public comment period. He noted that the Financial Regulation Standards and Accreditation (F) Committee has adopted Model #787 as an accreditation standard, recommended to be effective Sept. 1, 2022, with enforcement beginning Jan. 1, 2023. He stated that his preference was to not provide a formal recommendation to the Committee, leave the current recommendation in place for adoption by the Executive (EX) Committee and Plenary, and allow the Financial Regulation Standards and Accreditation (F) Committee to review and address potential accreditation issues on a case-by-case basis.

Dan Schelp (NAIC) stated that the Accreditation Program Manual provides a definition of “substantially similar” that does not require a state to adopt every significant element of a model, but the state may also rely on an administrative practice that results in solvency regulation that is similar in force and no less effective than the NAIC model law or regulation for that standard. He stated that on an annual basis, the NAIC Legal Division will perform a Part A review of the state’s laws and regulations and will then provide an opinion to the Financial Regulation Standards and Accreditation (F) Committee as to whether a state’s administrative practices or other laws or regulations are similar in force and no less effective than the model.
He noted that this is normally an outcomes-based approach, and if the state is achieving “substantially similar” financial solvency results as under the model, the practice would be considered “substantially similar.”

Mr. Schelp noted that there is a caveat that the department of insurance (DOI) must not have encountered a successful challenge to the required administrative practice by an insurer, and the DOI must generally support compliance with the practice by the insurers. He stated that it is the opinion of NAIC staff that AG 48 is an administrative practice that if enforced by a state would result in financial solvency regulation that is “substantially similar” to Model #787. He noted that the Financial Regulation Standards and Accreditation (F) Committee generally accepts the opinion of the NAIC Legal Division, but this issue remains at the discretion of the Committee.

Becky Meyer (NAIC) stated that all companies are currently complying with AG 48 without a need to take the penalty. She noted that concerns have been expressed that the reason for compliance is the strong emphasis on making Model #787 an accreditation standard and the penalty that comes with non-compliance with Model #787. She noted that having Model #787 as the accreditation standard, along with an outcomes-based approach that allows AG 48 as an administrative practice rather than a strict recommendation that states must adopt Model #787, provides flexibility to ensure that the goals of the standard are met by all states.

Ms. Belfi stated that based on the comments provided by Mr. Schelp and Ms. Meyer, Connecticut agrees with the approach of not providing any further recommendation from the Task Force to the Financial Regulation Standards and Accreditation (F) Committee.

Mr. Rehagen stated that the Task Force will not make any further recommendations to the Financial Regulation Standards and Accreditation (F) Committee, and it will rely on the Committee’s judgment, based on the case-by-case analysis of whether a state is in compliance with the accreditation standard.

3. Adopted the Uniform Checklist for Reciprocal Jurisdiction Reinsurers and Updates to the Uniform Application Checklist for Certified Reinsurers

Mr. Rehagen stated that because of the 2019 revisions to Model #785 and Model #786, there are minor revisions needed for the existing Uniform Application Checklist for Certified Reinsurers (Attachment One-C), and a new Uniform Checklist for Reciprocal Jurisdiction Reinsurers (Attachment One-D) is needed. He stated that the Reinsurance Financial Analysis (E) Working Group was tasked with creating and modifying these checklists. On May 4, the Task Force exposed the checklists for a 21-day public comment period, and two comment letters (Attachment One-E) were received: 1) one from the International Underwriting Association of London (IUA); and 2) a combined letter from the Reinsurance Association of America (RAA) and Lloyd’s.

Mr. Schelp stated that in addition to the comment letters received, informal comments had been provided by the Association of Bermuda Insurers and Reinsurers (ABIR) and the European Commission. He stated that as a result of the comments received, a revised version of the Uniform Checklist for Reciprocal Jurisdiction Reinsurers was sent via email by NAIC staff on June 8 (Attachment One-F). He provided a brief description of these revisions.

Mr. Wake stated that he agrees with revisions that were made and are included in the version that was emailed by NAIC staff on June 8.

Mr. Bruggeman asked if both checklists would be required for companies that have both certified reinsurer business and reciprocal jurisdiction reinsurer business. Mr. Schelp stated that companies will be required to file both if they are doing both types of business.

Karalee C. Morell (RAA) stated that the RAA agrees with the revisions that were included in the draft sent by NAIC staff on June 8. Sabrina A. Miesowitz (Lloyd’s) stated that Lloyd’s agrees with the RAA’s statement.

Mr. Kaumann made a motion, seconded by Mr. Wake, to adopt the revised Uniform Application Checklist for Certified Reinsurers (Attachment One-C) and the new Uniform Checklist for Reciprocal Jurisdiction Reinsurers with the edits that were sent out by NAIC staff via email on June 8 (Attachment One-F). The motion passed unanimously.

Having no further business, the Reinsurance (E) Task Force adjourned.
The Reinsurance (E) Task Force met via conference call March 11, 2020. The following Task Force members participated: Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Raymond G. Farmer, Vice Chair, and Daniel Morris (SC); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Sheila Travis (AL); Ricardo Lara represented by Monica Macaluso and Kim Hudson (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Kathy Belfi and Jim Jakielo (CT); Trinidad Navarro represented by Dave Lonchar (DE); David Altmaier represented by Carolyn Morgan (FL); John F. King represented by Martin Sullivan (GA); Dean L. Cameron represented by Nathan Faragher (ID); Robert H. Muriel represented by Eric Moser and Susan Berry (IL); Stephen W. Robertson represented by Roy Eft (IN); Vicki Schmidt represented by Chut Tee (KS); Sharon P. Clark represented by Russell Coy (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by Christopher Joyce (MA); Eric A. Cioppa, represented by Robert Wake (ME); Jon Godfread represented by Colton Schulz (ND); Bruce R. Ramey represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by John Tirado (NJ); Barbara D. Richardson represented by Joel Bengo (NV); Linda A. Lacewell represented by Michael Campanelli (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Diane Carter (OK); Kent Sullivan represented by Doug Slape and Mike Boerner (TX); Todd E. Kiser represented by Reed Stringham (UT); Scott A. White represented by David Smith and Doug Stolte (VA); Michael S. Pieciak represented by Sandra Bigglestone (VT); and Mark Afable represented by Randy Milquel (WI).

1. **Adopted a Recommendation to the Financial Regulation Standards and Accreditation (F) Committee that the 2019 Revisions to Model #785 and Model #786 Should be an Accreditation Standard for RRGs**

Mr. Rehagen stated that at the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) as an accreditation standard. The Executive (EX) Committee and Plenary are expected to consider it for final adoption at the Spring National Meeting, to be effective Sept. 1, 2022.

Dan Schelp (NAIC) stated that during the drafting process for the 2019 revisions to Model #785 and Model #786, risk retention groups (RRGs) were never specifically addressed. He stated that a memorandum (Attachment One-A1) was prepared by NAIC staff that recommended that both the 2011 revisions and 2019 revisions to Model #785 and Model #786 should be adopted as an accreditation standard. He stated that the memorandum also recommends that the 2011 revisions to the models relating to certified reinsurers and qualified jurisdictions also be made a part of the accreditation standard since the 2019 revisions are based on the earlier revisions. Finally, the Risk Retention Group (E) Task Force unanimously adopted this recommendation during its March 2, 2020, conference call.

Mr. Kaumann made a motion, seconded by Mr. Stolte, to adopt the motion to confirm the Task Force’s support for the memorandum prepared by NAIC staff, specifically that both the 2011 revisions to Model #785 and Model #786 relating to certified reinsurers and qualified jurisdictions and the 2019 revisions relating to reciprocal jurisdictions be applicable to RRGs for accreditation purposes, with an effective date of Sept. 1, 2022. The motion passed unanimously.

2. **Discussed Whether Compliance with AG 48 Should be Considered “Substantially Similar” to Model #787 for Accreditation Purposes**

Mr. Rehagen stated that at the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as an accreditation standard with an effective date of Sept. 1, 2022. Model #787 is a codification of Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48), with the primary exception that AG 48 and Model #787 contain different penalty provisions.

Mr. Rehagen stated that during the Jan. 29, 2020, call of the Task Force, there was a discussion about whether compliance with AG 48 should be considered to be “substantially similar” to Model #787 for accreditation purposes. As a result of this discussion, the Task Force exposed a memorandum (Attachment One-A2) on Feb. 5, 2020, for a 21-day public comment period.
Mr. Rehagen stated that three comment letters were received, one from the American Academy of Actuaries (Academy), one from the Connecticut Insurance Department, and a combined letter from New York Life and Northwestern Mutual (Attachment One-A3). He stated that the three comment letters supported the adoption of Model #787, rather than reliance on AG 48 for the Reinsurance Ceded accreditation standard.

Mr. Schelp provided background information on this issue. He noted that the recommendation from the Task Force to the Financial Regulation Standards and Accreditation (F) Committee in 2017 was to make Model #787 an accreditation standard effective Jan. 1, 2020, which coincided with the effective date of the accreditation standard for principle-based reserving (PBR). He noted that it was recognized that some states might have problems meeting this expedited schedule, so the Task Force also recommended that in such cases, a state’s compliance with AG 48 should be considered as satisfactory to the Committee as substantial compliance with Model #787. The adoption of Model #787 as an accreditation standard was delayed by the Committee due to the issuance of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017.

Mr. Schelp stated that the issue is whether AG 48 should be considered to be substantially similar to Model #787 for accreditation purposes. He noted that the requirements under both AG 48 and Model #787 are virtually identical, except for the penalty provision if the requirements are not met. Under AG 48, the penalty is a qualified actuarial opinion and an increase in the Authorized Control Level Risk-Based Capital (RBC) equal to the primary security shortfall. The penalty under Model #787 is that the ceding insurer is required to establish a liability equal to the excess of the credit for reinsurance taken over the amount of primary security.

Mr. Schelp stated that the Accreditation Program Manual has a definition of “substantially similar” that declares that a state is required to demonstrate that its law, regulation or administrative practice is similar in force and no less effective than the NAIC model. Since 2016, NAIC staff have been assessing compliance with AG 48, and it has ascertained that there were no transactions that had either a primary security shortfall or another security shortfall in any of the years reviewed.

Mr. Hudson stated that he understood AG 48 to be temporary and that it was to be replaced by Model #787. Mr. Schelp stated that at the time that Model #787 was being contemplated, the intention was for it to replace AG 48 for accreditation purposes. He stated that the accreditation standards are usually based on NAIC model laws, which are required to be adopted by the states. He noted that Model #787 was the codification of AG 48. He stated that after Model #787 was adopted, AG 48 was updated and revised to make it consistent with Model #787. He noted that AG 48 has a sunset provision that it will sunset when a state adopts a regulation substantially similar to Model #787, but it will continue to apply only with respect to the limited number of states in which their version of Model #787 applies prospectively only. Mr. Stolte stated that the intention was for AG 48 to be a temporary transition guidance until Model #787 was adopted by the states.

Ms. Belfi referred to the comment letter from the Connecticut Insurance Department, and she stated that there are substantial differences between Model #787 and AG 48. She noted that the impact of a qualified actuarial opinion results in a modified RBC for AG 48 instead of the direct balance sheet effect as prescribed by Model #787, which is a significant difference. Ms. Berry asked if Ms. Belfi’s only objection was with the difference in the penalty and whether modifying the penalty in AG 48 would be satisfactory. Mr. Rehagen noted that evaluation of credit for reinsurance is part of the state insurance regulator’s role and not that of actuaries, so it is his opinion that the penalty provision of AG 48 cannot be changed to match that of Model #787.

Ms. Belfi proposed modifying AG 48 to include provisions from Model #787 and allowing more time for the states to adopt Model #787. Mr. Schelp stated that actuarial guidelines generally only affect reserves, while Model #787 directly affects credit for reinsurance. Mr. Boerner noted that a stronger penalty could be added to AG 48, but Texas prefers that AG 48 be considered substantially similar to Model #787 for accreditation purposes. He stated that while AG 48 and Model #787 have different penalties, they have had the same outcome of preventing these transactions.

Richard Daillak (American Academy of Actuaries—Academy) stated that the Academy’s concern is with the difference in penalty between AG 48 and Model #787. He stated that the Academy has concerns with having a forced qualified actuarial opinion as the penalty mechanism, and he stated that AG 48 was intended to sunset after a state adopts Model #787.

Mr. Boerner asked if the Academy agrees that AG 48 should remain effective for contracts that were already in force prior to adoption of Model #787. Mr. Daillak stated that in that case, it would be appropriate to use AG 48 for those contracts, but he recommended the elimination of the use of AG 48 for everything else. Mr. Bruggeman stated that with AG 48, a company can
correct the problem with reserves prior to the qualified actuarial opinion being issued, and the company will then receive an unqualified actuarial opinion.

Mr. Slape stated that if a company is in compliance with either AG 48 or Model #787, it will receive an unqualified actuarial opinion, and if it is out of compliance with either AG 48 or Model #787, it will receive a qualified actuarial opinion. Mr. Wake stated that there is a difference between legal compliance and compliance with actuarial guidelines. He stated that there is an actuarial penalty for violating either AG 48 or Model #787, but only Model #787 has the regulatory penalty of a denial of credit for reinsurance, which results in a direct balance sheet impact, in addition to the indirect impact on the reserves. Mr. Jakielo noted that Model #787 does not have a requirement of a qualified actuarial opinion.

Doug Wheeler (New York Life) made reference to his letter, and he stated that the process to create Model #787 was a multi-year process and was heavily negotiated. He noted that there are fundamental differences between the penalties in Model #787 and AG 48. He stated that he agrees with giving the states more time to adopt Model #787 and moving the effective date of the accreditation standard further into the future. Andrew T. Vedder (Northwest Mutual) agreed with the points made by Mr. Wheeler, and he agreed that Model #787 should be the accreditation standard.

Mr. Rehagen asked the Task Force members if the recommendation to the Financial Regulation Standards and Accreditation (F) Committee should be that the effective date should be moved into the future and they should discuss allowing AG 48 with added penalty provisions as a substitute for Model #787. Mr. Hudson stated that California believes that Model #787 should be the standard, and it does not support AG 48 as a permanent substitute. Mr. Bruggeman stated that Ohio intends to adopt Model #787, but the effective date of Sept. 1, 2022, will be too soon to get the legislative work completed. He stated that extending that date may be a solution.

Ms. Belfi asked if there is a way to allow a reprieve to allow the states more time to adopt Model #787 and increase the RBC penalty for violating AG 48. Mr. Slape stated that the effective date is not the issue for Texas, and they believe that AG 48 and Model #787 are substantially similar. Mr. Bruggeman stated that extending the date would be helpful for Ohio. Mr. Jakielo suggested working through the RBC instructions to make the penalty equivalent for AG 48 and Model #787.

Mr. Rehagen directed NAIC staff to create a document that outlines today’s discussion and includes arguments for and against having AG 48 be considered substantially similar to Model #787, which can be voted on by the Task Force during its April 2020 conference call.

Having no further business, the Reinsurance (E) Task Force adjourned.
MEMORANDUM

To: Financial Regulation Standards and Accreditation (F) Committee

From: NAIC Staff

Date: February 12, 2020

Re: 2011 & 2019 Revisions to Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786)—Applicability to Risk Retention Groups (RRGs)

Executive Summary

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786). These revisions were intended to incorporate the relevant provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017. At the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted these revisions to the Reinsurance Ceded accreditation standard effective Sept. 1, 2022, for consideration by the Executive (EX) Committee and Plenary for final adoption at the Spring National Meeting.

The purpose of this memorandum is to clarify the applicability of these revisions to risk retention groups (RRGs) organized as captives. The recommendation to this Committee is that the 2019 revisions to Model #785 and Model #786, as well as the 2011 revisions establishing certified reinsurers and qualified jurisdictions (which became applicable as an accreditation standard Jan. 1, 2019), also should be made applicable to RRGs.

Risk Retention Groups Organized as Captives

Article 3 (Reinsurance) of the Covered Agreement is applicable to ceding insurers, which Article 2(j) defines as “an undertaking which is authorized or licensed to take up or engage in the business of direct or primary insurance.” This would arguably include RRGs that are organized or incorporated by states as captive insurers. Reinsurance Ceded is part of the Part A accreditation requirements for RRGs, and requires that state law should contain Model #785 and Model #786, or substantially similar laws. The primary difference between the current reinsurance accreditation standard for RRGs is that “a state’s laws and regulations may allow RRGs to take credit for reinsurance without posting collateral in circumstances not contemplated by the Credit for Reinsurance Model Law and Regulation. For such cases, the Accreditation Interlineations include ‘Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers’ and a state’s laws and regulations must comply with the guidelines in order to be considered substantially similar with this standard.”

NAIC staff has reviewed the laws and regulations with respect to the fifteen (15) NAIC jurisdictions which currently license multi-state RRGs as captive insurers (AL, AZ, CO, DE, DC, HI, KY, ME, MT, NV, NC, OK, SC, TN and VT), and each meets the current Reinsurance Ceded accreditation standard in a very similar manner. First, each
states’ laws require that an RRG must be licensed as a captive insurer (and in some instances, a specific type of captive insurer) subject to its captive insurance laws. Second, the captive insurance laws generally exempt captive insurers from the general laws with respect to traditional insurers, except as is otherwise specified in statute. Finally, the statutes make RRGs that are licensed as captive insurers subject to the state’s credit for reinsurance laws, either generally (e.g., an RRG licensed as a captive insurer must comply with all of the laws, rules, regulations and requirements applicable to insurers chartered and licensed in the state) or specifically (e.g., an RRG licensed as a captive insurer must comply with the laws specified in this chapter, including specifically the credit for reinsurance laws). We also reviewed the proposed legislation of the five states currently considering adoption of the 2019 revisions to the models (ME, OK, SC, TN & VT), and the proposed legislation would not change this outcome.

**Recommendation**

NAIC staff recommends that the Committee consider making the 2019 revisions to Model #785 and Model #786 an accreditation standard for RRGs effective Sept. 1, 2022, with enforcement of the standard to commence Jan. 1, 2023. Staff further recommends that the 2011 revisions to the models relating to certified reinsurers and qualified jurisdictions also be made a part of the accreditation standard, because the 2019 revisions are in large part based on these earlier revisions. Finally, we recommend that the changes in the attached redlined accreditation standard be adopted as the new accreditation standard for reinsurance ceded to RRGs. [The Risk Retention Group (E) Task Force met on March 2, and approved these recommendations.]
10. Reinsurance Ceded

State law should contain the NAIC Credit for Reinsurance Model Law (#785), the NAIC’s Credit for Reinsurance Model Regulation (#786) or substantially similar laws.

Complete the following question only if this is an interim annual review:

Have there been any changes to the department’s ceded reinsurance requirements since last year’s review?

YES  NO

If the response is NO, there is no further information needed regarding this standard, please proceed to the next standard.

If the response is YES, in the reference column please provide the applicable citation for each of the questions in this particular standard. Additionally, please attach a copy of the statutes or regulations that had a change and ensure that they are clearly marked for the changes that have been made (i.e., highlight the changes, redlined version, etc.) Please place an asterisk (*) in the reference column on the right-hand side of the page by each citation that has been changed. Also, please include below a brief description of the nature or reason for the change.

If the department is completing the self-evaluation guide due to an upcoming full review, please provide the applicable citation for each of the questions in this particular standard. Additionally, please attach a copy of the statutes or regulations that are listed in the reference column.

<table>
<thead>
<tr>
<th>Credit for Reinsurance Model Law (#785)</th>
<th>REFERENCE</th>
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<tbody>
<tr>
<td>a. Credit allowed for reinsurance ceded to a licensed insurer? If the reinsurer is licensed as a RRG, then the ceding RRG or its members must qualify for membership with the reinsurer.</td>
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<tr>
<td>b. Credit allowed for reinsurance ceded to an accredited insurer who meets requirements similar to those in Section 2B of the model law?</td>
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<tr>
<td>c. Credit allowed for reinsurance ceded to an insurer domiciled and licensed in a state which employs substantially similar standards regarding credit for reinsurance and who maintains capital and surplus of at least $20,000,000 and submits to this states authority to examine its books and records?</td>
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<tr>
<td>d. Credit allowed for reinsurance ceded to an insurer who maintains a trust fund, established in a form approved by the Commissioner, in a qualified U.S. financial institution for the payment of the valid claims of its U.S. policyholders and ceding insurers, their assigns and successors in interest and who reports financial information annually to the Commissioner to determine the sufficiency of the trust fund?</td>
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<tr>
<td>e. In instances where reinsurance is ceded to insurers maintaining a trust fund, trustees of the trust required to report to the department annually, on or before February 28, the balance of the trust and a listing of the trust’s assets as of the end of the year and a certification of the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31?</td>
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f. Credit for reinsurance allowed under c. or d. above only permitted where assuming insurer agrees in the reinsurance agreements: 1) that in the event of a failure of the assuming insurer to perform its obligations, the assuming insurer shall submit to the jurisdiction of any court of competent jurisdiction in any state of the U.S.; and 2) to designate the Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process instituted by or on behalf of the ceding company.

g. Credit allowed for reinsurance ceded to an insurer meeting requirements similar to those in Section 2E (Certified Reinsurers) of the model law?

h. Credit allowed for reinsurance ceded to an insurer meeting requirements similar to those in Section 2F (Reciprocal Jurisdictions) of the model law?

Gi. Although not required for accreditation, a state’s laws and regulations may allow RRGs to take credit for reinsurance without posting collateral in circumstances not contemplated by the Credit for Reinsurance Model Law and Regulation. For such cases, the Accreditation Interlineations include “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers” and a state’s laws and regulations must comply with the guidelines in order to be considered substantially similar with this standard. If your state’s laws and regulations do allow credit for reinsurance without collateral as discussed in the Accreditation Interlineations, please include the citation.

Note: An RRG’s reinsurers as of Jan. 1, 2011, are grandfathered in as acceptable without meeting the requirements in the Reinsurance Guidelines. The requirements in the Reinsurance Guidelines should be used for new reinsurers with which business is placed after Jan. 1, 2011.

hj. Credit allowed for reinsurance ceded to an insurer not meeting the requirements of a., b., c., d., g., h., or gi. above in an amount not exceeding the liabilities carried by the ceding insurer and only in the amount of funds held by or on behalf of the ceding insurer in the form of cash, securities listed by the Securities Valuation Office of the NAIC and qualifying as admitted assets, clean, irrevocable, unconditional letters of credit, and other forms of security acceptable to the Commissioner?

Credit for Reinsurance Model Regulation (§786)

k.j. Credit for reinsurance allowed for reinsurance ceded by domestic reinsurers to assuming insurers that were licensed in the state as of the last date of the ceding insurers’ statutory financial statement? If the reinsurer is licensed as a RRG, then the ceding RRG or its members must qualify for membership with the reinsurer.

l.j. Credit for reinsurance provisions for accredited reinsurer similar to Section 5?

m.k. Credit for reinsurance provisions for reinsurers licensed and domiciled in other states similar to Section 6?
n. Credit for reinsurance provisions for reinsurers maintaining trust funds similar to Section 7?

o. Credit for reinsurance required by law similar to Section 9, to the extent permitted by 15 USC 3902(a)?

p. Reduction from liability for reinsurance ceded to an unauthorized assuming insurer similar to Section 10? Note: See significant element g. above regarding allowance of credit for reinsurance in certain situations not contemplated by the Model Law.

q. Provisions for trust agreements similar to Section 11?

r. Provisions for letters of credit similar to Section 12?

s. Provisions for unencumbered funds similar to Section 13?

t. Provisions for reinsurance contracts similar to Section 14? Note: For those reinsurance contracts for which credit is allowed under significant element g. above, the reinsurance contract should contain language similar to Section II of the “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers.”

u. The adoption of Form AR-1—Certificate of Assuming Insurer. Note: For situations in which credit for reinsurance is taken under significant element g. above, the reinsurance contract should contain language similar to Section II of the “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers.”

v. Credit for reinsurance provisions for certified reinsurers similar to Section 8?

w. Credit for reinsurance provisions for reciprocal jurisdictions similar to Section 9?
TO: Reinsurance (E) Task Force
FROM: NAIC Staff
RE: Comparison of Term and Universal Life Insurance Reserve Financing Model Regulation (#787) and Actuarial Guideline XLVIII
DATE: February 5, 2020

Executive Summary

At the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as an accreditation standard. The NAIC Executive (EX) Committee and Plenary are expected to consider it for final adoption at the Spring National Meeting, to be effective Sept. 1, 2022. On its conference call on Jan. 29, the Reinsurance (E) Task Force discussed whether compliance with Actuarial Guideline XLVIII (AG 48) should be considered “substantially similar” to Model #787 for accreditation purposes. Acting Chair John Rehagen (MO) directed NAIC staff to distribute a memorandum comparing the significant differences between AG 48 and Model #787 for a 21-day public comment period requesting comments on whether compliance with AG 48 should be considered substantially similar to Model #787.

2017 Recommendation on Accreditation

In its memorandum dated August 24, 2017, the Reinsurance Task Force recommended that “a state’s adoption of AG 48 will serve to satisfy this accreditation standard until such time that the state adopts the significant elements of Model #787.” (Appendix A). This recommendation was based on an expedited effective date for the accreditation standard of January 1, 2020. The Task Force recognized that “meeting the expedited date may not be feasible for some states in instances due, in whole or part, to other legislative priorities of the states. It is the recommendation of the Task Force that, in such cases, a state’s compliance with AG 48 should be considered as satisfactory to the Financial Regulation Standards and Accreditation (F) Committee as substantial compliance with Model #787.”

At that time the Committee deferred its consideration of Model #787 as an accreditation standard due to concerns expressed with respect to the impending Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance (Covered Agreement), which was signed on September 22, 2017. In 2017 AG 48 was amended “to redraft AG 48 to make it as consistent as possible with the provisions of Model #787.”

Comparison of Model #787 and AG 48

The primary difference between AG 48 and Model #787 are the consequences to an insurer if the requirements of either are not met. Paragraph 6B(1) of AG 48 (Appendix B) provides, as follows:
B. Qualified Actuarial Opinion; Remediation

(1) **The appointed actuary of the ceding insurer performing the analysis required by Section 6A above must issue a qualified actuarial opinion** as described in Section 6.D. of the AOMR or Section 3A(10) of VM-30 of the *Valuation Manual*, as applicable, unless:

(a) The requirements of Section 6A(1) and 6(A)(2) were fully satisfied as of the valuation date as to such reinsurance treaty; or

(b) Any deficiency has been eliminated before the due date of the Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of Section 6A(1) and 6A(2) to be fully satisfied as of the valuation date; or

(c) The ceding insurer has established a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to Section 6A(1).

[Emphasis Added]. A Drafting Note to this paragraph provides that the “remediation option set forth in Section 6B(1)(c) mirrors that set forth in Model #787.” In addition, the following proposals related to the XXX/AXXX Reinsurance Framework were adopted by the Capital Adequacy (E) Task Force on its June 30, 2015, conference call:

1. **2014-33-L-Mod Qualified Actuarial Opinion** – This proposal modifies the interrogatory on LR027 Interest Rate Risk and Market Risk. This interrogatory allows companies submitting an unqualified opinion to receive a one-third reduction in the factors. It was modified to prevent an opinion qualified solely due to the direction in AG 48, which is line of business specific, from impacting all lines of business.

2. **2014-35b-L-Mod Primary Securities Shortfall** – This proposal adds a new schedule showing the primary security shortfall by individual cession. The cumulative amount of primary security shortfalls, with no offset for any surpluses, is then taken as a dollar-for-dollar addition to the reporting company’s Authorized Control Level.

3. **2014-42-L-Mod RBC Shortfall** – This proposal adds a new schedule which shows the RBC calculation by individual captive. The cumulative amount of RBC shortfalls, with no offset for any surpluses, is then taken as a dollar-for-dollar reduction to the reporting company’s Total Adjusted Capital.

In summary, the Qualified Actuarial Opinion under paragraph 1-above does not constitute an RBC penalty in and of itself, but is a required element to trigger the RBC penalty under paragraph 2 and is applicable only with respect to AG 48. The RBC penalty under paragraph 3 is applicable to both noncompliance with AG 48 and Model #787. Section 7B of Model #787 then provides the following additional consequences for failure to follow its requirements:
B. Requirements at Inception Date and on an On-going Basis; Remediation

   (1) The requirements of Section 7A must be satisfied as of the date that risks under
Covered Policies are ceded (if such date is on or after the effective date of this
regulation) and on an ongoing basis thereafter. Under no circumstances shall a
ceding insurer take or consent to any action or series of actions that would result
in a deficiency under Section 7A(3) or 7A(4) with respect to any reinsurance
treaty under which Covered Policies have been ceded, and in the event that a
ceding insurer becomes aware at any time that such a deficiency exists, it shall
use its best efforts to arrange for the deficiency to be eliminated as expeditiously
as possible.

   (2) Prior to the due date of each Quarterly or Annual Statement, each life insurance
company that has ceded reinsurance within the scope of Section 3 shall perform
an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty
under which Covered Policies have been ceded, whether as of the end of the
immediately preceding calendar quarter (the valuation date) the requirements of
Sections 7A(3) and 7A(4) were satisfied. The ceding insurer shall establish a
liability equal to the excess of the credit for reinsurance taken over the
amount of Primary Security actually held pursuant to Section 7A(3), unless
either:

   (a) The requirements of Section 7A(3) and 7A(4) were fully satisfied as of the
valuation date as to such reinsurance treaty; or

   (b) Any deficiency has been eliminated before the due date of the Quarterly or
Annual Statement to which the valuation date relates through the addition
of Primary Security and/or Other Security, as the case may be, in such
amount and in such form as would have caused the requirements of
Section 7A(3) and 7A(4) to be fully satisfied as of the valuation date.

[Emphasis added]. Finally, Paragraph 8 of AG 48 provides that it will sunset when a state adopts a
regulation substantially similar to Model #787, but will continue to apply only with respect to the
limited number of states in which their version of Model #787 applies prospectively only.

Substantially Similar

The NAIC Financial Standards and Accreditation Program provides the following definition of
“substantially similar”:

For those standards included in the Part A: Laws and Regulations Standards where the term
“substantially similar” is included, a state must have a law, regulation, administrative practice or
a combination of the above which addresses the significant elements included in the NAIC
model laws or regulations… It is NOT required that states adopt every “significant” element in
the interim annual review form by law or regulation. Instead, it is required that the state
demonstrate that the law, regulation, administrative practice or a combination of the above
enforced by a state insurance department results in solvency regulation that is similar in force
and no less effective than the NAIC model law or regulation for that standard.
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee
FROM: Reinsurance (E) Task Force
DATE: August 24, 2017
RE: Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

Executive Summary

The NAIC membership adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) at the 2016 Fall National Meeting on Dec. 13, 2016. At that same time, the NAIC membership also adopted revisions to Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) to conform with the provisions of Model #787, effective Jan. 1, 2017. Model #787 establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees, and ensures that funds consisting of primary security and other security are held in the forms and amounts required.

At its meeting on Aug. 7, 2017, the Reinsurance (E) Task Force agreed to submit the following recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

1. Model #787 should be adopted as a new accreditation standard by the NAIC, with significant elements as outlined in Attachment A.

2. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this standard. The Task Force recommends that the accreditation standard become effective Jan. 1, 2020. The Task Force further recommends that a state’s adoption of AG 48 will serve to satisfy this accreditation standard until such time that the state adopts the significant elements of Model #787.

3. The 2016 revisions to the Credit for Reinsurance Model Law (#785) should be considered acceptable but not required by the states.

In addition to the preceding recommendations, the Task Force is offering the following additional information in order to assist the Financial Regulation Standards and Accreditation (F) Committee in reviewing the proposed accreditation standard for Model #787.
Substantially Similar

The Task Force has recommended in the draft accreditation standard that the “substantially similar” standard be utilized to meet the minimum requirements of the standard. However, the Task Force did note that Drafting Notes to Section 2, Section 3 and Section 5 of Model #785 might suggest a stronger standard of review than “substantially similar.” The Drafting Notes provide, as follows: “To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such reinsurance arrangements.” [Emphasis added]. In recognition of this, and to assist in review of the actuarial method used to determine the required level of primary security as described in Section 6 of Model #787, the Task Force recommends that the NAIC Legal Division specifically note any material changes in a state’s regulation during an accreditation review for consideration by the Financial Regulation Standards and Accreditation (F) Committee.

State Adoption of AG 48

The Task Force recommends that the accreditation standard become effective on an expedited basis beginning Jan. 1, 2020. However, the Task Force further recognizes that meeting the expedited date may not be feasible for some states in instances due, in whole or part, to other legislative priorities of the states. It is the recommendation of the Task Force that, in such cases, a state’s compliance with AG 48 should be considered as satisfactory to the Financial Regulation Standards and Accreditation (F) Committee as substantial compliance with Model #787. AG 48 became effective Jan. 1, 2015, and became part of the Accounting Practices and Procedures Manual through its inclusion in Appendix C, and has been amended to conform with Model #787 effective Jan. 1, 2017.

2016 Revisions to Model #785

The Task Force does not recommend that the 2016 revisions to Model #785 be included in the proposed accreditation standard. These revisions provide that the commissioner may adopt regulations with respect to: 1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; 2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; 3) variable annuities with guaranteed death or living benefits; 4) long-term care insurance policies; and 5) other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance. The revisions to Model #785 also contain a “professional reinsurer exemption” for reinsurers that maintain at least $250 million in capital and surplus when determined in accordance with the Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is: 1) licensed in at least 26 states; or 2) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

The reasoning of the Task Force is that Model #787 only applies to term life and universal life with secondary guarantees (XXX/AXXX) captive reinsurance transactions, and that variable annuities, long-term care insurance and other life and health insurance and annuity products are not currently addressed. Therefore, it would be considered to be premature to require the states to adopt these provisions. In addition, the professional reinsurer exemption of Section 5B(4) of Model #785 is specifically referenced in the draft accreditation standard. Therefore, it is the recommendation of the Task Force that the 2016 revisions to Model #785 are optional, and should be considered as acceptable but not required by the states.
Proposed Accreditation Standard

Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

State statute and/or regulation should be substantially similar to uniform, national standards that govern reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees, to ensure that both the total security and the primary security are provided in forms and amounts that are in compliance with the requirements set forth in the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

a. Provides that the Credit for Reinsurance Model Regulation (#786) and Model #787 shall both apply to reinsurance treaties that cede liabilities pertaining to Covered Policies; provided, that in the event of a direct conflict between the provisions of Model #787 and the provisions of Model #786, the provisions of Model #787 shall apply, but only to the extent of the conflict, substantially similar to Section 3 of Model #787?

b. Provides that Model #787 does not apply to reinsurance exempt by the provisions of Section 4 of Model #787, including reinsurance ceded to an assuming insurer that meets the requirements of either Section 5B(4)(a) of the Credit for Reinsurance Model Law (#785), which pertains to certain certified reinsurers, or Section 5B(4)(b) of Model #785, which pertains to reinsurers meeting certain threshold size and licensing requirements?

c. Provides definitions of “Covered Policies,” “Grandfathered Policies,” “Required Level of Primary Security,” “Actuarial Method,” “Primary Security,” “Other Security” and “Valuation Manual” that are substantially similar to such terms as defined in Section 5 of Model #787?

d. Provides for an Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation that is substantially similar to the methodology as set forth in Section 6A of Model #787?

e. Provides for valuations to be used 1) in calculating the Required Level of Primary Security pursuant to the Actuarial Method; and 2) in determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, that are substantially similar to the valuations set out in Section 6B of Model #787?

f. Provides for requirements to obtain credit for reinsurance with respect to ceded liabilities pertaining to Covered Policies that are substantially similar to the requirements set out in Section 7A of Model #787?

g. Provides for requirements at inception date and on an ongoing basis substantially similar to Section 7B(1) of Model #787?

h. Provides that if the requirements to hold Primary Security and total security are not both satisfied, the ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held, unless any deficiency has been eliminated pursuant to remediation provisions substantially similar to Section 7B(2) of Model #787?

i. Includes a prohibition against avoidance provision similar to Section 9 of Model #787?
Appendix B

Actuarial Guideline XLVIII
(Appplies to 2017 and Subsequent Year Valuations)

ACTUARIAL OPINION AND MEMORANDUM REQUIREMENTS FOR THE REINSURANCE OF POLICIES REQUIRED TO BE VALUED UNDER SECTIONS 6 AND 7 OF THE NAIC VALUATION OF LIFE INSURANCE POLICIES MODEL REGULATION (MODEL #830)

Background

The NAIC Principle-Based Reserving Implementation (EX) Task Force (“PBRI Task Force”) serves as the coordinating body for all NAIC technical groups involved with projects related to the Principle-Based Reserves (PBR) initiative for life and health policies. The PBRI Task Force was also charged with further assessing, and making recommendations regarding, the solvency implications of life insurance reserve financing mechanisms addressed in the June 6, 2013 NAIC White Paper of the Captives and Special Purpose Vehicle Use (E) Subgroup of the Financial Condition (E) Committee. Some of these reinsurance arrangements have been referred to as “XXX/AXXX Captive arrangements,” although not all such arrangements actually involve reinsurers organized as captives. In this connotation, XXX denotes the reserves prescribed by Section 6 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model #830) while AXXX denotes the reserves prescribed by Section 7 of Model #830, and by Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38). On June 30, 2014, the PBRI Task Force adopted a framework as found in Exhibits 1 and 2 of the June 4, 2014 report from Rector & Associates, Inc. (the “June 2014 Rector Report”). Exhibit 2 of the report included a charge to the Life Actuarial (A) Task Force (LATF) to develop a level of reserves (the “Required Level of Primary Security”) that must be supported by certain defined assets (“Primary Security”). The level of reserves is to be calculated by a method referred to as the “Actuarial Method.” Another charge to LATF was to promulgate an actuarial guideline specifying that, in order to comply with the NAIC Actuarial Opinion and Memorandum Regulation, Model 822 (“AOMR”) as it relates to XXX/AXXX reinsurance arrangements, the opining actuary must issue a qualified opinion as to the ceding insurer’s reserves if the ceding insurer or any insurer in its holding company system has engaged in a XXX/AXXX reserve financing arrangement that does not adhere to the Actuarial Method and Primary Security forms adopted by the NAIC. The initial version of Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) was developed in response to that charge, with an effective date of January 1, 2015.

Coordination between this Actuarial Guideline and the NAIC Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787)

Subsequently, on January 8, 2016, the NAIC adopted revisions to the Credit for Reinsurance Model Law (Model #785). Among other things, the revisions to Model #785 provide commissioners with the authority to enact, by regulation, additional requirements for ceding insurers to claim credit for reinsurance with respect to certain XXX/AXXX financing arrangements. On December 13, 2016, the NAIC adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787) as the regulation permitted by Model #785. LATF subsequently received a charge to redraft AG 48 to make it as consistent as possible with the provisions of Model #787. The current version of this actuarial guideline is the result.

The following is an overview of the interrelationship between this actuarial guideline and Model #787, and the regulatory strategy that led to the adoption of each:

1. The initial version of this actuarial guideline immediately established national standards for the use of XXX/AXXX financing arrangements in an attempt to quickly set minimum standards based on the framework adopted by the PBRI Task Force on June 30, 2014. This initial version applied to such reinsurance arrangements entered into on or after 1/1/2015.

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2. The revised statute (the NAIC Credit for Reinsurance Model Law (Model #785)) and a new regulation (the NAIC Term and Universal Life Insurance Reserve Financing Model Regulation (Model #787)) were then developed and adopted by the NAIC.

3. Except as noted in #4 below, this actuarial guideline will cease to be effective, on a state by state basis, as individual states enact Model #785 and adopt Model #787 to replace it.

4. Notwithstanding, it is anticipated that in a small number of states, Model #787 will need to be adopted on a “prospective” basis only (that is, it will only apply to ceded policies issued on or after the effective date thereof). In those cases, this actuarial guideline will remain as the authority for ceded policies subject to this actuarial guideline but to which Model #787, as adopted in a given state, does not apply. So although its role might diminish, this actuarial guideline will remain an essential part of the regulatory framework for a small number of states for many years to come.

5. To ensure uniformity of treatment between states, companies, and ceded policies (whether governed by this actuarial guideline or by Model #787) and to avoid confusion, this actuarial guideline is being updated, effective as of January 1, 2017, to make it as substantively identical to Model #787 as possible.

Authority, Avoidance, and Purpose

The requirements in this actuarial guideline derive authority from Section 3 of the AOMR, or, after the Operative Date of the Valuation Manual, from Section 1 of VM-30 of the Valuation Manual. Both Section 3 of the AOMR and Section 1 of VM-30 provide that the commissioner has the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items. As contained in the framework adopted by the PBRI Task Force on June 30, 2014, this actuarial guideline defines new terms, such as Primary Security and Required Level of Primary Security, specifies the Actuarial Method used to calculate the Required Level of Primary Security, and specifies other requirements that must be followed when reinsurance is involved in order for the appointed actuary to render an actuarial opinion that is not qualified.

No statute, regulation or guideline can anticipate every potential XXX/AXXX captive arrangement. Common sense and professional responsibility are needed to assure not only that the text of this actuarial guideline is strictly observed, but also that its purpose and intent are honored scrupulously. To that end, and to provide documentation to the appointed actuary as to the arrangements that are subject to review under this actuarial guideline, the appointed actuary may request from each ceding insurer, and may rely upon, the certification by the Chief Financial Officer or other responsible officer of each ceding insurer filed with the insurer’s domiciliary regulator that the insurer has not engaged in any arrangement or series of arrangements involving XXX or AXXX reserves that are designed to exploit a perceived ambiguity in, or to violate the purpose and intent of, this actuarial guideline.

The purpose and intent of this actuarial guideline is to establish uniform, national standards governing XXX or AXXX reserve financing arrangements in conformity with the PBRI Task Force framework and, in connection with such arrangements, to ensure that Primary Security, in an amount at least equal to the Required Level of Primary Security, is held by or on behalf of the ceding insurer. As described further in

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1 In general, reserve financing arrangements are those where the security/assets backing part or all of the reserves have one or more of the following characteristics: such security/assets (1) are issued by the ceding insurer or its affiliates; and/or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; and/or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any of its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance arrangement).
Section 4.B., the provisions of this actuarial guideline are not intended to apply to policies that were issued prior to 1/1/2015 if those policies were included in a captive reserve financing arrangement as of 12/31/2014. Further, the requirements of this actuarial guideline should be viewed as minimum standards and are not a substitute for the diligent analysis of reserve financing arrangements by regulators. A regulator should impose requirements in addition to those set out in this actuarial guideline if the facts and circumstances warrant such action.

Text

1. Authority

Pursuant to Section 3 of the AOMR or, after the Operative Date of the Valuation Manual, to Section 1 of VM-30 of the Valuation Manual, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

2. Scope

This actuarial guideline applies to reinsurance contracts that cede liabilities pertaining to Covered Policies as that term is defined in Section 4.

3. Exemptions

This actuarial guideline does not apply to the situations described in Subsections A through F.

A. Reinsurance of:

(1) Policies that satisfy the criteria for exemption set forth in Section 6F or Section 6G of Model #830; and which are issued before the later of:

   (a) The effective date of Model #787 in the state of domicile of the ceding insurer, and
   (b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than January 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in Section 6E of Model #830 and which are issued before the later of:

   (a) The effective date of Model #787 in the state of domicile of the ceding insurer, and
   (b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than January 1, 2020;

(3) Any universal life policy that meets all of the following requirements:

   (a) Secondary guarantee period, if any, is five (5) years or less;
(b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables and valuation interest rate applicable to the issue year of the policy; and

(c) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period;

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year; or

B. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Section 2D of Model #785; or

C. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Sections 2A, 2B or 2C, of Model #785, and that, in addition:

(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer’s reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1—Accounting Policies, Risks & Uncertainties and Other Disclosures (“SSAP No. 1”); and

(2) Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in the NAIC Risk-Based Capital (RBC) for Insurers Model Act (Model #312) when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or

D. Reinsurance ceded to an assuming insurer that meets the applicable requirements of Sections 2A, 2B or 2C, of Model #785, and that, in addition:

(1) Is not an affiliate, as that term is defined in Section 1A of the NAIC Insurance Holding Company System Regulatory Model Act (Model #440), of:

(a) The insurer ceding the business to the assuming insurer; or

(b) Any insurer that directly or indirectly ceded the business to that ceding insurer;

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;
(3) Is both:

(a) Licensed or accredited in at least 10 states (including its state of domicile), and

(b) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in Model #312 when its risk-based capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer’s reported surplus; or

E. Reinsurance ceded to an assuming insurer that meets the requirements of either Section 5B(4)(a) of Model #785, pertaining to certain certified reinsurers or Section 5B(4)(b) of Model #785, pertaining to reinsurers meeting certain threshold size and licensing requirements; or

F. Reinsurance not otherwise exempt under Subsections A through E if the commissioner, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this actuarial guideline (as described in the Authority, Avoidance and Purpose section above);

(2) The risks are included within the scope of this actuarial guideline only as a technicality; and

(3) The application of this actuarial guideline to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall publicly disclose any decision made pursuant to this Section 3F to exempt a reinsurance treaty from this actuarial guideline, as well as the general basis therefor (including a summary description of the treaty).

Drafting Note: The exemption set forth in Section 3F was added to address the possibility of unforeseen or unique transactions. This exemption exists because the NAIC recognizes that foreseeing every conceivable type of reinsurance transaction is impossible; that in rare instances unanticipated transactions might get caught up in this actuarial guideline purely as a technicality; and that regulatory relief in those instances may be appropriate. The example that was given at the time this exemption was developed pertained to bulk reinsurance treaties where the ceding insurer was exiting the type of business ceded. The exemption should not be used with respect to so-called “normal course” reinsurance transactions; rather, such transactions should either fit within one of the standard exemptions set forth in Sections 3A, B, C, D, or E or meet the substantive requirements of this actuarial guideline.
4. Definitions

A. “Actuarial Method” means the methodology used to determine the Required Level of Primary Security, as described in Section 5.

B. “Covered Policies” means the following: Subject to the exemptions described in Section 3, Covered Policies are those policies, other than Grandfathered Policies, of the following policy types:

(1) Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or,

(2) Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

Note: Although “Covered Policies” is defined to include all the policies described in Subsections B1 and B2 above, it is noted that whether a given “Covered Policy” is subject to this actuarial guideline or, instead, to Model #787 should be determined under Section 8 (Sunset).

C. “Grandfathered Policies” means policies of the types described in Subsections B1 and B2 above that were:

(1) Issued prior to January 1, 2015; and

(2) Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in Section 3 had that section then been in effect.

D. “Non-Covered Policies” means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.

E. “Required Level of Primary Security” means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.

F. “Primary Security” means the following forms of security:

(1) Cash meeting the requirements of Section 3A of Model #785;

(2) Securities listed by the Securities Valuation Office meeting the requirements of Section 3B of Model #785, but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

(3) For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

(a) Commercial loans in good standing of CM3 quality and higher;

(b) Policy Loans; and
(c) Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

G. “Other Security” means any security acceptable to the commissioner other than security meeting the definition of Primary Security.

H. “Valuation Manual” means the valuation manual adopted by the NAIC as described in Section 11B(1) of the Standard Valuation Law, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.


5. The Actuarial Method

A. Description of Actuarial Method

The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this actuarial guideline shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

(1) For Covered Policies described in Section 4B(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in Section 4B(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations. The mortality basis for the NPR shall be the 2017 CSO Mortality Table.

(2) For Covered Policies described in Section 4B(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met. The mortality basis for the NPR shall be the 2017 CSO Mortality Table.

(3) Except as provided in Paragraph (4) below, the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.

(4) If the reinsurance treaty cedes less than one hundred percent (100%) of the risk with respect to the Covered Policies then the Required Level of Primary Security may be reduced as follows:

(a) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under Subparagraph (c) below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;
(b) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(c) If a portion of the Covered Policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be reduced by the amount resulting by applying the Actuarial Method including the reinsurance section of VM-20 to the portion of the Covered Policy risks ceded in the exempt arrangement, except that for Covered Policies issued prior to Jan 1, 2017, this adjustment is not to exceed \[c_\times \times (2 \times \text{number of reinsurance premiums per year})\] where \(c_\times\) is calculated using the same mortality table used in calculating the Net Premium Reserve; and

(d) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security.

It is possible for any combination of Subparagraphs (a), (b), (c), and (d) above to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than one hundred percent (100%) of the risk.

The Adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

(5) In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

(6) If the ceding insurer cedes risks with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this actuarial guideline, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this actuarial guideline.
(7) If a reinsurance treaty subject to this actuarial guideline cedes risk on both Covered and Non-Covered Policies:

(a) The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies; and

(b) Any Primary Security and/or Other Security used to meet any requirements pertaining to the Non-Covered Policies may not be used to satisfy any requirements related to the Required Level of Primary Security and/or Other Security for the Covered Policies.

B. Valuation Used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

(1) For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer’s general account and without taking into consideration the effect of any prescribed or permitted practices; and

(2) For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the NAIC’s Life Actuarial (A) Task Force no later than the December 31 on or immediately preceding the valuation date for which the Required Level of Primary Security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.

6. Required Actuarial Analysis and Actuarial Opinion and Memorandum Requirements

A. Required Actuarial Analysis

Before the due date of each actuarial opinion, as to each reinsurance treaty in which Covered Policies have been ceded, the appointed actuary of each ceding insurer must perform an analysis on a treaty by treaty basis, of such Covered Policies to determine whether, as of the immediately preceding December 31 (the valuation date):

(1) Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of Section 3 of Model #785, on a funds withheld, trust, or modified coinsurance basis; and

(2) Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (1) above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of Section 3 of Model #785; and
**Note:** For the sake of clarity, funds consisting of Primary Security pursuant to Paragraphs (1) may exceed the Required Level of Primary Security, and Other Security is only required under Paragraph (2) to the extent that there is any portion of the statutory reserves as to which Primary Security is not so held. For example, if a ceding insurer’s statutory reserves equal $1 Billion, its Required Level of Primary Security is $600 Million, and it holds $1 Billion in Primary Security pursuant to Paragraph (1), no Other Security is required under Paragraph (2).

(3) Any trust used to satisfy the requirements of this Section 6 complies with all of the conditions and qualifications of Section 11 of the NAIC Credit for Reinsurance Model Regulation (Model #786), except that:

(a) Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in Section 5B, be valued according to the valuation rules set forth in Section 5B, as applicable; and

(b) There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of Section 6A(1); and

(c) The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by Section 6A(1)) below 102% of the level required by Section 6A(1) at the time of the withdrawal or substitution.

**B. Qualified Actuarial Opinion; Remediation**

(1) The appointed actuary of the ceding insurer performing the analysis required by Section 6A above must issue a qualified actuarial opinion as described in Section 6.D. of the AOMR or Section 3A(10) of VM-30 of the Valuation Manual, as applicable, unless:

(a) The requirements of Section 6A(1) and 6A(2) were fully satisfied as of the valuation date as to such reinsurance treaty; or

(b) Any deficiency has been eliminated before the due date of the Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of Section 6A(1) and 6A(2) to be fully satisfied as of the valuation date; or

(c) The ceding insurer has established a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to Section 6A(1).

(2) In addition to the requirement set forth in Section 6B(1) above, the appointed actuary of the ceding insurer performing the analysis required by Section 6A above must issue a qualified actuarial opinion as described in Section 6.D. of the AOMR or Section 3A(10) of VM-30 of the Valuation Manual, as applicable, if the appointed actuary for any affiliated reinsurer of the ceding insurer issues a qualified actuarial opinion with respect to such affiliated reinsurer where (a) the affiliate reinsures Covered Policies of the ceding insurer and (b) the qualified actuarial opinion pertaining to the affiliated reinsurer results, in whole or in part, from the analysis required by this actuarial guideline.
Note: The remediation option set forth in Section 6B(1)(c) mirrors that set forth in Model #787. Under this option, a ceding company may choose to avoid the consequence (a qualified opinion under this actuarial guideline) by establishing a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held. For example, suppose a ceding insurer has established statutory reserves of $1 Billion and has Primary Security of $550 Million and Other Security of $450 Million. Suppose further that the actuary determines that the insurer’s Required Level of Primary Security is $600 Million. Under Section 6B(1)(c), the insurer may avoid a qualified opinion by establishing a liability equal to $450 Million (the difference between the statutory reserve of $1 Billion and the $550 Million amount of Primary Security actually held).

C. Additional Requirements for the Actuarial Opinion and Memorandum for Companies that have Covered Policies Requiring the Analysis Pursuant to this actuarial guideline

(1) In the statement of actuarial opinion, the appointed actuary of the ceding insurer must state whether (i) he has performed an analysis, as to each reinsurance arrangement under which Covered Policies have been ceded, of the security supporting the Covered Policies and whether funds consisting of Primary Security in an amount at least equal to the Required Level of Primary Security are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis and (ii) funds consisting of Primary Security or Other Security in an amount equal to the statutory reserves are held by or on behalf of the ceding insurer as security under the reinsurance arrangement.

(2) In the actuarial memorandum as described by Section 7 of the AOMR or Section 3B of VM-30 of the Valuation Manual, as applicable, the appointed actuary of the ceding insurer must document the analysis and requirements applied by this actuarial guideline as to each reinsurance arrangement under which Covered Policies are ceded.

(3) In the event that a reinsurance treaty contains both (1) Covered Policies subject to this actuarial guideline rather than to Model #787, and (2) Covered Policies subject to Model #787 rather than to this actuarial guideline, the treaty shall be tested as a whole for purposes of a ceding insurer’s compliance with both (a) the requirements of Section 6A(1) and Section 6A(2) of this actuarial guideline and (b) the requirements of Section 7A(3) and Section 7A(4) of Model #787; provided further, that:

(a) If funds consisting of Primary Security are held in amounts less than the Required Level of Primary Security, such funds consisting of Primary Security shall be allocated first to fulfill the Required Level of Primary Security for the Covered Policies subject to this actuarial guideline, with any remainder allocated to those Covered Policies subject to Model #787; and

(b) If funds consisting of Other Security are held in amounts less than the requirements of Section 6A(2), such funds consisting of Other Security shall be allocated first to fulfill the Other Security requirements for the Covered Policies subject to this actuarial guideline, and any remainder shall be allocated to those Covered Policies subject to Model #787.
7. Effective Date
This actuarial guideline shall become effective as of January 1, 2017 with respect to all Covered Policies. This actuarial guideline supersedes and replaces all previous versions thereof with respect to actuarial opinions rendered as to valuation periods ending on or after January 1, 2017.

Note: For the avoidance of doubt, actuarial opinions issued with respect to the year ended December 31, 2016, shall be governed by the version of AG 48 in effect on December 31, 2016, as included in the Accounting Practices and Procedures Manual.

8. Sunset Provision
This actuarial guideline shall cease to apply as to Covered Policies that are both (a) issued by ceding insurers domiciled in a jurisdiction that has in effect, as of December 31st of the calendar year immediately preceding the year in which the actuarial opinion is to be filed, a regulation substantially similar to Model #787 adopted by the NAIC on December 13, 2016; and (b) subject to Model #787 as so adopted by the ceding insurer’s jurisdiction of domicile. This Actuarial Guideline shall continue to apply, without interruption, to any and all Covered Policies not included in both (a) and (b) of the immediate preceding sentence.

Note: It is anticipated that, for most states, this actuarial guideline will sunset pursuant to (a) and (b) of Section 8 and will continue only with respect to the limited number of states in which their version of Model #787 applies prospectively only, i.e., applies only to Covered Policies issued on or after the effective date of their version of Model #787. It is anticipated, however, that most states will be able to adopt a version of Model #787 that, like the Model itself, applies to all Covered Policies (subject to the applicable exemptions and grandfathering provisions) that are “in force” on or after the effective date, even if the policies were originally issued prior to that effective date. The goal of Section 8 is to ensure that all Covered Policies ceded in reinsurance transactions within the scope of this actuarial guideline continue to be subject to this actuarial guideline unless and until they become subject to Model #787.
February 26, 2020

Director Chlora Lindley-Myers
Chair, Reinsurance (E) Task Force
Attn: John Rehagen
National Association of Insurance Commissioners (NAIC)

Dear Director Lindley-Myers,

The Life Reinsurance Work Group (“the Work Group”) of the American Academy of Actuaries appreciates the opportunity to comment on the NAIC’s Model #787 Exposure Memorandum, requesting comments on whether compliance with Actuarial Guideline XLVIII (AG 48) should be considered to be “substantially similar” to Model #787 under the NAIC Financial Standards and Accreditation Program.

In the Work Group’s view, Model #787 and AG 48 differ in significant ways, and a sunset of AG 48 and its replacement by Model #787, wherever possible, is important to achieve, for reasons described below.

Model #787 and AG 48 differ principally in the means by which they require or incentivize companies to conform their captive reinsurer arrangements (if they have them) to certain standards. For business within its scope, Model #787 defines the standards in order for the cedent to receive full reserve credit for reinsurance. Further, Model #787 directly requires the ceding insurer to establish an additional liability if there is an uncorrected shortfall in amounts of Primary Security or Other Security, as defined in the model. AG 48 sets out similar standards and definitions of required amounts of Primary Security and Other Security for a captive arrangement and requires the cedent’s Appointed Actuary to issue a “Qualified Actuarial Opinion” on the cedent reserves in cases where the AG 48 standards are not met. The Qualified Actuarial Opinion, along with adverse risk-based capital (RBC) consequences for any shortfall in amount of Primary Security, together constitute the enforcement means for AG 48.

Throughout the development of AG 48 in 2014, the Academy’s Life Practice Council expressed concerns several times with the NAIC’s proposed forced use of a Qualified Actuarial Opinion to achieve the goals of the new captive regulatory framework. We stated these concerns in our June 25, 2014, letter to the PBR Implementation (EX) Task Force; our Sept. 17, 2014, letter to the Life Actuarial Task Force (LATF); and our Oct. 30, 2014, letter to the PBR Implementation (EX) Task Force.

In the Work Group’s view, a forced Qualified Actuarial Opinion is inconsistent with the purpose and intent of the Actuarial Opinion and Memorandum Requirements (AOMR) in VM-30, which places responsibility on the appointed actuary to issue an opinion as to the overall adequacy of reserves.

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
Codifying circumstances when an appointed actuary must qualify his/her opinion reduces the independence given to the appointed actuary in the AOMR in forming his/her opinion.

The AOMR is designed to ensure the overall adequacy of an insurer’s reserves based on asset adequacy analysis and is not designed or intended to implement new transaction-specific calculation requirements. Section 1(A)(3) of the VM-30 provides (emphasis added):

The AOM requirements shall be applied in a manner that allows the appointed actuary to use his or her professional judgment in performing the actuarial analysis and developing the actuarial opinion and supporting actuarial memoranda, conforming to relevant ASOPs. However, a state commissioner has the authority to specify methods of analysis and assumptions when, in the commissioner’s judgment, these specifications are necessary for the actuary to render an acceptable opinion relative to the adequacy of reserves and related actuarial items. For purposes of VM-30, the requirements of Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48), of the AP&P Manual, shall be applicable.

The reference to actuarial methods and assumptions in Section 1(A)(3) supports our view that the AOMR is focused on reserve adequacy with an independent, professional actuarial opinion as its cornerstone.

Although the Work Group acknowledges that the NAIC took steps in 2015 to distinguish the RBC consequences of an actuarial opinion deemed as qualified solely on account of AG 48, we still have strong concerns with the approach taken in AG 48 requiring that the Appointed Actuary issue a qualified opinion in a specific circumstance. We continue to believe it is anomalous for regulators to mandate a Qualified Actuarial Opinion via AG 48, the AOMR, or otherwise. In our view, the Appointed Actuary’s Opinion should be preserved as just that—a professional opinion rendered by the Appointed Actuary.

In 2014, the NAIC implemented its new captive regulatory framework via actuarial guideline (namely, AG 48) principally to expedite implementation of the new framework, recognizing that implementation through model law, model regulation, and NAIC adoption as an accreditation standard would take years. The expressed plan, explicit in AG 48 itself, was to sunset AG 48 once the equivalent model law and regulation was adopted at NAIC and by the states. The Work Group believes that if AG 48 is deemed substantially similar to Model #787, then its replacement by Model #787 could be deferred indefinitely by some states, and deferral would maintain the use of a forced Qualified Actuarial Opinion, which we believe is undesirable.

Should you have questions regarding these suggestions, please contact Ian Trepanier, the Academy’s life policy analyst, at trepanier@actuary.org.

Sincerely,

Richard Daillak, MAAA, FSA
Chairperson, Life Reinsurance Work Group
American Academy of Actuaries
Mr. John Rehagen  
Acting Chair, Reinsurance (E) Task Force  
National Association of Insurance Commissioners  
Via email: Dan Schelp (dschelp@naic.org)

Dear John:

Connecticut appreciates the opportunity to comment on the February 5, 2020 staff memo to the Reinsurance Task Force comparing the significant differences between AG48 and NAIC Model Regulation #787. We would also like to acknowledge the thoroughness of the staff review of the subject matter.

We concur that the primary difference between AG48 and Model #787 is the consequence to an insurer if the requirements of either are not met. AG48 merely calls for the filing of a qualified actuarial opinion, whereas Model #787 calls for the ceding insurer to establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held.

Normally a qualified actuarial opinion generates a substantial (50%) increase in the Interest Rate Risk and Market Rate Risk factors used in determining minimum RBC requirements. However, the normal RBC penalty normally associated with a qualified actuarial opinion is not being applied in this instance. Instead, a dollar-for-dollar addition to the reporting company’s ACL RBC amount equal to the shortfall in Primary Security is mandated.

The staff memo notes the existence of a second potential RBC “penalty” related to cessions to captives. Since any such penalty is applicable to noncompliance with both AG48 and Model #787, we do not feel that penalty is germane to the discussion at hand.

The staff memo also notes that the Financial Regulation Standards and Accreditation (F) Committee chose to defer consideration of Model #787 as an accreditation standard in recognition of the impending adoption of the Covered Agreement. We would like to point out that the functional word is “defer”, as the Committee’s main consideration was to avoid asking states to revise their regulations and statutes multiple times in a short time span. Hence the wording of the August 24, 2017 recommendation of the Reinsurance Task Force that “a state’s adoption of AG48 will serve to satisfy this accreditation standard until such time that the state adopts the significant elements of Model #787”.

Connecticut does not consider the consequences of a modest change to the cedant’s RBC ratio to be substantially similar to reducing surplus by the entire excess of the credit for reinsurance taken over the amount of Primary Security actually held. Simply put, AG48 does not
contemplate or effect a balance sheet adjustment. Further, we are aware that the drafters of Model #787 considered and ultimately rejected incorporating a more modest consequence of non-compliance that would have limited the balance sheet adjustment to the shortfall from full coverage of the Required Level of Primary Security.

Regards,

Kathy Belfi, CPA
Director, Financial Regulation
February 26, 2019

Via Electronic Delivery

Director Chlora Lindley-Myers
Missouri Department of Commerce & Insurance
P.O. Box 690
Jefferson City, MO 65102

Attention: John Rehagen, Jake Stultz and Dan Schelp

Re: Reinsurance (E) Task Force Exposure Comparing Model # 787 and AG 48

Director Lindley-Myers:

New York Life Insurance Company and The Northwestern Mutual Insurance Company offer the following comments on the February 5, 2020 memorandum (the “Memo”) from NAIC Staff to the Reinsurance Task Force (the “Task Force”) entitled “Comparison of Term and Universal Life Insurance Reserve Financing Model Regulation (#787) and Actuarial Guideline XLVIII”. Our companies have engaged extensively with the NAIC and the Task Force over the years as it considered the recommendations made in the Rector Report and subsequently developed both AG 48 and Model 787.

Background of Accreditation Discussions

In 2017, we submitted several joint comment letters supporting the NAIC’s efforts to make Model 787 an accreditation standard. We continue to believe that taking this step will strengthen the state-based system of insurance regulation, ensuring the consistent adoption of the NAIC’s framework for regulating the solvency of XXX and AXXX life insurer captives.

At that time, the NAIC was contemplating making Model 787 an accreditation standard on an expedited basis so that it would become effective concurrently with the nation-wide transition to principles-based reserving. However, at the 2017 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee (“F Committee”), while strongly supporting moving forward, agreed to defer this recommendation in light of the then-pending changes to the Credit for Reinsurance Model Law and Regulation (respectively, “Models 785 and 786”) to reflect the US-EU Covered Agreement. This step as articulated by F Committee members was intended to prevent state legislatures from needing to reopen the reinsurance-related provisions of the insurance code multiple times in a short period. It was the F Committee’s clear intention that accreditation standards for Models 785, 786 and 787 would ultimately proceed alongside one another.

In the years since this decision, the NAIC has completed its revisions to Models 785 and 786 and a few states have moved forward with adopting Model 787, notwithstanding the absence of an accreditation standard. At the 2019 Fall National Meeting, the F Committee adopted a recommendation to make Model 787 an accreditation standard on an expedited basis, which would move in parallel with the accreditation standards for Models 785 and 786. This adoption
was consistent with the discussions in 2017, which focused not on whether Model 787 should be an accreditation standard, but rather the timing for the standard’s effective date.

Reliance on AG 48 for Accreditation Purposes

The Memo explores whether states could, for accreditation purposes, rely on ongoing enforcement of AG 48 as a “substantially similar” provision to Model 787. While the definition of “substantially similar” is seemingly broad enough to encompass this position, there are meaningful differences between Model 787 and AG 48, including both the penalty provisions and the reliance upon the actuarial opinion.

The Penalty Provisions in AG 48 and Model 787 Differ Significantly

As noted in the Memo, the primary difference between Model 787 and AG 48 is the consequences to an insurer if an insurer fails to hold a sufficient level of Primary Security. Model 787 contains a penalty provision specifically aimed at deterring behavior that contravenes its positions: the loss of reinsurance credit for improperly reserved transactions.

AG 48’s penalty provision, in contrast, is indirect. In the event of a deficiency in Primary Security, insurers are subject to an RBC penalty commensurate with the amount of the shortfall. As you know, RBC was designed as an early warning system for the identification of weakly capitalized companies. It was never intended to evaluate well-capitalized companies. Ultimately, while AG 48’s penalty could have a meaningful effect on RBC ratios, reliance on such ratios to bring regulatory attention to Primary Security shortfalls or otherwise deter non-compliance with AG 48’s requirements is inconsistent with the purposes for which RBC was developed.

The inclusion of an RBC penalty in AG 48 reflects several factors arising from the intensive negotiations regarding the implementation of the Rector Framework, including an acknowledgment that additional penalties could not be included in an Actuarial Guideline, and that AG 48 itself would ultimately sunset once Model 787 was adopted. A similar logic undergirds AG 48’s reliance on the issuance of a qualified actuarial opinion as a trigger for these penalty provisions. Generally speaking, an actuarial opinion is designed to be an independent actuarial assessment of overall reserve adequacy, and is not intended as a compliance mechanism for a particular regulatory requirement. Indeed, the Academy of Actuaries, among others, expressed serious concerns with AG 48 being the permanent, or even the temporary, solution. However, all parties agreed to stand down on the issue when it became clear that AG 48 would be used in limited, short-term circumstances.

Regulators Intended AG 48 to be Temporary Solution

At the time that the NAIC first considered making Model 787 an accreditation standard, it was acknowledged that the expedited time frame could present challenges for some states. The solution to this was not to keep AG 48 in place forever and for all XXX and AXXX business, but rather to develop some exceptions for specific circumstances.
In states that were unable to comply with the expedited time frame, the Task Force acknowledged that compliance with AG 48 would be satisfactory for accreditation purposes. The Task Force’s acknowledgment did not envision, however, that AG 48 would remain in place in those states indefinitely.

This is consistent with the introductory language of AG 48 itself, which notes that AG 48 was adopted to “quickly set minimum standards” for XXX/AXXX reinsurance transactions. The introductory language also contemplates that AG 48 would eventually sunset in most states as Model 787 was adopted to replace it. The only caveat to that expectation is a recognition that “in a small number of states,” Model 787 would be adopted on a prospective basis (meaning it would only apply to policies issued after the date that the state adopted the model). In that minority of cases, AG 48 would remain in effect (along with Model 787) for the subset of policies issued after January 1, 2015 but before a state adopted the Model.

Conclusion

Finally, we would note that when the F Committee agreed in 2017 to delay the adoption of an accreditation standard for Model 787, they were responding to regulators’ legitimate concerns that they would need to approach their legislatures several times in quick succession regarding revisions to Model 785. There was no discussion at that time about never approaching legislatures to obtain the requisite authority to issue Model 787. If regulators remain concerned with making repeated requests on similar topics then we would urge them to include both the changes responsive to the US-EU Covered Agreement and the authorizing language in their legislative packages. If regulators remain concerned with completing the revisions to Model 785, 786 and 787 on an expedited basis then we would suggest that a preferable solution is to extend the time frame for making Model 787 an accreditation standard rather than to allow states to rely on AG 48 in perpetuity for all XXX/AXXX business.

*   *   *
We are grateful for your time and attention to our comments. If you would like to discuss this letter with us, please let us know.

Sincerely,

Douglas A. Wheeler  
Senior Vice President, Office of Governmental Affairs  
New York Life Insurance Company

Andrew T. Vedder  
Vice President – Solvency Policy & Risk Management  
The Northwestern Mutual Life Insurance Company
The Reinsurance (E) Task Force met via conference call Jan. 29, 2020. The following Task Force members participated:

Chlora Lindley-Myers, Chair, represented by John Rehagen (MO); Raymond G. Farmer, Vice Chair, represented by Lee Hill (SC); Jim L. Ridling represented by Richard Ford (AL); Allen W. Kerr represented by Mel Anderson (AR); Ricardo Lara represented by Monica Macaluso and Kim Hudson (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Kathy Belfi (CT); Trinidad Navarro represented by Charles Santana (DE); David Almtaier represented by Robert Ridenour (FL); John F. King represented by Martin Sullivan (GA); Doug Ommen represented by Carrie Mears (IA); Dean L. Cameron represented by Eric Fletcher (ID); Robert H. Muriel represented by Eric Moser (IL); Stephen W. Robertson represented by Roy Eft and Amy Beard (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Rodney Hugle (KY); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by Christopher Joyce (MA); Jon Godfread represented by Matt Fischer (ND); Bruce R. Ramge represented by Lindsay Crawford (NE); Alexander K. Feldvebel represented by Doug Bartlett and Patricia Gosselin (NH); Marlene Caride represented by John Tirado (NJ); Barbara D. Richardson represented by Joel Bengo (NV); Linda A. Lacewell represented by Michael Campanelli (NY); Jillian Froment represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Kent Sullivan represented by Doug Slate and Mike Boerner (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Michael S. Pieciak represented by Stacey Alden (VT); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted Technical Edits to Model #787**

Mr. Rehagen stated that at the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as an accreditation standard. The NAIC Executive (EX) Committee and Plenary are expected to consider it for final adoption at the Spring National Meeting, to be effective Sept. 1, 2022. He noted that several technical edits are required to Model #787 prior to becoming an accreditation standard. Mr. Rehagen stated that the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) were also adopted as accreditation standards at the 2019 Fall National Meeting, but that there are no revisions to Model #785 and Model #786 currently being considered.

Dan Schelp (NAIC) stated that the NAIC adopted Model #787 in 2016 to address captive reinsurance transactions involving term life and universal life with secondary guarantees (ULSG), which are often referred to as XXX/AXXX policies. This was part of a long process that included adoption of the XXX/AXXX Captive Reinsurance Framework in 2013, as well as Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) in 2014. In 2015, the NAIC amended the Preamble of the Accreditation Program Manual to provide that XXX/AXXX Captive Reinsurers that reinsure business covering risks residing in at least two states are multistate insurers and are subject to the accreditation standards. However, they can satisfy these standards by complying with the XXX/AXXX Captive Reinsurance Framework. NAIC staff confirm each year that captive reinsurers are complying with this requirement. Model #787 was then intended to codify AG 48 and be adopted as its own accreditation standard.

Mr. Schelp stated that the NAIC adopted revisions to Model #785 in 2016, which included a new Section 5B. He stated that Section 5B(1)-(3) provide enabling legislation permitting a commissioner to adopt Model #787 and other related regulations, and that Section 5B(4) provides an exemption for “professional reinsurers” from Model #787. Mr. Schelp stated that at the 2017 Summer National Meeting, the Task Force presented a new recommended accreditation standard but did not include Model #785 as part of that accreditation standard. He noted that it does include reinsurance exempted under Section 4 of Model #787, which covers an assuming insurer meeting the requirements of either Section 5B(4)(a) or Section 5B(4)(b) of Model #785. Mr. Schelp stated that these requirements were only referenced in Model #787, but the actual technical exemptions themselves are only included in Model #785. The Financial Regulation Standards and Accreditation (F) Committee deferred action on Model #787 at that time due to uncertainties surrounding the Covered Agreement.

Mr. Schelp stated that the proposed revisions to Model #787 are technical in nature and may be adopted by the Task Force. They would still need to be reported to the Financial Condition (E) Committee and NAIC Executive (EX) Committee and Plenary.
Mr. Slape stated that the memorandum from the Task Force to the Financial Regulation Standards and Accreditation (F) Committee in 2017 noted that adoption of AG 48 was substantially similar to adoption of Model #787, and he asked if this is still the case.

Mr. Schelp stated that AG 48 was not included in the motion related to making Model #787 an accreditation standard at the 2019 Fall National Meeting. He noted that the main differences between AG 48 and Model #787 are the penalty provisions. He stated that if a company does not meet the standards of AG 48, it must file a qualified actuarial opinion, and if a company does not meet the standard of Model #787, it will not receive credit for reinsurance with respect to the securities that do not meet the standard of Model #787. Mr. Schelp added that AG 48 sunsets in a state once that state has enacted Model #787.

Becky Meyer (NAIC) stated that the Financial Regulation Standards and Accreditation (F) Committee will make the ultimate determination of whether AG 48 and Model #787 are substantially similar and that the Committee will welcome recommendations from the Task Force.

Mr. Slape stated that he believes that AG 48 and Model #787 are substantially similar. He noted that in addition to the penalties described by Mr. Schelp, there is a risk-based capital (RBC) impact for companies that file a qualified actuarial opinion under AG 48. He stated that Texas supports the Task Force considering AG 48 and Model #787 as substantially similar. Mr. Boerner provided some additional information on the RBC impact of a violation of AG 48.

Ms. Belfi stated that she disagrees with the position that AG 48 and Model #787 are substantially similar and that she would provide her comments in writing to the Task Force. She also recommended that the American Academy of Actuaries (Academy) be contacted for comment.

Mr. Rehagen directed NAIC staff to create a memorandum that shows the differences between AG 48 and Model #787 and expose that memorandum for a 21-day public comment period to solicit comments on whether they should be considered substantially similar for the accreditation standard.

Ms. Beard stated that Indiana is working on an expedited process to implement Model #787 and that this process must be done in the next few weeks to work within the legislative session. She said she will need the feedback as soon as possible to ensure that it is enacted correctly.

Ms. Belfi made a motion, seconded by Mr. Hill, to adopt the technical revisions to Section 1, Section 4E and Section 7 of Model #787 (Attachment One-B1). The motion passed, with Ohio and Texas abstaining.

Having no further business, the Reinsurance (E) Task Force adjourned.
TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING MODEL REGULATION

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Section 1. Authority

This regulation is adopted and promulgated by [title of supervisory authority] pursuant to [insert provision of state law equivalent to section 5A of the Credit for Reinsurance Model Law] of the [name of state] Insurance Code.

Section 2. Purpose and Intent

The purpose and intent of this regulation is to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees; and to ensure that, with respect to each such financing arrangement, funds consisting of Primary Security and Other Security, as defined in Section 5, are held by or on behalf of ceding insurers in the forms and amounts required herein. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer (1) are issued by the ceding insurer or its affiliates; or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any of its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).

Section 3. Applicability

This regulation shall apply to reinsurance treaties that cede liabilities pertaining to Covered Policies, as that term is defined in Section 5B, issued by any life insurance company domiciled in this state. This regulation and [insert provision of state law equivalent to the Credit for Reinsurance Model Regulation] shall both apply to such reinsurance treaties; provided, that in the event of a direct conflict between the provisions of this regulation and [insert provision of state law equivalent to the Credit for Reinsurance Model Regulation], the provisions of this regulation shall apply, but only to the extent of the conflict.

Section 4. Exemptions from this Regulation

This regulation does not apply to the situations described in Subsections A through F.

A. Reinsurance of:

1. Policies that satisfy the criteria for exemption set forth in [insert provision of state law equivalent to Section 6F of the Valuation of Life Insurance Policies Model Regulation] or [insert provision of state law equivalent to Section 6G of the Valuation of Life Insurance Policies Model Regulation]; and which are issued before the later of:
(a) The effective date of this regulation, and
(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than Jan 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in [insert provision of state law equivalent to Section 6E of the Valuation of Life Insurance Policies Model Regulation] and which are issued before the later of:
(a) The effective date of this regulation, and
(b) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies’ statutory reserves, but in no event later than Jan. 1, 2020;

(3) Any universal life policy that meets all of the following requirements:
(a) Secondary guarantee period, if any, is five (5) years or less;
(b) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Commissioners Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and
(c) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period;

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; nor

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

B. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provision of state law equivalent to Section 2D of the Credit for Reinsurance Model Law]; or

C. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provisions of state law equivalent to Sections 2A, 2B or 2C, of the Credit for Reinsurance Model Law], and that, in addition:

(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer’s reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1 (“SSAP 1”); and

(2) Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in [insert provision of state law equivalent to the Risk-Based Capital (RBC) for Insurers Model Act] when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or

D. Reinsurance ceded to an assuming insurer that meets the applicable requirements of [insert provisions of state law equivalent to Sections 2A, 2B or 2C, of the Credit for Reinsurance Model Law], and that, in addition:
(1) Is not an affiliate, as that term is defined in [insert provision of state law equivalent to Section 1A of the Insurance Holding Company System Regulatory Model Act], of:

(a) The insurer ceding the business to the assuming insurer; or

(b) Any insurer that directly or indirectly ceded the business to that ceding insurer;

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

(3) Is both:

(a) Licensed or accredited in at least 10 states (including its state of domicile), and

(b) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in [insert provision of state law equivalent to the Risk-Based Capital (RBC) for Insurers Model Act] when its Risk-Based Capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer’s reported surplus; or

Reinsurance ceded to an assuming insurer that meets the requirements of either [insert provision of state law equivalent to Section 5B(4)(a) of the Credit for Reinsurance Model Law, pertaining to certain certified reinsurers] or [insert provision of state law equivalent to Section 5B(4)(b) of the Credit for Reinsurance Model Law, pertaining to reinsurers meeting certain threshold size and licensing requirements]; or

Reinsurance not otherwise exempt under Subsections A through E if the commissioner, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this regulation (as described in Section 2 above);

(2) The risks are included within the scope of this regulation only as a technicality; and

(3) The application of this regulation to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall publicly disclose any decision made pursuant to this Section 4F to exempt a reinsurance treaty from this regulation, as well as the general basis therefor (including a summary description of the treaty).

Drafting Note: The exemption set forth in Section 4F was added to address the possibility of unforeseen or unique transactions. This exemption exists because the NAIC recognizes that foreseeing every conceivable type of reinsurance transaction is impossible; that in rare instances unanticipated transactions might get caught up in this regulation purely as a technicality; and that regulatory relief in those instances may be appropriate. The example that was given at the time this exemption was developed pertained to bulk reinsurance treaties where the ceding insurer was exiting the type of business ceded. The exemption should not be used with respect to so-called “normal course” reinsurance transactions; rather, such transactions should either fit within one of the standard exemptions set forth in Sections 4A, B, C, D, or E or meet the substantive requirements of this regulation.

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Section 5. Definitions

A. “Actuarial Method” means the methodology used to determine the Required Level of Primary Security, as described in Section 6.

B. “Covered Policies” means the following: Subject to the exemptions described in Section 4, Covered Policies are those policies, other than Grandfathered Policies, of the following policy types:
   
   (1) Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or,
   
   (2) Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

C. “Grandfathered Policies” means policies of the types described in Subsections B1 and B2 above that were:
   
   (1) Issued prior to January 1, 2015; and
   
   (2) Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in Section 4 had that section then been in effect.

D. “Non-Covered Policies” means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.

E. “Required Level of Primary Security” means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.

F. “Primary Security” means the following forms of security:
   
   (1) Cash meeting the requirements of [insert provision of state law equivalent to Section 3A of the Credit for Reinsurance Model Law];
   
   (2) Securities listed by the Securities Valuation Office meeting the requirements of [insert provision of state law equivalent to Section 3B of the Credit for Reinsurance Model Law], but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and
   
   (3) For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:
      
      (a) Commercial loans in good standing of CM3 quality and higher;
      
      (b) Policy Loans; and
      
      (c) Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

G. “Other Security” means any security acceptable to the commissioner other than security meeting the definition of Primary Security.

H. “Valuation Manual” means the valuation manual adopted by the NAIC as described in Section 11B(1) of the Standard Valuation Law, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

Drafting Note: Section 5H presumes that each state is permitted under its state laws to directly reference the Valuation Manual adopted by the NAIC. If a state is required by its state laws to reference a state law or regulation, it should modify Section 5H as appropriate to do so.

Drafting Note: Sections 5H and I presume that each state is permitted under its state laws to “adopt” the Valuation Manual in a manner similar to how the Accounting Practices and Procedures Manual becomes effective in many states, without a separate regulatory process such as adoption by regulation. It is desirable that all states adopt the Valuation Manual requirements and that such adoption be achieved without a separate state regulatory process in order to achieve uniformity of reserve standards in all states. However, to the extent that a state may need to adopt the valuation manual through a formal state regulatory process, these sections may be amended to reflect any state’s need to adopt the Valuation Manual through regulation or otherwise.

Section 6. The Actuarial Method

A. Actuarial Method

The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

(1) For Covered Policies described in Section 5B(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in Section 5B(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

(2) For Covered Policies described in Section 5B(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

(3) Except as provided in Paragraph (4) below, the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.

(4) If the reinsurance treaty cedes less than one hundred percent (100%) of the risk with respect to the Covered Policies then the Required Level of Primary Security may be reduced as follows:

(a) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under Subparagraph (c) below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

(b) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(c) If a portion of the Covered Policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be
(d) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security.

It is possible for any combination of Subparagraphs (a), (b), (c), and (d) above to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than one hundred percent (100%) of the risk.

The Adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

(5) In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

(6) If the ceding insurer cedes risks with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this Regulation, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this Regulation;

(7) If a reinsurance treaty subject to this Regulation cedes risk on both Covered and Non-Covered Policies, credit for the ceded reserves shall be determined as follows:

(a) The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies, and Section 7 shall be used to determine the reinsurance credit for the Covered Policy reserves; and

(b) Credit for the Non-Covered Policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of Subparagraph (a), is held by or on behalf of the ceding insurer in accordance with [cite the state’s version of Sections 2 and 3 of the Credit for Reinsurance Model Law]. Any Primary Security used to meet the requirements of this Subparagraph may not be used to satisfy the Required Level of Primary Security for the Covered Policies.

B. Valuation used for Purposes of Calculations

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

(1) For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer’s general account and without taking into consideration the effect of any prescribed or permitted practices; and

(2) For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the
Section 7. Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation

A. Requirements

Subject to the exemptions described in Section 4 and the provisions of Section 7B, credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to Covered Policies pursuant to [insert provisions of state law equivalent to Sections 2 or 3 of the Credit for Reinsurance Model Law] if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

(1) The ceding insurer’s statutory policy reserves with respect to the Covered Policies are established in full and in accordance with the applicable requirements of [insert provisions of state law equivalent to the Standard Valuation Law] and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this regulation does not exceed the proportionate share of those reserves ceded under the contract; and

(2) The ceding insurer determines the Required Level of Primary Security with respect to each reinsurance treaty subject to this regulation and provides support for its calculation as determined to be acceptable to the commissioner; and

(3) Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of [insert provision of state law equivalent to Section 3 of the Credit for Reinsurance Model Law], on a funds withheld, trust, or modified coinsurance basis; and

(4) Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (3) above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of [insert provision of state law equivalent to Section 3 of the Credit for Reinsurance Model Law]; and

(5) Any trust used to satisfy the requirements of this Section 7 shall comply with all of the conditions and qualifications of [insert provision of state law equivalent to Section 12 of the Credit for Reinsurance Model Regulation], except that:

(a) Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in Section 6B, be valued according to the valuation rules set forth in Section 6B, as applicable; and

(b) There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of Section 7A(3); and

(c) The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by Section 7A(3)) below 102% of the level required by Section 7A(3) at the time of the withdrawal or substitution; and

(d) The determination of reserve credit under [insert provision of state law equivalent to Section 12 of the Credit for Reinsurance Model Regulation] shall be determined according to the valuation rules set forth in Section 6B, as applicable; and
B. Requirements at Inception Date and on an On-going Basis; Remediation

(1) The requirements of Section 7A must be satisfied as of the date that risks under Covered Policies are ceded (if such date is on or after the effective date of this regulation) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under Section 7A(3) or 7A(4) with respect to any reinsurance treaty under which Covered Policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

(2) Prior to the due date of each Quarterly or Annual Statement, each life insurance company that has ceded reinsurance within the scope of Section 3 shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which Covered Policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of Sections 7A(3) and 7A(4) were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to Section 7A(3), unless either:

(a) The requirements of Section 7A(3) and 7A(4) were fully satisfied as of the valuation date as to such reinsurance treaty; or

(b) Any deficiency has been eliminated before the due date of the Quarterly or Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of Section 7A(3) and 7A(4) to be fully satisfied as of the valuation date.

(3) Nothing in Section 7B(2) shall be construed to allow a ceding company to maintain any deficiency under Section 7A(3) or 7A(4) for any period of time longer than is reasonably necessary to eliminate it.

Section 8. Severability

If any provision of this regulation is held invalid, the remainder shall not be affected.

Section 9. Prohibition against Avoidance

No insurer that has Covered Policies as to which this regulation applies (as set forth in Section 3) shall take any action or series of actions, or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of such action, transaction or arrangement or series thereof is to avoid the requirements of this regulation, or to circumvent its purpose and intent, as set forth in Section 2.

Section 10. Effective Date

This regulation shall become effective [insert date] and shall pertain to all Covered Policies in force as of and after that date.
Uniform Application Checklist for Certified Reinsurers
(Initial and Renewal Applications)

Applicant Information

Company Name:
Address:
Primary Contact:
Domiciliary Jurisdiction / Supervisory Authority:
Applicable Lines of Business:

I. Filing Requirements for Reinsurer Currently Certified by Another NAIC-Accredited Jurisdiction

If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the [Commissioner] has the discretion to defer to that jurisdiction’s certification and assigned rating; i.e., “passporting.” To assist the [Commissioner] in the determination to defer to another jurisdiction’s certification the following application procedures should be followed:

a. Has the applicant been certified by an NAIC accredited jurisdiction? (Yes or No) ____;

   [If “Yes,” this state (the “Lead” state) will confirm that the initial or renewal certification has been reviewed by the NAIC Reinsurance Financial Analysis (E) Working Group (“ReFAWG”) for passporting purposes.]

b. If the answer to question I.a. (above) is “No,” please proceed to Section II of this application.

c. If the answer to question I.a. (above) is “Yes,” the applicant shall provide the information specified in the table below for consideration by the [Commissioner]. In the alternative, the [Commissioner] may permit the applicant to provide written certification that some or all the required information was previously filed with the Lead State and the ReFAWG.

Note: The ReFAWG and the Lead State may have already collected, reviewed and approved relevant documentation such as; Biographical Affidavits, Certificates of Good Standing, Licenses, Rating Agency Reports, Reports of Auditors and other certification documents. States are encouraged to accept these prior filings as complete, in lieu of duplicative filing requests.

<table>
<thead>
<tr>
<th>Citation to State Law / Regulation</th>
<th>Requirements</th>
<th>Y or N</th>
<th>Reference and Supporting Documents</th>
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<tbody>
<tr>
<td>Status of Domiciliary Jurisdiction:</td>
<td>The applicant must be domiciled and licensed in a Qualified Jurisdiction, as determined by this state.</td>
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<td>Verification of Certification Issued by an NAIC Accredited Jurisdiction:</td>
<td>If the applicant is requesting that the Commissioner recognize the certification issued by another NAIC accredited jurisdiction (i.e., passporting), the applicant must provide a copy of the approval letter or other documentation provided to the applicant</td>
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At a minimum, this letter must confirm the following information:

a. Name of state(s) in which applicant is currently certified.

b. The rating and collateral percentage assigned by the accredited jurisdiction with respect to the applicant.

c. The effective and expiration dates with respect to the certification.

d. The lines of business to which the certification is applicable.

e. The applicant’s commitment to comply with all requirements necessary to maintain certification.

Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer:
The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. If the applicant intends to utilize a multi-beneficiary trust for this purpose, the applicant must submit (1) a copy of the approval from the domiciliary regulator with regulatory oversight of the 100% collateral and reduced collateral multi-beneficiary trusts or its intention to secure the approval of the domiciliary regulator of the trust before either trust can be used. (2) the form of the trust that will be used to secure obligations incurred as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status, i.e., the applicant’s 100% collateralized trust (if applicable). The form of each trust is required to be submitted pursuant to state law in order to ensure that security for these obligations will be kept separate and to ensure that each trust meets the requirements of the jurisdiction.
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<tr>
<th>Citation to State Law / Regulation</th>
<th>Requirements</th>
<th>Y or N</th>
<th>Reference and Supporting Documents</th>
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<tr>
<td>state’s Credit for Reinsurance statute and/or regulation.</td>
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<td><strong>NOTE:</strong></td>
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<td><em>The MBT includes a provision that:</em></td>
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<td>The certified reinsurer must bind itself by the language of the multi-beneficiary trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.</td>
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<td>Form CR-1 (For Initial and Renewal Applications):</td>
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<td>The applicant must provide [insert name of state] Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form. [Insert link to copy of form on state web site.]</td>
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<td>Fee:</td>
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<td>[Insert $ amount of the fee applicable in this state.]</td>
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<td>Other Requirements:</td>
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<td>The applicant must:</td>
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<td>a. Commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Failure to comply with such other requirement could disqualify the reinsurer from certification.</td>
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<td>b. Provide a statement that the applicant agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.</td>
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II. **Filing Requirements for Full Application**

a. The applicant shall provide the information required within Section II if:
   - The applicant has not been certified by an NAIC accredited jurisdiction; or
   - The Commissioner makes a determination not to recognize or defer to the certification issued by another NAIC accredited jurisdiction; or
   - The applicant is renewing its certification with the lead state or a state is not relying on the certification by another NAIC accredited jurisdiction.

b. Check appropriate box:
   - [ ] Initial Application
   - [ ] Renewal Application

### Status of Domiciliary Jurisdiction / Proof of Licensure and Good Standing

The applicant must be domiciled and licensed in a Qualified Jurisdiction, as determined by this state. The applicant must be in good standing (or the jurisdiction’s equivalent classification) and maintain capital and surplus in excess of its domiciliary jurisdiction’s highest regulatory action level.

The Commissioner will consider the following information with respect to the applicant’s domiciliary jurisdiction:
a. Whether the domestic supervisory authority been approved as a Qualified Jurisdiction in this state.

b. Confirmation as to whether the domestic supervisory authority is included on the NAIC List of Qualified Jurisdictions.

The applicant must provide the following information:

a. A copy of the certificate of authority or license to transact insurance and/or reinsurance from the applicant’s domiciliary jurisdiction.

b. A certification from the applicant’s domestic supervisory authority affirming that the applicant is in good standing (or the jurisdiction’s equivalent classification) and maintains capital and surplus in excess of the jurisdiction’s highest regulatory action level.

**Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer:**
The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. If the applicant intends to utilize a multi-beneficiary trust for this purpose, the applicant must submit (1) a copy of the approval from the domiciliary regulator with regulatory oversight of the 100% collateral and reduced collateral multi-beneficiary trusts or its intention to secure the approval of the domiciliary regulator of the trust before either trust can be used; (2) the form of the trust that will be used to secure obligations incurred as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status, i.e., the applicant’s 100% collateralized
trust (if applicable). The form of each trust is required to be submitted pursuant to state law in order to ensure that security for these obligations will be kept separate and to ensure that each trust meets the requirements of the state’s Credit for Reinsurance statute and/or regulation.

**NOTE:**
*The MBT includes a provision that:*
The certified reinsurer must bind itself by the language of the multi-beneficiary trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

### Financial Strength Ratings (Stand-Alone or Group):
The applicant must maintain interactive financial strength ratings from two or more acceptable rating agencies. Initial or Affirmed financial strength rating dates must be within 15 months of the application date/renewal filing date. The applicant must provide the following:

a. Confirm all interactive financial strength ratings currently maintained by the applicant.

b. Specify the type of financial strength rating (i.e., stand-alone or group).

c. If the financial strength rating is not on a stand-alone basis, provide the rationale for the group rating.

d. Copies of full rating agency reports with respect to all financial strength ratings currently maintained by the applicant. If a full report is not available, the applicant must provide a letter from the applicable rating agency.
agency affirming its current financial strength rating. Initial or Affirmed financial strength rating dates must be within 15 months of the application date/renewal filing date.

e. An explanation of any changes in the financial strength rating during the last three years.

**NOTE:** Acceptable rating agencies include A.M. Best, Fitch Ratings, Moody’s Investor Service, Standard & Poor’s, Kroll Bond Rating Agency, or any other Nationally Recognized Statistical Rating Organization recognized by the SEC to provide financial strength ratings on insurance companies.

### Disputed and/or Overdue Reinsurance Claims / Business Practices:
The Commissioner may consider the applicant’s business practices in dealing with its ceding insurers, including compliance with contractual terms and obligations. The applicant must provide the following if 1) applicant’s reinsurance obligations to U.S. cedents that are in dispute and/or more than 90 days past due exceed 5% of its total reinsurance obligations to U.S. cedents as of the end of its prior financial reporting year; or 2) the applicant’s reinsurance obligations to any of the top 10 U.S. cedents (based on the amount of outstanding reinsurance obligations as of the end of its prior financial reporting year) that are in dispute and/or more than 90 days past due exceed 10% of its reinsurance obligations to that U.S. cedent,

Then, in either case, the applicant will provide:

a. Notice of that fact to the Commissioner and a detailed explanation regarding the reason(s) for the amount of disputed or overdue claims exceeding the levels noted above; and
b. A description of the applicant’s business practices in dealing with U.S. ceding insurers and a statement that the applicant commits to comply with all contractual requirements applicable to reinsurance contracts with U.S. ceding insurers. 

Upon receipt of such notice and explanation, the Commissioner may request additional information concerning the applicant’s claims practices with regard to any or all U.S. ceding insurers.

### Schedules for Reinsurance Assumed and Reinsurance Ceded:
The applicant must provide the following:

a. For applicants domiciled in the U.S., provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health).

b. For applicants domiciled outside the U.S. provide Form CR-F (property/casualty) and/or Form CR-S (life and health), completed in accordance with the instructions adopted by the NAIC [include link to instructions.]

### Regulatory Actions:
The applicant must provide a description of any regulatory actions taken against the applicant.

a. Include all regulatory actions, fines and penalties, regardless of the amount.

b. Provide a description of any changes in with respect to the provisions of the applicant’s domiciliary license.

[NOTE: Reinsurance-FAWG requires this information for the last three years for passporting purposes.]

### Financial/Regulatory Filings:
The applicant must provide the following:
a. A copy of the most recent report of the independent auditor.

b. Copies of the audited financial statements for the last three years filed with its jurisdiction supervisor. Financial statements must demonstrate that the applicant has minimum capital and surplus, or the equivalent, of at least $250,000,000. If the applicant is an association including incorporated and individual unincorporated underwriters, statements must demonstrate that the applicant has capital and surplus equivalents (net of liabilities) of at least $250,000,000, and a central fund containing a balance of at least $250,000,000. Please note the following requirements with respect to these financial statements:

c. Audited U.S. GAAP basis statements must be submitted if available.

d. Audited IFRS basis statements are acceptable but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis.

With the permission of the Commissioner, an applicant may be allowed to submit audited IFRS basis statements with reconciliation to U.S. GAAP certified by an officer of the applicant. The reconciliation of equity and net income must include all adjustments (positive or negative) by line item equal to or greater than 5% of equity and/or in aggregate equal to or greater than 10% of equity where each line item is less than 5% of equity.

Upon the initial certification, the Commissioner may consider audited financial statements for the last three years as filed with the applicant’s non-U.S. jurisdiction.
<table>
<thead>
<tr>
<th><strong>jurisdiction supervisor. If the Commissioner accepts such statements in the initial filing, the applicant must acknowledge and commit that future financial statement filings will include the appropriate reconciliation to a U.S. GAAP basis, as indicated above.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>e.b.</strong> A copy of the Actuarial Opinion and other regulatory filings, as filed with the applicant’s reinsurer’s domiciliary jurisdiction supervisor. [NOTE: Reinsurance-FAWG requires a stand-alone Actuarial Opinion for passporting purposes, or the functional equivalent under the Supervisor’s applicable Actuarial Function Holder Regime.]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Solvent Schemes of Arrangement:</strong> The applicant must provide:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong> A description of any past, present or proposed future participation in any solvent scheme of arrangement, or similar procedure, involving U.S. ceding insurers.</td>
</tr>
<tr>
<td><strong>b.</strong> A statement that the applicant commits to notify the commissioner of any future proposed participation in any solvent scheme of arrangement, or similar procedure, as soon as practicable.</td>
</tr>
</tbody>
</table>

| **Form CR-1 (For Initial and Renewal Applications):** The applicant must provide [insert name of state] Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form. [Insert link to copy of form on state web site.] |

| **Fee:** [Insert $ amount of the fee applicable in this state.] |
### Other Requirements:
The applicant must:

- **a.** Commit to comply with other reasonable requirements deemed necessary for certification by the certifying state.

- **b.** Provide a statement that the applicant agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

### Public Notice Requirement:
The [Commissioner] is required to post notice on the insurance department’s website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The [Commissioner] may not take final action on the application until at least [insert number of days required in the specific state] days after posting such notice. The [Commissioner] will consider any comments received during the public notice period with respect to this application.

---

1 Protocol for Considering a Group Rating

Section 8B(4) of the NAIC Credit for Reinsurance Model Regulation (#786) provides, in relevant part: “Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate.” Understanding the rating agency basis for utilizing a group rating is a key factor in determining whether an applicant’s group rating may be considered appropriate. The recommended protocol for understanding the rationale involves one or more of the following protocol steps:

- For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency utilizes the group rating as a consequence of finding that the company had sufficient interconnectivity with the group;
- For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency enhances the group rating due to the subsidiary’s potential benefit of capital support from one or more affiliated companies;
- The group rating was utilized because the subsidiary derives benefit from its inclusion within a financially strong and well-capitalized insurance group;
- The lead state has contacted the rating agency and was provided a written explanation for the use of the group rating;
- Other factors deemed appropriate by the Reinsurance Financial Analysis (E) Working Group; or
- To assist the Lead State in the assessment of the appropriateness of the use of a group rating, applicants are encouraged to provide their rationale for the use of a group rating.

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Uniform Checklist for Reciprocal Jurisdiction Reinsurers

Reciprocal Jurisdiction Reinsurer Information:
Company Name:
Address:
Primary Contact:
Domiciliary Jurisdiction / Supervisory Authority:
Applicable Lines of Business:

I. Filing Requirements for “Lead State” of Reciprocal Jurisdiction Reinsurer

Check appropriate box:

☐ Initial Filing
☐ Annual Filing

The “Lead State” will uniformly require assuming insurers to provide the following documentation so that other states may rely upon the Lead State’s determination:

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<thead>
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<th>Requirements</th>
<th>Y or N</th>
<th>Reference and Supporting Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model #786 § 9A &amp; B</td>
<td>Status of Reciprocal Jurisdiction: The assuming insurer must be licensed to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model #785 §2F(1)(a)</td>
<td>write reinsurance by, and has its head office or is domiciled in, a Reciprocal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jurisdiction that is listed on the NAIC List of Reciprocal Jurisdictions:</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• A non-U.S. jurisdiction that is subject to an in-force Covered Agreement</td>
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<tr>
<td></td>
<td>with the United States;</td>
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<td></td>
<td>• A U.S. jurisdiction that meets the requirements for accreditation under the</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NAIC Financial Standards and Accreditation Program;</td>
<td></td>
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<tr>
<td></td>
<td>• A Qualified Jurisdiction that has been determined by the commissioner to</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>meet all applicable requirements to be a Reciprocal Jurisdiction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation to State Law / Regulation</td>
<td>Requirements</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| Model #786 § 9C(2)                | **Minimum Capital and Surplus:** The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction:  
  - No less than $250,000,000 (USD); or  
  - If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:  
    - Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000 (USD); and  
    - A central fund containing a balance of the equivalent of at least $250,000,000 (USD).  
  
  *The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer complies with this requirement.* |       |                                   |
| Model #786 § 9C(7)                | **Minimum Solvency or Capital Ratio:** The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio.  
  - The ratio specified in the applicable in-force Covered Agreement where the assuming insurer has its head office or is domiciled; or  
  - If the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized |       |                                   |
<p>| Model #785 §2F(1)(b)             |                                                                                                                                          |       |                                   |
| Model #785 §2F(1)(g)             |                                                                                                                                          |       |                                   |</p>
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<tr>
<td>Model #786 § 9C(7)</td>
<td>control level, calculated in accordance with the formula developed by the NAIC; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model #785 §2F(1)(g)</td>
<td>• If the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with this requirement.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model #786 § 9C(4)</td>
<td><strong>Form RJ-1:</strong> The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer. [Insert link to copy of form on state web site.]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model #785 §2F(1)(d)</td>
<td><strong>Financial/Regulatory Filings:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domicile jurisdiction, as applicable, including the external audit report;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation to State Law / Regulation</td>
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</tbody>
</table>
| Model #786 § 9C(5)(d)            | of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and  
  - Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer. **This is for purposes of evaluating Prompt Payment of Claims.** |      |                                    |
| Model #786 § 9C(6)              | Prompt Payment of Claims:  
The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:  
  - More than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner;  
  - More than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a Covered Agreement; or  
  - The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as |      |                                    |
II. Filing Requirements for “Passporting State” of Reciprocal Jurisdiction Reinsurer

In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

If an NAIC accredited jurisdiction has determined that the conditions set forth under the Filing Requirements for Lead States have been met, the commissioner has the discretion to defer to that jurisdiction’s determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC.

The following documentation must be filed with the Passporting State:

<table>
<thead>
<tr>
<th>Citation to State Law / Regulation</th>
<th>Requirements</th>
<th>Y or N</th>
<th>Reference and Supporting Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model #786 § 9E(2)</td>
<td>Form RJ-1: An assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require, except to the extent that they conflict with a Covered Agreement.</td>
<td></td>
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</tr>
<tr>
<td>Model #785 §2F(3)</td>
<td>Lead State: If an NAIC accredited jurisdiction has determined that the required conditions have been met, the commissioner has the discretion to defer to that jurisdiction’s determination. The commissioner may accept financial</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
III. Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers

Under Section 8A(5) of the Credit for Reinsurance Model Regulation (#786), credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the Credit for Reinsurance Model Law (#785), credit may be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have certain blocks of business that are fully collateralized under the prior provisions of Model #785 and Model #786. The NAIC blanks will be amended to reflect the status of these reinsurers with respect to each type of insurance assumed.
26th May 2020

Mr Rehagen
NAIC

Response submitted via -email

IUA Response to NAIC Uniform Checklist for Reciprocal Jurisdiction Reinsurers and the Uniform Application Checklist for Certified Reinsurers

Dear Mr Rehagen,

We are pleased to be able to provide comments to the National Association of Insurance Commissioners (NAIC) in relation to the above checklists.

The International Underwriting Association of London (IUA) represents international and wholesale insurance and reinsurance companies operating in or through London. It exists to promote and enhance the business environment for its members. The IUA’s London Company Market Statistics Report shows that overall premium income for the company market in 2018 was £28.4376bn. Gross premium written in London totalled $19,559bn, while a further £8.877bn was identified as written in other locations, but managed and overseen by London operations. For further information about our organization and membership, please visit our web site, www.iua.co.uk, under the section “About the IUA.”

While we do not have any general comments on the proposals, we do propose to request further clarification to specific questions.

Specific Questions

The comments on the Uniform Checklist for Reciprocal Jurisdiction Reinsurers are as follows.

1. We would appreciate further clarification on who is required to evidence the criteria under section “Prompt Payment of Claims.” It is understood that the first and second criteria may require the US ceding insurance company to provide evidence. In respect of the third criteria, does the criterion response need to be confirmed by the reciprocal reinsurer?

2. We would also appreciate further clarification on the format and details required by the fourth criteria under section “Financial/Regulatory Filings.” It would be helpful, perhaps, to define the requirements in a similar way to the corresponding requirement in the checklist for certified reinsurers, under “Schedules for Reinsurance Assumed and Reinsurance Ceded.”

We have no comments on the changes to the Uniform Application Checklist for Certified Reinsurers.
We hope that our comments will help NAIC officials to add clarity in those areas in which we feel could assist the market. We would be pleased to clarify or expand on our comments as required.

Yours sincerely,

Helen Dalziel BSc(Hons), Dip CII

Senior Legal & Market Services Executive
International Underwriting Association of London
Tel: +44 (0)20 7617 5449
Email: helen.dalziel@iua.co.uk
May 26, 2020

Director Chlora Lindley-Myers, Chair
Reinsurance (E) Task Force
National Association of Insurance Commissioners
c/o Mr. Jake Stultz
Via e-mail jstultz@naic.org

Re: NAIC Request for Comments on NAIC Exposure Draft Uniform Checklist for Reciprocal Reinsurers

Dear Director Lindley-Myers:

The Reinsurance Association of America (RAA) and the Lloyd’s market appreciate the opportunity to submit comments on the NAIC’s Exposure Draft of the Uniform Checklist for Reciprocal Reinsurers. The Reinsurance Association of America (RAA) is a national trade association representing reinsurance companies doing business in the United States. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross-border basis. The RAA also has life reinsurance affiliates. The Lloyd’s market is one of the largest non-U.S. domiciled sources of reinsurance capacity to the U.S. insurance industry. In 2019, Lloyd’s underwriters assumed over $5.96 billion in reinsurance premiums from U.S. cedants.

We appreciate the continued work of the Task Force to implement the 2019 changes to the NAIC Credit for Reinsurance Model Law and Regulation. This process is critical to honoring the U.S.’s commitments under the U.S./EU and U.S./UK covered agreements, as well as to providing the opportunity to extend equal treatment to other reinsurers from other jurisdictions that meet the requirements specified in the revised Model Law/Regulation.

Section I: Filing Requirements for “Lead State” of Reciprocal Jurisdiction Reinsurer

The use of the term “lead state” in this context may cause confusion, as the model and state holding company acts use a lead state concept that is different than the concept reflected here. Perhaps the phrase “Primary State” or “Lead Submission State” could be used to differentiate this term from the lead state concept in other contexts.

Status of Reciprocal Jurisdiction: It would be helpful if the checklist could make clear what reference and supporting documents would be required for this element. Would it be sufficient for the applicant to submit a statement that it is domiciled in a reciprocal jurisdiction? Would the applicant be required to submit a copy of the covered agreement? Would the reference to the applicant’s domiciliary jurisdiction on the top of the checklist be sufficient?

Form RJ-1: To the extent that this form will resemble Form CR-1, our members may have some comments. We respectfully request that a draft of the form be released for public comment.
Financial Regulatory Filings: As drafted, the checklist appears to take language from the model regulation that gives a commissioner the discretion to ask for more information and elevate those items to regulatory requirements. The model regulation indicates that the reinsurer must provide the information in Model #786 9C(5) “if requested by the commissioner.” The checklist should be amended to reflect the “only on request” nature of these items. In general, regulators are unlikely to need the “on request” information for most applicants. The discretion to request additional information would allow a regulator to dig deeper into applicants where there is a question or concern. This provision should not be converted to a requirement that applies broadly.

In addition, the reference on page 3 to “prior to entry into the reinsurance agreement” is confusing when considered in reference to large global reinsurers that enter into many reinsurance agreements and make annual reciprocal jurisdiction reinsurer filings. We suggest removing that phrase from the uniform checklist.

Section III: Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers.

In addition to the information contained in this section, it is clear that some states will adopt the revised model laws and regulations before other states adopt them. This has already occurred. The checklist should include information about how passporting will work if the “Lead State” (proposed “Primary State”) has adopted the revised model law and regulation and other passporting states have not adopted it.

Lastly, in conjunction with the release of the final version of the uniform checklist, we urge the NAIC to develop and host training sessions for state reviewers so that we can achieve more operational uniformity. Uniform implementation of these rules is crucial to assure that all parties receive equal treatment and equal benefits from their application.

Conclusion

We appreciate the opportunity to offer comments and work with the NAIC on the Exposure Draft of the Uniform Checklist for Reciprocal Reinsurers. Please do not hesitate to contact us with any questions or concerns.

Sincerely,

Karalee C. Morell
Reinsurance Association of America

Sabrina Miesowitz
Lloyd’s
Uniform Checklist for Reciprocal Jurisdiction Reinsurers

Reciprocal Jurisdiction Reinsurer Information:
Company Name:
Address:
Primary Contact:
Domiciliary Jurisdiction / Supervisory Authority:
Applicable Lines of Business:

I. Filing Requirements for “Lead State” of Reciprocal Jurisdiction Reinsurer

Check appropriate box:

☐ Initial Filing  ☐ Annual Filing

The “Lead State” will uniformly require assuming insurers to provide the following documentation so that other states may rely upon the Lead State’s determination:

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<tbody>
<tr>
<td>Model #786 § 9A &amp; B</td>
<td>Status of Reciprocal Jurisdiction: The assuming insurer must be licensed to write reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction that is listed on the NAIC List of Reciprocal Jurisdictions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model #785 §2F(1)(a)</td>
<td>• A non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction.</td>
<td></td>
<td></td>
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<td>Citation to State Law / Regulation</td>
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</tr>
</tbody>
</table>
| Model #786 § 9C(2)                | **Minimum Capital and Surplus:** The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction:  
  - No less than $250,000,000 (USD); or  
  - If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:  
    - Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000 (USD); and  
    - A central fund containing a balance of the equivalent of at least $250,000,000 (USD).  
  The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer complies with this requirement. |       |                                    |
| Model #785 §2F(1)(b)              |                                                                                                                                             |       |                                    |
| Model #786 § 9C(7)                | **Minimum Solvency or Capital Ratio:** The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio.  
  - The ratio specified in the applicable in-force Covered Agreement where the assuming insurer has its head office or is domiciled; or  
  - If the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized |       |                                    |
| Model #785 §2F(1)(g)              |                                                                                                                                             |       |                                    |

© 2020 National Association of Insurance Commissioners
<table>
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</thead>
<tbody>
<tr>
<td>Model #786 § 9C(7) Model #785 §2F(1)(g)</td>
<td>control level, calculated in accordance with the formula developed by the NAIC; or • If the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency. <strong>The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with this requirement.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model #786 § 9C(4) Model #785 §2F(1)(d)</td>
<td><strong>Form RJ-1:</strong> The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer. [Insert link to copy of form on state web site.].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model #786 § 9C(5) Model #785 §2F(1)(e)</td>
<td><strong>Financial/Regulatory Filings:</strong> • For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, The assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report; • For the two years preceding entry into the reinsurance agreement, The solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor; • Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, An updated</td>
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</table>

The Reciprocal Jurisdiction Reinsurer shall provide this information if requested by the commissioner consistent with the requirements of Model #785 & Model #786.
<table>
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<tr>
<td>Model #786 § 9C(5)(d)</td>
<td>list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and</td>
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<td>• Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer. <strong>This is for purposes of evaluating Prompt Payment of Claims.</strong></td>
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</tr>
<tr>
<td>Model #786 § 9C(6) Model #785 §2F(1)(f)</td>
<td><strong>Prompt Payment of Claims:</strong> The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:</td>
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<td></td>
<td>• More than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner;</td>
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<td></td>
<td>• More than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a Covered Agreement; or</td>
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<td>• The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as</td>
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</table>
II. **Filing Requirements for “Passporting State” of Reciprocal Jurisdiction Reinsurer**

In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

If an NAIC accredited jurisdiction has determined that the conditions set forth under the *Filing Requirements for Lead States* have been met, the commissioner has the discretion to defer to that jurisdiction’s determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC.

The following documentation must be filed with the Passporting State:

<table>
<thead>
<tr>
<th><strong>Citation to State Law / Regulation</strong></th>
<th><strong>Requirements</strong></th>
<th><strong>Y or N</strong></th>
<th><strong>Reference and Supporting Documents</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Model #786 § 9E(2)</td>
<td><strong>Form RJ-1:</strong> An assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require, except to the extent that they conflict with a Covered Agreement.</td>
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<tr>
<td>Model #785 §2F(3)</td>
<td><strong>Lead State:</strong> If an NAIC accredited jurisdiction has determined that the required conditions have been met, the commissioner has the discretion to defer to that</td>
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</tbody>
</table>

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III. Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers

Under Section 8A(5) of the Credit for Reinsurance Model Regulation (#786), credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the Credit for Reinsurance Model Law (#785), credit may be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have certain blocks of business that are fully collateralized under the prior provisions of Model #785 and Model #786. The NAIC blanks will be amended to reflect the status of these reinsurers with respect to each type of insurance assumed.
2021 Proposed Charges
Reinsurance (E) Task Force

202120 Charges

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

The Qualified Jurisdiction (E) Working Group will:
A. Maintain the NAIC List of Qualified Jurisdictions and the NAIC List of Reciprocal Jurisdictions in accordance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.
B. Perform a yearly due diligence review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions.
C. Consider evaluations of any additional jurisdictions for inclusion on the NAIC List of Qualified Jurisdictions.

The Reinsurance Financial Analysis (E) Working Group will:
A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified Reinsurers.
B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities or individuals.
D. Support, encourage, promote and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.
E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.
F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
G. Ensure the public passorting website remains current.
H. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.
Implementation of the 2019 Revisions to the Credit for Reinsurance Model Law #785
[status as of July 7, 2020]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.

Implementation of the 2019 Revisions to the Credit for Reinsurance Model Regulation #786 [status as of July 7, 2020]
RISK RETENTION GROUP (E) TASK FORCE

The Risk Retention Group (E) Task Force did not meet at the Summer National Meeting.
VALUATION OF SECURITIES (E) TASK FORCE

Valuation of Securities (E) Task Force Aug. 7, 2020, Minutes ........................................................................................ 10-1514
Valuation of Securities (E) Task Force July 1, 2020, Minutes (Attachment One) ............................................................. 10-1518

Amendment for Technical NAIC Designation Category Corrections (Attachment One-A) ....................................................... 10-1522
P&P Manual Amendment to Rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the NAIC U.S. Government Money Market Fund List and Discontinue the NAIC Bond Fund List (Attachment One-B) .................................................................................................................................. 10-1534
Valuation of Securities (E) Task Force May 14, 2020, Minutes (Attachment Two) ............................................................... 10-1538
Valuation of Securities (E) Task Force Feb. 4, 2020, Minutes (Attachment Two-A) .............................................................. 10-1546

P&P Manual Amendment to Reflect the U.S. Securities and Exchange Commission’s (SEC) Adoption of a New Rule to Modernize the Regulation of Exchange-Traded Funds (ETFs) (Attachment Two-A1) .................................................................................................................................. 10-1550
P&P Manual Amendment to Map Financial Modeled Residential Mortgage-Back Securities (RMBS)/Commercial Mortgage-Backed Securities (CMBS) Designations to NAIC Designation Categories (Attachment Two-B) .................................................................................................................. 10-1553
P&P Manual Amendment for Principal Protected Securities (PPS) with an Updated Definition and Instructions (Attachment Two-C) .................................................................................................................................. 10-1556
P&P Manual Amendment to Map Short-Term Credit Rating Provider (CRP) Ratings to NAIC Designation Categories (Attachment Three) .................................................................................................................................. 10-1565
P&P Manual Amendment to Add Supranational Entities Filed with the NAIC Securities Valuation Office (SVO) to the Sovereign NAIC Designation Equivalent List (Attachment Four) .................................................................................................................................. 10-1570
The Valuation of Securities (E) Task Force met via conference call Aug. 7, 2020. The following Task Force members participated: Robert H. Muriel, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by William Arfanis (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Carolyn Morgan (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Bruce R. Ramge represented by Lindsay Crawford (NE); Marlene Caride represented by John Sirovetz (NJ); Linda A. Lacewell represented by Jim Everett (NY); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Tim Hays (WA); and Mark Afable represented by Randy Milquet (WI).

1. Adopted its July 1 and May 14 Minutes

Mr. Fry said he is representing Director Muriel for the Illinois Department of Insurance, serving as the chair of the Task Force. The first item on the agenda was the adoption of its July 1 and May 14 minutes.

Mr. Fletcher made a motion, seconded by Ms. Clements, to adopt the Task Force’s July 1 (Attachment One) and May 14 (Attachment Two) minutes. The motion passed unanimously.

2. Adopted a P&P Manual Amendment to Map Short-Term CRP Ratings to NAIC Designation Categories

Mr. Fry said that during the Task Force’s May 14 conference call, the National American Securities Valuation Association (NASVA) requested that the table in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual)* mapping credit rating provider (CRP) ratings for short-term instruments be updated to also map them to NAIC designation categories. The Task Force directed the Securities Valuation Office (SVO) staff to make this update, and during its July 1 conference call, the Task Force received this amendment updating the table to map short-term CRP ratings to NAIC designation equivalents, along with updated references to policies related to the use of credit ratings in the P&P Manual and a new footnote.

Mr. Fry said the amendment was exposed for a 25-day public comment period ending July 27. The Task Force did not receive any comments from the industry.

Mr. Kozak made a motion, seconded by Ms. Doggett, to adopt this proposed P&P Manual amendment to map short-term CRP ratings to NAIC designation categories (Attachment Three). The motion passed unanimously.

3. Adopted a P&P Manual Amendment to Add Supranational Entities Filed with the SVO to the Sovereign NAIC Designation Equivalent List

Mr. Fry said the SVO staff reported that they had received several requests from insurers for an NAIC designation equivalent for supranational entities. The SVO publishes a list of Sovereign NAIC Designation Equivalents, and insurers use that list when reporting on the Supplemental Investment Risk Interrogatories (SIRI). Lines 5–10 of the SIRI requires insurers to list foreign investments by country sovereign rating. The guidance indicates that a country not on the SVO’s Sovereign NAIC Designation Equivalents list should be reported as an NAIC 3 or below. Supranational entities like the European Union (EU) and the World Trade Organization (WTO) are international groups or unions that share decision making and vote on issues concerning the collective body; however, they are not controlled by a single sovereign country, and they do not currently get added to Sovereign NAIC Designation Equivalents list.

Mr. Fry said this proposed amendment would permit the SVO to include supranational entities on the Sovereign NAIC Designation Equivalents list if they were submitted to it for review by an insurer and the SVO is able to determine an appropriate NAIC designation equivalent. The Task Force did not receive any comments from industry.
Ms. Mears made a motion, seconded by Ms. Crawford, to adopt this proposed P&P Manual amendment to include supranational entities filed with the SVO to the Sovereign NAIC Designation Equivalents list if the SVO can determine an appropriate NAIC designation (Attachment Four). The motion passed unanimously.

4. Exposed a Proposed P&P Manual Amendment to Add Instructions for ETFs that Contain a Combination of Preferred Stocks and Bonds

Mr. Fry said this item on the agenda is a proposed amendment to add instructions for exchange-traded funds (ETFs) that contain both preferred stocks and bonds—two security types that the SVO designates. This amendment was first discussed during the Task Force’s Oct. 31, 2019, conference call, but action on it was deferred. Current instructions permit the SVO to consider for inclusion on the bond or preferred stock ETF list only those that predominantly invest in one or another of the security types, but not both.

Mr. Fry said the SVO brought this proposal before the Task Force because no preferred stock ETFs currently qualify to be on the preferred stock ETF list. This is because preferred stock ETFs have had to include, because of availability, other security types such as hybrids—a security that contains both debt and equity characteristics—and these other securities are considered bonds under the Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds. To alleviate this limitation, the SVO is recommending that ETFs that predominately invest in both preferred stocks and bonds, both of which are security types already permitted to receive NAIC designations, be allowed on the preferred stock ETF list.

Mr. Fry said the SVO would still be responsible for determining if such ETFs would generate predictable and periodic cash flows in a manner broadly similar to a situation in which the holdings were of preferred stock and qualify as fixed income like. This will enable the ETFs that have preferred stock that are mixed with a lot of hybrid principally and are still more like a preferred stock that will give the SVO the policy to include those as a preferred stock on the list. The SVO recommends exposing this for a 30-day public comment period.

Mr. Fry directed the SVO staff to expose this proposed P&P Manual amendment, adding instructions for ETFs that contain a combination of preferred stocks and bonds onto the preferred stock ETF list, for a 30-day public comment period ending Sept. 6.

5. Exposed a Proposed P&P Manual Amendment to Update Guidance on Initial and Subsequent Annual Filings and Methodologies and Documentation

Mr. Fry said the next item is a proposed amendment to the P&P Manual to update guidance on initial and subsequent annual filings, methodologies and documentation.

Charles Therriault (NAIC) said the SVO staff have recently experienced a few insurers declining to provide the documents necessary to analyze the investment filed. The refusal has been accompanied by an unusual challenge, asking where in the P&P Manual it requires these documents to be submitted. This amendment is intended to clarify and fill in any gaps that may exist in the P&P Manual. The amendment reflects a longstanding expectation by the Task Force that insurers will provide the SVO staff with the materials required to analyze investments submitted for review. In the absence of the SVO being specifically named as a party to the transaction, it falls upon insurers to provide the documentation necessary for the SVO analysts to perform their work. The clarifications in this amendment are just that, clarifications of existing guidance requiring insurers to provide items such as financial statements, internal analysis, legal agreements, and any applicable forms. Without this required information and authority to request it, the SVO will not be able to fulfill its analytical responsibilities. This is just a clarification of existing instructions. It should help clarify the SVO’s expectations on what information it will be looking for.

Mr. Fry directed the SVO staff to expose this proposed P&P Manual amendment to update guidance on initial and subsequent annual filings, methodologies and documentation for a 30-day public comment period ending Sept. 6.


Julie Gann (NAIC) first provided an update on four adoptions of the Statutory Accounting Principles (E) Working Group.

a. SSAP No. 32R—Preferred Stock – The Working Group adopted a substantively revised preferred stock SSAP to revise the definitions, measurement and impairment guidance pursuant to the investment classification project. The effective date of the new SSAP is Jan. 1, 2021. There was a question about early adoption, and the Working Group is looking into it.
b. Bond Tender Offers – The Working Group adopted nonsubstantive revisions to clarify that bond tender offers, which function similarly to a call but the holder has to accept the offer, shall follow the guidance in SSAP No. 26R for the recognition of investment income or capital gain/loss when a bond is liquidated prior to its scheduled maturity date. Although reporting entities that historically applied this practice shall not change past practices, an effective date of Jan. 1, 2021, with early application permitted, was provided for the companies that need to make system changes.

c. Financing Derivatives – The Working Group adopted nonsubstantive revisions to SSAP No. 86—Derivatives to require the gross reporting of derivatives, without the inclusion of financing components. Furthermore, amounts owed to or from the reporting entity from the acquisition or writing of derivatives shall be separately recognized. Revisions are being incorporated into the Blanks to clarify that financing premiums will be factored into the determination of derivative net exposure.

d. Update SVO Listings – The Working Group adopted revisions to eliminate references to the “NAIC Bond Fund List” from SSAP No. 26R and include reference to the “NAIC Fixed Income-Like SEC Registered Funds List” in SSAP No. 30R—Unaffiliated Common Stock. This action was in response to a referral received from the Task Force. Corresponding Blanks revisions will be proposed; but due to the timing of the adoption, they will not be reflected in the year-end 2020 annual statement instructions. These revisions will be reflected in the instructions for 2020. Reporting entities shall follow the adopted SSAP guidance.

Ms. Gann said the following items were exposed by the Working Group:

e. Related Party Transactions – The Working Group exposed revisions to SSAP No. 25—Affiliates and Other Related Parties to clarify the type of relationships that should be reflected as related parties, that non-controlling ownership interest greater than 10% is a related party subject to related party disclosures, and guidance for disclaimers of affiliation and control for statutory accounting. This item was previously exposed, and the current version reflects consideration of interested party comments, as well as an additional disclosure to capture all owners that hold more than 10% of an ownership interest in an insurance reporting entity.

f. Participation Mortgages – The Working Group exposed clarifying provisions to assist in identifying the rights that need to be present for a mortgage loan participation agreement to be in scope of SSAP No. 37—Mortgage Loans. With the exposed edits, it is clarified that a participation agreement does not require an insurer to have the right to solely initiate legal action; foreclosure; or under normal circumstances, require the ability to communicate directly with the borrower.

g. Residential Mortgage-Backed Securities (RMBS)/Commercial Mortgage-Backed Securities (CMBS) Designations – The Working Group exposed revisions to SSAP No. 43R—Loan-Backed and Structured Securities to reflect the revisions adopted by the Task Force for the mapping of RMBS and CMBS securities to a final NAIC designation category under the financial modeling process.

h. Perpetual Bonds – The Working Group exposed revisions to specify that perpetual bonds, which do not have a maturity date and therefore do not amortize, shall be reported at fair value. These revisions are in SSAP No. 26R, and they would be in line with the recent revisions adopted to SSAP No. 32R for perpetual preferred stock.

i. Credit Tenant Loans (CTLs) – The Working Group received the CTL referral from the Task Force and exposed an agenda item addressing CTLs for statutory accounting. This agenda item provides detail of CTLs, as well as some of the recent issues with how non-conforming CTLs were reported in scope of SSAP No. 43R and on Schedule D. This agenda item provides options to clarify the accounting and reporting of CTLs for statutory accounting. The first option is to clarify that CTLs will continue to be in scope of SSAP No. 43R, but only if they are on an SVO identified list. That option will require scope revisions to SSAP No. 43R and reference to an SVO list similar to “SVO Identified Bond ETFs.” CTLs that are not on the list would then be required to be specified in either SSAP No. 37 or SSAP No. 21R—Other Admitted Assets. The second option is to incorporate all CTLs in scope of SSAP No. 21R and report them on Schedule BA, with the CTLs reviewed by the SVO reported with an NAIC designation for risk-based capital (RBC) purposes. The agenda item was exposed with the two options. After comments are considered, the Working Group will be asked to provide direction to NAIC staff on which option is preferred for drafting accounting revisions. The Working Group also directed a referral back to the Task Force, informing them of this action.
j. SSAP No. 43R – The Working Group, which met July 30, received notice that comment letters for the exposed SSAP No. 43R issue paper were due July 31. Since then, one comment letter (67 pages) has been received from interested parties. This comment letter has been posted with the exposed issue paper. It is anticipated that the Working Group will schedule subsequent calls to discuss this.

Ms. Gann said the comment deadline for current exposures is Sept. 18.

7. **Heard an NAIC Staff Report on RMBS/CMBS Modeling**

Eric Kolchinsky (NAIC) said he will be discussing the process for year-end 2020. The NAIC Structured Securities Group (SSG) has started discussions with BlackRock on this year’s modeling assumptions. It was hoped that there would be something clear to work with in terms of the cycle resolution. Unfortunately, the aftershocks from the pandemic are still going on. Some of the uncertainty will be incorporated in the scenarios that will be proposed this year. The plan is to provide proforma breakpoints for insurance companies to see where their portfolios would do at year end, possibly in late October or early November. The timing of the whole process is working slightly against us because there is a deadline for publishing and quality assurance. The SSG will provide those numbers to insurance companies, and a data set will be available for those who would like to purchase it.

8. **Discussed its 2021 Proposed Charges**

Mr. Fry said the Task Force’s 2021 proposed charges are identical to the Task Force’s 2020 charges. The charges do not have to be adopted today, but they will be considered for adoption during an interim meeting.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
The Valuation of Securities (E) Task Force met via conference call July 1, 2020. The following Task Force members participated: Robert H. Muriel, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi (CT); David Altmaier represented by Ray Spudeck (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Kathleen A. Birrane represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Bruce R. Ramge represented by Lindsay Crawford (NE); Marlene Caride represented by John Sirovetz (NJ); Linda A. Lacewell represented by Jim Everett (NY); Jessica K. Altman represented by Doug Stolte (VA); and Mark Afable represented by Randy Milquet (WI).

1. **Adopted a P&P Manual Amendment for Technical NAIC Designation Category Corrections**

Mr. Fry said this proposed nonsubstantive amendment was received during the Task Force’s May 14 conference call and was exposed for a 30-day public comment period that ended on June 17. The amendment makes several technical updates that are needed prior to year-end, related to the implementation of NAIC designation categories. The NAIC Securities Valuation Office (SVO) identified 14 policy-based instructions that assign NAIC designations. In this case, the SVO is only assigning one through six, and under the new NAIC designation category, the Task Force has to break that down in 20 of either 1.A. or 1.B. or 2.A. B, C. There are 14 policy-based decisions that needed to be corrected in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual). One example of these are the U.S. government securities that were assigned an NAIC 1 and now are an NAIC 1.A under the new policy.

Charles A. Therriault (NAIC) said the SVO had permitted some proposals when this was originally considered in December 2017 when it first came up with the concept of NAIC designation categories. He said the SVO had put some ideas out there about administrative symbols for the U.S. Government Full Faith and Credit and other government entities, but the Task Force directed the SVO not to proceed with it in 2018. This is why the NAIC has the category symbols it has today. Mr. Therriault said the SVO is happy to initiate a second project to look at that in conjunction with Capital Adequacy (E) Task Force and believes it to be beneficial for that purpose.

Mr. Everett said he had received comments from a couple of companies that suggested this will be helpful because some companies have the securities in and have to pull out for asset valuation reserve (AVR) and interest maintenance reserve (IMR). Using this will prevent the necessity of two calculations when just being able to identify them through designation will enable them to pull them out easily.

Mr. Thomas made a motion, seconded by Mr. Milquet, to adopt the proposed P&P Manual amendment for technical NAIC designation category correction (Attachment One-A). The motion passed unanimously.

2. **Adopted a P&P Manual Amendment to Rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the NAIC U.S. Government Money Market Fund List and Discontinue the NAIC Bond Fund List**

Mr. Fry said the next item on the Task Force’s agenda is to consider adoption of an amendment to rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the NAIC U.S. Government Money Market Fund List and discontinue the NAIC Bond Fund List. This was first discussed by the Task Force during its Oct. 31, 2019, conference call. The proposal was exposed for a 45-day public comment period that ended on Dec. 16, 2019. It was also referred to the Statutory Accounting Principles (E) Working Group.

Mr. Fry said, as mentioned in the staff memorandum dated Sept. 30, 2019, the first proposed change is to rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the much simpler description, and the second is to eliminate the NAIC U.S. Government Money Market Fund List.
Mr. Fry said there were only four funds on this list for 2019; only one of those four was owned by an insurance company. Part of the criteria to be on the list is to maintain the highest market risk rating. Market risk ratings is going to go away, and this will not be a criterion anymore. This is another reason why this list should go away, and there is still the exchange-traded fund’s (ETF) approved route.

Mr. Everett asked what will be replacing the risk rating. Mr. Therriault said there is no replacement for the market risk rating.

Ms. Mears made a motion, seconded by Mr. Kozak, to adopt the proposed P&P Manual amendment to rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the NAIC U.S. Government Money Market Fund List and discontinue the NAIC Bond Fund List (Attachment One-B). The motion passed unanimously.

3. Exposed a Proposed P&P Manual Amendment to Map Short-term CRP Ratings to NAIC Designation Categories

Mr. Fry said that during the Task Force’s May 14 conference call, the North American Securities Valuation Association (NASVA) requested the table in the P&P Manual mapping credit rating provider ratings for short-term instruments be updated to also map them to NAIC designation categories. The Task Force directed SVO staff to draft that update, now reflected in this amendment. He asked Mr. Therriault to provide a summary of this change.

Mr. Therriault said short-term ratings do not have a one-for-one mapping to long-term credit ratings. The short-term ratings cover a range of long-term ratings. Moody’s Prime-1 (P1) short-term rating covers the long-term rating range that includes: Aaa, Aa1, Aa2, Aa3, A1, A2 and A3. The SVO recommends mapping the NAIC designation category to the mid-point of these long-term rating ranges. In this instance, the P1 short-term rating would be mapped to the NAIC designation category of 1.D or a Moody’s long-term rating equivalent of Aa3. This approach was applied to each short-term rating mapping.

Mr. Therriault said there were also updated references to policies related to the use of credit ratings in the P&P Manual along with a footnote to identify that there are many more ratings symbols than those displayed on the this generic list when the various combinations of prefixes and suffixes are included. There was also one previous erratum in the long-term ratings table that was identified; the AM Best rating symbol bbb+ was mapped to both NAIC designation category 2.A and 2.B. The table was missing the AM Best rating symbol bbb, which has now been added and mapped to 2.B. This was only an issue in the P&P Manual and did not affect any NAIC system.

Mr. Therriault said the SVO does not currently translate, compile or publish short-term security ratings into NAIC designations in the Automated Valuation Service (AVS+) system. If the Task Force would like the SVO to do so, it would need to be a separate initiative. The SVO recommends the Task Force expose this nonsubstantive update for public comment.

Mr. Monahan (American Council of Life Insurers—ACLI) said the ACLI supports an expedited 25-day exposure period for this item. Mr. Fry directed the SVO to expose this P&P Manual amendment for a 25-day public comment period ending July 27.

4. Exposed a Proposed P&P Manual Amendment to Add Supranational Entities Filed with the SVO to the Sovereign NAIC Designation Equivalent List

Mr. Fry introduced the next item to add supranational entities filed with the SVO to the Sovereign NAIC Designation Equivalent List. He asked Mr. Therriault to provide a summary.

Mr. Therriault said the SVO publishes a list of sovereign NAIC designation equivalents that are used to cap the NAIC designation and NAIC designation category that can be assigned by the SVO. This amendment refers to that list but is unrelated to the proposal the Task Force discussed earlier this year on constraining all NAIC designations to the Sovereign NAIC Designation Equivalent List. Instead, this proposal is being recommended to address insurer reporting issues on the Supplemental Investment Risk Interrogatories (SIRI) reports. Lines 5–10 of that report require insurers to list foreign investments by country sovereign rating. The guidance indicates that a country not on the SVO’s Sovereign NAIC Designation Equivalent List should be reported as an NAIC 3 or below. Supranational entities are international groups or unions that share decision making and vote on issues concerning the collective body. The European Union (EU) and the World Trade Organization (WTO) are both supranational entities. Operating in multiple countries, supranational entities are not controlled by a single sovereign country and, in this context, it is only being used for governmental entities.
Mr. Therriault said the proposed amendment would permit the SVO to include on the Sovereign NAIC Designation Equivalent List supranational entities, submitted to it for review by insurers, for which the SVO is able to determine an appropriate NAIC designation equivalent. The SVO recommends the Task Force expose the amendment for a public comment period. If adopted by the Task Force, the SVO would recommend this being referred to the Blanks (E) Working Group to request updates to the Supplemental Investment Risk Interrogatory instructions to reference the Sovereign NAIC Designation Equivalent List for both sovereign countries and supranational entities and to remove direct references to rating agency ratings (e.g., Moody’s and Standard & Poor’s [S&P]) on the report.

Mr. Monahan said the ACLI supports an expedited 25-day exposure period for this item also.

Mr. Fry directed SVO staff to expose this proposed P&P Manual amendment adding instructions to include supranational entities filed with the SVO to the Sovereign NAIC Designation Equivalent List if the SVO can determine an appropriate NAIC designation for a 25-day public comment period ending July 27.


Mr. Fry said the next item on the agenda is the proposed amendment to the P&P Manual to incorporate updates made to Statement of Statutory Accounting Principles (SSAP) No. 105R—Working Capital Finance Investments, which the Statutory Accounting Principles (E) Working Group adopted on May 20. He asked Marc Perlman (NAIC) to explain the amendment.

Mr. Perlman said early last year, industry requested modifications to the working capital finance investments (WCFI) requirements in SSAP No. 105. SSAP No. 105 took a fixed approach to a number of legal and structural issues in WCFI transactions, which are routinely handled differently, and thereby prevented the SVO from exercising proper analytical discretion. The Task Force referred industry’s request to the Statutory Accounting Principles (E) Working Group in March 2019. The Working Group incorporated seven of the industry-requested modifications to the WCFI program requirements in what is now SSAP No. 105R, which became effective June 30.

Mr. Perlman said the SVO is proposing amending the WCFI section of the P&P Manual to remove certain requirements that were removed from SSAP No. 105 and thereby make it consistent with the new version, SSAP No. 105R. These amendments include removing the requirement that the SVO determine if the international finance agent is the functional equivalent of the U.S. regulator. Removing the finance agent prohibitions on commingling and broadening the independent review requirements allow independent review of the finance agent by either audit or through an internal control report.

Mr. Fry said that this would need more time for consideration and suggested a 45-day public comment period. Mr. Monahan said the ACLI supports a 45-day public comment period. Mr. Everett also recommended a 45-day public comment period.

Mr. Fry directed the SVO staff to expose this proposed P&P Manual amendment to update guidance for WCFI consistent with the Statutory Accounting Principles (E) Working Group adoption of changes to SSAP No. 105R for a 45-day public comment period ending Aug. 17.

6. Exposed an SVO Staff Report on the Use and Regulation of Derivatives in ETFs

Mr. Fry said the next item on the agenda is to receive a memorandum from the SVO on the use and regulation of derivatives in ETFs. Mr. Fry asked Mr. Perlman to provide a summary

Mr. Perlman said that, at the instruction of the Task Force, the SVO drafted this memorandum so that the Task Force can better understand: 1) how ETFs currently use derivatives; 2) how that use is currently regulated; 3) how that regulation might change; and 4) how all this affects the SVO’s analysis of ETFs that use derivatives.

Mr. Perlman said ETFs, like other U.S. Securities and Exchange Commission (SEC)-registered fund types, use derivatives to manage exposure to specific investments and risks as part of their investment strategies. Derivatives involve leverage, which can magnify an ETF’s gains and losses, and obligate the ETF to make a future payment or deliver assets to a counterparty. Losses on derivatives, therefore, can result in counterparty payment obligations that directly affect the capital structure of an ETF and the relative rights of the ETF’s counterparties and shareholders.
Mr. Perlman said Section 18 of the federal Investment Company Act of 1940 was designed to limit the leverage a fund can incur. In a subsequent Policy Release and several no-action letters, the SEC has taken the position that “evidence of indebtedness” would include all contractual obligations to pay in the future, including commonly used derivatives. Funds, however, were permitted to use “segregated accounts” to cover their senior securities. The SEC has commented, though, that asset segregation may not be providing the intended protections and may not address undue speculation and asset sufficiency concerns.

Mr. Perlman said that in November 2019, the SEC proposed Rule 18f-4 to “provide an updated and more comprehensive approach to the regulation of funds’ use of derivatives.” The rule would generally permit funds, including ETFs, to enter into “derivative transactions” so long as the fund complies with certain conditions and disclosures. These include compliance with an outer limit on fund leverage based on the fund’s value-at-risk (VaR) when compared with a designated reference index, which would approximate the VaR of the fund’s unleveraged portfolio. The board of directors would need to create a new role of derivatives risk manager to administer a derivatives risk management program, which would include all policies and procedures designed to manage the fund’s derivative risks, including: 1) risk identification and assessment; 2) guidelines; 3) stress testing; 4) backtesting; 5) internal reporting; and 6) periodic review.

Mr. Perlman said, importantly, the proposed rule would create an exception for limited users of derivatives, which would not need to comply with many of the requirements like the VaR and the derivatives risk management program. Funds with derivative exposure of less than 10% of its assets and those that solely hedge currency risk would be considered limited users.

Mr. Perlman said the comment period for Rule 18f-4 ended in March, and the final rule has not been published.

Mr. Perlman said the SVO does not expect the rule to affect how it analyzes derivatives in ETFs. According to the P&P Manual, the purpose of a fund derivative (or speculative characteristics) analysis is to determine whether the cash flow is fixed income (or bond)-like. The SVO’s primary analytic focus will remain the determination of whether an ETF’s cash flows, accounting for its use of derivatives, is fixed income-like. It is possible that derivatives risk management programs and VaR limits testing could provide increased transparency about an ETF’s use of derivatives, which could instruct the SVO’s determination of whether an ETF’s cash flow is fixed income-like. However, because ETFs on the SVO-Identified Bond ETF List and SVO-Identified Preferred Stock ETF List should “predominantly hold” bonds or preferred stock, respectively, pursuant to the P&P Manual, most eligible ETFs likely already fall under the exception for limited users of derivatives and may not need to comply with all requirements of the rule.

Mr. Monahan requested that the SVO staff report be exposed for a 45-day public comment period.

Mr. Fry directed the SVO staff to expose the SVO report on the use and regulation of derivatives in ETFs for a 45-day public comment period ending Aug. 17.

7. Discussed Other Matters

Mr. Monahan mentioned that there was a discussion by the Capital Adequacy (E) Task Force on hybrid securities.

Mr. Therriault explained that there was a discussion about assigning only NAIC designations and not NAIC designation categories to hybrid securities. He said any securities that would be translated by the SVO would follow the Valuation of Securities (E) Task Force instructions to produce NAIC designation categories. He said he recommends using the greater granularity provided by the NAIC designation categories. He also said he is uncertain if a referral would be made from the Capital Adequacy (E) Task Force to the Valuation of Securities Task (E) Force requesting its opinion and recommendation on this issue.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

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MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
   Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
       Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau


DATE: April 30, 2020

1. **Summary** – With the introduction of NAIC Designation Categories, the 20 granular delineations of credit risks adopted by the Task Force on Jun. 11, 2018, several policy-based assignments of NAIC Designations did not receive a mapping. This amendment identifies the appropriate NAIC Designation Category to be assigned for these policy-based assignments.

2. **Recommendation** – The SVO recommends that the Task Force update the guidance in the P&P Manual to reflect these policy-based assignments of an NAIC Designation Category.

3. **Proposed Amendment** – The following text in red shows the proposed revisions in Part One, Part Two, Part Three and Part Four.
PART ONE

POLICIES OF THE NAIC

VALUATION OF SECURITIES (E) TASK FORCE

FILING EXEMPTION FOR CERTIFICATES OF DEPOSIT
REPORTED AS BONDS UNDER SSAP NO. 26R

65. The NAIC Designation for Certificates of Deposit described above shall be **NAIC 1** and the NAIC Designation Category shall be **NAIC 1.A**. The NAIC Designation for Certificates of Deposit described above shall be derived by application of the filing exempt conversion process.

... FILING EXEMPTION FOR U.S. GOVERNMENT SECURITIES

SVO Publishing Conventions for Filing Exempt U.S. Government Securities

67. **U.S. Treasury Obligations** – U.S. Treasury Obligations are added to the VOS Process automatically, and they appear in the VOS Product. The NAIC Designation is **NAIC 1** and the NAIC Designation Category is **NAIC 1.A**.

Other Filing Exempt U.S. Government Securities

68. A single entry is in the AVS+ Products in its normal CUSIP sequence, followed by the description “All Issues” for the securities listed below.

69. Because these securities are Filing Exempt, CUSIP numbers are not published in the AVS+ Products. The securities should, however, be reported with a CUSIP in the appropriate section of Schedule D. The NAIC Designation is **NAIC 1** and the NAIC Designation Category is **NAIC 1.A**.

...
Filing Exemption for Other U.S. Government Obligations

79. Obligations issued and either guaranteed or insured, as to the timely payment of principal and interest, by the government agencies or government-sponsored enterprises listed below are filing exempt. They are not backed by the full faith and credit of the U.S. Government. The filing exemption here is based on an analytical judgment that the combined creditworthiness of the entity itself and U.S. government support for that entity provides confidence that the issuer will be able to pay its obligation on a full and timely basis at the level of an NAIC 1 quality designation and an NAIC Designation Category of NAIC 1.A. For the avoidance of doubt, preferred stock or similar securities of the government agencies or government-sponsored enterprises listed below are not considered guaranteed or insured and hence are not subject of this section.
NAIC Designations

…

NAIC General Interrogatory

66. **NAIC 5GI** and **NAIC Designation Category NAIC 5.B GI** is assigned by an insurance company to certain obligations that **meet all of the following criteria:**

- Documentation necessary to permit a full credit analysis of a security by the SVO does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
- The issuer or obligor is current on all contracted interest and principal payments.
- The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

…
PART TWO
OPERATIONAL AND ADMINISTRATIVE INSTRUCTIONS
APPLICABLE TO THE SVO
COMPILATION AND PUBLICATION OF THE SVO LIST OF INVESTMENT SECURITIES

U.S. Treasury Securities Process


Exempt U.S. Government Securities Process

137. The SVO will convert the counterparty’s or the guarantor’s financial strength ratings as assigned by an NAIC CRP (e.g., S&P Financial Programs Ratings, Moody’s Counterparty’s Ratings or Fitch Counterparty Risk Ratings) into an equivalent NAIC Designation. In the absence of an NAIC CRP counterparty financial strength rating, the SVO may convert the counterparty’s senior unsecured rating, as assigned by an NAIC CRP, into the equivalent NAIC Designation. In the absence of an NAIC CRP counterparty financial strength or senior unsecured rating, the SVO will conduct a review of the counterparty’s financial statements to assign an NAIC Designation. For purposes of the application of this section, all U.S. domiciled exchanges are assigned an NAIC 1 Designation and an NAIC Designation Category of NAIC 1.A.
PART THREE
SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION
OF NAIC DESIGNATIONS
PROCEDURE APPLICABLE TO FILING EXEMPT (FE) SECURITIES AND PRIVATE LETTER (PL) RATING SECURITIES

Conditions to Filing Exemption for PL Securities Issued on or After January 1, 2018

14. An insurer that owns a PL security that is not filing exempt shall either: (a) file the security with the necessary documentation with the SVO for an analytically determined NAIC Designation; or (b) self-assign an NAIC 5GI and an NAIC Designation Category of NAIC 5.B GI to the security and report using the Interrogatory procedure; in either case within 120 days of purchase.

20. If the SVO verifies that the security:
   - Has been assigned a credit rating but that the credit rating is not an Eligible NAIC CRP Credit Rating; or
   - Has not been rated by an NAIC CRP; or
   - Is no longer subject to a private letter rating
The SVO shall notify the insurer that the security is not eligible for filing exemption. The insurance company shall then either file that security and necessary documentation with the SVO for an independent credit assessment or assign an NAIC 5GI Regulatory Designation and an NAIC Designation Category of NAIC 5.B GI to the security in the related Interrogatory.

21. An NAIC 5GI Designation and an NAIC Designation Category of NAIC 5.B GI may also be used in connection with the designation of PL securities rated by an NAIC CRP (i.e., for private letter ratings issued on or after January 1, 2018) when the documentation is not available for the SVO to assign an NAIC Designation. For purposes of this section, the documentation is not available for the SVO to assign an NAIC Designation if the NAIC CRP credit rating is not included in the applicable CRP credit rating feed (or other form of direct delivery from the NAIC CRP) and the insurer is unable to provide a copy of the private letter rating documentation necessary for the SVO to assign an NAIC Designation.
The NAIC Bond Mutual Fund List

Regulatory Treatment of Eligible Funds

263. A bond mutual fund on the NAIC Bond Mutual Fund List is in scope of SSAP No. 26R—Bonds, reported with an **NAIC 1** designation and **NAIC 1.A Designation Category** on Schedule D, Part 1 – Long-Term Bonds on the “SVO Identified Funds – Bond Mutual Funds” line. The insurance company reports an **NAIC 1** Designation and **NAIC 1.A Designation Category** in accordance with Annual Statement Instructions. These investments are reported at fair value unless the investment qualifies for and the reporting entity elects systematic value.
PART FOUR
THE NAIC STRUCTURED SECURITIES GROUP

...
### ANALYTICAL ASSIGNMENTS

28. Securities subject to *SSAP No. 43R—Loan-Backed and Structured Securities* that cannot be modeled by the SSG and are not rated by an NAIC CRP or designated by the SVO are either: (a) assigned the NAIC administrative symbol **ND** (not designated), requiring subsequent filing with the SVO; or (b) assigned the NAIC Designation for Special Reporting Instruction [i.e., an **NAIC 5GI**, **NAIC Designation Category NAIC 5.B GI** or **NAIC 6* (six-star)**].
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
    Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)

CC: Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)
    Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office
    (P&P Manual) to Rename the U.S. Direct Obligations/Full Faith and Credit Exempt List to the NAIC U.S.
    Government Money Market Fund List and Discontinue the NAIC Bond Fund List

DATE: September 30, 2019

1. Summary – The P&P Manual authorizes the SVO to maintain two special fund list. The first is the NAIC
    U.S. Direct Obligations/Full Faith and Credit Exempt Money Market Funds List. This list of Money Market Funds
    (MMF) gets special treatment because they can be reported as a cash equivalent on Schedule E, Part 2. The SVO
    proposes simplifying the title of this list to “NAIC U.S. Government Money Market Fund List.” This is only a title
    change to simplify the title of the list.

    The second is the NAIC Bond Fund List, where the SVO reviews that a fund maintains the highest credit quality
    rating, maintains the highest market risk rating (this rating type that is no longer assigned), and invests 100% of its
    total assets in U.S. Government securities along with several other restrictive criteria. Only four funds qualify for
    this list and the four insurers invested in the fund have a combined exposure of $11.8 million BACV in one of the
    four qualify funds as of December 31, 2018. With the adoption of the Comprehensive Instructions for Fund
    Investments on April 7th that provided new instructions for Fixed Income-Like SEC Registered Funds and given the
    limited number of insurers investing in the funds on the NAIC Bond Fund List, the SVO proposes eliminating this
    list when the four funds come up for renewal in 2020. The funds on the NAIC Bond Fund List would be eligible for
    NAIC Fixed Income-Like SEC Registered Funds List and the SVO would be willing to allow these fund issuers to
    apply to be on this new list at their renewal, if they were so interested. This change would require a referral to the
    Statutory Accounting Principles (E) Working Group as the NAIC Bond Fund List is referenced in SSAP No. 26R –
    Bonds.

2. Proposed Amendment – The text referencing these instructions for U.S. Direct Obligations/Full Faith and
    Credit Exempt Money Market Funds List and NAIC Bond Fund List is shown below, edits in red-underline, as it will
2019 P&P Manual

Part Three – SVO Procedures and Methodology for Production of NAIC Designations

Investment in Funds

The NAIC U.S. Government Money Market Fund List U.S. Direct Obligations/Full Faith and Credit Exempt Money Market Funds List

247. **Regulatory Treatment of Eligible Funds** – A money market mutual fund on the NAIC U.S. Government Money Market Fund List U.S. Direct Obligations/Full Faith and Credit Exempt List is reported as a cash equivalent on Schedule E, Part 2 on the “Exempt Money Market Mutual Funds – as Identified by the SVO” line. These “exempt” money market mutual funds are reported at fair value and incur a zero percent (0%) risk-based-capital (RBC) charge. Other money market mutual funds are also reported as cash equivalents on Schedule E, Part 2 on the “All Other Money Market Mutual Funds” line. The “all other” money market mutual funds are also reported at fair value but incur an RBC charge similar to other cash equivalents.

248. **Required Documentation** – An insurance company or the sponsor of a money market mutual fund requests an SVO evaluation that a money market mutual fund is eligible to be listed on the NAIC U.S. Government Money Market Fund List U.S. Direct Obligations/Full Faith and Credit Exempt List by submitting the following documentation to the SVO:

- The money market mutual fund application form.
- Authorization letter requesting review of the fund for the purpose of being added to the List.
- The most recent fund:
  - Prospectus;
  - Statement of Additional Information (SAI); and
  - Annual, and if available, the semi-annual report.
- Rating letter from an NAIC CRP dated in the year of the filing.

249. **Eligibility Criteria** – A money market mutual fund is eligible for inclusion on the NAIC U.S. Government Money Market Fund List U.S. Direct Obligations/Full Faith and Credit Exempt List if the fund meets the following conditions:

- The fund maintains a money market mutual fund rating of AAAm from Standard & Poor’s or Aaa-mf from Moody’s Investor Services or an equivalent money market mutual fund rating from any NAIC CRP.
- The fund maintains a stable net asset value per share of $1.00.
- The fund allows a maximum of seven-day redemption of proceeds.
- The fund invests 100% of its total assets in securities that are direct obligations of the U.S. Government and/or in securities that are backed by the full faith and credit of the U.S. Government or collateralized repurchase agreements comprised of such obligations at all times.

**NOTE:** Please refer to text below for a list of securities considered to be direct obligations of the U.S. Government and entities that are entitled to the full faith and credit of the U.S. Government.

250. **Verification Procedure** – Upon receipt of the documentation, the SVO examines the prospectus, schedule of fund portfolio holdings and related materials to verify that the fund meets the established criteria.
The NAIC Bond Mutual Fund List

251. Regulatory Treatment of Eligible Funds — A bond mutual fund on the NAIC Bond Mutual Fund List is in scope of SSAP No. 26R — Bonds, reported with an NAIC 1 designation on Schedule D, Part I — Long-Term Bonds on the “SVO Identified Funds — Bond Mutual Funds” line. The insurance company reports an NAIC 1 Designation in accordance with Annual Statement Instructions. These investments are reported at fair value unless the investment qualifies for and the reporting entity elects systematic value.

252. Required Documentation — An insurance company or the sponsor of a bond mutual fund requests an SVO evaluation that a bond mutual fund is eligible for inclusion on the Bond Mutual Fund List by submitting the following documentation to the SVO:

- The bond fund application form.
- Authorization letter requesting review of the fund for the purpose of inclusion on the Bond Mutual Fund List.
- The most recent fund:
  - Prospectus;
  - Statement of Additional Information (SAI); and
  - Annual, and if available, the semi-annual report.
- Rating letter from an NAIC CRP dated in the year of the filing.

253. Eligibility Criteria — A bond mutual fund is eligible for inclusion on the Bond List if the fund meets the following conditions:

- The fund shall maintain the highest credit quality rating given by an NAIC CRP.
- The fund shall maintain at least the highest market risk rating given by an NAIC CRP to a fund that invests in class 1 bonds that are issued or guaranteed as to payment of principal and interest by agencies and instrumentalities of the U.S. Government, including loan-backed bonds and collateralized mortgage obligations, and collateralized repurchase agreements comprised of those obligations.
- The fund shall allow a maximum of seven-day redemption of proceeds.
- The fund shall invest 100% of its total assets in the U.S. Government securities listed in the section below, class 1 bonds that are issued or guaranteed as to payment of principal and interest by agencies and instrumentalities of the U.S. Government, including loan-backed bonds and collateralized mortgage obligations, and collateralized repurchase agreements comprised of those obligations at all times.
- The fund shall declare a dividend of its net investment income each day prior to calculating its net asset value per share.
- The fund shall not invest in any derivative instruments, as that term is defined in the NAIC Accounting Practices and Procedures Manual.
- The fund shall not invest in any bonds that receive some or all of the interest portion of the underlying collateral and little or no principal, or in any bonds with coupons which reset periodically based on an index and which vary inversely with changes in the index.
- The fund shall not invest in the following types of securities: (a) leveraged or deleveraged notes that pay a multiple or fraction of an index or indices; (b) notes that pay principal or interest linked to foreign currencies, non-U.S. dollar interest rates, equity or commodities indices or any other index that is not composed of U.S. dollar denominated fixed-income instruments; or (c) notes that pay principal or interest linked to more than one index.
Verification Procedure—Upon receipt of the documentation, the SVO examines the prospectus, schedule of fund portfolio holdings and related materials to verify that the fund meets the established criteria.

...
The Valuation of Securities (E) Task Force met via conference call May 14, 2020. The following Task Force members participated: Robert H. Muriel, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi (CT); David Altmaier represented by Ray Spudeck (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by John Turchi (MA); Al Redmer Jr. represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Bruce R. Ramge represented by Lindsay Crawford (NE); Marlene Caride represented by John Sirovetz (NJ); Linda A. Lacewell represented by Jim Everett (NY); Jessica K. Altman represented by Randy Milquet (WI).

1. **Adopted its Feb. 4, 2020, and 2019 Fall National Meeting Minutes**

Mr. Fry said the Task Force met Feb. 4, 2020, and Dec. 8, 2019. During its Feb. 4, 2020, meeting, the Task Force took the following action: 1) discussed amendments to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to: a) remove the financial modeling instructions for residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS); and b) clarify that the sovereign rating limitation applies to filing exemption (FE); 2) received an updated amendment to the P&P Manual for the definition and instructions for principal protected notes (PPNs); and 3) adopted an amendment to reflect the U.S. Securities and Exchange Commission’s (SEC) adoption of a new rule to modernize the regulation of exchange-traded funds (ETFs).

Mr. Thomas made a motion, seconded by Ms. Clements, to adopt the Task Force’s Feb. 4, 2020 (Attachment Two-A) and Dec. 8, 2019 (see *NAIC Proceedings – Fall 2019, Valuation of Securities (E) Task Force*) minutes. The motion passed unanimously.

2. **Adopted a Revised P&P Manual Amendment to Map Financial Modeled RMBS/CMBS Designations to NAIC Designation Categories**

Mr. Fry said the next item is to discuss the amendment to map the financially modeled RMBS/CMBS securities to NAIC designation categories. This amendment was received at the 2019 Fall National Meeting, and its purpose is for year-end 2020 to have an electronic-only column that will capture the 20 new NAIC designation categories. The existing NAIC designation 1 through designation 6 will still apply for RBC, but the NAIC designation categories will be captured to study that data. This amendment will map into that electronic-only NAIC designation category column.

Comments were received from the industry about mapping zero loss securities, and in talking with NAIC staff, the mapping was made to the midpoint of the NAIC designation category. NAIC staff agreed that, with zero loss securities, it may make sense to consider mapping them to the NAIC 1.A designation, which is the strongest result through the modeling process where there are no losses through the most extreme scenarios. The Task Force did look at the policy issue of whether it should continue to use price break points in the future, and it talked about using a single NAIC designation, as was done in the past before modeling. The Task Force received comments from different stakeholders that it was not the direction that many wanted to go; that option is not being considered at this time.

Josh Bean (Transamerica Capital Strategy), representing the American Council of Life Insurers (ACLI), said the ACLI and the North American Securities Valuation Association (NASVA) joint comment letter expressed support for the proposal but did request the maintenance of the standard for mapping RMBS and CMBS tranches that have no expected loss under any of the modeling scenarios to the highest grade of NAIC designation categories.

Steve Broadie (American Property Casualty Insurance Association—APCIA) said he also supports the amendment, as revised.
Mr. Kozak made a motion, seconded by Ms. Crawford, to adopt the revised P&P Manual amendment to map financially modeled NAIC designations for RMBS/CMBS to NAIC designation categories, including mapping the zero-loss bonds to the NAIC 1.A designation category (Attachment Two-B). The motion passed unanimously.

3. Adopted a P&P Manual Amendment for PPNs with an Updated Definition and Instructions

Mr. Fry said this agenda item is to consider adoption of the updated amendment defining principal protected securities. The Task Force began discussing this agenda item at the 2019 Summer National Meeting. NAIC staff identified certain classes of securities where the credit ratings did not reflect a state insurance regulator’s view of risk. NAIC staff recommended that those securities no longer be eligible for FE and should be filed with the NAIC Securities Valuation Office (SVO). The Task Force asked NAIC staff to work with the industry and other interested parties on the definition to create language that would not create any unintended consequences but still achieve the objective of the Task Force.

Charles Therriault (NAIC) said, as mentioned, NAIC Investment Analysis Office (IAO) staff met with the industry many times to exchange ideas on this proposal and hear each other’s concerns on the definition of principal protected securities. The updated definition in this amendment, which was previously exposed, is the culmination of those discussions and provides an excellent outline of the regulatory and analytical issues presented by these securities. The framework identifies principal protected securities (PPS) as a type of security that repackages one or more underlying investments for which contractually promised payments according to a fixed schedule (principal and, if applicable, interest, make whole payments and fees) are satisfied by proceeds from an underlying bond(s) and that if purchased by an insurance company on a stand-alone basis would be eligible for FE, but for which the repackaged security structure enables potential returns from other underlying investments. Also, the insurer would obtain a more favorable risk-based capital (RBC) charge or regulatory treatment for the PPS through FE than it would were it to separately file the underlying investments. Investments meeting these criteria will need to be filed with the SVO to determine if the security possesses other non-payment risks, something that only the SVO can assess under its Subscript S authority. There were a few noted exclusions, such as defeased or pre-refunded securities, and broadly syndicated securitizations.

Mr. Therriault said NAIC staff believe this criteria, which was discussed exhaustively with interested parties, hit upon the core issue: restructuring an investment to receive a more favorable RBC charge without a commensurate change to the risk profile. The SVO would also have adequate analytical discretion necessary to make those determinations. At the industry’s request, included in the definition are examples of these transactions. The goal of adding the examples was to provide additional clarity as to the regulatory concern. However, the examples are only meant to be examples and do not reflect all possible variants. The current stressed credit markets only reinforce how critically important it is to accurately reflect the investment risk. He said IAO staff recommend that the Task Force adopt this amendment but consider an adequate time for insurers to transition to this new requirement.

Mr. Fry said one message that is clear is that if the Task Force were to adopt this amendment and make these securities ineligible for FE, there is still a route to assign an NAIC designation. The NAIC designation might be different, but it is likely that most of these could be assigned an NAIC designation. One thing for the Task Force to consider is how it will implement this change and give time to those insurers that have exposure to these investments. An effective implementation date of Jan. 1, 2021, would mean that for year-end 2020, there would not be an RBC impact and give insurers time in year 2021. There should be a date by which they should be filed with the SVO in 2021 to give the SVO time to review them, if the Task Force took that approach instead of an immediate adoption.

Ms. Belfi, Mr. Thomas, Mr. Sirovetz, Mr. Milquet, Ms. Becker and Ms. Mears all agreed to extend the effective date for the amendment to Jan. 1, 2021, with a mid-year 2021 filing deadline.

Mr. Fry said there were three comment letters. One was from Connie Jasper Woodroof (Sapiens), which requested the amendment title be changed from “principal protected notes” to avoid confusion with the abbreviation “PPN,” which has another meaning. These securities could instead be called “principal protected securities.”

Mr. Bean said the joint ACLI and NASVA comment letter supports the adoption of the scope guidance and also supports the discussion by the members of the Task Force on the effective date. The comment letter did request some continuing engagement by the IAO as this advances into the implementation phase with an illustrated walkthrough of the weighted average rating factor (WARF) methodology specially using a transaction type example that was provided in the proposed amendment and some additional discussion around the new administrative filing process.
John Guyot (Security Benefit Life Insurance Company) said there were no additional comments other than what was provide in their comment letter and that he appreciates the direction in delaying the implementation effective date.

Mr. Milquet asked what the procedure would be for securities purchased after the Jan. 1, 2021, implementation effective date. Mr. Therriault said it would only be the securities acquired prior to the Jan. 1, 2021, implementation effective date that would need to be filed by the suggested July 1, 2021, deadline and any PPS acquired after the implementation effective date would follow the existing filing deadline instructions.

Ms. Belfi made a motion, seconded by Mr. Sirovetz, to adopt the proposed P&P Manual amendment, with the title and text revised to call them principal protected securities (PPS), removing these securities from FE eligibility and requiring all PPS, including those currently designated under the FE process, to be submitted to the SVO for review under the Subscript S authority beginning Jan. 1, 2021, and filed with the SVO by July 1, 2021, if previously owned (Attachment Two-C). The motion passed unanimously.

4. Received and Exposed an IAO Issue Paper on NAIC Staff Concerns about Bespoke Securities and Reliance on CRP Ratings

Mr. Fry said item four on the agenda is to receive an IAO issue paper on bespoke securities and reliance on credit ratings provider (CRP) ratings. This item was discussed at the 2019 Summer National Meeting, where the Task Force began talking about this concept of certain securities that were not broadly marketed and with one rating or a private rating. The Task Force has tried to develop a process for state insurance regulators to better understand these risks and, after hearing that report, directed NAIC staff to work on recommendations along those lines.

Mr. Therriault said NAIC staff have been raising their concerns about bespoke securities and the excessive reliance upon rating agency ratings to the Task Force for some time. The paper mentions the discussion that occurred during the Task Force’s May 2019 educational seminar, but these concerns go back much further. During the 2019 Summer National Meeting, the Task Force requested NAIC staff to summarize these concerns and make recommendations to remediate them in an issue paper, which was done with this memorandum. Two primary but interrelated concerns were identified:

a) Bespoke securities: These are securities that are not broadly syndicated, created for one or a few investors, and assigned a rating—often private—by only one ratings provider, and the participants often deliberately keep the terms of structure private.

b) Reliance on CRP ratings: The Task Force uses ratings to determine NAIC designations under the FE policy, which includes recognizing private ratings, but there is no explicit oversight assigned to the NAIC staff to monitor CRP rating use or their analytical basis despite this extensive reliance.

As requested by the Task Force, NAIC staff have made several recommendations in this issue paper that they believe will remediate many of these issues. In preparing these recommendations, NAIC staff also considered the recommendations made in response to the 2008 Great Recession by the Ratings Agency (E) Working Group in its memorandum, dated April 28, 2010, to the Financial Condition (E) Committee. Those recommendations were subsequently adopted by that Committee and the NAIC membership. A few of the Ratings Agency (E) Working Group’s recommendations are included in the issue paper, and its full report to the Financial Condition (E) Committee is included as an attachment to the issue paper. Many of the recommendations by the Working Group are consistent with the recommendations in this issue paper, including:

a) Explore how to reduce reliance on ratings.

b) Consider alternatives to assess insurers’ investment risk, including expanding the role of and state insurance regulator reliance on the SVO.

c) When considering continuing to use ratings in insurance regulation, take into account steps taken to correct the prior ratings shortfalls.

d) Establish a process to monitor and evaluate rating agency activities, including permitting timely intervention to set regulatory treatment of risk securities.

e) Modify the FE rule, including developing alternative methodologies for assessing structured security risks.

Mr. Therriault said these recommendations were approved by the Financial Condition (E) Committee in 2010, but they were not fully implemented, and many are being recommended again in this issue paper, as they are still relevant today. The IAO staff recommend that the issue paper be exposed for a lengthy comment period. There are no actionable items in the issue paper, but
the Task Force is requested to authorize the SVO to begin developing proposals to remediate these long-standing issues identified in the issue paper and by the Ratings Agency (E) Working Group.

Mr. Fry said he believes a long exposure period would be appropriate. The Task Force is not looking to make changes in the middle of this current financial situation and is aware of work going on with other groups. It is important to expose this and continue the discussion. He said he recalls the work in 2010 of the Ratings Agency (E) Working Group. That report did not say the Task Force would not use ratings; it said the Task Force should not blindly rely on ratings. In certain situations, RMBS and CMBS, the Task Force no longer uses ratings and models those securities. There was a similar decision today with PPS. The purpose of this paper is to identify areas where ratings are not working for regulatory purposes, and the Task Force encourages the SVO to make incremental recommendations to address these situations.

Mike Reis (Northwestern Mutual), representing the ACLI, said the ACLI supports a long exposure due to the COVID-19 pandemic and what it is doing to the ACLI’s capability to address these issues. He also said he thinks there is overlap with what is occurring at the Statutory Accounting Principles (E) Working Group.

Mr. Everett made a motion, seconded by Mr. Guerin, to expose the issue paper for a 90-day public comment period ending Aug. 16 and to begin drafting incremental recommendations for the Task Force to consider addressing these risks. The motion passed unanimously.

5. Received and Exposed a Proposed P&P Manual Amendment with Updated Instructions for Nonconforming CTL Transactions that Relied on Credit Ratings

Mr. Fry said the next item relates to P&P Manual instructions for nonconforming credit tenant loan (CTL) transactions. All CTL transactions need to be filed and designated by the SVO, rating agency ratings cannot be used, and CTLs are not eligible for FE. There is a set of securities that do not meet the criteria for CTL but have been rated by rating agencies. The industry made the assumption that these transactions were eligible for FE, which the Task Force has now said they are not. In 2019, the Task Force agreed to try to find a solution for these securities and not take any immediate action. Part of this was worked out for some of these nonconforming CTLs with the recent adoption of guidance for ground lease financing transactions.

Mr. Fry said Marc Perlman (NAIC) will summarize this amendment to address this additional group of securities.

Mr. Perlman said the Task Force and NAIC staff heard from the industry on a few occasions that they are very concerned about this population of securities that have the basic legal and structural characteristics of a CTL but have a variation or deviation that does not conform to the existing guidance. Included with this CTL amendment, there is an update to the Task Force policy on “The Use of Credit Ratings of NRSROs in NAIC Processes.”

The policy currently states, “The sole NAIC objective in obtaining and using publicly available credit ratings is to conserve limited regulatory resources; e.g., the resources of the SVO.” The policy then clarifies that in its use of CRP ratings, the NAIC is not “endorsing the credit rating or analytical product of any CRP.” Nothing about the policies related to the use of CRP ratings should be interpreted, as was seemingly the case with the nonconforming CTLs and certain other investments, that the Task Force has approved the use of CRP ratings for the determination of NAIC designations or for any other purpose, other than conserving SVO staff resources. The updates to this policy guidance affirm the Task Force’s role in making all decisions on the use of CRP ratings and provides additional guidance to insurance company filers on what to do if they are uncertain about the filing procedure to avoid this situation in the future.

The SVO further recommends a “grandfathering” provision for previously owned nonconforming CTLs by filing them with the SVO for assessment. It will also authorize the SVO to use its judgement in assessing eligibility and assignment of an NAIC designation. SVO staff recommend exposing this amendment and simultaneously referring it to the Statutory Accounting Principles (E) Working Group requesting it to affirm that it would consider these nonconforming CTLs to have the characteristics of a bond if assigned an NAIC designation by the SVO staff.

Mr. Everett asked if SVO staff know how far back these deals go and what the documentation is going to entail. Mr. Therriault said they do go back some time and expects that documentation will be available. The SVO would be looking for the transaction legal agreements and the rating agency analysis and expects that the industry will still have those documents for investments they own.
Mr. Reis said there is a meaningful number of these securities that currently do not have a home and need to be addressed. He said the ACLI appreciates this issue being brought forward along with the referral to Statutory Accounting Principles (E) Working Group.

John Garrison (Lease-Backed Securities Working Group) said the Lease-Backed Securities Working Group has been working with the SVO over the past few years on several types of securities not explicitly covered in the P&P Manual, such as ground lease financing transactions and other lease-based securities that do not meet the P&P Manual’s definition of a CTL. The group is committed to working closely with the SVO, the Task Force, the Private Placement Investors Association (PPIA), the ACLI, NASVA and other key parties to develop clear and consistent guidelines for all real estate and lease-backed securities. Mr. Garrison said the collective goal should be to avoid using terms such as “nonconforming CTLs,” which may create confusion and complexity to investors, state insurance regulators and the industry alike.

In December 2019, the Task Force adopted guidance for ground lease financing transactions, and Mr. Fry complimented this work as “the best of what the Task Force does when it works with the industry,” noting that the SVO worked closely with the industry to come to a solution. It was also noted at that meeting that the Task Force will need to do additional work to determine a solution for these other types of lease-backed securities that do not meet the strict definitions of either CTLs or ground lease financing (GLF) transactions. The framework for GLF transactions could be used for this effort. The first few months of this year have been devoted to filing the new GLF transactions through the Regulatory Treatment Analysis Service (RTAS) process, and these efforts have resulted in appropriate outcomes and facilitated ongoing refinements to the submission process.

Mr. Fry said the April 30 memorandum from the SVO notes that “nonconforming CTL transactions acquired by insurers after Dec. 31, 2019, shall not be reported as bonds,” and the Lease-Backed Securities Working Group believes this guidance would be a mistake. He thanked Mr. Garrison for his comments. Mr. Fry said this was just an exposure and that the Task Force would strive for a solution by the end of the year.

Ms. Thomas made a motion, seconded by Ms. Rankin, to expose the proposed P&P Manual amendment updating the Task Force policy on “The Use of Credit Ratings of NRSROs in NAIC Processes” and instructions for nonconforming CTL transactions that relied upon credit ratings for a 30-day public comment period ending June 17 and send a referral to the Statutory Accounting Principles (E) Working Group.

6. Received and Exposed a Proposed P&P Manual Amendment for Technical NAIC Designation Category Corrections

Mr. Fry said the agenda item is to receive an amendment for technical NAIC designation category corrections. This agenda item is similar to what the Task Force did earlier when preparing to create an electronic-only column that will have 20 designations, and there were some decisions that had to be made with where on the scale does the 1 fall—1.A or 1.F. A few recommendations have been made about this exposure for some securities to receive a 1.A, which is the strongest of the seven categories of an NAIC 1. There are also recommendations for the 5 GI process to set them to a 5.B GI. This guidance needs to be updated in the P&P Manual.

Mr. Everett said in the RBC instructions, there are no lines for these. He asked what the use of the designation would be here.

Mr. Therriault said every security on schedule D requires an NAIC designation and an accompanying NAIC designation category. This is a technical correction to give reporting instructions for NAIC designations assigned by policy to also have an NAIC designation category.

Mr. Everett asked if any of these anticipated changes or identified securities might be adjusted for more than an administrative adjustment.

Mr. Therriault said the recommendations in the amendment were for NAIC designations set by policy, such as the 5GI being set to 5.B GI, in NAIC staff’s recommendation, to accommodate the NAIC designation category using the midpoint NAIC designation modifier, in this instance.

Nancy Bennett (American Academy of Actuaries—Academy) said the exposure appears to be putting U.S. government Treasury securities in category 1.A, which means that those types of securities will get an RBC factor assigned to them. She said U.S. Treasury securities have always gotten a zero RBC and asked if that was intentional or a mistake.
Mr. Therriault said this amendment is for a production of an NAIC designation, and there are separate instructions for RBC purposes.

Ms. Bennett suggested that what is being proposed looks different from what was adopted a couple of weeks ago.

Mr. Fry said he believes there is a category that is different from a 1.A for RBC reporting, but that can be sorted out in the exposure period.

Chris Anderson (Anderson Insights LLC) said there are seven designations—zero through six. He said if the full faith and credit Treasury is listed in the P&P Manual and picks up an NAIC 1, it will pick up an RBC factor. In order to avoid that, it will have to be zero. If an NAIC 1 is assigned to these exempt securities, they will pick up RBC factors in the calculations.

Mr. Therriault said the text in the amendment is an existing instruction in the P&P Manual to assign these securities an NAIC designation by policy. The only new instruction in this amendment is the addition of the NAIC designation category; all the other declarations for NAIC designation treatment by policy remain the same.

Julie Gann (NAIC) said NAIC staff have been working with RBC staff regarding the mapping. The additional category that separated out these securities would be 1.A for reporting and would be divided in the RBC calculations. Ms. Gann said she would work with the RBC team to make sure that is clear and, if need be, to revise the RBC guidance during the exposure period.

John Dubois (MassMutual) said for an extension of this, it will also need to apply to the asset valuation reserve (AVR), as well as RBC. He said the exempt are also getting a zero factor for AVR.

Mr. Anderson said while this is an update of the language that is in the P&P, as it exists today, it does not provide for zero factor.

Karla Streeter (MetLife) said at the last NASVA meeting in March, the need to include an NAIC designation category grid for short-term securities in the P&P Manual was discussed with Mr. Therriault. The long-term securities have the NAIC designation modifier, but there is not one for the short-term investments. She said insurance companies need those because it is required for the schedules at year-end.

Mr. Therriault said he had asked NASVA to bring it up so the Task Force can consider adding those to the P&P Manual grid. He said a separate amendment to address this can be drafted.

Mr. Milquet made a motion, second by Mr. Sirovetz, to receive the proposed P&P Manual amendment for technical NAIC designation category corrections and expose it for a 30-day public comment period ending June 17.

7. Heard a Report from the SSG on RMBS and CMBS

Mr. Fry said the next item on the agenda is to hear a report from Eric Kolchinsky (NAIC) on RMBS and CMBS.

Mr. Kolchinsky said that as a result of the fallout from COVID-19, as well as the various shutdowns and disruptions in business activities, there has been a number of questions on how the NAIC Structured Securities Group (SSG) will respond with year-end modeling, given these developments. The first way this can be addressed is through the economic scenarios. Starting in 2016, interested parties requested that the NAIC to explore “through the cycle” (TTC) modeling, meaning the models for real estate would not change depending upon what part of the cycle you were in. The current models are pro-cyclical (depend upon what part of the cycle you are in). As year-end approaches, there is a good chance that there will be downward economic scenarios that may not be the best alternative.

Mr. Kolchinsky said NAIC staff was, and continues to be, supportive of TTC modeling. A set of RMBS TTC economic scenario models was exposed in 2017, including R code, that could be used to generate those scenarios. However, due to time constraints, corresponding CMBS scenarios were never developed. Developing these TTC models is within the Task Force’s discretion. Mr. Kolchinsky said if this is something that the Task Force would like the SSG to pursue, the TTC models can be re-exposed, and the SSG can begin working on a CMBS TTC model.
Mr. Kolchinsky said the SSG has also been asked to consider adjustments for collateral. In many cases, there is an increase in forbearances in mortgages. It is difficult to determine how much is going through the system because of the lag in reporting on the residential and commercial loan side. Lodging, retail and office space seem to have been affected the greatest in the medium-to-long term. SSG staff believe that considering that our analysis will take place at year-end, it is too early to make these decisions. With the benefit of time, a better understanding of the permanence of the effects of the COVID-19 non-payments will emerge. He said the SSG would like guidance from the Task Force on the development of the TTC models.

Mr. Kolchinsky said SSG staff will come back to the Task Force with any recommendation on collateral adjustments and hope to produce mid-year analysis this year, most likely in early fall.

Mr. Fry said the Task Force has looked at the TTC models before, but they received a lukewarm reception by the industry. Given the current environment, he said the Task Force would appreciate feedback on these models.

8. Temporarily Extended Insurers’ 2020 Initial Filing Deadline from 120 Days to 165 Days for Newly Acquired or Securities in Transition

Mr. Fry said the next item to discuss is to temporarily extend the 2020 initial filing deadline from 120 days to 165 days for newly acquired or in-transition securities. NAIC staff recommended this because of the challenges of working from home due to COVID-19.

Tracey Lindsey (Nationwide), representing NASVA, and Michael Monahan (ACLI) said they appreciate and fully support the initial filing extension for this year, as there will likely be additional work filing material credit events and providing additional information on annual updates.

Mr. Fry asked if there were any objections to this filing deadline extension by the Task Force members, and no members objected. Mr. Fry directed NAIC staff to include in the minutes that the filing deadline for the initial filing of newly acquired or in-transition securities in 2020 would be 165-days instead of the usual 120-days.

9. Heard an NAIC Staff Report on Rating Agency Actions YTD

Michele Wong (NAIC) said the global economic impact of the COVID-19 pandemic and the sharp decline in oil prices have contributed to significant pressure on credit quality. Many companies are experiencing a decline of revenue and cash flow. Rating agencies have taken a record number of negative rating actions. The credit impact has been broad-based, touching all sectors. The sectors experiencing the most rating actions are autos, transportation, travel and leisure, hotel and gaming, media and entertainment, retail and restaurants, and oil and gas. Highly leveraged companies account for the majority of rating action, as they tend to have weaker liquidity and refinancing profiles.

Moody’s took approximately 1,200 rating actions in March and April, with approximately half resulting in downgrades. About 18% of Moody’s global corporate rated universe, with 90% of that high yield and 10% investment grade. Moody’s downgraded 23% of high yield companies, but only about 6% of investment grade companies. About one-third of Moody’s rated portfolio has a negative bias reflecting the high level of uncertainty surrounding the end of the health crisis and the speed and shape of economic recovery. At the end of April, about 8% of companies across all rating categories were on review for downgrade, and 27% carried a negative outlook. Fallen angels are issuers that have been downgraded from investment grade to high yield. Moody’s had 27 fallen angels. Oil, gas, auto and retail sectors account for 85% of that “fallen angel” debt. The number of potential fallen angels, or issuers that are currently rated and either under review for downgrade or have a negative outlook, has increased to 75 issuers from about 35 at the beginning of 2020.

Standard & Poor’s (S&P) took almost 1,700 rating actions as of May 8 with almost half resulting in downgrades, 10% credit watch negative placement and the rest negative outlook revisions. S&P downgrades represented 18% of rated issuer universe, and 4.5% of rated issuers were downgraded more than one notch. High-yield issuers represented about 70% of S&P’s rating actions, with 60% of them at the single-B and below ratings level. More than two-thirds of issuers in the auto, oil and gas, retail, and leisure sectors are on CreditWatch negative or have a negative outlook, so further downgrades are possible. At S&P, fallen angels totaled 23 as of mid-April. The midstream energy, oil and gas, autos, and retail and restaurants sectors have had the largest number of fallen angels.

Ms. Wong said this information is being shared with members of the Task Force in a “Rating Agency Newsletter.”
Mr. Kolchinsky responded that this information is publicly available to subscribers to those rating agency services but that the NAIC is not permitted to share that information with outside parties.

10. Heard an NAIC Staff Report on Requirements for Material Credit Events and Issuer Amendments or Refinancing an Existing Issue

Linda Phelps (NAIC) said business disruptions related to COVID-19 are obviously affecting many of the companies that insurers have invested in. The SVO would like to remind insurers to remain vigilant in their surveillance activities and remember to promptly file material change statements with the SVO. An insurance company is obligated to report any “material change” of an investment that could affect the assessment of credit quality. Guidance on what is considered a “change in credit characteristics” or a “material change” can be found in the P&P Manual and can include the following:

- Any material changes in business or financial characteristics.
- A bankruptcy, insolvency or court-ordered reorganization.
- A payment default or an uncured and unaunched covenant default.
- A workout or restructuring resulting in modification of terms (e.g., interest rate, extension of the time for the payment of any amount due).
- A determination that an issue is impaired.

Material change filings are the responsibility of all holders of the investment, not just the lead lender.

- Filing should include any relevant business or financial information and/or legal documentation relating to loan modification or forbearance activity.

For 2020 filings, the SVO’s overall measured and thoughtful approach to assessing credit quality has not changed and is in line with the approach taken by many rating agencies.

- Continue to consider the business and financial positions of the companies.
- Look at both historical financial information along with more recent performance based on information provided by filers and publicly available sources.
- Liquidity will be an important consideration.
- The impact to designations as a result of COVID-19 disruptions will vary by industry and for individual participants. The SVO anticipates outcomes will range from no change at all to multi-notch downgrades to defaults.
- The impact of business disruptions is expected to be greater for speculative grade companies as compared to better positioned investment grade companies.

The SVO expects the evaluation of credit risk to be a fluid process throughout the year, given the many unknowns at this point. While the SVO does not typically receive many material change filings, they will be important this year, and the SVO encourages insurers to file them promptly.

11. Heard an NAIC Staff Report on the Year-End Process and Carry-Over

Mr. Therriault said as of Dec. 31, 2019, the SVO had completed 11,060 filings for the year and had a total backlog of 869 security filings. This security filings backlog was down 241 filings versus the Dec. 31, 2018, backlog of 1,110 security filings. This was the first year-end using the carry-over administrative symbols. There were 354 year-end (symbol “YE”), carry-over filings that had their previous NAIC designation extended over year-end. There were 514 initial-filing (symbol “IF”) carry-over filings that permitted self-reporting of an NAIC designation, reflecting that it was properly filed with the SVO. There was only one filing that the SVO was unable to accept for year-end carry-over processing. As of April 30, 2020, there were only six remaining filings from the prior filing year. From the SVO perspective, the 2019 backlog was manageable, and the new carry-over administrative process worked as expected.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
The Valuation of Securities (E) Task Force met via conference call February 4, 2020. The following Task Force members participated: Robert H. Muriel, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi (CT); David Altmaier represented by Ray Spudeck (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary Anderson represented by John Turchi (MA); Al Redmer Jr. represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Bruce R. Ramge represented by Lindsay Crawford (NE); Marlene Caride represented by Diana Sherman (NJ); Linda A. Lacewell represented by Jim Everett (NY); Jessica K. Altman represented by Kimberly Rankin (PA); Kent Sullivan represented by Jamie Walker (TX); Todd E. Kiser represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA).

1. **Discussed a Proposed P&P Manual Amendment to Remove the Financial Modeling Instruction for RMBS/CMBS Securities and Direct IAO Staff to Produce NAIC Designations and NAIC Designation Categories for these Securities**

Mr. Fry said the first item on the agenda is to discuss the amendment to remove financial modeling instructions for residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) securities. This proposed amendment to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) was received at the 2019 Fall National Meeting, where NAIC staff recommended moving to a single NAIC designation and NAIC designation category for the modeled assessment of credit risk for RMBS/CMBS to simplify NAIC and insurer operational processes, along with improving uniformity.

The Task Force has discussed moving away from price-break points and towards determining a single NAIC designation. There have been some concerns expressed by industry that there will be significant adverse risk-based capital (RBC) consequences from making such a change now.

Mr. Fry said he has also had discussion with the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) staff, and they believe that they could produce a mapping process between the NAIC designations based on the current price-break points and the NAIC designation categories until new RBC factors are adopted. Once those new RBC factors are adopted, additional price-break points would be needed. This does not prevent the Task Force from possibly eliminating price-break points in the future, but it should eliminate these immediate concerns.

Mr. Fry said that if Task Force members do not object, SVO staff are directed to draft a new proposed P&P Manual amendment mapping the current NAIC designations derived from price-break points to an NAIC designation category and to expose that proposed amendment for a 30-day public comment period. There were no objections.

2. **Discussed a Proposed P&P Manual Amendment to Clarify That the Sovereign Rating Limitation Applies to FE**

Mr. Fry said the next item is to discuss a proposed P&P Manual amendment to clarify that the sovereign rating limitation applies to filing exemption (FE). He said this amendment was exposed during the Task Force’s Oct. 31, 2019, conference call. This change was proposed because the current limitation could be interpreted to mean that only NAIC designations assigned by the SVO (as opposed to those produced through the FE process) are capped at the NAIC Foreign Sovereign Designation Equivalent List. The amendment addressed that potential interpretation inconsistency by clarifying that all NAIC designations for foreign securities will be capped according to the NAIC Foreign Sovereign Designation Equivalent List published on the SVO’s web page.

Mr. Fry said the industry has expressed to him that there can be legitimate reasons why a rating should be allowed to be higher than the sovereign rating and that limiting it may negatively affect them. The SVO mentioned that the methodologies permitting sovereign rating exceptions can vary greatly.
Mr. Fry asked Charles Therriault (NAIC) if SVO staff could look at developing criteria for an acceptable sovereign rating exception methodology. Mr. Therriault said the SVO staff could review sovereign rating exception methodologies and propose an updated P&P Manual amendment. A few of the possible criteria could include: 1) assets of the issuer located outside of the domicile of the issuer; 2) collateral or other structural protections; 3) lockbox and escrow payment provisions; and 4) parent company or ownership interests of the issuer located outside of the domicile of the issuer.

John Petchler (Conning), representing the Private Placement Investors Association (PPIA), thanked the Task Force for listening to the PPIA’s comments and said they look forward to working constructively on this issue.

Eric Hovey (Payden & Rygel) said they appreciate the opportunity to comment on this issue and that they also look forward to working with the SVO.

Mr. Fry directed SVO staff to work on updating the proposed P&P Manual amendment.

3. Exposed a Revised P&P Manual Amendment to Update the Definition and Instructions for PPNs

Mr. Fry said this agenda item was discussed at the 2019 Summer National Meeting, where the Task Force’s observation was that certain classes of structured securities received ratings that may not reflect a state insurance regulator’s view of the risk. A proposed P&P Manual amendment was exposed that would effectively take securities that were defined as principal protected notes (PPNs) out of the FE space, and they would need to be filed with the SVO. Comments were received on that proposal, and it became clear that the scope of the definition would need to be refined to cover just this class of securities. The Task Force directed the SVO staff to work with the American Council of Life Insurers (ACLI) and others to develop this refined definition of a PPNs. Mr. Fry asked Mr. Therriault to review that update.

Mr. Therriault said there were many conversations with the industry working group along with multiple versions of the definition. The resulting product in this updated amendment reflects that collaboration. The amendment needed to be expanded beyond just a simple definition and into a full new section of the P&P Manual. The definition framework described at the 2019 Fall National Meeting is still consistent. The identifying characteristics of a PPN is a type of security that repackages one or more underlying investments and for which contractually promised payments according to a fixed schedule (principal and, if applicable, interest, make whole payments and fees thereon) are satisfied by proceeds from an underlying bond(s) that, if purchased by an insurance company on a stand-alone basis, would be eligible for FE, but for which the repackaged security structure enables potential returns from the underlying investments in addition to the contractually promised cash flows paid to such repackaged security according to a fixed schedule; or the contractual interest rate paid by the PPN is zero, below market or, in any case, equal to or below the comparable risk-free rate. Given those two provisions, the insurer would also obtain a more favorable RBC charge or regulatory treatment for the PPN through FE than it would were it to separately file the underlying investments in accordance with the policies in the P&P Manual.

Mr. Therriault said this criteria really focuses on the core regulatory issue and identifies these other non-payment risks. Assessing the other non-payment risk aspects, which the SVO believes these securities possess, is a function uniquely assigned to the SVO for evaluation under its Subscript S identification authority. The restructuring an investment to receive a more favorable RBC treatment is really the core issue. Industry requested that examples be include in the definition. Some have been added, but they do not encompass all variants. Mr. Therriault recommended exposing this proposed update for a 30-day public comment period.

Ms. Becker said she would like more information on the proposed timeline for this. If exposed today for a 30-day public comment period, she asked how the Task Force would anticipate it will move forward from that point. Mr. Fry explained that the Task Force process of exposing for 30 days would permit the Task Force to review all the comment letters and then consider the proposed amendment at the Spring National Meeting.

Josh Bean (Aegon), representing the ACLI, said that the ACLI supports the exposure and that it was difficult to come up with a mosaic that captures all potential items in the definition. By working together and not letting perfect get in the way of the good, an appropriate level of guidance was able to be drafted and support this exposure.

Michelle Werner (American International Group—AIG) said she participated on drafting the proposed definition. She said it was a great coordinated team approach and resulted in a definition that provides more clarity around the specific structure that the SVO was concerned about. This would permit the SVO to review these investments and allow for further evaluation of them. She asked about having an opportunity to collaborate with them on a methodology that ensures the risks, structures and
the cash flow are appropriately analyzed. The goal is to achieve the least amount of market disruption as possible by working together to develop a meaningful methodology that clearly addresses the risk. She said she was concerned that the wrong methodology could make these investments prohibitively expensive and, therefore, uneconomical if the risk factors as identified by the SVO are not analyzed with the appropriate methodology.

Mr. Fry said it is worth pointing out that these securities will still likely be classified as bonds even after the SVO review. The methodology may lower the designation, but the securities is not be removed from schedule D. As far as looking at the methodology, Mr. Fry asked Mr. Therriault to comment.

Mr. Therriault said that, in looking at the P&P Manual, there is little, if any, prescriptive or formulaic methodologies, as being requested, for any of the SVO’s analytic work. It is intentional that the Task Force has empowered the SVO to have wide analytical discretion on the securities it reviews, and the SVO requests the Task Force continue granting that discretion for these securities too. Analytical discretion is very necessary for the SVO in reviewing these transactions given the wide variety of structures and the nature of these risks.

Mr. Nablach (Security Benefit) said the new definition of PPN explicitly includes scoping in collateralized loan obligation (CLO) combination notes. The inclusion of CLO combination notes may have been influenced by a report published in December 2019 by the NAIC Capital Markets Bureau (CMB) relating to CLOs and stress tests. Security Benefit and other market participants have serious concerns related to the methodology and analytical outcomes of this stress test, specifically, but no limited to:

- The methodology by which defaults are measured.
- The results failed to include post global financial crisis data, including loan losses, as well as structural changes that have been made to CLOs and changes that have been made to the investment guidelines governing the assets of CLOs, which made them a lot more robust prior to the global financial crisis.
- The stress recovery assumptions that were used in the analysis.
- The lack of clarity or insight on how losses on CLO notes were derived.

Mr. Nablach suggested that the Task Force engage an independent expert to conduct, factually and analytically correct, analysis on the asset class. There is good precedence for engaging an independent expert to resolve factual differences, and this independent study is something that should take a fairly limited amount of time and result in the best outcome for the NAIC and industry participants.

Eric Kolchinsky (NAIC) said research was recently published with some of these concerns and that he can discuss any of these points. He said he looks forward to any comment submissions that may occur as part of this process and respond to them in the context of a regulatory perspective versus somebody who is a holder of an equity piece who will analyze them. He said he does not believe there is a need for an independent expert. These combination notes have been looked at for a long time, and this research was merely something that could bolster a case. These securities are not being prohibited; they are merely being looked at in a way that is consistent with other products. Mr. Kolchinsky said he looks forward to receiving the written comments and will prepare a response to them.

Mr. Therriault said his recollection of the research that was done from the Capital Markets Bureau, CLOs as an asset class, was affirmed as performing quite well. It was really the restructuring of CLOs into a CLO combination note, which is a completely different structure, that was actually identified as a problem. He said that the PPN recommendation before the Task Force is on the repackaged investment, the CLO combination note, that is a completely different security from a CLO.

Mr. Kolchinsky said they did find that CLOs, as an asset class, especially where most insurance invested—at the top of the capital structure—were extremely robust. They found that the CLO combination notes, which rely on a large portion of the principal return to the equity or residual portion of CLO, were sensitive to default assumptions, and if things did not go very well, the result is a large loss.

Mr. Fry directed SVO staff to expose this proposed P&P Manual amendment for 30-day public comment period ending March 5.
4. **Adopted a P&P Manual Amendment to Reflect the SEC’s Adoption of a New Rule to Modernize Regulation of ETFs**

Mr. Fry said item four on the agenda is a proposed P&P Manual amendment to reflect the U.S. Securities and Exchange Commission’s (SEC’s) adoption of a new rule to modernize regulation of exchange-traded funds (ETFs). At the 2019 Fall National Meeting, the SVO proposed a nonsubstantive P&P Manual amendment to reflect updates adopted by this. He asked Marc Perlman (NAIC) to give a brief update on this change and the proposed amendment to incorporate this change in the P&P Manual.

Mr. Perlman said the rule became effective Dec. 23, 2019, and, as discussed at the 2019 Fall National Meeting, the rule permit ETFs that satisfy certain conditions to operate without first obtaining an exemptive order from the SEC under the federal Investment Company Act of 1940 (the “Act”). The SEC has stated that the intent of the rule is to modernize the regulatory framework for ETFs by reducing expenses and delays in creating new ETFs, promoting greater consistency, transparency and efficiency for ETFs and facilitating greater competition among ETFs.

Mr. Perlman said ETFs contain certain features that distinguish them from the types of investment companies originally contemplated by the Act and its rules and, therefore, have needed to rely on SEC exemptive orders to operate as investment companies under the Act. The new rule will end the need for most exemptive relief. Additionally, the rule permits ETFs to use “custom baskets,” which do not reflect a pro rata representation or representative sampling of the ETF’s portfolio holdings, and the SEC is rescinding current ETF marketing restrictions.

Mr. Perlman said that in order to rely on the new rule, an ETF must satisfy a new definition of ETF and various conditions including: 1) updated website disclosures (such as historical net asset value [NAV], premium and discount, and bid-ask spread information) and adoption of policies and procedures that govern the construction and acceptance of baskets. The new rule will rescind the exemptive orders from existing ETFs, which will be able to rely on the rule going forward. However, certain categories of ETF will not be covered by the rule.

Mr. Perlman said the SVO takes the position that since the new rule primarily affects SEC exemptive relief and ETF reporting and disclosure, it will not affect the quantitative and qualitative factors the SVO considers when analyzing ETFs. As such, the SVO recommends nonsubstantive P&P Manual amendments to remove references to SEC exemptive orders from descriptions of ETFs and clarification that Regulatory Treatment Analysis Service (RTAS) application filers only need to provide SEC exemptive orders to the SVO to the extent they are applicable.

Mr. Bean said the ACLI does not have any concerns with these updates to align the P&P Manual terminology with SEC guidance.

Mr. Thomas made a motion, seconded by Ms. Cross, to adopt the P&P Manual amendment to remove references to SEC exemptive orders from descriptions of ETFs and clarification that Regulatory Treatment Analysis Service (or RTAS) application filers only need to provide SEC exemptive orders to the SVO to the extent they are applicable (Attachment Two-A1). The motion passed unanimously.

5. **Discussed Other Matters**

Mr. Therriault said it has come to the SVO’s attention that there has been some confusion regarding the new NAIC Fixed Income-Like SEC Registered Funds List. Funds on this list are permitted to be reported on the common stock schedule, Schedule D-2, Part 2, with an NAIC designation. The SVO did not have any funds on this list as of Dec. 31, 2019, so there are no funds to report on the common stock schedule with an NAIC designation for year-end 2019. This list is maintained similarly to the ETF list. The SVO will add the fund’s security ID to the list on the SVO’s web page after it has been reviewed. Insurers must still file the fund it owns in the NAIC’s VISION application, so that it is reviewed by the SVO for the current year. After the security has been reviewed, the SVO assigns it an NAIC designation, which is then published in the Automated Valuation Service (AVS+). The SVO does not publish NAIC designations on its web page on the fund lists, only in AVS+. Again, there were no funds on this list for 2019, so there is nothing for insurers to report for 2019. Some vendors made this a required field in their systems; it only needs to be reported if an NAIC designation was assigned to the fund and published in AVS+.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
     Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office

CC: Marc Perlman, Investment Counsel, NAIC Securities Valuation Office
    Eric Kolchinsky, Director, NAIC Structured Securities Group and Capital Markets Bureau

DATE: November 15, 2019


1. Introduction – On September 26, 2019, the SEC adopted rule 6c-11 (the “Rule”) under the Investment Company Act of 1940 (the “Act”) which will permit exchange-traded funds (“ETFs”) that satisfy certain conditions to operate without first obtaining an exemptive order from the SEC under the Act. The SEC has stated that the intent of the rule is to modernize the regulatory framework for ETFs by reducing expenses and delays in creating new ETFs, to promote greater consistency, transparency and efficiency for ETFs and to facilitate greater competition among ETFs. The Rule becomes effective December 23, 2019, followed by a one year transition period for compliance.

ETFs contain certain features that distinguish them from the types of investment companies originally contemplated by the Act and its rules and, therefore, have needed to rely on SEC exemptive orders to operate as investment companies under the Act. Current ETF exemptive orders provide relief from: (i) Sections 2(a)(32) and 5(a)(1) which require shares to be redeemable; (ii) Section 22(d) and Rule 22c-1 which require sales of redeemable securities to be at the public offering price and the redemption price to be at current net asset value (“NAV”); (iii) Section 22(e) which requires redemption proceeds to be delivered within seven days; (iv) Sections 17(a)(1) and (2) which prohibit affiliates from selling to, or purchasing from, an ETF; and (v) Section 12(d)(1) which places limits on funds of funds. The new Rule will end the need for exemptive relief for each of these requirements except item (v). Additionally, the Rule permits ETFs to use “custom baskets” which do not reflect a pro rata representation or representative sampling of the ETF’s portfolio holdings and the SEC is rescinding current ETF marketing restrictions.

In order to rely on the new Rule, an ETF must satisfy (i) the new definition of ETF as (a) an open-end management company that issues and redeems creation units to and from authorized participants in exchange for baskets and cash balancing, if any, and (b) which issues shares that are listed on a national securities exchange and traded at market determined prices and (ii) various conditions including: (a) updated website disclosure of holdings and baskets, NAV per share, market price, premiums or discounts, median bid-ask spread, and (b) adoption of policies and procedures that govern the construction and acceptance of baskets, including custom baskets.

The Rule will rescind the exemptive orders from existing ETFs which will be able to rely on the Rule, going forward. However, certain categories of ETF will not be covered by the Rule, including leveraged ETFs, inverse ETFs, ETFs...
organized as Unit Investment Trusts (UITs), share class ETFs and non-transparent active ETFs. The SEC expects most ETFs to be covered by the Rule.

2. **Recommendations** – The SVO takes the position that since the Rule primarily affects SEC exemptive relief and ETF reporting and disclosure, it will not impact the quantitative and qualitative factors the SVO considers, in accordance with the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (“P&P Manual”), when analyzing ETFs. As such, the SVO recommends the following non-substantive changes (shown below with strikethrough and underline) to the P&P Manual to remove references to SEC exemptive orders from descriptions of ETFs and clarify that Regulatory Treatment Analysis Service application filers only need to provide SEC exemptive orders to the SVO when applicable.

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**2019 P&P MANUAL**

Part Three – SVO Procedures and Methodology for Production of NAIC Designations

...:

**Investments in Funds**

...:

**Directive**

246. The VOS/TF directs that the SVO establish and maintain: the various NAIC Lists of fund investments or compilation processes hereinafter identified; administrative procedures to receive applications of insurance companies and of fund sponsors; procedures to disseminate the Lists to insurance companies and state insurance regulators and analytical criteria and methodology to evaluate fund eligibility. The SVO shall evaluate:

...:

* Exchange Traded Funds (ETFs) registered with the SEC and operating under Exemptive Orders under the Act that predominantly hold bonds (or preferred stock) (as more fully described below) to determine if they are eligible for inclusion on the SVO-Identified Bond ETF list (reported on Schedule D, Part 1) [or SVO-Identified Preferred Stock ETF List (reported on Schedule D, Part 2, Section 1)].

---

**NAIC FUND LISTS**

...:

**The SVO-Identified Bond ETF List and the SVO-Identified Preferred Stock ETF List**

255. **Description** – At this time, ETFs operate under an Exemptive Order granted by the SEC that provides relief from the application of provisions of the Investment Company Act of 1940 that would otherwise apply. ETFs issue creation units to initial investors in exchange for a specified portfolio of bonds. The initial investor can hold the creation units or sell the ETF shares that constitute the creation unit on the exchange on which the ETF is registered. Other investors may purchase ETF shares; including to reconstitute and redeem a creation unit. Shares of ETF are not redeemable to the fund but are traded on registered exchanges at a price set by the market. Shares of ETFs are expected to trade at or near par because of arbitrage related to the value of the portfolio or of the ETF shares. For inclusion on the SVO-Identified bond ETF list, the ETF must hold a portfolio of bonds (or preferred stock) that tracks a specified bond index (a passive investment) or it a portfolio of bonds (or of preferred stock) that it actively manages pursuant to a specified investment objective.
277. An insurance company or the sponsor of a bond or preferred stock fund that request that the SVO conduct the look through and credit assessment submits the following required documentation to the SVO:

- In the case of an ETF, copies of the Application, Notice and Order associated with the fund sponsor’s request for Exemptive Relief from the SEC or a link to the SEC’s EDGAR where the SVO can obtain the documents if applicable.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force  
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)

CC: Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)  
Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Updated Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Include Instructions for Financial Modeled RMBS/CMBS Securities to Map NAIC Designations to NAIC Designation Categories

DATE: February 10, 2020

1. Summary – On the Feb. 4, 2020 interim meeting of the Valuation of Securities (E) Task Force NAIC staff were directed to draft and expose a P&P Manual amendment retaining the Financial Modeling and book/adjusted carrying value price ranges for modeled RMBS/CMBS securities but add mapping instructions from the resulting NAIC Designation to produce an NAIC Designation Category so that insurers can report an NAIC Designation Category. This mapping from an NAIC Designation to the NAIC Designation Category midpoint would be a temporary measure until new Risk Based Capital factors are adopted for each NAIC Designation Category and new price ranges can be developed. As requested by the Task Force, there would be no regulatory capital impact from this proposed change.

2. Recommendation – The IAO staff recommend these updated instructions be adopted by the Task Force to provide insurers and their system vendors guidance for year-end. It also recommends referring this amendment, if adopted, to the Statutory Accounting Principles (E) Working Group to inform them that there would be no change to SSAP 43R - Loan-Backed and Structured Securities, at this time.

3. Proposed Amendment – The following text shows the revisions needed in Part Four with edits in red-underline.
PART FOUR
THE NAIC STRUCTURED SECURITIES GROUP
27. The NAIC Designation and NAIC Designation Category for a given modeled RMBS or CMBS CUSIP owned by a given insurance company depends on the insurer’s book/adjusted carrying value of each RMBS or CMBS, whether that carrying value, in accordance with SSAP No. 43R—Loan-Backed and Structured Securities, paragraphs 25 through 26a, is the amortized cost or fair value, and where the book/adjusted carrying value matches the price ranges provided in the model output for each NAIC Designation and the mapped NAIC Designation Category, reflected in the table below, to be used for reporting an NAIC Designation Category until new Risk Based Capital factors are adopted for each NAIC Designation Category and new prices ranges developed; except that an RMBS or CMBS tranche that has no expected loss under any of the selected modeling scenarios and that would be equivalent to an NAIC 1 Designation and NAIC 1.A Designation Category if the filing exempt process were used, would be assigned an NAIC 1 Designation and NAIC 1.A Designation Category regardless of the insurer’s book/adjusted carrying value.

**NOTE:** Please refer to the detailed instructions provided in SSAP No. 43R.

<table>
<thead>
<tr>
<th>NAIC Designation Determined by Modeled Price Ranges</th>
<th>Mapped NAIC Designation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.D</td>
</tr>
<tr>
<td>2</td>
<td>2.B</td>
</tr>
<tr>
<td>3</td>
<td>3.B</td>
</tr>
<tr>
<td>4</td>
<td>4.B</td>
</tr>
<tr>
<td>5</td>
<td>5.B</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

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MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group
Marc Perlman, Investment Counsel, NAIC Securities Valuation Office

DATE: January 27, 2020 (Updated per the May 14, 2020 meeting)

RE: Updated - Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to Update the Definition and Instructions for Principal Protected Securities

1. **Summary** – The Task Force on the Oct. 31 call directed NAIC staff to work with industry on the definition for Principal Protected Securities. NAIC staff reported at the Fall National Meeting that it had met with industry representatives on Dec. 3, Nov. 22, Nov. 15 and Nov. 8. The attached updated amendment reflects the discussions to date and staff’s recommendation for a definition of this security; including, expanding this to a new P&P Manual section that provides examples. The update is consistent with the general framework that was outlined at the Fall National Meeting.

2. **Recommendation** – NAIC staff recommends exposing this updated amendment for comment (new text is identified in red).
PART ONE
POLICIES OF THE NAIC VALUATION OF SECURITIES (E) TASK FORCE
POLICIES APPLICABLE TO SPECIFIC ASSET CLASSES

PRINCIPAL PROTECTED SECURITIES

Defined

115. Principal Protected Securities (PPS) are a type of security that repackages one or more underlying investments and for which contractually promised payments according to a fixed schedule are satisfied by proceeds from an underlying bond(s) but for which the repackaged security generates potential additional returns as described in the detail criteria for PPSs, along with examples, in Part Three of this Manual.

Intent

116. Transactions meeting the criteria of a PPS as defined this Manual may possess Other Non-Payment Risks and must be submitted to the SVO for review under its Subscript S authority.
PART THREE

SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION
OF NAIC DESIGNATIONS
PROCEDURE APPLICABLE TO FILING EXEMPT (FE) SECURITIES AND PRIVATE LETTER (PL) RATING SECURITIES

FE SECURITIES

Filing Exemption

3. Bonds, within the scope of SSAP No. 26R and SSAP No. 43R (excluding RMBS and CMBS subject to financial modeling) and Preferred Stock within scope of SSAP No. 32, that have been assigned an Eligible NAIC CRP Rating, as described in this Manual, are exempt from filing with the SVO (FE securities) with the exception of Bonds and or Preferred Stock explicitly excluded below.

Specific Populations of Securities Not Eligible for Filing Exemption

4. The filing exemption procedure does not apply to:

- **Principal Protected Securities (PPS)** - Transactions meeting the criteria of a PPS as specified in this Manual may possess Other Non-Payment Risks and must be submitted to the SVO for review under its Subscript S authority.

  *(NOTE: This change is effective as of Jan. 1, 2021. PPS acquired prior to Jan. 1, 2021 must be filed with the SVO by Jul. 1, 2021.)*
Principal Protected Securities

( NOTE: This change is effective as of Jan. 1, 2021. PPS acquired prior to Jan. 1, 2021 must be filed with the SVO by Jul. 1, 2021.)

Definition

324. Principal Protected Securities (PPSs) are a type of security that repackages one or more underlying investments and for which contractually promised payments according to a fixed schedule are satisfied by proceeds from an underlying bond(s) (including principal and, if applicable, interest, make whole payments and fees thereon) that if purchased by an insurance company on a stand-alone basis would be eligible for Filing Exemption, but for which:

(i) the repackaged security structure enables potential returns from the underlying investments in addition to the contractually promised cash flows paid to such repackaged security according to a fixed schedule;

OR

b. the contractual interest rate paid by the PPS is zero, below market or, in any case, equal to or below the comparable risk-free rate;

AND

(ii) the insurer would obtain a more favorable Risk Based Capital charge or regulatory treatment for the PPS through Filing Exemption than it would were it to separately file the underlying investments in accordance with the policies in this Manual.

Exclusions

325. For the avoidance of doubt, PPSs shall not include defeased or pre-refunded securities which have separate instructions in this Manual; broadly syndicated securitizations, such as collateralized loan obligations (CLOs) (including middle market CLOs) and asset backed securities (ABS), except as described in the examples in this section; or CLO or ABS issuances held for purposes of risk retention as required by a governing law or regulation.
Filing Requirements

326. Investments in PPSs must be submitted to the SVO for review because they may possess Other Non-Payment Risks that the SVO must assess under its Subscript S authority. If the SVO determines in its judgement that there are not any Other Non-Payment Risks, the SVO will permit the security to benefit from Filing Exemption, if it is otherwise eligible.

327. In addition to Filing Process and Required Documents outlined in Part Two of this manual, the following additional information is required for PPSs:

- Disclosure of any Subsidiary, Controlled or Affiliated relationship between the PPS or any of the underlying investments and the insurer; including, how the underlying investments were acquired.

- Prior four quarterly financial statements, if produced, trustee or collateral agent reports from the entity issuing the PPS sufficient to identify: security specific details of each underlying investment (security identifier, descriptive information, all Eligible NAIC CRP Credit Ratings (if any), par value, market value, and explanation as to how the market value was determined).

Example Transactions

328. The following transaction examples are included for demonstrative purposes only, to highlight the core regulatory concern (that there are Other Non-payments Risks associated with PPSs beyond the contractually promised payments that may not be reflected in a CRP rating) but are not intended to encompass all possible PPS variants. Each of these examples meets the definition of a PPS.

329. In this initial example there are only two components: 1) a $10 million par United States Treasury (UST) zero-coupon bond sold at discount (ex. $70) from par ($100) that will pay par ($100) at maturity and 2) a return linked to any positive performance of call options on the S&P 500 Index (if the S&P 500 Index has a negative performance, investors will only receive an amount equal to their initial investment). The CRP rating would be AAA/AA+ or an NAIC 1.A, based solely on the risk of the UST security; whereas, the Weighted Average Ratings Factors (WARF) applied by the SVO would result in an NAIC 4.B when it includes the exposure to the call options on the S&P 500 Index.
330. In the second example there are multiple components: 1) a $22 million corporate bond paying a fixed coupon (ex. 4.50%) with a stated maturity date (ex. 9/30/2049), 2) the corporate bond has two CRP ratings (Moody’s Baa2, S&P BBB+), 3) the Special Purpose Vehicle (SPV) also invests $25 million in additional undisclosed and unrated assets, 4) the SPV pays a below market semi-annual coupon of 0.80%, 5) the excess coupon difference (4.50% - 0.80% = 3.70%) is used to accumulate into the required principal to pay at maturity, and 6) a CRP rated the PPS a BBB or NAIC 2.B. Again, the PPS rating is based solely on the corporate bonds that represent less than 50% of the total investment in this example, whereas, the WARF methodology would result in an NAIC 4.C when the exposure to all of the underlying investments are included.
The third example is a repackaging of collateralized loan obligation (CLO) notes into a CLO Combination Note (Combo Note). The initial CLO holds $250 million of syndicated loans and issues $255 million of notes (the CRP rating for each tranche is listed before the Class, ranging from AAA to B-) and Equity / Subordinated Notes. The Combo Note is formed in this example by re-packing the Class B, C, D, and Equity / Subordinated Note tranches together. The total notional amount of all the tranches in the Combo Note is $52.25 million. The Combo Note raises proceeds by issuing a single $50 million notional tranche of debt through an SPV. The cashflows from the Class B and C notes are sufficient to repay the $50 million Combo Note principal and interest, if any; which, may constitute a reclassification of the Class B and C tranche interest to repay principal on the Combo Note. Payments from the underlying investments in the Class D and Equity / Subordinated Note tranches provide returns to the repackaged security in addition to the contractually promised cash flows according to a fixed schedule that are based upon the payments from the Class B and Class C Notes. The Combo Note receives a BBB- rating or NAIC 2.C on the notional of $50 million based upon payments from the Class B and Class C Notes. The Combo Note receives a BBB- rating or NAIC 2.C on the notional of $50 million based upon payments from the Class B and C tranches even though $29.5 million or 57% of the underlying investments are rated BB- or unrated, whereas, the WARF would result in an NAIC 4.B when the exposure to all of the underlying investments are included.
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
    Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
    Marc Perlman, Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Proposed Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) with Update to the General Mapping of Credit Rating Provider Ratings, Long and Short-term, to NAIC Designations and NAIC Designation Categories

DATE: April 30, 2020

1. Summary – On the Task Force call of May 14, 2020 the North American Securities Valuation Association (NASVA) requested that the table mapping Credit Rating Provider (CRP) ratings for short-term instruments be updated to also map them to NAIC Designation Categories. The Task Force directed the SVO to draft an update to this general mapping table. Unlike long term ratings, there is not a direct one-for-one set of rating symbols for short-term investments that map to every NAIC Designation Category. Because there is not a direct one-for-one mapping, SVO staff have used their judgement to map the NAIC Designation Category to the mid-point of the range of long term ratings covered by each short-term rating. As an example, Moody’s Prime-1 or P1 short-term rating covers the long-term rating range consisting of Aaa, Aa1, Aa2, Aa3, A1, A2 and A3 (Moody’s - Rating Symbols and Definitions, June 2018). The SVO staff has recommended mapping the Moody’s short-term P1 rating symbol to the mid-point of this range or an NAIC Designation Category 1.D. The SVO staff applied this mid-point approach to each short-term rating mapping.

The SVO staff also updated the description of the mappings for both long-term and short-term rating symbols to reflect that these are “Generic Rating Symbols.” CRPs use a variety of symbols; including, combinations of prefixes and suffixes that provide additional information about the rating symbol which are described in the CRP’s documentation. There are over 2,000+ unique rating symbols used by CRPs to describe long-term securities. The SVO webpage (https://www.naic.org/svo.htm) maintains a master list of Credit Ratings Eligible for Translation to NAIC Designations.

The SVO does not currently translate short-term security ratings as part of its Compilation and Publication of the SVO List of Investment Securities to produce the NAIC designations incorporated into the NAIC’s AVS+ product. If the Task Force would like the SVO to also produce, compile and publish translations for the short-term securities, a separate project will need to be initiated.
2. **Recommendation** – The SVO staff recommends mapping the short-term CRP rating symbols to the NAIC Designation Category which is equivalent to the mid-point of the range of long term ratings covered by the short term rating. The SVO staff also recommends updating the title of the mapping tables to reflect that these are “generic” rating symbols, referencing additional sections of the P&P Manual pertinent to the use of CRP ratings and Filing Exemption and adding a footnote describing where to locate the master list of Credit Ratings Eligible for Translation to NAIC Designations on the SVO webpage.

3. **Proposed Amendment** – The following shows the proposed revisions in Part Three with *drafting notes* identifying the changes.
PART THREE

SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS
### LIST OF NAIC CREDIT RATING PROVIDERS


<table>
<thead>
<tr>
<th>Credit Rating Providers</th>
<th>NAIC Designation</th>
<th>NAIC Designation Modifier</th>
<th>NAIC Designation Category</th>
<th>Moody's Investor's Service</th>
<th>Standard and Poor's</th>
<th>Fitch Ratings</th>
<th>Dominion Bond Rating Service</th>
<th>A.M. Best Company</th>
<th>Morningstar Credit Ratings, LLC</th>
<th>Egan Jones Rating Agency</th>
<th>Kroll Bond Rating Agency</th>
<th>ER Ratings de Mexico, S.A. de C.V.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAIC Designation</td>
<td>NAIC Designation Modifier</td>
<td>NAIC Designation Category</td>
<td>NAIC Designation Category</td>
<td>Standard and Poor's</td>
<td>Commercial Paper and Short Term Counterparty Ratings</td>
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<td>Commercial Paper and Short Term Debt</td>
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<td>1A</td>
<td>Commercial Paper</td>
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Credit Rating Providers include Moody’s Investor’s Service, Standard and Poor’s, Fitch Ratings, Dominion Bond Rating Service, A.M. Best Company, Morningstar Credit Ratings, LLC, Egan Jones Rating Agency, Kroll Bond Rating Agency, and ER Ratings de Mexico, S.A. de C.V.
… (Table orientation changed for display in this amendment. The two tables below would be inserted.)

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MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
    Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
       MarcPerlman, Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Proposed Amendment to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to Permit Supranational Entities Filed with the SVO to be Added to the Sovereign NAIC Designation Equivalent List

DATE: April 30, 2020

1. Summary – The SVO maintains the Sovereign NAIC Designation Equivalent list and publishes it on its webpage (https://www.naic.org/svo.htm). This list is used to cap the NAIC Designation that can be assigned by the SVO to an investment at the Sovereign Designation Equivalent. The SVO discussed this list with the Task Force at its February 4, 2020 meeting and received instructions from the Task Force to research and develop criteria for an acceptable sovereign rating exception methodology, the SVO is still working on that separate issue. Insurers have been using this list to assist them in their reporting of Sovereign NAIC Designation Equivalents on the Supplemental Investment Risks Interrogatories (SIRI). The SVO has received requests from insurers to include supranational organizations or entities on the Sovereign NAIC Designation Equivalent list to assist with this SIRI reporting. This amendment proposes adding supranational entities to the Sovereign NAIC Designation Equivalent list if an insurer files a request with the SVO and the SVO can determine an appropriate NAIC designation equivalent.

2. Description - A supranational organization is an international group or union in which the power and influence of member states transcend national boundaries or interests to share in decision making and vote on issues concerning the collective body. The European Union and the World Trade Organization are both supranational entities. In the EU, each member votes on policies that will affect all member nations. The benefits of this construct are the synergies derived from social and economic policies and a stronger presence on the international stage.

For an organization to be supranational, it must operate in multiple countries. While applicable to multinational corporations, the term in this context is being used only for government entities because they often have regulatory responsibilities within their standard operations. These responsibilities can include the creation of international treaties and standards for international trade. As an entity that operates in multiple countries, a supranational organization is not controlled by a single sovereign country.

3. Recommendation – The SVO staff recommends permitting it to include supranational entities on the Sovereign NAIC Designation Equivalent list if an insurer files the supranational entity with the SVO and the SVO can determine an appropriate NAIC designation equivalent.

4. Proposed Amendment – The following shows the proposed revisions in Part Three with text in red identifying the changes.
PART THREE

SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS
FOREIGN SECURITIES

Foreign Sovereign Government and Supranational Entities

34. A reporting insurance company that owns a security issued by a foreign sovereign government, an agency or political subdivision of a foreign sovereign government or a supranational entity (entities with more than one sovereign government as a member), or that is guaranteed directly or indirectly by such an entity, must file such security with the SVO accompanied by a prospectus and investment committee memorandum.

35. Insurance companies shall not file issues with the SVO if the issuer does not have a sovereign rating from an NAIC CRP. If the issuer is not rated by an NAIC CRP, proof of a guarantee from an NAIC CRP-rated foreign sovereign government may be submitted. Where a reporting insurance company has filed a foreign security accompanied by an Audited Financial Statement, in English, the SVO will assess the security in accordance with the applicable corporate methodology, but the NAIC Designation it may assign shall be limited by the sovereign rating of the issuer's country of origin, or the issuing supranational entity, as applicable, as reflected in the Sovereign NAIC Designation Equivalent list. This section should not be read as prohibiting the presentation of transactions structured to eliminate foreign sovereign risk.

36. The insurance company must file all foreign securities for which the information required by this Manual is available. For those foreign securities held by a “Sub-paragraph D Company” as defined in Part One, where the required information is not available for the SVO to value the security, the NAIC Designation may be determined by the reporting insurance company. This determination shall carry an F suffix. In no case shall the NAIC Designation exceed the sovereign rating of the issuer’s country of origin, or the issuing supranational entity, as applicable, as reflected in the Sovereign NAIC Designation Equivalent list. The company shall provide its domestic regulator with a description of the procedure it used to evaluate and assign ratings to these foreign securities. In addition, the company shall retain the documentation supporting each designation assigned by it until the next domestic insurance department examination.

37. The SVO shall maintain and publish a list of Sovereign NAIC Designation Equivalents on its webpage (https://www.naic.org/svo.htm) and may include on that list the NAIC Designation equivalent for supranational entities submitted to it for review by insurers if, in its sole discretion, it is able to determine an appropriate NAIC Designation equivalent.
FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

Financial Regulation Standards and Accreditation (F) Committee Aug. 12, 2020, Minutes..........................................................11-2
Memorandum Regarding Items Impacting Current Accreditation Standard (Attachment Two).........................................................11-11
Memorandum Regarding Accreditation Standards – Changes to the Risk-Based Capital (RBC)
Formulas and Instructions for Life and Property/Casualty (P/C) (Attachment Three).................................................................11-15
Memorandum Regarding Consideration for Financial Accreditation Standards – 2020 Financial Condition Examiners Handbook (Attachment Four).................................................................11-17
Memorandum Regarding Report of the Valuation of Securities (E) Task Force (Attachment Five) .........................................................11-19
Memorandum Regarding 2011 and 2019 Revisions to the Credit for Reinsurance Model Law (#785)
and the Credit for Reinsurance Model Regulation (#786) – Applicability to Risk Retention
Groups (RRGs) (Attachment Six) ..........................................................................................................................11-26
Memorandum Regarding Technical Revisions to the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) as an Accreditation Standard (Attachment Seven).........................................................11-31
Memorandum Regarding Proposed Revisions to the Accreditation Program Manual to Reference Salary Ranges (Attachment Eight) .........................................................................................................................11-41
Memorandum Regarding Part B1: Analysis Guidelines for RRGs (Attachment Nine).................................................................11-46
The Financial Regulation Standards and Accreditation (F) Committee met via conference call Aug. 12, 2020. The following Committee members participated: Todd E. Kiser, Chair (UT); Elizabeth Kelleher Dwyer, Vice Chair, (RI); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling (AL); Andrew N. Mais (CT); Sharon P. Clark (KY); Gary Anderson (MA); Eric A Cioppa (ME); Mike Causey represented by Jackie Obusek (NC); Bruce R. Ramge (NE); Jillian Froment (OH); Larry D. Deiter (SD); Scott A. White (VA); Michael S. Pieciak represented by Kevin Gaffney (VT); and Jeff Rude (WY). Also participating were: Justin Schrader (NE); and Sandra Bigglestone (VT).

1. **Adopted its 2019 Fall National Meeting Minutes**

Commissioner White made a motion, seconded by Superintendent Dwyer, to adopt the Committee’s Dec. 7, 2019, minutes (see NAIC Proceedings – Fall 2019, Financial Regulation Standards and Accreditation (F) Committee). The motion passed unanimously.

Commissioner Kiser said the Committee also met Aug. 10, July 21 and June 23 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings. During its June 23 meeting, the Committee voted to award continued accreditation to Delaware, Louisiana and Rhode Island. During its Aug. 10 meeting, the Committee voted to award continued accreditation to Maryland, Oregon and Washington.

2. **Adopted Revisions to the 2019 NAIC Publications Referenced in the Accreditation Standards**

Commissioner Kiser said there are several NAIC publications currently included in the accreditation standards by reference. Each year, the Committee is to review revisions made to these publications in the prior year. Each of the applicable groups that developed revisions to the publications in 2019 have provided the Committee with a memorandum discussing the revisions, and they indicated whether the revisions should be considered significant or insignificant for accreditation purposes. This included the following publications: Accounting Practices and Procedures Manual (AP&P Manual) (Attachment One); Annual and Quarterly Statement Blanks and Instructions (Attachment Two); Risk-Based Capital (RBC) Formulas and Instructions for Life and Property/Casualty (P/C) Insurers (Attachment Three); Financial Condition Examiners Handbook (Attachment Four); and Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) (Attachment Five). The working group or task force responsible for each of these publications has deemed their 2019 changes as insignificant to the accreditation process.

Commissioner Clark made a motion, seconded by Superintendent Cioppa, to adopt the revisions to each of the publications immediately by reference to the accreditation standards. The motion passed unanimously.

3. **Adopted 2019 Revisions to Model #785 and Model #786 as an Accreditation Standard Applicable to RRGs**

Commissioner Kiser stated that on June 25, 2019, the Executive (EX) Committee and Plenary unanimously adopted revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786), which incorporate relevant provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement). Subsequently, at the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted the revisions as an update to the Credit for Reinsurance accreditation standard effective Sept. 1, 2022, with enforcement to begin Jan 1, 2023. Due to the relationship of these new provisions to the EU Covered Agreement, this was done on an expedited basis through the waiver process for adoption of accreditation standards. However, applicability of the standards to risk retention groups (RRGs) licensed as captives was not specifically addressed.

Dan Schelp (NAIC) summarized the memorandum (Attachment Six), recommending that both the 2011 and 2019 revisions to Model #785 and Model #786 apply to RRGs.
Commissioner Mais made a motion, seconded by Commissioner Ridling, to adopt the March 3 referral to update the Credit for Reinsurance accreditation standard for RRGs to include the 2011 and 2019 revisions to Model #785 and Model #786, effective Sept. 1, 2022, with enforcement to begin Jan. 1, 2023. The motion passed unanimously.

4. **Adopted Technical Changes to Model #787 as an Update to the Accreditation Standards**

Commissioner Kiser stated that at the 2019 Fall National Meeting, the Committee adopted the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787), more commonly referred to as the XXX/AXXX Model Regulation, as a new accreditation standard. This model establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees. Model #787 also includes provisions to ensure that funds backing these captive reinsurance transactions, which consist of primary security and other security, are held in the forms and amounts that are appropriate. Following adoption of the new standard, technical changes were adopted to the model itself. The changes directly affect the significant elements adopted as part of the accreditation standard.

Becky Meyer (NAIC) summarized the memorandum (Attachment Seven), recommending that the new accreditation standard for Model #787 be updated to include technical revisions adopted earlier in 2020. These changes are not considered substantive, but they will ensure accuracy of the accreditation standard.

Commissioner White made a motion, seconded by Commissioner Clark, to adopt the technical change to the accreditation standard for Model #787 as described in the referral dated March 3. The motion passed unanimously.


Mr. Schrader stated that in 2017 the Risk-Focused Surveillance (E) Working Group formed a Compensation Drafting Group to study state insurance regulator resources and review existing salary recommendations. After reviewing job requirements for state insurance regulators conducting risk-focused surveillance, completing a detailed salary survey of over 40 states, and comparing the results against other similar regulatory and industry positions, the Drafting Group presented its recommendations to the Working Group at the 2018 Fall National Meeting. These recommendations included new salary ranges, as well as supporting guidance for inclusion in the *Financial Analysis Handbook* and the *Financial Condition Examination Handbook*. In addition, they outlined a process for the Working Group to maintain and update this guidance on an ongoing basis. Both groups adopted the proposed changes, and they were published in the 2020 editions of the handbooks.

One final task for this project was to consider how the new salary range recommendations and supporting guidance should affect accreditation standards and guidelines. Therefore, the Working Group adopted a referral (Attachment Eight) to recommend proposed revisions to the accreditation guidelines in Part C: Organizational and Personnel Practices. The Working Group recommends that the new salary ranges and supporting guidance be referenced in this section of the *Accreditation Program Manual* since it already addresses issues related to resources and compensation. In addition, this section of the accreditation standards is not taken into consideration by the review team in making a recommendation regarding the department’s overall accreditation standing. Therefore, placing references to the new handbook guidance and salary ranges in this section allows for a review of department practices in this area, without directly affecting a state’s accreditation standing if they cannot compensate state insurance regulators within the established ranges. It should also be noted that other standards relating to the sufficiency and qualifications of staff are already included in Part B of the accreditation standards, which are taken into consideration in making a recommendation on a department’s overall accreditation standing.

Director Ramge made a motion, seconded by Superintendent Dwyer, to expose the referral for a 30-day public comment period ending Sept. 11. The motion passed unanimously.

6. **Exposed a Referral from the Risk Retention Group (E) Task Force Regarding the RRG Analysis Guideline**

Ms. Bigglestone summarized the referral from the Risk Retention Group (E) Task Force (Attachment Nine), and she stated that the accreditation Review Team Guidelines include a guideline specifically related to RRGs within the financial analysis section (Part B1). This guideline was originally drafted by the Task Force and adopted by the Committee. It is the intention of the Task Force that this guideline is applied to all RRGs regardless of accounting treatment—U.S. generally accepted accounting principles (GAAP)/statutory accounting principles (SAP)—or organizational structure—captive/traditional laws. In 2017, several revisions were made to the accreditation guidelines to incorporate risk-focused analysis. In conjunction with
those revisions, a reference to the “Captives and/or Insurers Filing on a U.S. GAAP Basis Worksheet” in the Financial Analysis Handbook was added to the analysis guideline specific to RRGs. This worksheet can be a helpful tool; however, it applies only to U.S. GAAP filers with an emphasis on a review of accounting differences. Adding this reference implies that the accreditation guideline is only applicable to GAAP filers, which is inconsistent with the Task Force’s position that the guideline applies to all RRGs. Therefore, the Task Force asks the Committee to consider deleting the reference to the “U.S. GAAP Basis Worksheet.” In addition, the referral recommends changing “business plan” to “plan of operations” for consistency with terminology used in the federal Liability Risk Retention Act (LRRA).

Commissioner Mais made a motion, seconded by Commissioner Rude, to expose the referral for a 30-day public comment period ending Sept. 11. The motion passed unanimously.

Having no further business, the Financial Regulation Standards and Accreditation (F) Committee adjourned.
MEMORANDUM

TO: Commissioner Todd E. Kiser (UT), Chair, Financial Regulations Standards and Accreditation (F) Committee
    Elizabeth Kelleher Dwyer (RI), Vice Chair, Financial Regulations Standards and Accreditation (F) Committee

FROM: Dale Bruggeman (OH), Chair, Statutory Accounting Principles (E) Working Group
       Carrie Mears (IA), Vice Chair, Statutory Accounting Principles (E) Working Group

DATE: February 12, 2020


In 2001, the Financial Regulation Standards and Accreditation (F) Committee adopted a motion to adopt the Accounting Practices and Procedures Manual – Effective January 1, 2001, Version 1999 (AP&P Manual) as an accreditation standard. The intention of this memorandum is to update the Committee on changes the Statutory Accounting Principles (E) Working Group has made to the AP&P Manual in 2019. This memo is to provide the customary annual update regarding changes to the AP&P Manual.

Appendix A to this memo includes a detailed listing of the changes made to the AP&P Manual in 2019. On behalf of the Working Group, it is our opinion that none of these items, either individually or collectively, should be considered “significant” as defined by the financial solvency accreditation standards. Although some of the changes have been categorized as “substantive” by the Working Group, this is not meant to suggest the modifications are synonymous with the term “significant” within the Committee’s context.

As outlined in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles (SAP Policy Statement), modifications will be made to the AP&P Manual each year. As such, it will be reprinted with an “as of” date associated with it. For example, the next printing of the AP&P Manual, which encompasses the attached modifications, will be titled Accounting Practices and Procedures Manual – as of March 2020. This process allows for an efficient way to update the AP&P Manual and virtually guarantees that users have the latest version. Reprints and updates are necessary because of the evolutionary nature of accounting—in both the statutory accounting principles and the generally accepted accounting principles arenas—and are positive for users of the AP&P Manual.

The Working Group sincerely requests that the Committee consider the items listed in Appendix A as “insignificant” changes to the AP&P Manual. We will continue to notify the Committee of any changes to the AP&P Manual and to advise if, in our opinion, those changes are “significant” by financial solvency accreditation standards.

cc Becky Meyer, Sara Franson, Sherry Shull, Robin Marcotte, Julie Gann, Fatima Sediqzad and Jake Stultz

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Summary of Changes to the

As of March 2019 Accounting Practices and Procedures Manual
included in the As of March 2020 Manual

The following summarizes changes made to the As of March 2019 Accounting Practices and Procedures Manual (Manual) to create the As of March 2020 version.

Section 1 summarizes substantive revisions to statutory accounting principles. Substantive revisions introduce original or modified accounting principles and can be reflected in an existing or new SSAP. When substantive revisions are made to an existing SSAP, the effective date is identified in the Status section, and the revised text within is depicted by underlines (new language) and strikethroughs (removed language). This tracking will not be shown in subsequent manuals. New and substantively revised SSAPs are commonly accompanied by a corresponding issue paper that reflects the revisions for historical purposes. If language in an existing SSAP is superseded, that language is shaded and the new or substantively revised SSAP is referenced. Completely superseded SSAPs and nullified interpretations are included in Appendix H.

Section 2 summarizes the nonsubstantive revisions to statutory accounting principles. Nonsubstantive revisions are characterized as language clarifications which do not modify the original intent of a SSAP, or changes to reference material. Nonsubstantive revisions are depicted by underlines (new language) and strikethroughs (removed language) and will not be tracked in subsequent manuals. Nonsubstantive revisions are effective when adopted unless a specific effective date is noted.

Section 3 summarizes revisions to the Manual appendices.

### 1. Substantive Revisions – Statutory Accounting Principles

<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSAP No. 22R</td>
<td>2016-02</td>
<td>Revisions incorporate guidance from ASU 2016-02, Leases, but rejects the ASU 2016-02 with retention of the operating lease concept.</td>
</tr>
</tbody>
</table>

### 2. Nonsubstantive Revisions – Statutory Accounting Principles

<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preamble</td>
<td>2019-06</td>
<td>Revisions update references to U.S. GAAP guidance.</td>
</tr>
<tr>
<td>SSAP No. 2R</td>
<td>2018-18</td>
<td>Revisions clarify that derivative instruments shall not be reported as cash equivalents or short-term investments.</td>
</tr>
<tr>
<td>SSAP No. 16R</td>
<td>2018-40</td>
<td>Revisions adopt with modification ASU 2018-15, Customer’s Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract, allowing capitalization of implementation costs from a cloud hosting service contract as nonoperating system software with amortization not to exceed five years. Revisions provide guidance for cloud hosting arrangements that are not service contracts.</td>
</tr>
<tr>
<td>SSAP No. 21R</td>
<td>2018-04</td>
<td>Revisions clarify that an investment captured in scope of a different SSAP does not become a collateral loan because it is also secured with collateral.</td>
</tr>
<tr>
<td>SSAP No. 25</td>
<td>2019-03</td>
<td>Revisions clarify the application of this Statement and related party classification when a transaction is in substance a related party transaction.</td>
</tr>
<tr>
<td>SSAP No.</td>
<td>Year</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>26R</td>
<td>2018-18</td>
<td>Revisions clarify that structured notes are excluded from this Statement and shall be reported as derivatives.</td>
</tr>
<tr>
<td></td>
<td>2018-32</td>
<td>Revisions provide guidance for when bonds are called for consideration less than par, and also clarifies that in instances where consideration received is less than BACV, the entire difference shall be reported through investment income.</td>
</tr>
<tr>
<td></td>
<td>2019-03</td>
<td>Revisions clarify the application of SSAP No. 25—Affiliates and Other Related Parties, when a transaction is with a related party.</td>
</tr>
<tr>
<td></td>
<td>2019-07</td>
<td>Revisions direct the initial reported value for a bond received as a property dividend or as a capital contribution.</td>
</tr>
<tr>
<td>30R</td>
<td>2018-33</td>
<td>Revisions clarify that assets pledged to a Federal Home Loan Bank (FHLB) on behalf of an affiliate shall be nonadmitted.</td>
</tr>
<tr>
<td></td>
<td>2018-34</td>
<td>Revisions explicitly capture foreign open-end fund investments in scope.</td>
</tr>
<tr>
<td>32</td>
<td>2019-03</td>
<td>Revisions clarify the application of SSAP No. 25—Affiliates and Other Related Parties, when a transaction is with a related party.</td>
</tr>
<tr>
<td>37</td>
<td>2018-22</td>
<td>Revisions exclude “bundled” mortgage loans from the scope of this Statement and clarify requirements for participation agreements.</td>
</tr>
<tr>
<td>43R</td>
<td>2018-03</td>
<td>Revisions require securities with differing NAIC designations by lot to be reported in aggregate at the worst NAIC designation or separately by lot.</td>
</tr>
<tr>
<td></td>
<td>2018-18</td>
<td>Revisions clarify that mortgage-referenced securities issued from a government sponsored enterprise are captured in scope of this Statement.</td>
</tr>
<tr>
<td></td>
<td>2019-03</td>
<td>Revisions clarify the application of SSAP No. 25—Affiliates and Other Related Parties, when a transaction is with a related party and adds concepts to determine whether a structure is a related party investment.</td>
</tr>
<tr>
<td>48</td>
<td>2019-03</td>
<td>Revisions clarify the application of SSAP No. 25—Affiliates and Other Related Parties, when a transaction is with a related party.</td>
</tr>
<tr>
<td>50</td>
<td>2019-06</td>
<td>Revisions reject ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.</td>
</tr>
<tr>
<td>51R</td>
<td>2019-06</td>
<td>Revisions reject ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.</td>
</tr>
<tr>
<td>52</td>
<td>2019-06</td>
<td>Revisions reject ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.</td>
</tr>
<tr>
<td>54R</td>
<td>2019-06</td>
<td>Revisions reject ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.</td>
</tr>
<tr>
<td>55</td>
<td>2018-39</td>
<td>Revisions clarify the reporting of interest on accident and health claims.</td>
</tr>
<tr>
<td></td>
<td>2019-06</td>
<td>Revisions reject ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.</td>
</tr>
<tr>
<td>56</td>
<td>2019-06</td>
<td>Revisions reject ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.</td>
</tr>
<tr>
<td>62R</td>
<td>2019-11</td>
<td>Revisions clarify the effective date of reinsurance credit guidance adopted in agenda item 2017-28, noting application to the contracts in effect as of January 1, 2019.</td>
</tr>
<tr>
<td></td>
<td>2019-15EP</td>
<td>Revisions reflect editorial changes to incorporate formatting updates from Schedule F.</td>
</tr>
<tr>
<td></td>
<td>2019-44EP</td>
<td>Revisions reflect editorial changes to update references in an illustration and updates to Schedule F reference in a disclosure.</td>
</tr>
<tr>
<td>SSAP No.</td>
<td>Date</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>SSAP No. 68</td>
<td>2019-12</td>
<td>Revisions clarify that goodwill resulting from the acquisition of a subsidiary, controlled or affiliated (SCA) entity by an insurance reporting entity that is reported on the SCA’s financial statements (resulting from the application of pushdown) is subject to the 10% admittance limit based on the acquiring entity’s capital and surplus.</td>
</tr>
<tr>
<td></td>
<td>2019-29</td>
<td>Revisions reject ASU 2019-06, Extended the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities.</td>
</tr>
<tr>
<td>SSAP No. 71</td>
<td>2019-06</td>
<td>Revisions reject ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.</td>
</tr>
<tr>
<td>SSAP No. 72</td>
<td>2019-07</td>
<td>Revisions direct the initial reported value for a bond received as a property dividend or as a capital contribution.</td>
</tr>
<tr>
<td>SSAP No. 84</td>
<td>2019-15EP</td>
<td>Revisions reflect editorial changes to delete the paragraph duplicated from SSAP No. 4—Assets and Nonadmitted Assets.</td>
</tr>
<tr>
<td>SSAP No. 86</td>
<td>2018-18</td>
<td>Revisions clarify that structured notes are derivatives in scope of this Statement.</td>
</tr>
<tr>
<td></td>
<td>2018-46</td>
<td>Revisions reflect updated benchmark interest rates for hedge accounting permitted under U.S. GAAP.</td>
</tr>
<tr>
<td></td>
<td>2019-06</td>
<td>Revisions reject ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts.</td>
</tr>
<tr>
<td></td>
<td>2019-15EP</td>
<td>Revisions reflect editorial changes to eliminate the word “proposed” in adopted guidance.</td>
</tr>
<tr>
<td></td>
<td>2019-18</td>
<td>Revisions clarify the guidance for derivatives that do not qualify as hedging, income generation or replication transactions.</td>
</tr>
<tr>
<td></td>
<td>2019-27EP</td>
<td>Revisions reflect editorial changes to refer to SSAP No. 26R—Bonds for the structured note definition.</td>
</tr>
<tr>
<td>SSAP No. 92</td>
<td>2018-37</td>
<td>Revisions adopt with modification disclosure amendments in ASU 2018-14, Changes to the Disclosure Requirements for Defined Benefit Plans.</td>
</tr>
<tr>
<td>SSAP No. 95</td>
<td>2018-35</td>
<td>Revisions adopt with modification ASU 2018-07, Improvements to Nonemployee Share-Based Payment Accounting, and update previously adopted U.S. GAAP guidance.</td>
</tr>
<tr>
<td>SSAP No. 97</td>
<td>2018-47EP</td>
<td>Revisions reflect editorial changes to clarify that structures captured within SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies are not subject to the disclosures in this Statement unless specifically required in SSAP No. 48.</td>
</tr>
<tr>
<td></td>
<td>2019-23</td>
<td>Revisions clarify that if an unalleviated going concern is noted in the audited financial statements or audit opinion, the SCA shall be nonadmitted.</td>
</tr>
<tr>
<td></td>
<td>2019-29</td>
<td>Revisions reject ASU 2019-06, Extended the Private Company Accounting Alternatives on Goodwill and Certain Identifiable Intangible Assets to Not-for-Profit Entities.</td>
</tr>
<tr>
<td>SSAP No. 100R</td>
<td>2018-36</td>
<td>Revisions adopt with modification disclosure amendments in ASU 2018-13, Changes to the Disclosure Requirements for Fair Value Measurement.</td>
</tr>
<tr>
<td></td>
<td>2019-10</td>
<td>Revisions to the Implementation Q&amp;A clarify the admittance of deferred tax assets that can be offset by deferred tax liabilities, with clarification that scheduling is only required to the extent the reversal patterns of deferred tax items were used in determining the valuation allowance.</td>
</tr>
<tr>
<td>SSAP No. 102</td>
<td>2018-37</td>
<td>Revisions adopt with modification disclosure amendments in ASU 2018-14, Changes to the Disclosure Requirements for Defined Benefit Plans.</td>
</tr>
</tbody>
</table>
### 3. Revisions to the Appendices

<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>A-785</td>
<td>Revisions incorporate updates from the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) that address relevant provisions from the Covered Agreement.</td>
</tr>
<tr>
<td></td>
<td>A-791</td>
<td>Adds Q&amp;As regarding contracts with medical loss ratios and group yearly renewable term (YRT). The YRT guidance is effective Jan. 31, 2021.</td>
</tr>
<tr>
<td>Appendix B</td>
<td>2019-02</td>
<td>INT 19-02: Freddie Mac Single Security Initiative incorporates a limited-scope exception to SSAP No. 26R—Bonds and prescribes guidance for SSAP No. 43R specific to securities exchanged as part of the Freddie Mac Single Security Initiative.</td>
</tr>
<tr>
<td>Appendix C</td>
<td>AG43a</td>
<td>Interprets the standards for the valuation of reserves for variable annuity and other contracts for valuations prior to Jan. 1, 2020.</td>
</tr>
<tr>
<td></td>
<td>AG43b</td>
<td>Interprets the standards for the valuation of reserves for variable annuity and other contracts for valuations on or after Jan. 1, 2020, with early adoption permitted in 2019 pursuant to Actuarial Guideline LII—Variable Annuity Early Adoption.</td>
</tr>
</tbody>
</table>
### Appendix D

<table>
<thead>
<tr>
<th>Rejected as Not Applicable to Statutory Accounting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-41</td>
</tr>
<tr>
<td>2018-42</td>
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<tr>
<td>2018-43</td>
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<tr>
<td>2018-44</td>
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<tr>
<td>2018-45</td>
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<tr>
<td>2019-16</td>
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<tr>
<td>2019-17</td>
</tr>
<tr>
<td>2019-30</td>
</tr>
<tr>
<td>2019-31</td>
</tr>
</tbody>
</table>

### Appendix E

| 2018-17 | IP No. 160—Structured Settlements Acquired as Investments |
| 2016-02 | IP No. 161—Leases |
| 2017-28 | IP No. 162—Property and Casualty Reinsurance Credit |

### Appendix F

No revisions impacting this appendix were adopted in 2019.

### Appendix G

No revisions impacting this appendix were adopted in 2019.

### Appendix H

| 2019-01 | INT 19-01: Extension of Ninety-Day Rule for the Impact of California Camp Fire, Hill Fire and Woolsey Fire provided a temporary extension to the 90-day rule under SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers for policies impacted by the named fires. This INT was automatically nullified on April 25, 2019 |
TO: Honorable Todd E. Kiser, Chair  
Financial Regulation Standards & Accreditation (F) Committee

FROM: Jake Garn, Utah Chief Financial Examiner, Chair  
Blanks (E) Working Group

DATE: January 24, 2020

RE: Items Impacting Current Accreditation Standard

Please find attached a list of items adopted by the Blanks (E) Working Group during 2019. The Blanks Working Group adopts numerous changes to the Annual Statement Blanks and Instructions each year. Most of the changes are made to clarify current requirements or are considered enhancements to existing reporting. The changes adopted in 2019 do not represent a substantive change to any reporting requirements.

I am planning to be present when the Financial Regulation Standards & Accreditation (F) Committee meets in Phoenix, AZ in the event any member of the committee wishes to discuss these issues.
Changes to blanks and instructions adopted during 2019

1. Add question 34.1 and question 34.2 to the General Interrogatories, Part 2 for fraternal benefit societies only, along with instructions regarding question 34.2 (2018-23BWG) Effective 12/31/2019.


4. Add reference to reporting separate account or protected cell to the instructions for Note 5L(4). Modify the illustrations to include additional lines for separate accounts or protected cells in addition to the general account, with a notation indicating which lines apply to the general account and which lines apply to separate accounts or protected cells (2018-27BWG) Effective 12/31/2019.

5. Add instructions to Note 9, Income Taxes for new disclosures; Note 9H, Repatriation Transition Tax (RTT); and Note 9I, Alternative Minimum Tax (AMT) Credit. An illustration will be added for Note 9I and will be data-captured (2018-28BWG) Effective 12/31/2019.

6. In the separate accounts blank, remove line 5, Contract Loans, from the separate accounts asset page and renumber the remaining lines (2018-29BWG) Effective 12/31/2019.

7. Modify instructions and illustration Note 100, Subsidiary, Controlled or Affiliated (SCA) Loss Tracking to include references to Statement of Statutory Accounting Principles (SSAP) No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 48 entities (2018-30BWG) Effective 12/31/2019.

8. Add two new categories (unit investment trusts and closed-end funds) to the common stock categories on Schedule D. Add the new categories to the Summary Investment Schedule. Add definitions of “unit investment trusts” and “closed-end funds” to the Investment Schedules General Instructions and modify the definition of “mutual fund.” Add categories for “unit investment trusts” and “closed-end funds” to Schedule DL, Part 1 and Part 2 (2018-31BWG) Effective 12/31/2019.

9. For the VM-20 Reserves Supplement, Part 1, match the title under Part 1 to the title used in the blank. Add instructions to clarify the line reporting for the three product group types: term insurance; universal life with secondary guarantees; and all other. Add clarifying column instructions to indicate that the due and deferred premium asset should be reported in accordance with VM-20 (2019-02BWG) Effective 12/31/2019.

10. Add NAIC Designation column for use with mutual funds to the annual Schedule D, Part 2, Section 2 and modify the instructions to reflect the addition. Modify the instructions for the NAIC Designation and Administrative Symbol column for the quarterly Schedule D, Part 3 and Part 4 to reflect capturing designations for mutual funds (2019-03BWG) Effective 12/31/2019.

11. Remove the reference to “life and fraternal only” in the General Instructions for Schedule BA regarding investments that have the underlying characteristics of bonds or fixed instruments. Also remove the reference from the instructions for Schedule BA regarding the CUSIP Identification column and the NAIC Designation column. Add additional lines to the “Fixed or Variable Interest Rate Investments that Have the Underlying Characteristics of a Bond, Mortgage Loan or Other Fixed Income Instrument” and “Joint Ventures or Partnership Interests for Which the Primary Underlying Investments are Considered to Be Fixed Income Instruments” categories to distinguish between those that have been reviewed and approved by the Securities Valuation Office (SVO) and those that have not (2019-04BWG) Effective 12/31/2019.

12. Add new instructions and illustration (to be data-captured) to Note 21, Other Items for life policies where the reporting entity is owner and beneficiary or has otherwise obtained rights to control the policy. The new disclosure will be Note 21I for life/fraternal and health and Note 21H for property and title (2019-05BWG) Effective 12/31/2019.

13. Add a reference for structured settlements acquired by a reporting entity as an investment (where the company has acquired the legal right to receive payments) to the Schedule BA General Instructions in the “any other class of assets” definition (2019-06BWG) Effective 12/31/2019.

14. Modify the instructions for Note 20, Fair Value to reflect changes adopted for SSAP No. 100R—Fair Value. These changes reflect disclosure modifications adopted from U.S. generally accepted accounting principles (GAAP)

16. Add a reference to include mortgage-referenced securities in the “U.S. Special Revenue and Special Assessment Obligations and All Non-Guaranteed Obligations of Agencies and Authorities of Governments and Their Political Subdivisions” category in the Investment Schedules General Instructions. Also delete Note 5O, Structured Notes and modify the bond characteristics definition for Schedule D, Part 1 (2019-09BWG) Effective 12/31/2019.

17. Add instructions for determining the gain (loss) reported in column 18 and the prepayment penalty and/or acceleration fee amount in column 20 on Schedule D, Parts 4 and 5 for called bonds where consideration received is less than par (2019-10BWG) Effective 12/31/2019.

18. Modify the instructions and table illustrations for Note 5F, Note 5G, Note 5H and Note 5I to reflect changes to SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities. In addition, the presentation of some tables in the illustrations were changed to ensure they would fit on the page (2019-11BWG) Effective 12/31/2019.

19. Add a code for foreign mutual funds to Schedule D, Part 2, Section 2, Column 3. Add instruction for foreign open-end investment funds to be included as mutual funds in the Investment Schedules General Instructions (2019-12BWG) Effective 12/31/2019.


22. Modify the instructions for the Actual Cost column for Schedule D (Part 1, Part 3, Part 4 and Part 5) and Schedule DA to provide guidance for the amount to enter when bonds are received as a property dividend or capital contribution (2019-15BWG) Effective 12/31/2019.

23. Add new column “YRT Mortality Risk Only” to the Analysis of Operations by Lines of Business (Summary, Individual Life and Group Life) and Analysis of Increase in Reserves During Year (Individual Life and Group Life) blank pages and instructions for yearly-renewable-term reinsurance business where the only risk included is mortality (2019-16BWG) Effective 12/31/2019.

24. Add two new lines for affiliated bank loans to the parent, subsidiaries and affiliates category and modify the existing lines for bank loans to reference unaffiliated for Schedule D, Part 1; Schedule DA; Schedule DL, Parts 1 and 2; and Schedule E, Part 2. The subtotal line for bank loans under the total bond category will be the sum of the affiliated and unaffiliated lines. Change line description for Schedule D, Parts 3, 4 and 5 for Line 8299999 to say Unaffiliated Bank Loans (2019-17BWG) Effective 12/31/2019.


26. The Casualty Actuarial and Statistical (C) Task Force proposes addition of “Qualification Documentation” so the Appointed Actuary would be required to maintain workpapers explaining how the actuary meets the definition of “Qualified Actuary.” These proposed changes were adopted by the Task Force on June 11, 2019. The Executive (EX) Committee proposes the remainder of the changes, including a new objective definition of “qualified actuary” and the results of an assessment of actuarial educational syllabi in a “Accepted Actuarial Designation” section. These proposed changes were adopted by the Committee on June 25, 2019 (2019-20BWG) Effective 12/31/2019.

27. For Note 33, modify the illustration to disclosure individually Separate Account with Guarantees products and Separate Account Nonguaranteed products (2019-21BWG) Effective 12/31/2019.


30. Add a Life Experience Data Contact to the Electronic Jurat page for Life/Fraternal companies only. Health, Property and Title are included in the proposal due to the Jurat instructions being uniform for all statement types (2019-24BWG) Effective 1/1/2020.


MEMORANDUM

TO: Todd E. Kiser, Chair
   Financial Regulation Standards and Accreditation (F) Committee

FROM: Tom Botsko, Chair
       Capital Adequacy (E) Task Force

DATE: March 3, 2020

RE: Accreditation Standards – Changes to the RBC Formulas and Instructions for Life and P/C

Attached please find a brief description of changes to the 2019 Risk-Based Capital Report Including Overview and Instructions for health, life and property/casualty (P/C). These changes were adopted by the Capital Adequacy (E) Task Force and Executive (EX) Committee and Plenary in 2019. Significance of these changes was viewed as it relates to the overall risk-based capital (RBC) standard.

No changes to the RBC formulas or instructions were deemed to be significant for health, life or P/C.

Any questions can be directed to NAIC staff:
P/C – Eva Yeung
Life – Dave Fleming
Health — Crystal Brown

Health RBC Formula

Not Significant  The Operational Risk Informational Only Growth Risk page was removed from the health RBC formula.

Not Significant  The label for the H0 component was modified to be more accurate and to prevent confusion and misunderstanding.

Not Significant  The electronic-only stop-loss table 2 was split out between specific stop loss and aggregate stop loss.

Not Significant  The instructions and labels for bonds and preferred stock of Asset Concentration (XR011) were updated.

Life RBC Formula

Not Significant  Due to the elimination of the fraternal annual statement beginning with year-end 2019, the life RBC formula was modified to incorporate fraternals. This entailed minor changes to address items that are not applicable to fraternals and references to the fraternal annual statement blank.

Not Significant  Changes developed by the Variable Annuities Capital and Reserve (E/A) Subgroup and recommended to the Life Risk-Based Capital (E) Working Group to implement the Variable Annuities Framework were incorporated into the life RBC instructions.

Not Significant  The Operational Risk Informational Only Growth Risk page was removed from the life RBC formula.
Not Significant  The label for the C-0 component was modified to be more accurate and to prevent confusion and misunderstanding.

Not Significant  The electronic-only stop-loss table 2 was split out between specific stop loss and aggregate stop loss.

**P/C RBC Formula**

Not Significant  The RBC Instructions and Footnotes in PR027A and PR027B were modified to allow accepted internal catastrophe models as the basis for the catastrophe risk charge.

Not Significant  The label for the R0 component was modified to be more accurate and to prevent confusion and misunderstanding.

Not Significant  The electronic only stop loss tables were split out between specific stop loss and aggregate stop loss.

Not Significant  The labels of preferred stock and hybrid of Asset Concentration (PR011) were updated in the blanks and instructions.

Not Significant  The PR016 instructions were modified to address the inconsistencies between the instructions and the formula for the computation of the selected average growth rate.

Not Significant  The PR003 through PR005 instructions were modified to address the inconsistencies between the instructions and the formula for the computation of the affiliated stocks.

Not Significant  The Schedule BA Annual Statement line references were updated in PR008 and PR009.

Not Significant  The Line 4 Underwriting Risk Reserves and Premiums factors in PR017 and PR018 were updated based on the 2017 American Academy of Actuaries Report for Property and Casualty Risk-Based Capital Underwriting Line 4 Factors.

Not Significant  The PR017 and PR018 Line 1 industry average development factors were updated.
To: The Financial Regulation Standards and Accreditation (F) Committee  
From: Susan Bernard, Chair, Financial Examiners Handbook (E) Technical Group  
Date: February 27, 2020  
Subject: Consideration for Financial Accreditation Standards  
2020 Financial Condition Examiners Handbook

The Accreditation Program Manual includes Review Team Guidelines to be used for financial examinations performed using the risk-focused surveillance approach that is found in the NAIC Financial Condition Examiners Handbook (the Handbook). This memorandum is to update the FRSAC on changes that the Financial Examiners Handbook Technical Group (FEHTG) has made to the Handbook during 2019.

Modifications are made to the Handbook each year, and a new edition is printed annually. This process allows for an efficient way to update the Handbook and ensures that users have the latest version. The FEHTG made several changes to the Handbook in 2019. It is the FEHTG’s opinion that none of these changes should be considered “significant” for accreditation purposes. FEHTG defined “significant” as a change that may immediately warrant a change to at least one accreditation standard or the Review Team Guideline(s) for said standard. Although some changes may be categorized as “significant” by the FEHTG, this is not meant to suggest the modifications are synonymous with the term “significant” within the FRSAC context.

During 2019, the FEHTG made the following changes:

- Revised the format of Exhibit V – Overarching Prospective Risk Assessment to encourage a more in-depth review and assessment of prospective risks during an examination. Related changes were made to Exhibit AA – Summary Review Memorandum to incorporate definitions for Risk Assessment Level and Trend.

- Revised guidance related to C-Level interviews, including the following:
  - Narrative guidance to encourage meeting with the department analyst prior to conducting interviews to gain an understanding of analyst concerns as well as what information the department has already obtained
  - Narrative guidance recommending that exam teams interview the Chief Risk Officer as early in the interview process as possible due to the broad perspective this individual can have. Information gathered from an interview with the CRO can be used to inform subsequent interviews.
  - Creation of a new interview template for interviewing a Chief Marketing Officer.

- Revised guidance related to management letters. This guidance provides clarity regarding what information should be communicated via a management letter, as well as to whom within a holding company structure the letter should be provided. The guidance also clarifies that in some cases the significance and severity of issues to be communicated may necessitate preparation two different management letters; one to be
delivered to the management and/or board of directors at the legal entity level and one to a level of the organization above the legal entity.

- Added narrative guidance referencing the NAIC Troubled Insurance Company Handbook. The revisions provide expectations for various communication that should occur when a company is designated a priority one (troubled) or priority two (potentially troubled). Guidance revisions also include possible areas for review and testing during an examination of a troubled or potentially troubled insurance company.

- Revised guidance related to Information Technology (IT) in the following areas:
  - Revisions to clarify IT review conclusions
  - Revisions to clarify different types of third-party work that may be considered and how to use that work to supplement the IT review
  - Narrative guidance regarding how an IT examination may utilize the results of a company’s IT self-assessment.

- Added narrative guidance describing roles and responsibilities for commonly held regulatory positions as well as recommended salary ranges for those positions. Note, these changes are consistent with revisions adopted by the Financial Analysis Solvency Tools (E) Working Group for inclusion in the 2020 Financial Analysis Handbook. Additionally, the FEHTG is supportive of the proposed revisions referred to FRSAC by the Risk-Focused Surveillance (E) Working Group on this matter.

The FEHTG sincerely requests that the FRSAC consider the items listed above as insignificant changes to the Handbook. We will continue to notify the FRSAC of any changes to the Handbook and advise if, in our opinion, those changes are “significant” by accreditation expectations.

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MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: Kevin Fry (Ill), Chair Valuation of Securities (E) Task Force
       Charles Therriault, Director, NAIC Securities Valuation Office

CC: Dan Daveline, Director, NAIC Financial Regulatory Services
    Mark Perlman, Managing Investment Counsel, NAIC Securities Valuation Office

DATE: March 3, 2020

RE: Report of the Valuation of Securities (E) Task Force

A. Purpose – This report is presented to assist the Financial Regulation Standards and Accreditation (F) Committee to determine if amendments to the Purposes and Procedures Manual of the NAIC Investment Analysis Office adopted by the Valuation of Securities (E) Task Force in 2019 require corresponding changes in either the Financial Regulation Standards (defined below) or state laws or regulations adopted in conformity with Part A: Laws and Regulations of the Financial Regulation Standards.

B. Financial Regulation Standards – The NAIC Policy Statement on Financial Regulation Standards (SFRS) in the 2020 Accreditation Program Manual consists of four parts: Part A identifies laws and regulations deemed necessary to financial solvency regulation;1 Part B identifies regulatory practices and procedures that supplement and support enforcement of the financial solvency laws and regulations discussed in Part A;2 Part C contains three standards related to an insurance department’s organizational and personnel policies; and Part D focuses on Organization, licensing and change of control of domestic insurers. This report is concerned with the financial solvency standards in Part A. Those standards relevant to this report are shown immediately below and can be characterized as NAIC model legislation, codified NAIC guidance (i.e., the Accounting Practices and Procedures Manual): analytical work product of the NAIC staff (including the NAIC Investment Analysis Office) and state laws and regulations that contain substantially the same standards as NAIC model legislation or guidance. A review indicates that the work product of the NAIC Investment Analysis Office is directly or indirectly incorporated into the following Part A standards. For example:

- **Standard 5** requires that insurer owned securities be valued in accordance with the standards promulgated by the NAIC Investment Analysis Office;3
- **Standard 2**, the Risk-Based Capital (RBC) for Insurers Model Act (#312)4 assigns RBC factors for securities based on their credit risk as measured by NAIC Designations;
- **Standard 3**, the Accounting Practices and Procedures Manual5 uses NAIC Designations produced by the SVO or by insurers through the filing exempt process and or Price Grids produced by the SSG to identify valuation rules applicable to an investment and the reserved capital amount the insurer must report;
Standard 8, pertaining to state investment regulations often incorporate NAIC mechanisms that relate asset allocations to credit risk expressed in the form of NAIC Designations; and

Standard 10, the Credit for Reinsurance Model Act (#785) identifies insurer owned securities compiled by the SVO into a List of Investment Securities published quarterly in the NAIC AVS + Plus product, and letters of credits issued by the banks on the NAIC Bank List administered by the SVO, as eligible for use as collateral in reinsurance transactions.

C. Investment Analysis Office Standards Identified in the Purposes and Procedures Manual – All SVO and SSG standards related to the assessment of credit risk in insurer owned securities, identification of additional non-payment risk in securities, classification of certain assets as bonds or as bond-like for reporting purposes, the valuation of insurer owned securities, and other activities conducted by the SVO or the SSG in support of state insurance regulatory objectives, are determined and promulgated by the Valuation of Securities (E) Task Force and published in the Purposes and Procedures Manual. In 2019, the Purposes and Procedures Manual was revised once, in December, with all policies, analytical procedures and instructions adopted during 2019 effective for year-end financial reporting. Amendments to the Purposes and Procedures Manual would automatically be reflected in the SFRS if any or all of the SFRS Standards identified in paragraph A of this memorandum have been adopted by an accredited state or incorporated by reference into the laws or regulations of an accredited state. For example, amendments to the Purposes and Procedures Manual would be directly incorporated by reference if the laws or regulations of an accredited state refer to or incorporate Standard 5 on valuation. Amendments to the Purposes and Procedures Manual would be indirectly incorporated by reference if the law or regulations of a state refers to or incorporates any other Standard that itself uses NAIC Designations or other analytical products of the Investment Analysis Office as a component; for example, Standard 2 in the case of RBC and/or Standard 3 in the case of statutory accounting.

D. Conclusion – In our opinion, reasoning as discussed above, amendments to the Purposes and Procedures Manual adopted by the Valuation of Securities (E) Task Force in 2019 can be characterized as maintenance items consistent with the existing regulatory framework and automatically incorporated into the Part A Standards identified above. The amendments identified in Appendix One did not create processes or practices external to the Purposes and Procedures Manual or other NAIC model legislation, guidance or analysis of NAIC staff that would suggest the need to consider an amendment to NAIC model legislation or guidance or legislative action on the part of an accredited state.

We hope this is responsive to the issues and concerns before the Committee.
Appendix One

RECENT CHANGES TO THE PURPOSES AND PROCEDURES MANUAL
Published in the December 31, 2019 Publication

- **Adopted a comprehensive framework for funds that hold a portfolio of bonds** – The framework consolidates and modernizes long existing VOS/TF policies and practices applicable to investments in funds that hold bond portfolios and expands that policy to funds issued by closed end management companies and unit investments trusts registered and regulated by the U.S. Securities and Exchange Commission. The guidance encompasses the two verification procedures, exchange traded funds (ETFs), bond mutual funds and private funds reported on Schedule BA. The amendment adds definitions, documentation requirements and a transparent analytical framework. The Blanks Working Group will consider adding a column to Schedule D, Part 2, Section 2 so insurers can report an NAIC Designation for funds designated by the SVO and the Capital Adequacy (E) Task Force has been asked to consider how to include such NAIC Designations into the RBC calculation once NAIC Designations are added to Schedule D, Part 2, Section 2. The Valuation of Securities (E) Task Force adopted this amendment on April 7, 2019.

**Improved Disclosure on Securities Not Eligible for Filing Exemption** – The VOS/TF may exclude certain securities from filing exemption and this amendment modernized this by compiling these exclusions into a list of securities not eligible for Filing Exemption. Although this disclosure did not modify or delete the term Bond in the 2018 P&P Manual, the term was not included in the 2019 reformatted P&P Manual because the adoption of policy statements requiring coordination between the VOS/TF and the Statutory Accounting Principles (E) Working Group meant that the term “Bond” could only be defined by reference to statutory accounting guidance. The operative term for VOS/TF operations (i.e., the term Obligations, which is broader than the term Bonds) was retained. The Valuation of Securities (E) Task Force adopted this amendment on April 7, 2019.

**Modified Guidance for Regulatory Transactions** – This P&P Manual amendment clarified the status of an Investment Security that is used as a component in a Regulatory Transaction. Insurance companies shall not report a Regulatory Transaction as a Filing Exempt security, and the NAIC staff shall not assign an NAIC Designation to a Regulatory Transaction or add them to the Filing Exempt Securities Process of the SVO List of Investment Securities. This does not preclude the SVO from working directly with a state insurance department and issuing an opinion to the department consistent with the instructions outlined in this Manual. The Valuation of Securities (E) Task Force adopted this amendment on April 7, 2019.


• **Deleted the Definition of “Structured Notes” and Made Related Modifications** – The Statutory Accounting Principles (E) Working Group advised the VOS/TF that it had adopted, with a Dec. 31, 2019, effective date, a definition for “structured notes” that brings that financial activity in scope of the *Statement of Statutory Accounting Principles (SSAP) No. 86—Derivatives*. The new guidance defines structured notes as “an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due.” That determination removes these instruments from being in scope of SSAP No. 26R—*Bonds* and (with the exception of mortgage-referenced securities) SSAP No. 43R—*Loan-Backed and Structured Securities*. This amendment deletes the definition and adds a reference to the description of a structured notes SSAP No. 26R and SSAP No. 86. A note on the guidance on mortgage-referenced securities was also added clarifying that it is subject to assessment by SSG. The Valuation of Securities (E) Task Force adopted this amendment on August 4, 2019.
Added Instructions for Referencing Administrative Codes Used to Report Regulatory Transactions – The P&P Manual defines the term “regulatory transactions” and provides that such transactions: (a) are not eligible for credit assessment by the SVO; (b) are not eligible for filing exemption (FE); (c) cannot be self-assigned the administrative symbol Z under the 120 rule; (d) cannot be self-assigned as 5GI securities; and (e) cannot be entered into NAIC systems maintained for the VOS/TF. The P&P Manual also provides that a domiciliary state insurance department may request SVO or SSG assistance in the assessment of a regulatory transaction, with the understanding that the state can adopt the SVO or SSG work product as its own, but the determination is a state determination and not an NAIC work product. Despite this specified treatment, there was no specific instruction for reporting regulatory transactions, and reporting entities did not have any available reporting options when investment schedules require an NAIC Designation. This amendment addressed the reporting for regulatory transactions. A reporting entity would use the code “RTS” when the domiciliary state has received assistance from the SVO (or SSG) in reviewing a regulatory transaction. In those cases, the code would be reported with the “analytical value” (a new term defined below) assigned by the SVO and given to the state. The code “RT” would be used for all other regulatory transactions; i.e., those in which the domiciliary state did not ask the SVO for assistance or those where the SVO was unable to determine an analytical value for the transaction for the state and the “RT” code would be reported with an NAIC 6 Designation for measurement and risk-based capital (RBC) assessments. The Valuation of Securities (E) Task Force adopted this amendment on September 5, 2019.

Updated the Interim Instructions for Mortgage Reference Securities – This amendment to the P&P Manual updated guidance for Mortgage Reference Securities. The Structured Securities Group (SSG) is responsible to financially model this group of securities; however, they only review them during their annual surveillance process. Insurers did not have instructions to assign an NAIC Designation to a newly issued or newly acquired mortgage reference security prior to the publication of the annual surveillance data. This amendment provides that interim guidance. The Valuation of Securities (E) Task Force adopted this amendment on October 31, 2019.

Added Ground Lease Financing Transactions as New Asset Class – This amendment to the P&P Manual adds new instructions and guidance for Ground Lease Financing (GLF) Transactions. A GLF transaction typically has two components: (a) a ground lease for a long period (e.g., 99 years) between a ground lessor who owns the land and a ground lessee who attains a leasehold for the purpose of developing the land; and (b) the subleasing of space or operation of a business such as a hotel, warehouse, intermodal facility, etc., in an existing or to-be-constructed building to one or more tenants (space tenants) under shorter (e.g., 5–15 year) leases (space leases) or to the operator of a business such as a hotel, warehouse, intermodal facility, etc., under a franchise agreement or other arrangement. This amendment provides filing, structure and analysis guidance for GLFs. The Valuation of Securities (E) Task Force adopted this amendment on December 8, 2019.
Deleted the Administrative Symbols RP or P and a related methodology – The deletion of these symbols align the P&P Manual with changes to the Blanks introduced by a February 28, 2018, Blanks Proposal and Interrogatory. The Proposal replaced the use of the SVO assigned symbols with new lines and an instruction that the insurer aggregate the amount of such securities on the specified line. This amendment—effective December 31, 2019—deletes the SVO methodology and the Administrative Symbols from the P&P Manual. The Valuation of Securities (E) Task Force adopted this amendment on August 5, 2018, with an effective date of December 31, 2019.

Deleted Valuation Procedures but retained Administrative Symbols – The Administrative Symbols A, V, L, U and UP were used by the SVO in connection with the Valuation Procedures for common stock. The Valuation Procedures were deleted effective for year-end 2018 but the identified Administrative Symbols were retained until December 31, 2019, to align their deletion with the elimination of the same symbols from the Blanks process. The Valuation of Securities (E) Task Force adopted this amendment on September 4, 2018, with an effective date of December 31, 2019.

Modified the Administrative Symbol NR to ND – The Administrative Symbol NR means Not Rated. It was changed to ND, which means Not Designated, to align it with NAIC terminology and to avoid the technical and legal meaning of “rating” under federal securities law. The need to modify NAIC electronic platforms that use the system means it will not be possible to implement this change until year-end 2019. The Valuation of Securities (E) Task Force adopted this amendment on November 16, 2018 and was implemented for December 31, 2019.
The SFRS requires the use of the codified version of the Accounting Practices and Procedures Manual. Valuation procedures applicable to long-term invested assets are determined by the nature of the insurer (life or property/casualty) and the NAIC designation assigned to the security by the SVO or SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “…To satisfy this standard, …specific adoption of the NAIC Annual Statement Blank, NAIC Annual Statement Instructions, and the NAIC Accounting Practices and Procedures Manual [is required].…”

The SFRS requires a diversified investment portfolio. Although the Investment of Insurers Model Act (Defined Limits or Defined Standards) is not specifically identified, portions of one or the other model acts have been adopted by many of the states and these relate specific asset allocations to NAIC designations provided by the SVO or in some cases by the SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “…This standard …[will require] that statutes, together with related regulations and administrative practices, provide adequate basis …to prevent, or correct, undue concentration of investment by type and issue and unreasonable mismatching of maturities of assets and liabilities. The standard is not interpreted to require an investment statute that automatically leads to a fully diversified portfolio of investments.”

The NAIC Investment of Insurers Model Act (Defined Limits Version) (#280) imposes a 3% limit on the amount an insurer can invest in a single person (the threshold diversification limit) and also imposes a percentage limit on total investments of a defined credit quality, expressed by reference to NAIC Designation categories (the threshold credit quality limit). An additional percentage limit is then assigned to specific asset categories, which may or may not be subject to adjustment with the two threshold requirements. The limits identified in the Model Act are what would guide portfolio allocation decisions. Once made, the insurer would shift to monitoring changes in the portfolio and rebalancing the allocations accordingly. Assuming a process for the identification of concentrations caused by indirect exposures, the insurer would aggregate such exposures with similar risks across all activities.

The SFRS requires the adoption of the Credit for Reinsurance Model Act (#785), Credit for Reinsurance Model Regulation (#786) and Life and Health Reinsurance Agreement Model Regulation (#791) or substantially similar laws. The SVO maintains a list of banks that meet defined eligibility criteria to issue letters of credit in support of reinsurance obligations or that are eligible to serve as trustees under various arrangements required by state insurance law.
MEMORANDUM

To: Financial Regulation Standards and Accreditation (F) Committee
From: NAIC Staff
Date: March 3, 2020
Re: 2011 & 2019 Revisions to Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786)—Applicability to Risk Retention Groups (RRGs)

Executive Summary

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786). These revisions were intended to incorporate the relevant provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement), which was signed on Sept. 22, 2017. At the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted these revisions to the Reinsurance Ceded accreditation standard effective Sept. 1, 2022, for consideration by the Executive (EX) Committee and Plenary for final adoption at the Spring National Meeting.

The purpose of this memorandum is to clarify the applicability of these revisions to risk retention groups (RRGs) organized as captives. The recommendation to this Committee is that the 2019 revisions to Model #785 and Model #786, as well as the 2011 revisions establishing certified reinsurers and qualified jurisdictions (which became applicable as an accreditation standard Jan. 1, 2019), also should be made applicable to RRGs.

Risk Retention Groups Organized as Captives

Article 3 (Reinsurance) of the Covered Agreement is applicable to ceding insurers, which Article 2(j) defines as “an undertaking which is authorized or licensed to take up or engage in the business of direct or primary insurance.” This would arguably include RRGs that are organized or incorporated by states as captive insurers. Reinsurance Ceded is part of the Part A accreditation requirements for RRGs, and requires that state law should contain Model #785 and Model #786, or substantially similar laws. The primary difference between the current reinsurance accreditation standard for RRGs is that “a state’s laws and regulations may allow RRGs to take credit for reinsurance without posting collateral in circumstances not contemplated by the Credit for Reinsurance Model Law and Regulation. For such cases, the Accreditation Interlineations include Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers” and a state’s laws and regulations must comply with the guidelines in order to be considered substantially similar with this standard.”
NAIC staff has reviewed the laws and regulations with respect to the fifteen (15) NAIC jurisdictions which currently license multi-state RRGs as captive insurers (AL, AZ, CO, DE, DC, HI, KY, ME, MT, NV, NC, OK, SC, TN and VT), and each meets the current Reinsurance Ceded accreditation standard in a very similar manner. First, each states’ laws require that an RRG must be licensed as a captive insurer (and in some instances, a specific type of captive insurer) subject to its captive insurance laws. Second, the captive insurance laws generally exempt captive insurers from the general laws with respect to traditional insurers, except as is otherwise specified in statute. Finally, the statutes make RRGs that are licensed as captive insurers subject to the state’s credit for reinsurance laws, either generally (e.g., an RRG licensed as a captive insurer must comply with all of the laws, rules, regulations and requirements applicable to insurers chartered and licensed in the state) or specifically (e.g., an RRG licensed as a captive insurer must comply with the laws specified in this chapter, including specifically the credit for reinsurance laws). We also reviewed the proposed legislation of the five states currently considering adoption of the 2019 revisions to the models (ME, OK, SC, TN & VT), and the proposed legislation would not change this outcome.

Recommendation

NAIC staff recommends that the Committee consider making the 2019 revisions to Model #785 and Model #786 an accreditation standard for RRGs effective Sept. 1, 2022, with enforcement of the standard to commence Jan. 1, 2023. Staff further recommends that the 2011 revisions to the models relating to certified reinsurers and qualified jurisdictions also be made a part of the accreditation standard, because the 2019 revisions are in large part based on these earlier revisions. Finally, we recommend that the changes in the attached redlined accreditation standard be adopted as the new accreditation standard for reinsurance ceded to RRGs.

Note: The Risk Retention Group (E) Task Force met on March 2, and approved these recommendations. The Reinsurance (E) Task Force will meet March 11 to consider approval of the recommendations.
10. Reinsurance Ceded

State law should contain the NAIC Credit for Reinsurance Model Law (#785), the NAIC’s Credit for Reinsurance Model Regulation (#786) or substantially similar laws.

Complete the following question only if this is an interim annual review:

Have there been any changes to the department’s ceded reinsurance requirements since last year’s review?  

YES  NO

If the response is NO, there is no further information needed regarding this standard, please proceed to the next standard.

If the response is YES, in the reference column please provide the applicable citation for each of the questions in this particular standard. Additionally, please attach a copy of the statutes or regulations that had a change and ensure that they are clearly marked for the changes that have been made (i.e., highlight the changes, redlined version, etc.) Please place an asterisk (*) in the reference column on the right-hand side of the page by each citation that has been changed. Also, please include below a brief description of the nature or reason for the change.

If the department is completing the self-evaluation guide due to an upcoming full review, please provide the applicable citation for each of the questions in this particular standard. Additionally, please attach a copy of the statutes or regulations that are listed in the reference column.

**REFERENCE**

*Credit for Reinsurance Model Law (#785)*

a. Credit allowed for reinsurance ceded to a licensed insurer? If the reinsurer is licensed as a RRG, then the ceding RRG or its members must qualify for membership with the reinsurer.

b. Credit allowed for reinsurance ceded to an accredited insurer who meets requirements similar to those in Section 2B of the model law?

c. Credit allowed for reinsurance ceded to an insurer domiciled and licensed in a state which employs substantially similar standards regarding credit for reinsurance and who maintains capital and surplus of at least $20,000,000 and submits to this state’s authority to examine its books and records?

d. Credit allowed for reinsurance ceded to an insurer who maintains a trust fund, established in a form approved by the Commissioner, in a qualified U.S. financial institution for the payment of the valid claims of its U.S. policyholders and ceding insurers, their assigns and successors in interest and who reports financial information annually to the Commissioner to determine the sufficiency of the trust fund?

e. In instances where reinsurance is ceded to insurers maintaining a trust fund, trustees of the trust required to report to the department annually, on or before February 28, the balance of the trust and a listing of the trust’s assets as of the end of the year and a certification of the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31?
f. Credit for reinsurance allowed under c. or d. above only permitted where assuming insurer agrees in the reinsurance agreements: 1) that in the event of a failure of the assuming insurer to perform its obligations, the assuming insurer shall submit to the jurisdiction of any court of competent jurisdiction in any state of the U.S.; and 2) to designate the Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process instituted by or on behalf of the ceding company?

g. Credit allowed for reinsurance ceded to an insurer meeting requirements similar to those in Section 2E (Certified Reinsurers) of the model law?

h. Credit allowed for reinsurance ceded to an insurer meeting requirements similar to those in Section 2F (Reciprocal Jurisdictions) of the model law?

i. Although not required for accreditation, a state’s laws and regulations may allow RRGs to take credit for reinsurance without posting collateral in circumstances not contemplated by the Credit for Reinsurance Model Law and Regulation. For such cases, the Accreditation Interlineations include “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers” and a state’s laws and regulations must comply with the guidelines in order to be considered substantially similar with this standard. If your state’s laws and regulations do allow credit for reinsurance without collateral as discussed in the Accreditation Interlineations, please include the citation.

Note: An RRG’s reinsurers as of Jan. 1, 2011, are grandfathered in as acceptable without meeting the requirements in the Reinsurance Guidelines. The requirements in the Reinsurance Guidelines should be used for new reinsurers with which business is placed after Jan. 1, 2011.

j. Credit allowed for reinsurance ceded to an insurer not meeting the requirements of a., b., c., d., g., h. or i. above in an amount not exceeding the liabilities carried by the ceding insurer and only in the amount of funds held by or on behalf of the ceding insurer in the form of cash, securities listed by the Securities Valuation Office of the NAIC and qualifying as admitted assets, clean, irrevocable, unconditional letters of credit, and other forms of security acceptable to the Commissioner?

k. Credit for reinsurance allowed for reinsurance ceded by domestic reinsurers to assuming insurers that were licensed in the state as of the last date of the ceding insurers’ statutory financial statement? If the reinsurer is licensed as a RRG, then the ceding RRG or its members must qualify for membership with the reinsurer.

l. Credit for reinsurance provisions for accredited reinsurer similar to Section 5?

m. Credit for reinsurance provisions for reinsurers licensed and domiciled in other states similar to Section 6?
n. Credit for reinsurance provisions for reinsurers maintaining trust funds similar to Section 7?

o. Credit for reinsurance required by law similar to Section 9, to the extent permitted by 15 USC 3902(a)?

p. Reduction from liability for reinsurance ceded to an unauthorized assuming insurer similar to Section 10? Note: See significant element g. above regarding allowance of credit for reinsurance in certain situations not contemplated by the Model Law.

q. Provisions for trust agreements similar to Section 11?

r. Provisions for letters of credit similar to Section 12?

s. Provisions for unencumbered funds similar to Section 13?

t. Provisions for reinsurance contracts similar to Section 14? Note: For those reinsurance contracts for which credit is allowed under significant element g. above, the reinsurance contract should contain language similar to Section II of the “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers.”

u. The adoption of Form AR-1—Certificate of Assuming Insurer. Note: For situations in which credit for reinsurance is taken under significant element g. above, the reinsurance contract should contain language similar to Section II of the “Reinsurance Guidelines for Risk Retention Groups Licensed as Captive Insurers.”

v. Credit for reinsurance provisions for certified reinsurers similar to Section 8?

w. Credit for reinsurance provisions for reciprocal jurisdictions similar to Section 9?
TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: NAIC Staff

DATE: March 3, 2020

RE: Technical Revisions to the Term and Universal Life insurance Reserve Financing Model Regulation (#787) as an Accreditation Standard

At the 2019 Fall National Meeting, the Financial Regulation Standards and Accreditation (F) Committee adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787), commonly known as the XXX/AXXX model, as a new accreditation standard. The decision is pending approval by Plenary.

Following adoption by the Committee, the Reinsurance (E) Task Force adopted technical changes to Model #787, which included Section 4E as follows:

   E. Reinsurance ceded to an assuming insurer that meets the requirements of [insert provision of state law equivalent to Section 5B(4) of the Credit for Reinsurance Model Law]; or

The technical changes were due to revisions to the Credit for Reinsurance Model Law (#785) adopted by the NAIC in June 2019, which impacted sections referenced in Model #787. The referenced Section 5B(4) provides an exemption to Model #787 for what is commonly referred to as “professional reinsurers.” As defined in the 2016 version of Model #785 Section 5B(4)(a) and (b), these professional reinsurers are reinsurers that meet certain minimum capital requirements and are certified reinsurers in a certain minimum number of states. The 2019 revisions to Model #785 add a new Section 5B(4)(a) to provide a similar exemption for reinsurers domiciled in reciprocal jurisdictions, as defined in Section 2F of Model #785. This shifted the original (a) and (b) to (b) and (c).

A copy of the revised Section 5 is attached. To accurately reflect the exemption intended by the reference in Model #787, the entire Section 5B(4) is now referenced in Model #787.

NAIC staff therefore recommend that an equivalent change also be made to the accreditation standard. The proposed change affects significant element “b” as follows:

   b. Provides that Model #787 does not apply to reinsurance exempt by the provisions of Section 4 of Model #787, including reinsurance ceded to an assuming insurer that meets the requirements of Section 5B(4) of the Credit for Reinsurance Model Law (#785)?

The original referral from the Reinsurance (E) Task Force with the recommendation to the Committee regarding Model #787 as an accreditation standard, including the accreditation significant elements, is attached for reference.
CREDIT FOR REINSURANCE MODEL LAW

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Section 1. Purpose
Section 2. Credit Allowed a Domestic Ceding Insurer
Section 3. Asset or Reduction from Liability for Reinsurance Ceded by a Domestic Insurer to an Assuming Insurer not Meeting the Requirements of Section 2
Section 4. Qualified U.S. Financial Institutions
Section 5. Rules and Regulations
Section 6. Reinsurance Agreements Affected

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Section 5. Rules and Regulations

A. The commissioner may adopt rules and regulations implementing the provisions of this law.

Drafting Note: It is recognized that credit for reinsurance also can be affected by other sections of the enacting state’s code, e.g., a statutory insolvency clause or an intermediary clause. It is recommended that states that do not have a statutory insolvency clause or an intermediary clause consider incorporating such clauses in their legislation.

B. The commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in Paragraph (1) of this Section 5B.

Drafting Note: This new regulatory authority is being added in response to reinsurance arrangements entered into, directly or indirectly, with life/health insurer-affiliated captives, special purpose vehicles or similar entities that may not have the same statutory accounting requirements or solvency requirements as US-based multi-state life/health insurers. To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such policies and reinsurance arrangements.

(1) A regulation adopted pursuant to this Section 5B, may apply only to reinsurance relating to:

(a) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(b) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(c) Variable annuities with guaranteed death or living benefits;

(d) Long-term care insurance policies; or

(e) Such other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(2) A regulation adopted pursuant to Paragraph 1(a) or 1(b) of this Section 5B, may apply to any treaty containing (i) policies issued on or after January 1, 2015, and/or (ii) policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

Drafting Note: The NAIC’s Actuarial Guideline XLVIII (AG 48) became effective January 1, 2015, and covers policies ceded on or after this date unless they were ceded as part of a reserve financing arrangement as of December 31, 2014. One regulation contemplated by this revision to the NAIC Credit for Reinsurance Model Law (#785) is intended to substantially replicate the requirements for the amounts and forms of security held under the rules provided in AG 48. AG 48 was written to sunset upon a state’s adoption (pursuant to the enabling authority of the preceding paragraph) of a regulation with terms substantially similar to AG 48. The preceding paragraph is intended to provide continuity of rules applicable to those policies and reinsurance arrangements, including continuity as to the policies covered by such rules. The preceding paragraph is not intended to change the scope of, or collateral requirements for policies and treaties covered under AG 48.
(3) A regulation adopted pursuant to this Section 5B may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under Section 11B(1) of the NAIC Standard Valuation Law, including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

(4) A regulation adopted pursuant to this Section 5B shall not apply to cessions to an assuming insurer that:

(a) Meets the conditions set forth in Section 2F of the Credit for Reinsurance Model Law (#785) in this state or, if this state has not adopted provisions substantially equivalent to Section 2F of the Credit for Reinsurance Model Law (#785), the assuming insurer is operating in accordance with provisions substantially equivalent to Section 2F of the Credit for Reinsurance Model Law (#785) in a minimum of five (5) other states; or

(b) Is certified in this state or, if this state has not adopted provisions substantially equivalent to Section 2E of the Credit for Reinsurance Model Law (#785), certified in a minimum of five (5) other states; or

(c) Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is

(i) licensed in at least 26 states; or

(ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

(5) The authority to adopt regulations pursuant to this Section 5B does not limit the commissioner’s general authority to adopt regulations pursuant to Section 5A of this law.
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee
FROM: Reinsurance (E) Task Force
DATE: August 24, 2017
RE: Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

Executive Summary

The NAIC membership adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) at the 2016 Fall National Meeting on Dec. 13, 2016. At that same time, the NAIC membership also adopted revisions to Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48) to conform with the provisions of Model #787, effective Jan. 1, 2017. Model #787 establishes uniform, national standards governing reserve financing arrangements pertaining to term life and universal life insurance policies with secondary guarantees, and ensures that funds consisting of primary security and other security are held in the forms and amounts required.

At its meeting on Aug. 7, 2017, the Reinsurance (E) Task Force agreed to submit the following recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

1. Model #787 should be adopted as a new accreditation standard by the NAIC, with significant elements as outlined in Appendix A.

2. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this standard. The Task Force recommends that the accreditation standard become effective Jan. 1, 2020. The Task Force further recommends that a state’s adoption of AG 48 will serve to satisfy this accreditation standard until such time that the state adopts the significant elements of Model #787.

3. The 2016 revisions to the Credit for Reinsurance Model Law (#785) should be considered acceptable but not required by the states.

In addition to the preceding recommendations, the Task Force is offering the following additional information in order to assist the Financial Regulation Standards and Accreditation (F) Committee in reviewing the proposed accreditation standard for Model #787.
Substantially Similar

The Task Force has recommended in the draft accreditation standard that the “substantially similar” standard be utilized to meet the minimum requirements of the standard. However, the Task Force did note that Drafting Notes to Section 2, Section 3 and Section 5 of Model #785 might suggest a stronger standard of review than “substantially similar.” The Drafting Notes provide, as follows: “To assist in achieving national uniformity, commissioners are asked to strongly consider adopting regulations that are substantially similar in all material respects to NAIC adopted model regulations in the handling and treatment of such reinsurance arrangements.” [Emphasis added]. In recognition of this, and to assist in review of the actuarial method used to determine the required level of primary security as described in Section 6 of Model #787, the Task Force recommends that the NAIC Legal Division specifically note any material changes in a state’s regulation during an accreditation review for consideration by the Financial Regulation Standards and Accreditation (F) Committee.

State Adoption of AG 48

The Task Force recommends that the accreditation standard become effective on an expedited basis beginning Jan. 1, 2020. However, the Task Force further recognizes that meeting the expedited date may not be feasible for some states in instances due, in whole or part, to other legislative priorities of the states. It is the recommendation of the Task Force that, in such cases, a state’s compliance with AG 48 should be considered as satisfactory to the Financial Regulation Standards and Accreditation (F) Committee as substantial compliance with Model #787. AG 48 became effective Jan. 1, 2015, and became part of the Accounting Practices and Procedures Manual through its inclusion in Appendix C, and has been amended to conform with Model #787 effective Jan. 1, 2017.

2016 Revisions to Model #785

The Task Force does not recommend that the 2016 revisions to Model #785 be included in the proposed accreditation standard. These revisions provide that the commissioner may adopt regulations with respect to: 1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; 2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; 3) variable annuities with guaranteed death or living benefits; 4) long-term care insurance policies; and 5) other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance. The revisions to Model #785 also contain a “professional reinsurer exemption” for reinsurers that maintain at least $250 million in capital and surplus when determined in accordance with the Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is: 1) licensed in at least 26 states; or 2) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

The reasoning of the Task Force is that Model #787 only applies to term life and universal life with secondary guarantees (XXX/AXXX) captive reinsurance transactions, and that variable annuities, long-term care insurance and other life and health insurance and annuity products are not currently addressed. Therefore, it would be considered to be premature to require the states to adopt these provisions. In addition, the professional reinsurer exemption of Section 5B(4) of Model #785 is specifically referenced in the draft accreditation standard. Therefore, it is the recommendation of the Task Force that the 2016 revisions to Model #785 are optional, and should be considered as acceptable but not required by the states.
Appendix A

Proposed Accreditation Standard

Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

State statute and/or regulation should be substantially similar to uniform, national standards that govern reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees, to ensure that both the total security and the primary security are provided in forms and amounts that are in compliance with the requirements set forth in the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

a. Provides that the Credit for Reinsurance Model Regulation (#786) and Model #787 shall both apply to reinsurance treaties that cede liabilities pertaining to Covered Policies; provided, that in the event of a direct conflict between the provisions of Model #787 and the provisions of Model #786, the provisions of Model #787 shall apply, but only to the extent of the conflict, substantially similar to Section 3 of Model #787?

b. Provides that Model #787 does not apply to reinsurance exempt by the provisions of Section 4 of Model #787, including reinsurance ceded to an assuming insurer that meets the requirements of either Section 5B(4)(a) of the Credit for Reinsurance Model Law (#785), which pertains to certain certified reinsurers, or Section 5B(4)(b) of Model #785, which pertains to reinsurers meeting certain threshold size and licensing requirements?

c. Provides definitions of “Covered Policies,” “Grandfathered Policies,” “Required Level of Primary Security,” “Actuarial Method,” “Primary Security,” “Other Security” and “Valuation Manual” that are substantially similar to such terms as defined in Section 5 of Model #787?

d. Provides for an Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation that is substantially similar to the methodology as set forth in Section 6A of Model #787?

e. Provides for valuations to be used 1) in calculating the Required Level of Primary Security pursuant to the Actuarial Method; and 2) in determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, that are substantially similar to the valuations set out in Section 6B of Model #787?

f. Provides for requirements to obtain credit for reinsurance with respect to ceded liabilities pertaining to Covered Policies that are substantially similar to the requirements set out in Section 7A of Model #787?

g. Provides for requirements at inception date and on an ongoing basis substantially similar to Section 7B(1) of Model #787?

h. Provides that if the requirements to hold Primary Security and total security are not both satisfied, the ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held, unless any deficiency has been eliminated pursuant to remediation provisions substantially similar to Section 7B(2) of Model #787?

i. Includes a prohibition against avoidance provision similar to Section 9 of Model #787?
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: John F. Finston (CA)
Chair, Reinsurance (E) Task Force

DATE: March 20, 2017

RE: 2016 Revisions to Credit for Reinsurance Model Law (#785)
Term and Universal Life Insurance Reserve Financing Model Regulation (#787)

Executive Summary

On June 30, 2014, the Principle-Based Reserving Implementation (EX) Task Force adopted the recommendations in the report of Rector & Associates, Inc. dated June 4, 2014, regarding a proposal for the XXX/AXXX Reinsurance Framework. The Framework sought to address concerns regarding reserve financing transactions and to do so without encouraging them to move offshore. The changes would be prospective and apply only to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life with secondary guarantees business (XXX/AXXX). The NAIC Executive (EX) Committee adopted the Framework (in concept) on Aug. 17, 2014. As an interim step to implementing the Framework, the NAIC adopted Actuarial Guideline XLVIII Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model 830) (AG 48) on Dec. 16, 2014. It was expected that AG 48 would eventually be replaced by effective codification through the Credit for Reinsurance Model Law (#785) and creation of a new model regulation to establish requirements regarding the reinsurance of XXX/AXXX policies.

The NAIC adopted revisions to Model #785 on Jan. 8, 2016, which give insurance commissioners authority to issue regulations codifying AG 48 and the XXX/AXXX Reinsurance Framework. The Reinsurance (E) Task Force adopted the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) at the Summer National Meeting on Aug. 27, 2016, and it was adopted by the Financial Condition (E) Committee with slight revisions via conference call on Sept. 30, 2016. Model #787 was then adopted by the Executive (EX) Committee and Plenary on Dec. 13, 2016. At that same time, the NAIC also revised AG 48 to conform with the provisions of Model #787, effective Jan. 1, 2017.

The Reinsurance (E) Task Force hereby submits the following recommendations to the Financial Regulation Standards and Accreditation (F) Committee:

1. The 2016 revisions to Model #785 and new Model #787 should be adopted as a new accreditation standard by the NAIC.
2. The F-Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this standard. The Task Force would recommend that the accreditation standard become effective January 1, 2020.

A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:

The 2016 revisions to Model #785 provide that the commissioner may adopt regulations with respect to (1) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; (2) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; (3) variable annuities with guaranteed death or living benefits; (4) long-term care insurance policies; and (5) other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance. The revisions to Model #785 also contain a “professional reinsurer exemption” for reinsurers that maintain at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is (1) licensed in at least 26 states; or (2) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

Model #787 does not materially change the ability of insurers to obtain credit for reinsurance ceded to “certified” reinsurers or to obtain credit for reinsurance ceded to “licensed” or “accredited” reinsurers that follow statutory accounting and risk-based capital (RBC) rules. As a practical matter, the Model #787 requirements apply to reinsurance ceded to captive insurers, SPVs, reinsurers that are not eligible to become “certified” reinsurers, or reinsurers that materially deviate from statutory accounting and/or RBC rules. In those situations, subject to certain exemptions and grandfathering provisions, the ceding insurer may receive credit for reinsurance if:

- The ceding insurer continues to establish gross reserves, in full, using applicable reserving guidance;
- Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis;
- The Actuarial Method used to establish the Required Level of Primary Security for each reinsurance treaty subject to Model #787 is based on VM-20, applied on a treaty-by-treaty basis;
- Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held are held by or on behalf of the ceding insurer as security under the reinsurance contract; and
- The reinsurance arrangement is approved by the ceding insurer’s domestic regulator.

A statement as to why ultimate adoption by every jurisdiction may be desirable:

The NAIC Principle-Based Reserving Implementation (EX) Task Force serves as the coordinating body for all NAIC technical groups involved with projects related to the Principle-Based Reserves (PBR) initiative for life and health policies. This Task Force was also charged with further assessing, and making recommendations regarding the solvency implications of life insurance reserve financing mechanisms addressed in the June 6, 2013, NAIC White Paper Captives and Special Purpose Vehicles, which provides in relevant part:

The Captive and Special Purpose Vehicle (SPV) Use (E) Subgroup studied the use of captives and SPVs formed by commercial insurers. The Subgroup concluded that commercial insurers cede business to
captives for a variety of business purposes. The Subgroup determined that the main use of captives and SPVs by commercial insurers was related to the financing of XXX and AXXX perceived reserve redundancies. The implementation of principle-based reserving (PBR) could reduce the need for commercial insurers to create new captives and SPVs to address perceived reserve redundancies; however, existing captives and SPVs are likely to remain in existence for several years or decades, until the existing blocks of business are run-off. Regulators need to be able to assess and monitor the risks that captives and SPVs may pose to the holding company system, and the current regulatory process should be enhanced to provide standardized tools and processes to be used by all regulators when reviewing such transactions. Commercial insurer-owned captives and SPVs should not be used to avoid statutory accounting. To the extent that insurer-affiliated captives and SPVs may be created in the future for unforeseen purposes, additional guidance should be developed by the NAIC to assist the states in a uniform review of transactions. [Emphasis added].

In addition, in coordination with the adoption in principle of the XXX/AXXX Reinsurance Framework, the Financial Regulation Standards and Accreditation (F) Committee was given the following charge: “As the various work products are adopted by the Principle-Based Reserving (EX) Task Force, Executive Committee, and Plenary, consider them for inclusion in the Part A and Part B Accreditation Standards.”

Finally, effective Jan. 1, 2016, the NAIC amended the Preamble for Part A: Laws and Regulations of the NAIC Policy Statement on Financial Regulation Standards to apply to the regulation of a state’s domestic insurers licensed and/or organized under its captive or special purpose vehicle statutes or any other similar statutory construct with respect to XXX/AXXX business, which is deemed to satisfy the Part A accreditation requirements if the applicable reinsurance transaction satisfies the XXX/AXXX Reinsurance Framework requirements adopted by the NAIC. Further, the revised Preamble provided, as follows: “The revisions to the Credit for Reinsurance Model Act (#785) and the new XXX/AXXX Model Regulation will need to be specifically considered for accreditation purposes once adopted by the NAIC.”

A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:

AG 48 became effective Jan. 1, 2015, and became part of the NAIC Accounting Practices and Procedures Manual through its inclusion in Appendix C. As such, provisions similar to the proposal have been effective in all states since that date.

As of this date, three states (Louisiana, Oklahoma and Utah) have gone beyond AG 48 and have adopted the 2016 revisions to Model #785 giving commissioners authority to issue regulations codifying AG 48 and the XXX/AXXX Reinsurance Framework, with several other states currently considering such revisions.

The new Part A Preamble became effective Jan. 1, 2016, with regard to XXX/AXXX reinsurance captives. NAIC staff worked with necessary state insurance departments to assess compliance with the new Part A Preamble related to captives that assume XXX/AXXX business, and reported its findings at the 2016 Fall National Meeting to the Financial Regulation Standards and Accreditation (F) Committee. NAIC staff reviewed all of the Dec. 31, 2015, XXX/AXXX Reinsurance Supplements that were filed with the NAIC to first ascertain whether the appropriate level of primary and other securities was being held to back the non-exempt XXX/AXXX reinsurance transactions. NAIC staff reported that all of the transactions held the required amount of securities, and therefore, all of the transactions satisfied the new Part A requirements.

A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring
committee, task force or working group shall recommend those items that should be considered significant elements:

Regulators needed to be able to assess and monitor the risks posed with respect to XXX/AXXX captive reinsurance transactions, and the regulatory process was enhanced through the adoption of the XXX/AXXX Reinsurance Framework, AG 48 and Model #787 to provide standardized tools and processes to be used by all regulators when reviewing such transactions. However, these new tools are complex and technical in nature, requiring the use of a new actuarial methodology to achieve the desired financial solvency results. Therefore, the Reinsurance (E) Task Force recommends that any new accreditation standard developed for Model #787 be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program.

In addition, all of the elements of the XXX/AXXX Reinsurance Framework have been put into place, with the exception of the new accreditation standard. Therefore, F-Committee should consider a waiver in its normal timeline for adoption of an accreditation standard, and expeditiously consider adoption of this new standard effective as of January 1, 2020.

An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:

The NAIC has not performed a cost/benefit analysis with respect to Model #787, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, it should be noted that Model #787 does not require dramatic changes from how insurance companies have been financing XXX/AXXX captive reinsurance transactions since the NAIC’s adoption of AG 48. As with AG 48, Model #787 provides “standardized tools and processes to be used by all regulators when reviewing such transactions.” Prior to the adoption of AG 48, insurers would enter into various captive reinsurance transactions to “finance” different portions of the statutory reserve differently—i.e., to fund different portions of the reserve using different kinds of assets—based on what insurers believed to be a better correlation between the kind of asset used and the probability that it would be needed. Many state regulators were comfortable with these transactions in theory, but there was significant unease regarding how these transactions were being implemented, and especially as to the lack of consistency from insurer to insurer and regulator to regulator regarding key aspects as to how these transactions may have been approved. Such transactions are still permitted under Model #787, but now a clear and consistent process has been implemented to ensure that the proper amount and type of assets have been applied with respect to these transactions in order to ensure that they continue to meet strong financial solvency standards.
MEMORANDUM

TO: Commissioner Todd Kiser, Chair, Financial Regulation Standards and Accreditation (E) Committee

FROM: Justin Schrader, Chair, Risk-Focused Surveillance (E) Working Group

DATE: April 6, 2019

RE: Proposed Revisions to Accreditation Program Manual to Reference Salary Ranges

In 2017, the Risk-Focused Surveillance Working Group began work on a project to study regulator resources and review salary recommendations for financial regulators. After reviewing job requirements for financial regulators conducting risk-focused surveillance, completing a detailed salary survey of 40+ states and comparing the results against other similar regulatory and industry positions, the Working Group developed new salary range recommendations and supporting guidance for financial analyst and examiner compensation.

On Feb. 15, 2019, updated salary ranges and supporting guidance were referred to the Financial Analysis Solvency Tools (E) Working Group and the Financial Examiners Handbook (E) Technical Group for consideration of adoption into the NAIC’s Financial Analysis Handbook and Financial Condition Examiners Handbook respectively. It is expected that the updated salary ranges and supporting guidance will be included in the 2020 publication of these handbooks.

In addition to developing salary range recommendations, the Working Group was asked to consider how its work should impact the NAIC accreditation standards and guidelines, as outlined in the following charge:

Consider recommendations to the Financial Regulation Standards and Accreditation (F) Committee for the purpose of evaluating the suitability of insurance department staffing in relation to the necessary skillsets.

In fulfillment of this charge, the Working Group is referring proposed revisions to Part C: Organizational and Personnel Practices, as well as the Self-Evaluation Guide/Interim Annual Review Form of the NAIC’s Accreditation Program Manual to the Committee for consideration of adoption. We recognize that Part C is reviewed by the accreditation team members but is not included in the Recommendation A or B and therefore does not impact a state’s accredited status. Because of this assessment structure and because Part C already includes questions related to competitive pay structures, we feel this is a logical place to reference the updated salary ranges being incorporated into NAIC handbooks. In addition, we believe the proposed questions in the Self-Evaluation Guide/Interim Annual Review Form related to whether the state is paying below the recommended salary ranges would provide beneficial information to the accreditation team and the Committee. Therefore, we request that you consider adoption of the proposed additions/revisions to the Accreditation Program Manual, as shown in tracked-change format in Appendix A.

If there are any questions regarding the proposed revisions, please contact me or NAIC staff (Bruce Jenson at bjenson@naic.org) for clarification. Thank you for your consideration of this referral.
Appendix A – Proposed Revisions to the Accreditation Program Manual

Part C: Organizational and Personnel Practices

a. Professional Development

Standard: The department should recognize and provide necessary training needs for staff involved with financial surveillance and regulation. The department should also have a policy that encourages professional development through job-related college courses, professional programs and/or other training programs.

Results-Oriented Guidelines:

1. The department should have the ability to provide adequate training for staff involved in financial surveillance and regulation commensurate with the needs of the department. When assessing compliance with this guideline, consideration should be given to the following:
   - The department’s recognition of when financial surveillance personnel may require additional training.
   - Whether appropriate training is provided.
   - The effectiveness of training programs, including how the department assesses effectiveness.
   - The use of on-the-job training.
   - Sufficiency of budgeted hours and finances to support training needs of the department.

Process-Oriented Guidelines:

1. The department should have a policy that focuses on training and developing staff involved with financial surveillance and regulation—in particular, staff that is new to financial surveillance and regulation.

2. The department should have a continuing education policy that encourages professional development in place for staff involved with financial surveillance and regulation.

b. Minimum Educational and Experience Requirements

Standard: The department should establish minimum educational and experience requirements for all professional employees and contractual staff positions in the financial regulation and surveillance area, which are commensurate with the duties and responsibilities of the position.

Results-Oriented Guidelines:

1. Financial surveillance staff should have the ability to perform the necessary duties and responsibilities, as well as meet the minimum educational and experience requirements commensurate with each position’s role in financial surveillance.

Process-Oriented Guidelines:

1. The department should establish minimum educational and experience requirements for staff positions in the financial surveillance and regulation area.

2. The department should maintain current and relevant job descriptions for staff positions in the financial surveillance and regulation area.
c. Retention of Personnel

**Standard:** The department should have the ability to attract and retain qualified personnel for those positions involved with financial surveillance and regulation.

**Results-Oriented Guidelines:**
1. The department should demonstrate the ability to attract and retain qualified personnel for those positions involved with financial surveillance and regulation. When assessing compliance with this guideline, consideration should be given to the following:
   - The department’s hiring policy.
   - The overall retention of personnel in key financial surveillance regulation areas.
   - The performance appraisal, the review process and/or coaching programs.
   - The ability to provide promotional opportunities and/or career paths.
   - The ability to provide a competitive pay structure commensurate with the job duties and responsibilities, including whether average salaries fall below the ranges defined in the Examiners Handbook and Analysis Handbook.

**Process-Oriented Guidelines:**
1. The department should have a hiring policy that allows for personnel needs to be addressed.

2. The department should compare employee salaries to the suggested salary ranges defined in the Examiners Handbook and Analysis Handbook and identify how it determines that pay structures are or are not competitive for positions involved with financial surveillance and regulation.

3. The department should have a performance appraisal and/or coaching program for staff.

d. Use of Contract Personnel

**Standard:** A department that utilizes contract personnel to assist in financial surveillance and regulation should ensure that those hired in the capacity of a contractor are subject to standards that are comparable to or exceed those standards applicable to employees of the state.

**Results-Oriented Guidelines:**
1. The department should assess contractors used in performing financial surveillance and regulation activities to ensure the work being performed is commensurate with the department’s processes and procedures.

**Process-Oriented Guidelines:**
1. The department should have a process in place to consider qualifications, training and professional development of contractors performing financial surveillance and regulation activities.

2. The department should have the authority to terminate a contract for services related to financial surveillance and regulation on the basis of poor performance.
c) **Retention of Personnel**

The department should have the ability to attract and retain qualified personnel for those positions involved with financial surveillance and regulation.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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1. Is the department’s pay structure for those positions involved with financial surveillance and regulation competitive to:

- Attract qualified personnel?
  - YES    NO
- Retain qualified personnel?
  - YES    NO

2. Do the salaries of applicable department personnel fall below the suggested salary ranges defined in the Examiners Handbook and Analysis Handbook, adjusted for market and cost of living variances?

- Financial Analyst?
  - YES    NO
- Senior Financial Analyst?
  - YES    NO
- Supervisor/Assistant Chief Analyst?
  - YES    NO
- Chief Analyst?
  - YES    NO
- Financial Examiner?
  - YES    NO
- Senior Financial Examiner?
  - YES    NO
- Examiner-In-Charge (EIC)/Supervisor/Assistant Chief Examiner?
  - YES    NO
- Chief Examiner?
  - YES    NO

3. In a separate attachment, identify how the department determines that pay structures are or are not competitive. Discuss the conclusion and any compensating factors or future plans in place if the salaries are deemed not competitive or fall below the range.

   *If this is an interim annual review, only identify how the department determines that pay structures are or are not competitive if there have been substantial changes from the previous submission of this information, otherwise note “no changes”.  

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4. In a separate attachment, discuss the level of turnover that occurred during the past year and the reason for the turnover within the financial solvency monitoring staff, including the financial solvency senior management.

5. In a separate attachment, please discuss the department’s hiring policy that allows for addressing personnel needs.
   *If this is an interim annual review, only provide the department’s hiring policy that allows for addressing personnel needs if there have been substantial changes from the previous submission of this information, otherwise note “no changes”.

6. Does the department have a performance appraisal and/or coaching program for financial solvency monitoring staff?

7. If the answer to #5 above is yes, please briefly describe the department’s performance appraisal and/or coaching program for financial solvency monitoring staff.
   *If this is an interim annual review, only provide the department’s performance appraisal and/or coaching program for the financial solvency monitoring staff if there have been substantial changes from the previous submission of this information, otherwise note “no changes”.

MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee
FROM: Risk Retention Group (E) Task Force
DATE: August 3, 2019
RE: Part B1: Analysis Guidelines for Risk Retention Groups

The accreditation Review Team Guidelines include a guideline specifically related to risk retention groups (RRGs) within the financial analysis section (Part B1). This guideline was originally drafted by the Risk Retention Group (E) Task Force and adopted by the Financial Regulation Standards and Accreditation (F) Committee. It is the intention of the Task Force that this guideline is applied to all RRGs regardless of accounting treatment (GAAP/SAP) or organizational structure (captive/traditional laws).

In 2017, a number of revisions were made to the accreditation guidelines to incorporate risk-focused analysis. In conjunction with those revisions, a reference to the “Captive and/or Insurers Filing on a U.S. GAAP Basis Worksheet” in the NAIC Financial Analysis Handbook was added to the analysis guideline specific to RRGs. This worksheet can be a helpful tool, however, it applies only to GAAP filers with an emphasis on a review of accounting differences. Adding this reference implies the accreditation guideline is only applicable to GAAP filers, which is inconsistent with the Task Force’s position that the guideline applies to all RRGs.

The Task Force therefore asks the Committee to consider the following revision to B1(e), process-oriented guideline #8 to return to the language used prior to 2017 and clarify the guideline applies to all RRGs.

If the company is a risk retention group (RRG), the following procedures should be performed and documented within the analysis file, as applicable:

- Annual review of the plan of operation to ensure that it is unchanged from the prior year.
- Ensure that all changes in the plan of operations have been approved.
- Review of the Note 1 reconciliation to ensure that it appears accurate and can be relied upon by others.
- Review of the General Interrogatory, Part 2 question 13.1 and ensure that the amount agrees with the approved plan of operations.
- Ensure that the financial projections on file accurately reflect the operations as presently conducted.
- Ensure that the “Notes” relating to the operation of the company agree with the approved plan of operation.
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

International Insurance Relations (G) Committee Aug. 12, 2020, Minutes ................................................................. 12-2
International Insurance Relations (G) Committee June 3, 2020, Minutes (Attachment One) .................................................. 12-8
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NAIC Comments on the IAIS Draft Application Paper on Liquidity Risk Management
(Attachment Four-A) .................................................................................................................................................. 12-17
The International Insurance Relations (G) Committee met via conference call Aug. 12, 2020. The following Committee members participated: Gary Anderson, Chair (MA); Bruce R. Ramege, Vice Chair (NE); Ricardo Lara (CA); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmaier (FL); Doug Ommen (IA); James J. Donelon (LA); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Marlene Caride (NJ); Andrew R. Stolfi (OR); Jessica K. Altman (PA); and Hodgen Mainda (TN). Also participating was: Michael Powers (MA); and Justin Schrader (NE).

1. **Adopted its June 3, Feb. 3, Jan. 30, Jan. 15, and 2019 Fall National Meeting Minutes**

The Committee met June 3, Feb. 3, Jan. 30, Jan. 15, and Dec. 7, 2019, and took the following action: 1) heard an update on upcoming International Association of Insurance Supervisors (IAIS) committee meetings and activities; 2) heard an update on the Organisation for Economic Co-operation and Development (OECD) and other supervisory cooperation activities; 3) heard an update on the International Monetary Fund (IMF) Financial Sector Assessment Program (FSAP); 4) heard an update on international-related NAIC events; 5) approved submission of NAIC comments on the IAIS and Sustainable Insurance Forum (SIF) draft *Issues Paper on the Implementation of the Recommendations of the Task Force on Climate-related Financial Disclosures*; 6) heard a recap of IAIS committee meetings and an update on the insurance capital standard (ICS), including the aggregation method (AM) and comparability; 7) approved submission of NAIC comments on the IAIS draft *Application Paper on Liquidity Risk Management*; 8) adopted the report of the ComFrame Development and Analysis (G) Working Group; 9) adopted its 2020 proposed charges; 10) heard an update on key 2019 projects of the IAIS; 11) heard an update on international activities; and 12) heard an update on the FSAP.

Commissioner Caride made a motion, seconded by Commissioner Mais, to adopt the Committee’s June 3 (Attachment One), Feb. 3 (Attachment Two), Jan. 30 (Attachment Three), Jan. 15 (Attachment Four), and Dec. 7, 2019, (see NAIC Proceedings – Fall 2019, International Insurance Relations (G) Committee) minutes. The motion passed unanimously.

2. **Heard an Update on Key 2020 Projects of the IAIS**

Commissioner Anderson announced that the Louisiana Department of Insurance (DOI) has become a member of the IAIS Multilateral Memorandum of Understanding (MMoU), which strengthens supervisors’ ability to work cooperatively with other supervisors and monitor large cross-border insurers, which is critically important to promoting effective supervision and protecting consumers. He said since the first jurisdiction was admitted in June 2009, the number of MMoU members has grown significantly to now include 74 signatories, representing approximately 76% of worldwide premium volume, and Louisiana is the twentieth U.S. state to sign the MMoU.

   a. **Holistic Framework**

   Commissioner Anderson said with regard to the holistic framework, the IAIS decided to focus this year’s global monitoring exercise, both the individual insurance assessment and the sector-wide monitoring, on COVID-19-related information. He said during the June conference calls of the IAIS’s Macroprudential and Executive committees, initial results of the data analysis were provided, focusing on the areas of solvency, profitability, liquidity, assets and liabilities. He noted that given the limited data coverage and early stage of data validation work, these results were preliminary in nature, so further work will be done over the summer, which will be discussed at the next set of IAIS committee conference calls in September.

   Commissioner Anderson said on the recent Financial Stability (EX) Task Force conference call, there was a question about whether the IAIS would collect COVID-19-related data for the third and fourth quarters of 2020. He clarified what was said on the conference call, noting that a proposal to collect information on additional quarters was discussed during the IAIS committee calls in June; however, this has not yet been decided. He explained that IAIS members first want to assess how useful and complete the data for the first and second quarters is before agreeing to collect additional COVID-19-related data, which reflects the IAIS’s recognition of the need for operational relief during this time.

   Regarding implementation of the holistic framework, Commissioner Anderson said the IAIS is currently conducting a baseline assessment using a questionnaire that focuses on the relevant Insurance Core Principle (ICP) and Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) standards adopted in November 2019, and it is designed
to help the IAIS assess the level and means of implementation by jurisdictions. He said this assessment forms the first part of the IAIS process so that in November 2022, the Financial Stability Board (FSB) can review, based on the initial years of implementation of the holistic framework, the need to either discontinue or re-establish the annual identification of global systemically important insurers (G-SIIs). He said once the baseline assessment is finalized, the IAIS will share the outcomes of it with the broader IAIS membership, the FSB, and the general public in March 2021. He said following the conclusion of the baseline assessment, the IAIS will undertake targeted jurisdictional assessments to determine the consistency of implementation of holistic framework material in 2021 and 2022 with the objective to determine whether the supervisor has and exercises, when required, the legal authority and supervisory practices to effectively perform the requirements of the relevant holistic framework supervisory material. He said the IAIS is still working through the details of the targeted jurisdictional phase, such as scope of the assessment, jurisdictions involved, and how it will be operationalized; these topics will be discussed in September, and more information will be made publicly available in the future.

b. **ICS and Monitoring Period**

With regard to the ICS, Commissioner Anderson explained that the IAIS has begun a five-year monitoring period for the ICS for internationally active insurance groups (IAIGs). He said during this period, data will also be collected on the AM, and a decision will be made on whether the AM delivers comparable outcomes to the ICS, thereby being an “outcome-equivalent” implementation to the ICS.

Commissioner Anderson said on April 23, the IAIS released ICS and AM data collection packages to volunteer groups, it will be holding regular calls with volunteers, and it has a “question and answer” process for addressing issues that come up during the reporting process. He said because of the pandemic, the due date for ICS and AM reporting was moved from Aug. 31 to Oct. 31.

On comparability, Commissioner Anderson said work continues at the IAIS by the ICS and Comparability Task Force, and while the plan was to have a document on principles for developing the assessment criteria ready for consultation this summer, the timeline for this work has been adjusted with the consultation to take place later this year. He said as work continues towards developing an AM that delivers comparable outcomes to the ICS, one open issue is scalars, which are percentages that will be applied to each local capital requirement to bring them to a globally comparable level. He noted that scalars will be used in both the NAIC Group Capital Calculation (GCC) and the AM, though they are of particular importance for IAIGs. He said academic research in this area would be helpful, as there are many possible scalar methodologies that can be used.

Steve Jackson (American Academy of Actuaries—Academy) outlined a project that the Academy is undertaking on the scaling of regulatory capital requirements across jurisdictions, looking at theoretical and practical considerations of various methodologies. He explained that this project is being done in four stages: 1) clarifying objectives; 2) assembling an inventory of possible methodologies; 3) deriving a set of criteria for evaluation of methodologies; and 4) developing an annotated bibliography. He said by a targeted completion date of March 1, 2021, the Academy will offer assessments of major possible methods, but it will not recommend a method of scalars. He said the project is designed to assist state insurance regulators as they develop scalars for the AM and to educate the actuarial community.

Jeffrey L. Johnson (John Hancock) asked for clarification regarding the objectives of scalars and whether comparability would be part of the scope. Mr. Jackson responded that the Academy would be looking at how different scalar methodologies provide comparability between various regulatory capital requirements across jurisdictions, not comparability as it relates to the AM and the ICS.

c. **Responses to COVID-19**

Jonathan Dixon (IAIS) provided an overview of the IAIS’ work to date on COVID-19 and what it will be looking at going forward. He explained that over the past several months, the IAIS has pivoted to COVID-19-related projects, including: 1) refocusing the 2020 Holistic Framework Global Monitoring Exercise; 2) gathering information on supervisors’ COVID-19 supervisory responses; 3) collaboration with the FSB and other standard-setting bodies; and 4) stakeholder engagement. He noted that as a result of providing operational relief to both IAIS members and stakeholders, the IAIS has extended deadlines or postponed the work of some projects.

Commissioner Anderson noted that NAIC representatives to the IAIS have been sharing the input and experiences of state insurance regulators in responding to COVID-19, and many of the discussions at the IAIS mirror those at the NAIC.
Commissioner Lara asked if the IAIS is looking at solutions to the issue of pandemic coverage in business interruption policies for businesses affected by the pandemic, including using innovation. Mr. Dixon responded that the IAIS is gathering information on business interruption coverage on an ongoing basis, including looking at conduct of business issues. He said given different jurisdictional issues, legal environments, and mandates of supervisors, it is difficult to identify common practices; although, the IAIS is trying to collect as many examples as possible of business interruption coverage to share with supervisors. He also said the IAIS Executive Committee was interested in conducting a business interruption coverage stocktake regarding the pandemic, and he noted that there are discussions around the world regarding potential supervisory solutions, including risk-sharing between the public and private sectors. He added that he expects this work to progress during the second half of the year. Commissioner Anderson noted that, similar to the NAIC statement on pandemic coverage in business interruption, the IAIS also released such a statement in May 2020.

Mr. Powers asked Mr. Dixon for examples of supervisory responses to COVID-19. Mr. Dixon responded that collected responses from various jurisdictions have focused primarily on strengthening operational resilience of supervisors and insurers, business continuity, providing operational relief for insurers to facilitate uninterrupted services, insurer solvency, and market conduct issues.

Robert Neill (American Council of Life Insurers—ACLI) asked if there has been any thought to extending the ICS monitoring period, given the interruptions caused by COVID-19. Mr. Dixon said the IAIS made adjustments to the timeline for IAIS data collection and increased engagement with volunteer groups. Romain Paserot (IAIS) added that while the IAIS has extended the data submission deadline for this year, it is unclear how long the pandemic will cause operational stress to insurers, but the IAIS has good ongoing dialogue with the volunteers.

3. **Heard an Update on the FSAP**

Mr. Schrader explained that the 2020 U.S. FSAP concluded earlier in the week with publication of final documents describing the IMF’s findings and opinions on the U.S. financial regulatory system. He said reports related to the 2020 U.S. FSAP, including those relevant to insurance, are posted to the IMF’s website, as well as the U.S. Department of the Treasury (Treasury Department) website.

Mr. Schrader said the FSAP was established by the IMF in 1999 to examine a jurisdiction’s financial regulatory system, assess its observance with current international standards in all three major financial sectors—banking, insurance and securities—and offer recommendations for improvement. He said last year, the IMF and U.S. authorities, including the Treasury Department, the Federal Reserve, state insurance regulators, and others began the process for the third IMF assessment of the U.S. financial regulatory system.

Mr. Schrader explained that the 2020 FSAP included two “missions” with separate workstreams, with Mission 1 focusing on many aspects of insurance supervision, as well as stress testing, and Mission 2 focusing on climate risk and resilience, the incidence of natural catastrophes, and mortgage insurance. He said Mission 1 took place during the fall of 2019 with meetings at all the NAIC offices and four states, and Mission 2 took place in February and March of this year, with meetings at the NAIC with leadership of certain NAIC working groups and two states. He added that the IMF met with insurance trades and companies in many of these states as part of their review.

Mr. Schrader said the main documents of relevance for the insurance sector that were recently released by the IMF include: 1) Insurance Technical Note, which provides the IMF’s views of the strengths and weaknesses of solvency and market conduct supervision in the U.S.; 2) Risk Analysis and Stress Testing the Financial Sector Technical Note (Stress Testing Note); and 3) Financial System Stability Assessment (FSSA), which provides the IMF’s overall assessment of the whole U.S. financial sector, including insurance. He said while there is an appendix addressing the impact of COVID-19 in both the Stress Testing Note and the FSSA, the FSAP was largely completed prior to the start of the pandemic.

Mr. Schrader explained that in contrast to the two earlier U.S. FSAPs, there are no ratings of observance of specific ICPs, the international insurance standards established by the IAIS. Instead, the IMF performed a targeted review of cross-cutting themes, building on the detailed assessment of the ICPs conducted in 2015, resulting in recommendations relative to these topics that, in the IMF’s opinion, would help to improve insurance supervision in the U.S.

Mr. Schrader said while there are several findings and conclusions drawn by IMF staff that state insurance regulators may ultimately disagree with, their view that the U.S. insurance system is in line with the ICPs and that key 2015 FSAP recommendations are being addressed is welcomed.
Mr. Schrader noted that in the published reports, the IMF highlighted enhancements and strengths of the U.S. state-based system, including:

- Implementation of principle-based reserving (PBR) in the life insurance industry is a step toward addressing the issues found on valuation in the 2015 FSAP.
- Implementation of risk-focused surveillance in financial analysis and financial examinations is another key step forward.
- The NAIC’s framework for monitoring individual asset-side risks is quite advanced.
- The financial stability risks stemming from the insurance sector appear contained for now.

Mr. Schrader highlighted some of the IMF’s recommendations, including: 1) further development of risk-based supervision; 2) consistency of life insurer liability valuation methods; 3) further regulatory requirements in corporate governance; and 4) enhancing regulatory responses to the increasing risk and severity of natural catastrophes. He said state insurance regulators believe some of the IMF’s statements regarding the ICS, including recommending “developing the Generally Accepted Accounting Principles (GAAP) Plus Global Risk based ICS based on U.S. GAAP” as an “internationally consistent way forward to addressing the current gap in insurance group capital requirements in the United States” are inconsistent with the current discussions at the IAIS, which recognize the potential of the AM to provide comparable outcomes to the ICS. He said the IMF also recommends that if the “NAIC’s proposed GCC is adopted, it should be made into a requirement not merely a calculation.” He noted that the NAIC questions the certainty with which the IMF speaks when suggesting, before the GCC has even been adopted and implemented, that a calculation cannot be as equally useful as something that is deemed a requirement.

Mr. Schrader stated that, as with the previous U.S. FSAPs, state insurance regulators and NAIC staff will review all the IMF recommendations and allocate, where appropriate, such recommendations to the relevant NAIC committees and working groups for further consideration. He also thanked participating states for their significant time and commitment to this project, as well as NAIC staff.

Andrew T. Vedder (Northwestern Mutual) asked whether the IMF’s decision not to include ratings on observance of ICPs represents a decision by the IMF that jurisdictions will not be rated in this way going forward. Gita Timmerman (NAIC) responded that conducting more thematic reviews without ratings reflects a general trend seen with FSAPs for other jurisdictions as well.

Commissioner Anderson thanked Mr. Schrader for his time and effort as the lead U.S. state insurance regulator for the project, and he thanked the involved states and NAIC staff for their hard work, in particular Ms. Timmerman and Rashmi Sutton.

4. **Heard an Update on International Activities**

   a. **Regional Supervisory Cooperation**

Director Ramge said during the pandemic, state insurance regulators have continued to stay in touch with regulatory counterparts overseas, as it is even more critical in times of crisis to discuss issues in a frank and candid manner.

Director Ramge said in late June, the NAIC officers held a principal-level discussion with the Bermuda Monetary Authority (BMA) in order to: 1) update the BMA on the high-level observations from the NAIC’s first business interruption data call; 2) discuss the overall strength and capacity of Bermudan reinsurers and any possible impact COVID-19 may have on any potential claims handling resulting from the 2020 hurricane season or other U.S. natural catastrophe events; and 3) continue to share lessons learned with the BMA regarding remote supervision, COVID-19 response measures, and industry engagement.

Director Ramge said in mid-July, Director Cameron participated in a high-level virtual session on regulatory responses to COVID-19 organized jointly by the Financial Stability Institute (FSI), the Association of Insurance Supervisors of Latin America (ASSAL), and the IAIS. Director Ramge said this webinar included participation by a number of Latin American authorities. It provided a platform in which to exchange views on the various regulatory responses to COVID-19; trade-offs, including prudential approaches to soften implications related to COVID-19; and the challenges in the post-pandemic phase. Director Ramge added that this event replaced the ASSAL High-Level Meeting that was scheduled for this past April in Costa Rica.
Director Ramge said in late July, NAIC staff held a bilateral training session for the Superintendent of Brazil’s insurance regulator, who wanted to learn more about the U.S. system of regulation, and this was the first in a series of meetings for the Brazilian regulators, who also requested additional training in the future through the NAIC’s online education courses.

Director Ramge noted that the NAIC is exploring principal-level calls later in the year with Asian colleagues, such as Taiwan and Japan that have new commissioners leading their authorities, to discuss issues of mutual interest, including COVID-19.

Director Ramge said with regard to the U.S.-European Union (EU) Project, after the cancellation of the March public event and since the Committee’s last call in June, there have been several working group calls relating to the various workstreams of the Project. He said it is expected that the working groups on cybersecurity, cyberinsurance and big data will continue to meet virtually to discuss the next steps, as contained in the Project’s papers published in February 2020.

Director Ramge said, as reported previously, in light of COVID-19-related travel restrictions and office reopening policies, the fall session of the NAIC’s International Fellows Program will take the form of a virtual session in October. He said the application for participation is available on the NAIC website, and a number of applications for the session have already been received from international regulators from several regions around the world. He said while there is no substitute for the hands-on experience that fellows receive during the weeks they spend hosted by state insurance departments and meeting with NAIC staff, the NAIC is grateful to be able to offer international colleagues an opportunity for technical growth and relationship building during this difficult time.

Director Ramge said for the foreseeable future, the NAIC’s bilateral dialogues will continue to be held virtually, and state insurance regulators will continue to work closely with international counterparts, ensuring that lines of communication remain open, as ongoing communication with our international partners remains the utmost importance, especially in these challenging times.

b. **OECD**

Director Ramge said with regard to the OECD, its Insurance and Private Pensions Committee (IPPC) met virtually in June and discussed topics including: 1) supervisory, regulatory and industry responses taken on COVID-19; 2) the role of public-private partnerships to address the insurability of perils that are or are increasingly becoming uninsurable, such as pandemic/epidemics, as well as perils such as floods, wildfires and cyclones whose severity and frequency is being affected by a changing climate; 3) a draft preliminary report on the relationship between public and private sectors in the area of long-term care (LTC) and health care; and 4) a revised draft Recommendation of the Council on Financial Literacy.

Director Ramge said in early July, the OECD released a comprehensive report on COVID-19-related actions taken by supervisors, policymakers and industry in the insurance sector, and the paper can be found on the OECD’s website. He reported that the OECD has also published its mid-year report on insurance market trends, which shows gross premiums still rising in 2019; although, COVID-19 may curb the positive premium and investment income growth of insurers. He said this report is available on the OECD IPPC website, and a more detailed report on insurance market trends will be published later this year.

c. **SIF**

With regard to the SIF, Director Ramge said, as previously reported, the NAIC became a member of the SIF in February 2020, and it has participated in several virtual meetings this summer discussing topics such as member initiatives in the area of climate risk and sustainability and joint work with the IAIS on drafting an *Application Paper on the Supervision of Climate-related Risks in the Insurance Sector*. He said this paper will be out for public consultation later this fall, and it is scheduled to be published in early 2021. He said the strategic focus for the SIF for 2021 and beyond has also been discussed during the virtual meetings.

Director Ramge said examining the issue of climate and natural catastrophe risks and resiliency is central to state insurance regulators’ mission of protecting policyholders, and it is the focus of a newly created executive-level NAIC task force, which will help inform state insurance regulators’ contributions to the SIF going forward.
5. **Discussed Other Matters**

Commissioner Anderson said the Committee’s next conference call has not been scheduled; however, there are some upcoming activities and events that will merit a call, such as updates on the September IAIS meetings, the public consultation on the joint IAIS-SIF application paper, and addressing recommendations from the FSAP. He said once the timing on these items is better understood, a save-the-date will be sent.

Having no further business, the International Insurance Relations (G) Committee adjourned.

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The International Insurance Relations (G) Committee met via conference call June 3, 2020. The following Committee members participated: Gary Anderson, Chair (MA); Bruce R. Ramge, Vice Chair (NE); Ricardo Lara (CA); Andrew N. Mais (CT); David Altmaier (FL); Doug Ommen (IA); James J. Donelon (LA); Anita G. Fox represented by Judy Weaver (MI); Chlora Lindley-Myers (MO); Marlene Caride (NJ); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman (PA); Hodgen Mainda (TN); and Tregenza A. Roach (VI). Also participating was Justin Schrader (NE).

1. Heard an Update on International Activities
   a. IAIS

Commissioner Anderson said from an operational perspective, the International Association of Insurance Supervisors (IAIS) has suspended in-person meetings until the end of August. He noted that this includes the June Committee Meetings and Global Seminar the NAIC planned to host in Seattle, WA. Instead, the NAIC will host the Global Seminar in June 2023. Commissioner Anderson said the IAIS Executive Committee recently decided to cancel the Committee Meetings, Annual General Meeting and Annual Conference scheduled for November in Santiago, Chile. He said for both the June and November meetings, stakeholder events will be held virtually. He said as part of the June Committee Meetings, the IAIS will discuss whether it will resume other in-person meetings, such as at the subcommittee level, starting in September.

Commissioner Anderson explained that at the end of 2019, the IAIS finalized some key projects; i.e., the holistic framework for systemic risk in the insurance sector and moving into the global insurance capital standard (ICS) monitoring period. He said both projects involve a year-long process that had to be adjusted given the impact of COVID-19.

Regarding the holistic framework, Commissioner Anderson said it was decided to focus the global monitoring exercise, both the individual insurance assessment and the sector-wide monitoring, on COVID-19 related information. He said the results should help provide a global perspective regarding the impact of COVID-19 on the insurance sector. He noted that while this may not be the plan as envisioned going into 2020, this refocusing will hopefully show the value of moving to a more holistic approach that can look at risks and potential systemic impact regardless of the source.

Regarding the ICS, Commissioner Anderson said the monitoring period is underway with data collection for both the ICS and Aggregation Method having started around the end of April and the deadline extended until the end of October. He said work continues within the IAIS ICS Task Force to discuss comparability. He said while the plan was to have a document ready for consultation this summer, the timeline for this work has been adjusted too, with the consultation to take place later this year, likely in November.

Commissioner Anderson said the IAIS currently has two assessment activities underway. The first is a peer review of Insurance Core Principle (ICP) 19 (Conduct of Business) launched at the end of February. Commissioner Anderson said as with prior reviews, the plan was to give IAIS members a month to respond, but with the outbreak of COVID-19, an extension to June 15 has been given to allow jurisdictions more time to respond. He said per usual NAIC practice, about a handful of states have volunteered to participate in responding to this peer review. Second is the holistic framework baseline assessment (BLA) that launched May 1. Commissioner Anderson said Team USA will be coordinating the response to the BLA from a U.S. perspective, given that this assessment covers jurisdictions as a whole. He said the BLA results will be shared with relevant stakeholders, such as the Financial Stability Board (FSB) and the general public, once finalized in March 2021. He said in 2021, the IAIS will build on the BLA in undertaking targeted jurisdictional assessments to determine the consistency of the implementation of the holistic framework supervisory material, and it will deliver a final report to the FSB in 2022.

Commissioner Anderson said since mid-March, the IAIS Secretariat has been collecting information from IAIS members on supervisory measures related to COVID-19, and it has facilitated discussions on the situation in various jurisdictions on biweekly Executive Committee calls. He said a number of considerations on future IAIS work, as well as how the association operates, have arisen from these survey results and discussions. He noted that the IAIS recently formed a small, virtual group to help analyze the variety of COVID-19 supervisory measures and serve as a sounding board, providing recommendations to the Executive Committee as it starts to consider strategic implications. He said the small group’s first call was May 28, and it
focused on brainstorming possible areas that the IAIS may want to focus on to help IAIS members responding to the pandemic. He said state insurance regulators and the NAIC have been active in providing and updating input on the IAIS survey and on the Executive Committee calls to help share the experiences in the U.S. insurance sector and what supervisors have been doing in response to COVID-19. He said while this pandemic has caused challenges, it could also provide an opportunity for the IAIS to assess its current and future workstreams and how it operates, noting that the current crisis has highlighted the need to be responsive to new and emerging risks, to react in ways that are helpful for supervisors around the globe, and to be able to operate even outside of normal circumstances. He added that state insurance regulators and the NAIC have been learning lessons on these points, and they look forward to sharing them with the IAIS and other supervisors.

Robert Neill (American Council of Life Insurers—ACLI) said the ACLI hoped to work with members of the Committee on ICS comparability work to supplement what is being done through Team USA, and he asked if there are timelines that interested parties should be aware of in order to feed into the work. Commissioner Anderson responded that while there are not necessarily concrete deadlines for sharing information as the document is developed, it would be helpful if feedback on the work could be shared with the Committee before November. Ryan Workman (NAIC) said many IAIS workstreams have been adjusted in light of COVID-19, and discussions have slowed down as well, but there could be an update on the status of this document for the Committee at the NAIC Summer National Meeting.

d. **OECD**

Ekrem Sarper (NAIC) said the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee (IPPC) quickly pivoted earlier this year to focus on COVID-19 responses and the discussions and policy considerations of governments and state insurance regulators. He said in early April, the IPPC released a paper, “Initial Assessment of Insurance Coverage and Gaps for Tackling COVID-19 Impacts.” He said recently, the IPPC followed up with a paper, “Responding to the COVID-19 and Pandemic Protection Gap in Insurance,” which can be found on the OECD’s website. He said the focus of this policy paper is on how business interruption insurance against pandemic risk could be provided with support from governments and some of the challenges and considerations necessary for establishing such a program.

Mr. Sarper said similar to other organizations, the IPPC’s June in-person meeting has been canceled and instead will be held virtually. The virtual meeting will discuss policy responses to COVID-19 and future work for the IPPC; the insurability of perils, which are or are increasingly becoming uninsurable; and a draft preliminary report on the relationship between public and private sectors in the area of long-term care (LTC) and health care.

Mr. Neill asked whether any commissioners or states would be participating in the virtual IPPC meeting along with NAIC staff. Mr. Sarper responded that it would likely just be NAIC staff participating.

c. **FSAP**

Mr. Schrader explained that the International Monetary Fund (IMF) is about to conclude its third Financial Sector Assessment Program (FSAP) of the U.S. financial regulatory system. He said the FSAP includes Mission 1 and Mission 2. He said meetings for Mission 1 took place last fall with meetings at all the NAIC offices and four states, and Mission 2 took place in February and March with meetings both at the NAIC and several other states. He said relevant to the insurance sector, the IMF is expected to publish the Financial System Stability Assessment (FSSA) and technical notes on insurance and stress testing in July 2020. He said as with previous FSAPs, there will likely be areas in which the NAIC and state insurance regulators will continue to disagree with the IMF’s approach and recommendations, as well as areas in which constructive feedback will be provided to the IMF regarding inaccuracies or particular characterizations of the U.S. system of state-based insurance regulation in the documents before they are published. He thanked the participating states for the time they took to present to the IMF on the state-based system, as well as NAIC staff. He said he would provide an update and summary of the FSAP documents once they are published.

d. **Bilateral Supervisory Cooperation**

Commissioner Anderson said while the NAIC’s priorities have shifted to focus on COVID-19, so have the priorities for our regulatory counterparts overseas. He said over the years, the NAIC has been improving relationships with foreign regulators, so that in times of crisis, regulators would know how to reach each other. He added that these relationships are built through work at the IAIS and other standard-setting bodies, but more importantly through consistent bilateral outreach.
Commissioner Anderson said since early March, the NAIC and state insurance regulators have been in regular contact with supervisors and finance ministries throughout Asia, Latin America and Europe. He said many jurisdictions are facing the same challenges as the U.S., and in the past month, the NAIC has had several calls at the staff level with supervisors in Bermuda, the European Union (EU), Japan, and the United Kingdom (UK).

Commissioner Anderson said during these discussions, the NAIC shared information about the prudential measures taken by state insurance regulators, including heightened monitoring of insurers through uniform data calls on solvency impact and regulatory relief and forbearance in a number of critical areas, particularly in regard to various statutory accounting exceptions. He said the numerous market conduct related measures taken in response to COVID-19 were also discussed. He said international counterparts shared information about primary challenges that their jurisdictions are facing in responding to COVID-19 and measures they have taken on a prudential and market conduct basis.

Commissioner Anderson said for the foreseeable future, the NAIC’s bilateral dialogues will be held virtually; although, state insurance regulators will continue to work closely with international counterparts, ensuring that lines of communication remain open. He said it is important that the sharing of information continues relating to insurers jointly supervised across those jurisdictions, as well as various policy responses to COVID-19 and beyond.

e. NAIC Events

Commissioner Anderson said as previously announced, the NAIC decided to cancel this year’s International Insurance Forum. He said a good program was planned for the NAIC’s annual flagship international event, so it is unfortunate that it was canceled, but he noted that next year’s Forum will be held May 24–25, 2021.

Commissioner Anderson said going into 2020, it was decided not to hold the spring session of the NAIC International Fellows Program due to resource constraints associated with the FSAP. He said in light of COVID-19 and related travel restrictions and resource strains, the NAIC has decided to also cancel the fall session of the Fellows Program, and NAIC staff are exploring virtual alternatives to the fall session in order to continue to provide training opportunities for foreign insurance regulators interested in learning about the U.S. system of insurance regulation, including sessions prerecorded by NAIC technical experts, should resources allow.

Having no further business, the International Insurance Relations (G) Committee adjourned.
The International Insurance Relations (G) Committee met via conference call Feb. 3, 2020. The following Committee members participated: Gary Anderson, Chair (MA); Bruce R. Ramege, Vice Chair (NE); Ricardo Lara represented by Emma Hirschhorn (CA); Andrew N. Mais (CT); David Altmaier (FL); Doug Ommen (IA); James J. Donelon represented by Tom Travis (LA); Anita G. Fox represented by Judy Weaver (MI); Chlora Lindley-Myers (MO); Marlene Caride (NJ); Jessica K. Altman (PA); and Hodgen Mainda (TN).

1. Approved Submission of NAIC Comments on IAIS and SIF Draft Issues Paper on Implementation of the TCFD Recommendations

Commissioner Anderson explained the purpose of the conference call is to discuss and approve the submission of NAIC comments on the joint International Association of Insurance Supervisors (IAIS) and Sustainable Insurance Forum (SIF) draft Issues Paper on the Implementation of the Recommendations of the Task Force on Climate-related Financial Disclosures (TCFD Recommendations), which is out for public consultation.

Commissioner Anderson said that in June 2018, the IAIS and SIF released a joint Issues Paper on Climate Change Risks to the Insurance Sector. He said the draft issues paper serves as a follow-up to the 2018 paper and describes the role of the Financial Stability Board’s (FSB) TCFD Recommendations in establishing a framework for climate risk-related disclosures for the insurance sector. Commissioner Anderson said the draft issues paper draws on the results of an SIF survey conducted during the first half of 2019 on implementation of the TCFD Recommendations and provides examples of related supervisory practices from around the world.

Commissioner Anderson explained that, per the usual process, the draft issues paper was reviewed internally, including by the NAIC’s Climate Risk and Resilience (C) Working Group, which resulted in the initial draft NAIC comments that were circulated Jan. 21 in advance of the conference call. He said no additional input was received from state insurance regulators or interested parties in advance of the conference call.

Ryan Workman (NAIC) provided an overview of the draft NAIC comments on the draft issues paper, focusing on substantive comments.

David Snyder (American Property Casualty Insurance Association—APCIA) said that while the TCFD Recommendations have value, their implementation should be a voluntary process. He said the APCIA hopes the disclosure will be accepted as reporting in places where reporting is mandatory and noted that the APCIA looks forward to working with the NAIC on these issues.

Commissioner Caride made a motion, seconded by Commissioner Altmaier, to approve submission of the NAIC comments (Attachment Two-A). The motion passed.

Commissioner Anderson said the NAIC comments on the draft issues paper would be submitted in advance of the Feb. 5 deadline and urged interested parties to submit comments as well.

2. Discussed Other Matters

Commissioner Anderson thanked Committee members and interested parties for their participation during the recent Committee meeting and conference call held Jan. 30 in Washington, DC, on the aggregation method and comparability. He said it was a productive discussion and that the Committee looks forward to this ongoing dialogue over the course of 2020.

Having no further business, the International Insurance Relations (G) Committee adjourned.
<table>
<thead>
<tr>
<th>Section/Paragraph</th>
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<tbody>
<tr>
<td>General</td>
<td>The paper refers to “TCFD Recommendations”, “TCFD Framework” and sometimes simply “TCFD”. As in most places it seems these are referring to the same thing, it would be helpful if one term was used consistently throughout so as to avoid potential confusion.</td>
</tr>
<tr>
<td>Para 8</td>
<td>In the fifth sentence, it is not clear what or who these “coalitions” are; suggest rewording with the same intention to: “…both within individual jurisdictions and through collective activities,…”</td>
</tr>
<tr>
<td>Para 18</td>
<td>In the first sentence, it is not clear what or who these “coalitions” are; suggest rewording with the same intention to: “Supervisors collectively are developing…”</td>
</tr>
<tr>
<td>Para 34</td>
<td>Suggest some minor changes to be clearer that this paragraph is describing the results of the survey: “The majority of insurers surveyed that expect to be affected by climate change are non-life insurers, primarily those concerned with risks to underwriting liabilities, with some life insurers primarily concerned with investment activities. Insurers that reported they do not expect to be affected by climate change in any respect are predominately life insurers.”</td>
</tr>
<tr>
<td>Para 46</td>
<td>As Section 4 describes a variety of options to strengthen disclosures based on TCFD Recommendations, it is odd that this introductory paragraph starts off with the view of some that such disclosures should be made mandatory, which is one of the options described later. Suggest the first sentence be moved to become the first sentence of para 56 and the second sentence moved to become the first sentence of para 47 which would then provide a more general and broader introduction to this section.</td>
</tr>
<tr>
<td>Para 47</td>
<td>As Annex 1 only describes practices of individual jurisdictions, delete “and other relevant supervisory coalitions”.</td>
</tr>
<tr>
<td>Para 52</td>
<td>First sentence, suggest more appropriate wording describing a survey would be: “Analysis of the SIF Survey responses suggest that…”</td>
</tr>
<tr>
<td>Subsection 4.1.6</td>
<td>As paragraphs 53 and 54 focus on scenario analysis rather than multiple activities and para 54 says there are divergent perspectives on standardization, suggest the subheading would be more appropriate as: “Supporting TCFD-related scenario analysis”</td>
</tr>
<tr>
<td>Para 56</td>
<td>Suggest moving the first sentence to become a new first paragraph under 4.1.7 as this provides a more general and broader introduction to this subsection.</td>
</tr>
</tbody>
</table>
The International Insurance Relations (G) Committee met in Washington, DC, and via conference call Jan. 30, 2020. The following Committee members participated: Gary Anderson, Chair (MA); Bruce R. Ramge, Vice Chair, represented by Justin Schrader (NE); Ricardo Lara represented by Emma Hirschhorn (CA); Andrew N. Mais (CT); David Altmaier (FL); Doug Ommen (IA); James J. Donelon (LA); Anita G. Fox represented by Judy Weaver (MI); Chlora Lindley-Myers represented by John Rehagen (MO); Marlene Caride (NJ); Andrew R. Stolfi (OR); Jessica K. Altman (PA); and Hodgen Mainda (TN).

1. **Heard an Introduction**

Commissioner Anderson gave an overview of the agenda and said it would start with a recap of the agreements coming out of last year’s International Association of Insurance Supervisors (IAIS) meetings in Abu Dhabi, United Arab Emirates. He said there would then be a short overview of the aggregation method (AM) along with some discussion on its ongoing development, as well as how the NAIC can further help with the understanding and education of the AM. Finally, he said there will be a discussion on comparability, in particular looking at the definition of comparability and overarching approach and moving towards developing criteria and the overall assessment process.

Commissioner Anderson noted the IAIS is looking at these issues and that state insurance regulators are in the process of thinking through them as well. He said today’s meeting would consider a variety of points that will be part of further developing the AM and the comparability assessment. He said there may not be answers to every question, but that is in part due to the nature of the insurance capital standard (ICS) project. He added that there are a number of moving parts that will continue to evolve over the monitoring period.

2. **Heard a Recap of Abu Dhabi Agreements**

Ryan Workman (NAIC) provided an overview of the agreement reached at the IAIS meetings in Abu Dhabi, United Arab Emirates, in November 2019. This included the definition of comparable outcomes and the overarching approach to developing high-level principles and criteria for the comparability assessment that are to be done in such a manner that the AM is neither precluded at the outset as an outcome equivalent approach to the ICS for measuring group capital, nor given a free pass. Mr. Workman also walked through the work plan and timeline for the ICS project and the comparability assessment.

3. **Heard an Update on the AM Status**

Ned Tyrrell (NAIC) provided an overview of the AM, which is designed around the concept that group capital resources and requirements are derived from the aggregation of entity-level reporting. He described five components of the AM: 1) group financials and inventory; 2) adjustments for double-counting; 3) scaling; 4) capital instruments; and 5) aggregation. Mr. Tyrrell also provided an update on the status of each of these five design components.

Commissioner Anderson noted that while there is a relationship between the AM and the domestic group capital work, there is a difference. Commissioner Altmaier provided an update on the status of the NAIC’s group capital calculation (GCC) that is intended to be a regulatory tool for supervisors of U.S.-based groups. Thomas Sullivan (Federal Reserve Board—FRB) provided an update on the development of the FRB’s building-block approach capital standard for insurers it supervises.

Comments made on the development of and education on the AM included the following:

- While there may be questions about scalars and how they will work, it is a mechanism that is part art and part science, and there is no need to be defensive about their use and how the AM aggregates risk.
- Having regular workshops and educational sessions about the AM would be helpful, as well as having documents that explain its design and provide responses to frequently asked questions (FAQ). Such information would help educate people on how the AM meets the same goals as the ICS and to give input on the comparability assessment criteria.
- There is a need to distinguish between the AM and jurisdictional implementations of the AM; the AM is not simply risk-based capital (RBC). The more information that is available on the GCC, the more tangible the AM becomes, so having an exposure draft of the GCC by mid-2020 would be helpful.
• Problems can be hidden in a consolidation approach, whereas the AM can be more regionally reflective and provides the right level of information at the right level.
• Volatility is a concern with the ICS. There is a need to avoid false positives, which could be demonstrated by linking the AM to the economic impact assessment.

Commissioner Anderson said that while there will be “stability” with the AM, just as there is with the ICS over the monitoring period, similarly the NAIC hopes the data received over this period helps inform the AM and any improvements. He said there are some outstanding points to be decided, such as scalars, so there will be some additional changes as work progresses on the version that will be assessed for comparability.

4. Discussed Comparability

Commissioner Anderson opened the discussion on comparability by looking at the definition approved at the IAIS meetings in Abu Dhabi, United Arab Emirates, how to go from the overarching approach to principles on comparability and what the actual assessment process could look like.

Comments on the definition of comparable outcomes included the following:

• The definition should not be reopened as it would lead to a different outcome on the way forward on comparability. The definition emphasizes that while the ICS and AM have similar elements, they are done differently.
• The assessment would need to involve both quantitative and qualitative aspects. There is an opportunity for the AM if it can demonstrate quantitatively that the AM produces fewer false positives. The qualitative side is more about how supervisors use different supervisory action to get an outcome.
• Regardless of how quantitative or qualitative the assessment is, it needs to avoid being granular.
• In considering what is an appropriate scope and form of supervisory action, hard wiring specific triggers needs to be avoided.
• Consideration should be given to how useful the approach is to the internationally active insurance group’s (IAIG’s) supervisory college. However there also needs to be education on how colleges in the U.S. operate and what is done within them.

Comments on going from an overarching approach on comparability to principles included the following:

• For the overarching approach that addresses the prudence of the AM in relation to the ICS, the notion of prudence suggests consideration of the level of calibration, but it should also consider the prudent supervisory actions.
• The overarching approach that notes the scope of group under the AM and ICS should be consistent with that set out in the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) shows that not everything about the comparability assessment needs to be based on the ICS.
• The assessment of comparable outcomes could also look at the utility of the supervisory action taken to an end user, especially the supervisor.
• In moving from principles to criteria for the assessment, the ICS principles could be a good basis, minus those principles that are irrelevant.

Comments on the approach and work plan for the assessment process included the following:

• The economic impact assessment should take place midway through the monitoring period, not at the end. Otherwise, the results produced will not have any actual impact. The economic impact assessment should be performed by the IAIS.
• Some IAIS members interpret “level playing field” as everyone having to adopt a market adjusted valuation ICS. However, if a level playing field is only concerned with competition, the competition is not IAIG versus IAIG but rather an IAIG versus non-IAIGs in its jurisdiction. In this respect, the AM is better at delivering such a level playing field as it shows more of what is happening at the local levels.

Regarding next steps on comparability, Commissioner Anderson said that part of moving into the monitoring period is the data collection, a process that should be getting underway shortly. He said the NAIC appreciates the participation of our IAIGs who will be providing the ICS and/or AM data. Commissioner Anderson added that the IAIS has its first committee meetings at the...
end of February and as part of those meetings, members will be looking at how to go from the overarching approach to the principles that will be out for consultation later in July.

Commissioner Anderson commented that it has been helpful to get interested party views on the number of steps that will be part of the monitoring period and comparability assessment. As part of thinking into the future, he asked whether after the monitoring period when ComFrame is revised to reflect the ICS, should the AM also be integrated into ComFrame. Ian Adamczyk (Prudential) replied that if the AM is found to provide comparable outcomes, it should be included in ComFrame.

5. **Discussed Other Matters**

Commissioner Anderson reminded participants of the next Committee conference call planned on Feb. 3 to review and approve submission of NAIC comments on a draft joint issues paper by the IAIS and Sustainable Insurance Forum (SIF) on the implementation of the Task Force on Climate-related Financial Disclosures (TCFD) recommendations that is currently out for public consultation.

Having no further business, the International Insurance Relations (G) Committee adjourned.
The International Insurance Relations (G) Committee met via conference call Jan. 15, 2020. The following Committee members participated: Gary Anderson, Chair (MA); Bruce R. Ramge, Vice Chair (NE); Ricardo Lara represented by Emma Hirschhorn (CA); Andrew N. Mais (CT); David Altmaier represented by Ray Spudeck (FL); Doug Ommen represented by Carrie Mears (IA); James J. Donelon (LA); Anita G. Fox represented by Judy Weaver (MI); Chlora Lindley-Myers represented by John Rehagen (MO); Marlene Caride (NJ); Andrew Stolfi (OR); Jessica K. Altman (PA); and Hodgen Mainda represented by Trey Hancock (TN).

1. **Approved Submission of NAIC Comments on IAIS Draft Application Paper on Liquidity Risk Management**

Commissioner Anderson explained that the purpose of the conference call is to discuss and approve the submission of NAIC comments on the International Association of Insurance Supervisors (IAIS) draft Application Paper on Liquidity Risk Management, which is out for public consultation.

Commissioner Anderson noted that the IAIS recently revised certain Insurance Core Principles (ICPs) and the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) material as part of the development of the holistic framework for systemic risk in the insurance sector. He said that during this process, the IAIS enhanced the enterprise risk management (ERM) requirements in ICP 16, ERM for Solvency Purposes, to more explicitly address liquidity risk. He added that the IAIS developed this application paper to help provide further guidance on the relevant supervisory material related to liquidity risk management.

Commissioner Anderson said that per the usual NAIC process, the paper was reviewed internally, including by the NAIC’s Financial Stability (EX) Task Force, which resulted in the initial draft NAIC comments that were circulated Dec. 31, 2019, in advance of the conference call. He said no additional input was received from state insurance regulators or interested parties in advance of the conference call.

Ryan Workman (NAIC) provided an overview of the draft NAIC comments on the draft application paper, focusing on substantive comments.

Robert Neill (American Council of Life Insurers—ACLI) said he appreciates the NAIC comments, noting that the ACLI is supportive of the holistic framework overall and hopes it succeeds. However, he said the ACLI views the draft application paper as overly prescriptive in certain areas and plans to submit its own comments to the paper.

Commissioner Caride made a motion, seconded by Commissioner Mais, to approve submission of the NAIC comments (Attachment Four-A). The motion passed.

Commissioner Anderson said the NAIC comments on the draft application paper would be submitted in advance of the Jan. 20 deadline and urged interested parties to submit comments, as well.

2. **Discussed Other Matters**

Commissioner Anderson noted two upcoming Committee conference calls. He said there will be a conference call and in-person meeting Jan. 30 to discuss the aggregation method and the process for assessing comparable outcomes. He said there will be a conference call held Feb. 3 to review and approve submission of NAIC comments on a draft joint issues paper by the IAIS and the Sustainable Insurance Forum (SIF) on the implementation of the Task Force on Climate-related Financial Disclosures (TCFD) recommendations, which is currently out for public consultation. He said registration information and other details for both conference calls would be circulated shortly.

Having no further business, the International Insurance Relations (G) Committee adjourned.
### IAIS Draft Application Paper on Liquidity Risk Management - NAIC Approved Comments

<table>
<thead>
<tr>
<th>Section/Paragraph</th>
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<tbody>
<tr>
<td>General</td>
<td>Before finalizing, formatting and wording of the paper should be reviewed to ensure consistency with other IAIS material and style guides. In various parts of the paper, it needs to be clearer when the text is focusing on groups only versus all insurers. Some specific comments provided address this. Suggest reviewing the use of “any” and “all” as in some instances it may not be feasible or helpful to assess/review/consider/report/etc. any or all things. It may work to simply delete these words in certain places without changing the intended meaning.</td>
</tr>
<tr>
<td>Para 2</td>
<td>Suggest deleting the first sentence as it repeats the first paragraph. Start the second sentence with, “This Paper does not…”</td>
</tr>
<tr>
<td>Para 6</td>
<td>As readers of this paper are not necessarily native English speakers, suggest finding other wording to replace “sudden death” that may better describe the intended point.</td>
</tr>
<tr>
<td>Para 7</td>
<td>Last sentence, to be clearer on what “this” refers to, suggest rewording to: “Having such a view may assist the supervisor…”</td>
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<tr>
<td>Para 15</td>
<td>Editorial suggestion: “…presented in the this Paper can support the supervisor’s review of the insurers’ frameworks an insurer’s framework.”</td>
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<tr>
<td>Para 16</td>
<td>First sentence, it is unclear what “general guidelines” refers to. Is the intention more “the supervisor may follow its usual approach for the review of ERM.” Second sentence, as it is not the role of the supervisor to “ensure” the insurer does something itself, suggest: “…the supervisor should assess whether the insurer’s framework adequately considers…”</td>
</tr>
<tr>
<td>Para 17</td>
<td>Suggest making the last sentence a new paragraph as it is not related to the rest of the paragraph.</td>
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<tr>
<td>Para 18</td>
<td>Use dot bullets and add “whether” to the chapeau so the repetition can be deleted from each bullet.</td>
</tr>
<tr>
<td>Para 20</td>
<td>Penultimate sentence, as it is not the role of the supervisor to “ensure” the insurer does something itself, suggest “The supervisor should assess whether the insurer…” Last sentence, what type of coordination and which stakeholders should be included in testing aspects of the plan? Assume these would be relevant stakeholders, not all. Suggest clarifying.</td>
</tr>
<tr>
<td>Para 22</td>
<td>For consistency with other IAIS material, suggest: “…it should use the powers at its disposal to intervene and require the insurer to take effective and timely remedial action.”</td>
</tr>
<tr>
<td>Section 2</td>
<td>To the extent the guidance in this section refers to governance in general and points covered in existing standards or guidance, it would be helpful to include cross references. Otherwise this paper on liquidity risk management should not provide new or potentially contradictory guidance on governance in general.</td>
</tr>
<tr>
<td>Para 25</td>
<td>Last sentence, as it may not necessarily be the Board that does such a review, suggest: “The Board of the insurer should also periodically review the insurer’s liquidity risk practices…”</td>
</tr>
<tr>
<td>Para 26</td>
<td>As this is an Application Paper, appropriate wording should be used: “The insurer’s Senior Management is responsible for applying the insurer’s risk appetite in pursuit of its strategic objectives. In doing so, Senior Management is”</td>
</tr>
</tbody>
</table>
should be responsible for several key liquidity risk management functions. Most importantly, Senior Management is should be responsible for integrating the insurer’s risk appetite into day-to-day operations.”

Suggest making the two sentences in the middle of the paragraph on groups a separate paragraph: “In a group situation, As such, group-wide level Senior Management should receive clear and timely information from all material legal entities on the entities’ liquidity position and emerging liquidity stress events. The group-wide Senior Management should report periodically to the group Board of Directors or the relevant Board committee on the insurer’s group’s current liquidity risk profile both at a group level and for material legal entities.”

Para 27 For consistency with other IAIS material, suggest: “…the insurer’s Board of Directors or relevant Board Committee, Senior Management and other appropriate personnel. Reports to the insurer’s Board of Directors or relevant Board Committee…”

Para 29 Third sentence, to better distinguish that this is group related: “In a group situation, for material legal entities, this includes, where appropriate, locally developed stresses that reflect local business vulnerabilities and market conditions.”

Para 30 The first sentence is group-specific but it is not clear if the rest of the sentences in this paragraph are as well or else relevant to all insurers. Suggest clarifying.

Para 33 First sentence, it is not clear what an “insurer’s franchise” refers to. Second sentence, it is not clear what assumption is being referred to. Suggest clarifying both.

Para 38 Suggest including “borrowing costs” in the list of features to be taken into account since this may influence policyholders in their decision whether to take a policy loan.

Para 41 If this paragraph is addressing intragroup fungibility, assume the use of “insurer” should be “group”.

Last sentence, to avoid confusion with too many assumptions, suggest: “…will demonstrate that its approach to the assumptions it makes regarding fungibility is are realistic.”

Para 42 Footnote 2, as “closed blocks” can also refer to closed blocks of business, suggest making the footnote less definitional: “Here, “closed blocks” refers to discreet pools of assets…”

Para 43 Last sentence, for clarity, “…includes in the liquidity portfolio…”

Para 49 First sentence, for clarity, “…inclusion in the liquidity portfolio include…”

Para 53 First sentence, suggest deleting “and supervisors” as the supervisor does not decide what is in an insurer’s liquidity portfolio. Additionally, is this paragraph supposed to be under subheading 4.3? The first sentence says there are a number of additional considerations” but then only mentions double counting. It seems this would make more sense starting off the subsection on “Other portfolio considerations”.

Para 54 The second sentence is quite long and rather complex so it is hard to follow. Suggest revising to make it easier to understand.

Para 57 Penultimate sentence, additional amounts could be available for transfer to some entities, but transfer to all entities may not necessarily be helpful – suggest deleting “all”.

Para 60 As the guidance under Section 5 could suggest a rather complex and complicated contingency funding plan, suggest moving up the first sentence of para 60 that notes the use of proportionality given its importance. Suggest to add this sentence after the sentence in para 59 beginning “Such a plan should describe all existing strategies…” and then the subsequent existing sentences remain in para 60.
| Para 61 | To help with readability and clarity, suggest splitting the last sentence into two: “…liquidity stress. For instance, with an idiosyncratic liquidity stress the insurer…” |
| Para 66 | Second sentence, for consistency, “The report should set out…” Third sentence, if the report is for the insurer and supervisor, suggest “…so that any outside person familiar with the subject…” |
| Para 67 | For consistency, “…approved by the Board of Directors or the relevant Board Committee.” |
| Section 6.1 | In the paragraphs in this section, it is sometimes unclear whether it is the insurer’s overall risk appetite statement or the liquidity risk appetite statement that is being referred to. Suggest reviewing and revising as appropriate to clarify. |
| Para 71 | “liquidity risk guidelines” is not used or described elsewhere – assume this is supposed to say “liquidity risk appetite statement”? Similarly, should “liquidity risk management policies” be “liquidity risk management framework”? |
| Section 6.2 | The paragraphs under this subheading do not really address the framework – suggest considering a different subheading that would be more accurate. |
| Para 76 | For consistency with other IAIS material: “Insurance legal entities insurers that are part of a group…”. Additionally, need to review the use of “insurer” in the rest of this paragraph to be clear whether it is actually referring to a group, insurance legal entities or insurers overall. |
| Para 77 | Third bullet, suggest deleting “all” and using “material” as is done in the fourth bullet. |
| Para 81 | Editorial: “To the extent, however, to the extent that elements of the report are incorporated in other material, the supervisor may allow the insurer to satisfy the reporting requirement by reference to those other risk management materials policies and/or the ORSA.” |
| Para 83 | It is not clear why the text following this paragraph is in a blue box. As there are no other blue boxes in the paper, suggest this just be numbered para 84 and formatted normally. |
NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee Aug. 14, 2020, Minutes ...................................................................................... 13-2
NAIC/Consumer Liaison Committee June 19, 2020, Minutes (Attachment One) .............................................................. 13-7
NAIC/American Indian and Alaska Native Liaison Committee Aug. 3, 2020, Minutes (Attachment Two) ........................................ 13-13
NAIC/American Indian and Alaska Native Liaison Committee April 29, 2020, Minutes (Attachment Two-A) ...................................... 13-15
The NAIC/Consumer Liaison Committee met via conference call Aug. 14, 2020. The following Liaison Committee members participated: Michael Conway, Chair (CO); Andrew R. Stolfi, Vice Chair (OR); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling (AL); Ricardo Lara (CA); Andrew N. Mais represented by Kurt Swan (CT); Karima M. Woods (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier (FL); John F. King represented by Martin Sullivan (GA); Doug Ommen (IA); Dean L. Cameron (ID); Robert H. Muriel represented by Sara Stanberry (IL); Stephen W. Robertson (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane (MD); Steve Kelley (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Kathy Shortt (NC); Jon Godfread represented by John Arnold (ND); Bruce R. Ramge (NE); Russel Toal represented by Robert Doucette (NM); Barbara D. Richardson (NV); Jillian Froment represented by Jana Jarrett (OH); Glen Mulready represented by Ron Kreiter (OK); Jessica K. Altman (PA); Raymond G. Farmer represented by Joe Cregan (SC); Kent Sullivan represented by Dan Danzeiser (TX); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); and James A. Dodrill (WV). Also participating were: Elizabeth Kelleher Dwyer (RI); Larry D. Dieter (SD); Todd E. Kiser (UT); and Jeff Rude (WY).

1. **Adopted its June 19 and 2019 Fall National Meeting Minutes**

Commissioner Stolfi made a motion, seconded by Commissioner Altman, to adopt the Committee’s June 19 (Attachment One) and Dec. 9, 2019, minutes. The motion passed unanimously.

2. **Heard a Presentation on COVID-19-Related Business Interruption Claims, Coverage Issues, Disputes and Litigation**

Amy Bach (United Policyholders—UP) said Part 1 of the NAIC Property and Casualty Insurance Business Interruption Data Call on premiums and policy information related to COVID-19 was completed in June. She said companies were asked about: 1) whether forced closure orders, infiltration of insured premises, and/or imminent risk of grave harm met the common requirement of direct physical loss of, or damage to, insured property; 2) whether losses due to mandatory closure were covered under civil authority; 3) speculative, yet unknown loss projections or losses in progress possibly leading to trillion dollar loss projections and solvency fears; 4) the number of actual claims filed; 5) the volume of litigation; 6) the number of claims accepted or being processed; 7) the number of claims denied; and 8) litigation outcomes or forums. She said many, if not most, small businesses, especially restaurants, bars, and concert venues that were mandatorily closed by public safety orders, either do not have Business Interruption (BI) coverage or have BI coverage with virus exclusion. She said some higher education institutions have coverage for losses related to communicable diseases, and some large businesses have BI coverage without virus exclusions. She said the current administration has been quoted as saying insurance companies should pay for BI claims. She said one insurer reported spending $19 million in legal expenses defending BI claims. She said the company posted a $41 million underwriting loss, compared with a $48 million profit, which was attributed to $231 million of catastrophe and $65 million of pandemic-related losses and expenses according to Best’s News, July 27, 2020. She said the company’s net income more than doubled to $909 million in the second quarter after the company recognized an $825 million increase in the fair value of equity securities held. However, she said in 2003, Mandarin Oriental hotels in Hong Kong, Malaysia, Singapore and Thailand all lost business due to cancellations and reduced local food and beverage sales stemming from the severe acute respiratory syndrome (SARS) outbreak; and Mandarin Oriental International Limited received $16 million from its insurers to pay for business interruption losses suffered by the group’s hotels in Asia as a result of the SARS outbreak. She asked: 1) what regulators were told by insurers at the time that the 2006 Insurance Services Office (ISO) virus exclusion was added; 2) whether there should have been a rate decrease when the virus exclusion was adopted if insurers paid out on SARS claims; and 3) whether current assertions by insurers that pandemic losses were never covered are contradicted by the fact that SARS claims were paid in 2003. She also asked what insurers told business policyholders when policies were renewed with this new exclusion, but without any rate reduction. She said most policies do not mention pandemics nor government closures via public safety orders. She said the COVID-19 Coverage Litigation Tracker at [https://cclt.law.upenn.edu](https://cclt.law.upenn.edu/) indicated that filings peaked the week of May 4, with a cumulative total on July 31 of 312 cases being brought against three insurers with business income, extra expense and civil authority being the relief most frequently sought.
Commissioner Conway said COVID-19 is probably not going to be the last pandemic seen. He asked how the industry can make sure that coverage is available when the next one hits. Ms. Bach said her hope is that the entrepreneurial spirit would kick in to make that happen. She said some businesses will request full coverage, but most will want at least some coverage.

3. **Heard a Presentation on Digital Claims Handling and Photo Estimating**

Erica Eversman (Automotive Education & Policy Institute—AEPI) said photo estimating has serious side effects. She said the advantages are that it is fast and easy, putting the insurer on notice of claim immediately and giving the company the opportunity to provide consumers with assistance, should the need arise. Another advantage is that it allows the consumer to file a claim without personal contact, as required during a pandemic. Ms. Eversman said the disadvantages are that it is substantially under-reserving because photos only show what the consumer thinks looks damaged. She said consumers do not know what is important to capture in a photo. She said insurers are using desk reviewers to evaluate such claims, and only the insurer knows if the initial claim payment is being underestimated; the consumer does not. She said many consumers do not have their vehicles repaired, so they are not receiving the full benefits owed to them under the final claim settlement. She said this creates windfall profits for insurers because consumers just do not have the ability to protect themselves. She said there is confusion regarding the remedy elected because auto insurers do not inform consumers of the remedy elected under the policy. She said photo estimating suggests payment of loss in money remedy; but once a vehicle is in repair, the insurer wants involvement in the repair decisions being made. She said there is also insurer confusion over what election to repair truly means; however, there is nothing in an auto policy that allows an insurer to blend remedies or change a remedy election mid-claim. She said state laws may preclude photo estimating; and due to the pandemic, states have suspended requirements of in-person adjustment. She said consumers are entitled to have in-person claims adjustment, unless the insurer agrees that it is only paying the full loss in money and has no need or right to review the damage. She said digital claims handling makes it is easy to transfer adjustment activity to an adjuster or appraiser not licensed in the state. She said out-sourcing adjustments to third-party adjusters (TPAs) not licensed in the state leads to cross-border claims adjusting and a lack of accountability. She said consumers are told by TPAs that only insurers can provide estimates. She said when the consumer contacts the insurer, the consumer is told that only the TPA can provide such an estimate. She recommended that state insurance regulators: 1) require insurers to notify consumers that photo estimating will likely lead to them missing substantial damage that needs to be repaired; 2) alert consumers that even if the consumer chooses not to repair the vehicle now, the consumer can still have it repaired at later date; and 3) insurers offering photo estimating are required to over-reserve the claim by a specific percentage (e.g., 100–1,000%).

Commissioner Conway asked under what circumstances over-reserving of 50%, 100% or 1,000% would be appropriate over a photo estimate. Ms. Eversman said these percentages were derived from national surveys of actual consumer auto claims and payments. Commissioner Dodrill asked how additional damage, such as rust, might be addressed if a consumer decided not to have their vehicle repaired immediately following an accident, but to have it repaired later. Ms. Eversman said if the wait was desired due to the COVID-19 pandemic, the insurer and the consumer would have to address it later, with the insurer required to let consumers know that the initial payment check would not mean that the consumer cannot bring the vehicle in for a full estimate at a later date and receive more money over the initial claim amount received.

4. **Heard a Presentation Proposing a Model Law to Modernize Insurance Rate and Form Regulation that Would Address Algorithmic Bias Plans Used on Patients and Markets**

Birny Birnbaum (Center for Economic Justice—CEJ) said following the murder of George Floyd, insurers and state insurance regulators pledged to fight systemic racism and inherent bias in insurance. He said understanding the history of such bias would help industry to identify the actions needed to address this issue in insurance going forward. He said there has been a lack of minority voices and experience in insurer and state insurance regulator leadership, as well as an imbalance between consumer and insurer or producer access to critical regulatory and legislative processes. He said trade associations have been fighting to protect practices that reflect and perpetuate systemic racism in insurance. He also said regulatory authorities and infrastructure had been failing to keep up with seismic changes in insurer practices. He said to address systemic racism and modernize insurance market regulation, a model law should include: 1) reinforcement of risk pooling and cost-based practices as the foundation of insurance; 2) ensuring that consumers, generally, and minority consumers, particularly, have a strong voice in regulatory processes; 3) defining fair and unfair discrimination in insurance, including proxy discrimination against protected classes; 4) requiring insurers and state insurance regulators to proactively identify and minimize proxy discrimination against protected classes and provide safe harbors for insurers for such actions; 5) providing meaningful oversight by state insurance regulators of insurers’ use of data, algorithms and artificial intelligence (AI), including modernizing the definition and oversight of advisory organizations and statistical agents; 6) improving consumer control over their data, including Fair Credit Reporting Act (FCRA)-type protections for all personal consumer information used by insurers; and 7) improving competition in insurance markets with more accessible and actionable information to consumers. He said intentional discrimination is that which leads to disparate treatment, and proxy discrimination is that which leads to disparate impact. He also said intentional
discrimination and proxy discrimination can be addressed by regulatory oversight and statistical or technical treatment within the cost-based framework of insurance. He said systemic injustice means that systemic racism and inherent bias have so pervaded a particular community, that insurance costs are inseparable from the class characteristic. He said addressing this type of unfair discrimination by prohibiting racial discrimination is the role of legislators. He said fair discrimination means adherence to cost-based practices for pricing, claims settlement, and other aspects of insurer operations so consumers who are similarly situated are treated in a like manner. He said for pricing, including underwriting, rating, and payment plan eligibility, fair discrimination means charging the same rates and payment options to consumers posing similar expected costs for the period of coverage. He said rates should also not be excessive or inadequate. He said fair discrimination in claim settlement means similar claims outcomes for similar claims.

Mr. Birnbaum said unfair discrimination means treating similarly situated consumers differently without a justification based on expected claim costs or expenses associated with the transfer of risk for the period of coverage provided or claim presented to the insurer; based on a protected class; or the use of any data or characteristic of the consumer, vehicle, property, or natural or built environment unless approved by the commissioner. He said a protected class is consumers grouped together based on race, religion, national origin or another characteristic. He said discriminating on the basis of disparate treatment means that the outcomes are determined by the explicit application of a protected class characteristic. He said disparate impact or proxy discrimination means that the outcomes have a disproportionate impact on a protected class or practices that serve as a proxy for disparate treatment. He recommended that state insurance regulators strengthen consumer voices within the regulatory processes by establishing a public agency dedicated to representing insurance consumers before the department of insurance (DOI) and legislature and fund the Bureau of the Insurance Consumer Advocate (BICA) through a $0.10 to $0.25 process by establishing a public agency dedicated to representing insurance consumers before the department of insurance (DOI) and legislature and fund the Bureau of the Insurance Consumer Advocate (BICA) through a $0.10 to $0.25—depending on size of the state—assessment on every individual policy and certificate under a group or master policy issued in the state. He said BICA has standing to intervene on behalf of consumers in any insurance regulatory proceeding, including rulemaking and review of rate and form filings. He said BICA has access to non-public information received by the DOI subject to the same confidentiality as the DOI and related to the purposes of BICA. He said the Director of BICA would be selected by the Governor from a list of candidates prepared by an advisory committee of individuals engaged in consumer advocacy and would have a five-year term. He also recommended additional oversight of data, algorithms and advisory organizations via routine reporting by insurers of data sources, data uses, data vendors, and providers of algorithms. He said the definitions of advisory organization, statistical agent and statistical plan should be modernized to create a level playing field for the providers of algorithms used by insurers for marketing, pricing, claims settlement and anti-fraud prevention. He said advisory organization should be required to file algorithms so commissioners will have the authority to permit use of new data sources, algorithms and AI within a controlled environment for the purposes of data creation, data collection and evaluation. He recommended FCRA-type consumer protections for all consumer data used by insurers, such as the disclosure of data to be used, the source of data, the uses of data permission, consumer consent, notice of adverse action, consumer access to their own data, the ability to dispute and correct incorrect data, and the ability to request reconsideration based on corrected data; requiring the destruction of consumer data by the insurer when the insurer no longer needs it for business purposes; limiting the use of consumer data to stated and disclosed purposes; opt-in or consent for any purpose, with particular attention to consumer-generated data from devices used for insurance exposure and loss assessment and prevention.

Commissioner Conway asked if stress testing would be used to determine how the safe harbor would play into his recommendations. Mr. Birnbaum said he was looking for a more holistic approach, and it would be determined by responses to advisory organization examinations via proxy discrimination because the test is on the algorithm. Commissioner Conway asked if a penalty or restitution is a concern, but he said he would address his other questions with Mr. Birnbaum offline. Commissioner Ommen said state insurance regulators in Iowa and other states already had the authority and tools, such as the Unfair Trade Law and Federal Trade Commission, to regulate discrimination and account for the balance of injury. He asked Mr. Birnbaum why he thought that state insurance regulators need a new model to do it. Mr. Birnbaum said he was not recommending a trade-off of racism for risk pricing, and a model is needed because so many laws exist that a holistic approach is needed to address them all in the same model.

5. Heard a Presentation on Improving Equity in Health Care Access

Deborah Darcy (American Kidney Fund—AKF) said data from the U.S. Centers for Disease Control and Prevention (CDC) shows a disparate impact of COVID-19 among cases with known ethnicity and race. She said Hispanic persons represent 18% of the U.S. population but 33% of COVID-19 cases; black persons represent 13% of the population but 22% of COVID-19 cases; American Indian and Alaska Native persons represent 0.7% of the population but 1.3% of COVID-19 cases. She said there is also evidence of health disparities due to COVID-19 related to underlying illnesses, such as hypertension. She said hypertension is higher also with 40.3% of black persons, 27.8% of white persons, 25% of Asian persons, and 27.8% of Hispanic persons reported as having it. She said 21% of COVID-19 fatalities were individuals with hypertension, and 67% had circulatory diseases. In a nutshell, she said equitable access to coverage and care for people of color, people with disabilities,
people who are LGBTQ+, and people for whom English is not the first language means: 1) access to health insurance coverage with affordable premiums and cost sharing; and 2) access to providers within reasonable geographic proximity, without physical or language barriers, and who are able to provide culturally competent care.

Ashley Blackburn (Community Catalyst—CC) said the closing of rural hospitals left many geographic areas, most of them in the south and in lower income areas, without specialty care or other languages spoken, and it has rendered access to care nearly impossible. She said this problem was compounded during the pandemic due to the remaining hospitals at or over capacity with COVID-19 cases for weeks.

Wayne Turner (National Health Law Program—NHLP) said Section 1557 is the nondiscrimination portion of the federal Affordable Care Act (ACA) that applies to all health care plans. He said the current administration removed this section in June, exempting most of the nondiscrimination language via rule change. He said this did not change the law, and there are currently many lawsuits pending. He said the states that have taken positive actions to date include California, Colorado and Illinois. He also said America’s Health Insurance Plans (AHIP) has also helped to fill the gap. He said telehealth can help fill the gap in health inequity by increasing access for underserved communities and providing a convenient form of care, particularly for those with limited transportation access, work obligations and childcare responsibilities. However, he said there are still barriers to telehealth due to a lack of internet and broadband access. He said the best practices of some states include: 1) reimbursing telehealth service at the same rate as comparable in-person services (Colorado); 2) no cost-sharing for telehealth services during COVID-19 (Colorado); 3) requiring health insurers to allow all in-network providers to deliver clinically appropriate, medically necessary covered services via telehealth (New Hampshire); 4) allowing the home or any place to be the originating site—i.e., where the patient is located—(NC) or the distant site—i.e., where provider is located—(Colorado); 5) reimbursing for audio-only phone services (Arizona, Colorado, Connecticut and Kansas); 6) expanding the list of services or providers who can participate in telehealth and be reimbursed (Alabama, Colorado and Mississippi); and 7) enrolling consumers in Medicaid via telehealth (California).

Commissioner Lara said California offers health care coverage to everyone, including immigrants. He said it is discriminatory to forbid immigrants from paying into the ACA. He also said innovation under a Section 1332 Waiver is needed to allow such payment, as it could save the states money because immigrants have the money and are willing to pay into the ACA. Immigrants are keeping the economy going and making money delivering goods, picking produce, etc. Commissioner Altman asked about the role of network adequacy and culturally competent care. Ms. Blackburn said in past years, NAIC consumer representatives have done lots of work on best practices for the states on network adequacy, and she does not know how to include this other than to look at each state. Mr. Turner recommended looking at what California had done as a starting point. Commissioner Stolfi said Oregon is working on this issue now, but it has not found much on it, so it wants to do more offline.

6. Heard a Presentation on Addressing the Needs of Patients and Consumers in the COVID-19 Pandemic

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said there are many ways to address the needs of patients and consumers, but she will focus on utilization management (UM). She said UM techniques include step therapy, prior authorization, cost-sharing tiers, quantity limits and pharmacy restrictions. She said the principles used to govern UM regulation are to: 1) ground UM decisions in clinical guidelines or evidence; 2) streamline and make transparent UM clinical reviews and appeals processes; 3) promote market competition through access to cost-effective medications; 4) create safeguards for affordable access in the case of market failure (e.g., limited competition); and 5) ensure uninterrupted access to treatment. She said patient protections have been critical to ensure uninterrupted access to medications during the pandemic. She said a deep dive into human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) indicated that UM can be arbitrary or clinically based depending on which state is selected with higher incidents of prior authorization required in the southeast and midwest. She said different levels of prior authorization are used for different PREP medications with a lighter prior authorization required for generic brands when they are available. She said she is not advocating for free and open access to name brand PREP medications, but rather for reasonable prior authorization. She said reasonable prior authorization would mean no prior authorization on TRUVADA or tenofovir/emtricitabine (TDF/FTC); no prior authorization to identify risk for HIV; and light prior authorization on DESCOVY to ensure that the individual has the clinical markers making TDF/FTC not clinically indicated (e.g., bone and kidney disease). She said considerations for state insurance regulators would be to engage a range of stakeholders on solutions to cost and access; collect data from issuers on prior authorization, including frequency and timing of approvals and denials; require regular review of prior authorization criteria and issue guidance for issuers, particularly for conditions that are vulnerable to discriminatory plan design (e.g., PrEP U.S. Preventive Services Task Force [USPSTF] Bulletins); and ensure continued access to medications during public health emergencies (e.g., waive certain issuer restrictions for the duration of the emergency). She said recommendations for state insurance regulators and lawmakers to protect consumers during the COVID-19 pandemic include uninterrupted access to affordable insurance coverage, affordable COVID-19 and non-COVID-19 services, forward policies that mitigate health disparities and recognize the disproportionate
impact of COVID-19 on communities of color, and affordable access to LTC and supports; and developing comprehensive consumer education materials about COVID-19.

Commissioner Conway said a study done in late 2019 by New York on case management and health equity indicated that disparate racial impact for one group might be of value in a study of this issue. Ms. Killelea said she would look into it, and she noted that in the south, the group most discriminated against was young black and Latino gay men. She said prioritizing generic medications would help alleviate discrimination and disparate access to care.

7. Heard a Presentation on COBRA, Medicare and Model #120

Bonnie Burns (California Health Advocates—CHA) said the Coordination of Benefits Model Regulation (#120) unfairly penalizes Medicare beneficiaries, and only Medicare beneficiaries, by allowing and facilitating phantom benefits. She said the Medicare Part B exception to coordination of benefits within this act should be changed to “[a] person is eligible but not enrolled for benefits in Part B of Medicare.” She said state insurance regulators should: 1) remove unfair Medicare penalties from Model #120 by deleting phantom benefit language so it does not allow the same application to any other existing health benefits; 2) encourage the federal Centers for Medicare & Medicaid Services (CMS) to revise Medicare materials to include a clear explanation of Medicare and Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) decisions; 3) encourage COBRA carriers to use updated COBRA notices; and 4) coordinate anti-fraud efforts with state Senior Health Insurance Information Programs (SHIIPs) and Senior Medicare Patrols (SMPs).

Having no further business, the NAIC/Consumer Liaison Committee adjourned.
The NAIC/Consumer Liaison Committee met via conference call June 19, 2020. The following Liaison Committee members participated: Michael Conway, Chair (CO); Andrew R. Stolfi, Vice Chair (OR); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Mark Fowler (AL); Ricardo Lara (CA); Andrew N. Mais (CT); Karima M. Woods (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier (FL); Doug Ommen (IA); Robert H. Muriel represented by Lauren Peters (IL); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by Joy Hatchette (MD); Steve Kelley (MN); Chlora Lindley-Myers (MO); Mike Chaney represented by Ryan Blakeney (MS); Mike Causey represented by Tracy Beihm and Kathy Shortt (NC); Jon Godfrey (ND); Bruce R. Ramge (NE); Russel Toal represented by Paige Duhameel (NM); Linda A. Lacey represented by Sumit Sud (NY); Jillian Froment represented by Jana Jarrett (OH); Glen Mulready (OK); Jessica K. Altman (PA); Kent Sullivan (TX); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); and James A. Dodrill (WV). Also participating were: Yada Horace, Gina Hunt and Steve Ostlund (AL); Alan McClain (AR); Vanessa Darrah and Tom Zuppan (AZ); Natalie Brutton-Yenovkian, Bryant Henley, Lucy Jabourian and Camilo Pizarro (CA); Peg Brown, Kate Harris and Debra Judy (CO); Kurt Swan (CT); Howard Liebers, Flavian Marwa and Sharon Shipp (DC); Janice Davis, Carolyn Diggins, Becky Griffith, John Reilly and Chris Struk (FL); Chance McElhaney (IA); LeAnn Crow (KS); Shawn Boggs (KY); Jackie Horgan (MA); Renee Campbell (MI); Grace Arnold, Peter Brickwedge, Martin Fleischhacker, Jonathan Kelly, T.J. Patton and Matthew Vatter (MN); Carrie Couch (MO); John Arnold, Janelle Middlestead and Johnny Palsgaaef (ND); Martin Swanson (NE); Denise Lamy and Christopher Nicolopoulos (NH); Vienna Janakieva (NM); Winston Berkman-Breen, Avani Shah, and My Chi To (NY); Tynesia Dorsey (OH); Jim Marshall and Mike Rhoads (OK); Larry D. Deiter (SD); Jennifer Ramcharan and Vickie Trice (TN); Doug Danzeiser (TX); Todd E. Kiser (UT); Mike Beavers, Julie Blauvelt, Katie C. Johnson and Rebecca Nichols (VA); Todd Dixon and Hailey Hamilton (WA); and Mark Afable (WI).

1. **Heard Opening Remarks**

Commissioner Conway said in acknowledgement of Juneteenth and the death of George Floyd, he and Commissioner Stolfi have given considerable thought toward cancelling or postponing this meeting. In the end, Commissioner Conway said they decided to move forward with the meeting due to the critical nature of the COVID-19 subject matter during the global pandemic. He said some insurers voluntarily reduced their premiums and gave consumers premium refunds; however, he said not all insurers are acting so responsibly.

2. **Observed a Presentation on Consumer Protection Issues Resulting from, or Heightened by, COVID-19 and Measures to Reduce or Flatten Infections**

Birnbaum (Center for Economic Justice—CEJ) said state insurance regulators have responded to the pandemic with many important pro-consumer actions. However, he said personal auto insurance rates went from meeting statutory standards to becoming extremely excessive overnight due to quarantines. He said when vehicle miles traveled declined by 50–90% from late March through April, personal auto claims dropped dramatically because such claims are directly related to the number of vehicles on the road. He said empty roads meant far fewer claims. He said while some state insurance regulators encouraged insurers to provide relief, only three states have ordered relief to date. He also said state insurance regulators have not provided any guidance on the amount or method of relief. For example, the promise of relief upon policy renewal made by a few insurers does not provide relief for current premiums, and it does not get relief to consumers now when they need it most. Mr. Birnbaum said the pandemic has revealed the inadequacy of routine insurance regulatory data collection for market monitoring and market analysis. He said the most recent independent personal auto insurance data available to state insurance regulators is 2017 data, as published in the 2020 Auto Insurance Database. He said the absence of timely market regulation data contrasts sharply with detailed financial data that is reported frequently. He said the rapid transition to digital business in insurance has generally not resulted in consumer protection safeguards in two key areas—Algorithmic Bias and Dark Patterns—which are digital designs created to benefit the business, not the user. He said state insurance regulators believe they have the authority to address proxy discrimination against protected classes, NAIC model laws, and state statutes that do not explicitly recognize disparate impact against protected classes as unfair discrimination. He said there are no requirements for state insurance regulators and insurers to identify and minimize such proxy discrimination within the overall cost-based pricing framework. He said the time to
explicitly recognize disparate impact against protected classes as unfair discrimination in insurance is long past due. He said regulatory modernization requires this recognition plus guidance for state insurance regulators and insurers on how to identify and minimize such disparate impact and safe harbors for insurers who follow best practices. He said paper disclosures are not effective when digitalized, and they promote misleading marketing in volatile markets like a pandemic. He said the pandemic has brought volatility to financial markets, causing rapid swings in the price of financial instruments, which is challenging to consumers because it leaves consumers vulnerable to misleading promises about the cost and performance of financial products. He said life insurers have moved their focus from death benefit products to investment type products, which are sold with illustrations that are used to show applicants and policyholders how the products they are considering purchasing operate. He said misleading illustrations have been a long-standing problem in the life insurance and annuity markets. He also said NAIC model revisions continue to permit illustrations of risky investments without risk and the ability to borrow money from the policy without having to pay it back because the policy accumulates such great returns. He said significant re-engineering of the illustration regime for annuities and life insurance is needed. He said the design of illustrations must be consumer-driven, utilizing best practices in consumer information, education and disclosure, including consumer testing. He said the rapid completion and state implementation of the Lender-Placed Insurance Home Model Law, along with increased scrutiny of credit-related insurance market outcomes for consumers, is urgently needed. He said states insurance regulators need to identify risk classifications rendered unreliable by the pandemic and prohibit adverse actions until the reliability can be established.

Brendan Bridgeland (Center for Insurance Research—CIR) said life insurance applications containing questions related to COVID-19 are being filed with state insurance regulators. He said these questions are not uniform; many are vague and unlikely to solicit useful information. He said some of these questions inquire about antibody tests, despite these tests being shown to be unreliable. He said questions are also being asked about COVID-19 diagnosis in extended family members, regardless of whether they reside in the same household or country. He said coverage may be denied based on the answers to these extremely vague questions, leading to unfair and arbitrary underwriting. He said consumers may be restricted to Temporary Life Insurance Agreements instead of full coverage and permitting vague and irrelevant questions may invite post-claims underwriting, which is particularly problematic when the applicant is deceased and surviving partners or children are under duress. He said state insurance regulators should be evaluating COVID-19-related insurance questions, especially those for long-term care insurance (LTCI), and making them more uniform.

Commissioner Conway asked how stress tests should be done. Mr. Birnbaum said consumer outcome should be monitored using timely data on a granular level to determine its accuracy. He said NAIC data is from 2017, so it is not timely, leading to proxy discrimination in algorithms. He also said state insurance regulators need to act to minimize the effect of negative factors, especially those related to criminal history or biased data, used in correlation to data on consumers in a protected class set.

Commissioner Mais thanked Mr. Birnbaum for keeping these issues in the forefront for regulators. He suggested many states had attempted to address these issues on an individual basis. He said New York Circular No. 1 tried to address the issue of disparate impact last year. However, Commissioner Mais said perhaps not relying on individual states, but rather a NAIC model could be created as an application to address disparate impact; or perhaps a general data pool. Mr. Birnbaum suggested the NAIC develop a model law or revise existing procedures that insurers use to demonstrate compliance with a safe harbor for companies using the guidelines and additional data collection to determine if disparate impact is occurring. He said the most robust data collection, much like financial regulation, should be used for market regulation. Commissioner Conway said a couple of workstreams are already in place within the NAIC framework into which this issue would naturally fall. He said the NAIC develop a model law or revise existing procedures that insurers use to demonstrate compliance with a safe harbor for insurers who follow best practices. He said paper disclosures are not effective when digitalized, and they promote misleading marketing in volatile markets like a pandemic. He said the pandemic has brought volatility to financial markets, causing rapid swings in the price of financial instruments, which is challenging to consumers because it leaves consumers vulnerable to misleading promises about the cost and performance of financial products. He said life insurers have moved their focus from death benefit products to investment type products, which are sold with illustrations that are used to show applicants and policyholders how the products they are considering purchasing operate. He said misleading illustrations have been a long-standing problem in the life insurance and annuity markets. He also said NAIC model revisions continue to permit illustrations of risky investments without risk and the ability to borrow money from the policy without having to pay it back because the policy accumulates such great returns. He said significant re-engineering of the illustration regime for annuities and life insurance is needed. He said the design of illustrations must be consumer-driven, utilizing best practices in consumer information, education and disclosure, including consumer testing. He said the rapid completion and state implementation of the Lender-Placed Insurance Home Model Law, along with increased scrutiny of credit-related insurance market outcomes for consumers, is urgently needed. He said states insurance regulators need to identify risk classifications rendered unreliable by the pandemic and prohibit adverse actions until the reliability can be established.

3. Heard a Presentation on the Importance of High-Quality, Affordable Coverage During the Crisis: COVID-19 Testing

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said COVID-19 testing is a rapidly evolving landscape wherein categorization is still underway. She said there are four types of diagnostic tests that detect active infection—Polymerase Chain Reaction (PCR), which is the most accurate; PCR rapid; PCR home; and Antigen—and one type of serologic, or antibody, test that has limited accuracy. She said COVID-19 testing guidelines by the U.S. Centers for Disease Control and Protection (CDC) are also evolving as a high priority for hospitalized patients with symptoms; healthcare facility workers, workers in congregate living settings, and first responders with symptoms; residents in long-term care (LTC) facilities or other congregate living settings, including prisons and shelters, with symptoms; persons with symptoms of potential COVID-19 infection; and persons without symptoms who are prioritized by health departments or clinicians, for any reason (e.g., public health monitoring, sentinel surveillance, etc.). She said many questions about testing remain unanswered, such as what the criteria for asymptomatic testing are, what recommendations employers should follow to safely reopen workplaces (e.g.,
frequency of serial testing), and what constitutes “medically necessary” testing. She said the COVID-19 crisis highlights another important question of who pays for testing—private insurance or public health—which usually brings the issue of medically necessary diagnoses used by private insurance carriers versus surveillance used by public health authorities into question. She said there is no such thing as surveillance testing in the payor system. She said insurance coverage mandates include the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) requirements for Medicaid, Medicare and private insurance to cover diagnostic COVID-19 testing, including serologic tests, without cost sharing. She said government public health funding includes $10 billion in Epidemiology and Laboratory Capacity (ELC) funding to health departments to ramp up testing, contact tracing and surveillance. She said uninsured provider compensation includes $3 billion across several stimulus packages to reimburse providers for COVID-19 testing for uninsured individuals. She said the human immunodeficiency virus (HIV) and hepatitis testing case study should be used as a lens to look at COVID-19 testing issues. She said routine HIV and hepatitis C testing must be covered without cost sharing—U.S. Preventive Services Task Force (USPSTF) Grade A and B, respectively—where coverage is not based on risk, but on age cohorts. She said antibody testing is generally covered, as it helps to guide treatment decisions. She said health department HIV and hepatitis programs: 1) are encouraged to bill third parties for testing built from the immunization “Billables Project”; 2) are focused on billing in clinical settings; and 3) allow health departments to target resources by focusing on population testing in community-based settings. She said considerations for state insurance regulators are to: 1) issue guidance for issuers to apply transparent “medically necessary” criteria to testing coverage; 2) protect consumers from surprise out-of-network lab bills by prohibiting balance billing; and 3) work with public health programs in their state to ensure coordinated response across agencies.

Commissioner Conway asked about pop-up testing for which cities could split the cost of set up without a payment infrastructure. Ms. Killelea said drive through testing had been set up by public health and the federal government. She said urgent care in parking lots is more difficult to determine, but it should be paid by insurance coverage. Commissioner Conway asked how Medicaid would determine who pays. Ms. Killelea said there should be extra flexibility under the federal Centers for Medicare & Medicaid Services (CMS) to cover the uninsured in the same way as Medicaid. Harold Ting (Healthcare Consumer Advocate) said a change should be made to nursing home coverage to address testing due to the COVID-19 crisis. Katie Keith (Out2Enroll) asked if companies had asked for more public coverage. Ms. Killelea said she was not aware of any instances where that had occurred.

4. Heard a Presentation on the Impact of COVID-19 on Vulnerable Populations and Specific Issues for Older Adults

Ashley Blackburn (Community Catalyst) said according to the COVID-19 Tracking Project, there is a disproportionate impact due to the COVID-19 pandemic in the more vulnerable black and Native American communities where 23,251 black lives have been lost. She said black people account for 13% of the population and 24% of the deaths where race is known, which means the percentage of cases are two times higher than their population share. She said American Indian Studies at the University of California, Los Angeles (UCLA) illustrated a disparate impact in tribal nations and states with a total of 200 or more reported cases per 100,000 in population. She said the framework for solutions should include: 1) data collection disaggregated by race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, disability status and county; 2) coverage and affordability with coverage expansion for the uninsured and coverage for treatment without cost sharing; 3) access and quality with equal access to testing/treatment, public health information provided in their primary language, and expanded access to telehealth services; and 4) Social Determinants of Health (SDOH) to address food and housing security and reduce incarceration. She said state insurance regulators should coordinate with state commissions or workgroups charged with centering equity in COVID-19 response efforts like Michigan, New Jersey and Washington; evaluate their community connections; create feedback loops to help them understand problems; and improve data collection and transparency by ensuring that the data being collected informs a more equitable response in their state.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said due to COVID-19, there has been a decline in cancer screenings since March due to the public delaying most of their regular screening appointments. She said delayed cancer screenings equals undiagnosed cancer, which leads to more deaths attributable to cancer. She said colorectal cancer is the second leading cause of death for men and women combined. She said between mid-March and mid-April, the number of colonoscopies fell by nearly 90%. She said the United States Preventive Services Task Force- USPSTF, which is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services, recommends colonoscopy and at-home non-invasive screening tests for colorectal cancer. She said patients who receive a positive result from a non-invasive home test should receive a follow-up colonoscopy to complete the colon cancer screening colonoscopy. She said the problem is that patients can face cost sharing
associated with the follow-up colonoscopy that could prohibit them from completing the screening process. As a solution, she recommends that state insurance departments should make it clear to the public and industry through regulations or bulletins that insurers should waive cost sharing for invasive follow-up colonoscopies.

Bonnie Burns (California Health Advocates) said there has been a significant increase in the number of employed elders. In fact, she said 2019 recorded the highest number of working elders in the last 55 years, with pre-COVID-19 employment projections indicating that one-third of Americans age 65–70 would be employed by 2024. She said the employment numbers after COVID-19 resembled those in 2008 with Americans age 55 and over being the last hired and the first losing their jobs or being furloughed. She said while this segment of the population is eligible for Medicare, there is widespread ignorance about it due to no federal notice, which led to failure to enroll. She said there is also a disconnect between Social Security and Medicare, because Medicare eligibility is automatic at age 65, but there is no federal notice or automatic Medicare enrollment. However, full retirement for Social Security is roughly age 67 and may be higher or lower depending on the person’s date of birth. Ms. Burns said those who are disabled are automatically enrolled after receiving 24 months of Social Security Disability Income payments.

Ms. Burns said the reason why employed seniors are ignoring Medicare while they are working is because they do not know that their eligibility began at age 65, so they are waiting until they are eligible for Social Security retirement benefits. She said many consumers think that since they already have health coverage through their employer, they should wait until their employment ends so they do not duplicate employer costs or benefits and do not incur additional premium payments. They are completely unaware of Medicare eligibility rules. Ms. Burns said when it comes to employer health benefits and Medicare, Medicare Secondary Payer (MSP) rules apply to Employer Group Health Plans (EGHP) in that employer health benefits are primary: 1) at the employee’s age 65+ if the employer has 20 or more employees; 2) if the employee is disabled and the employer has 100 or more employees; and 3) for the first 30 months of End Stage Renal Disease (ESRD), regardless of the employer’s size. She said Medicare is secondary only while someone is actively employed according to the Internal Revenue Service (IRS) rules; and for smaller employers, MSP rules do not apply, so Medicare is the primary payor and the employer health plan is secondary.

Ms. Burns said MSP rules also do not apply to the continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), except during a 30-month coordination period for people with ESRD when COBRA is primary. She said MSP only applies to those actively employed, and Medicare is always primary to COBRA benefits, even if the person is not enrolled for Medicare Part B benefits; i.e., phantom benefits. She also said such mistakenly paid primary benefits are recoverable by a COBRA carrier.

Ms. Burns said the Coordination of Benefits Model Regulation (#120) unfairly penalizes Medicare beneficiaries, and only Medicare beneficiaries, by allowing and facilitating phantom benefits. She said the Medicare Part B exception to coordination of benefits within this act should be changed to, “A person is eligible but not enrolled for benefits in Part B of Medicare.” She said state insurance regulators should: 1) remove unfair Medicare penalties from Model #120 by deleting phantom benefit language so it does not allow the same application to any other existing health benefits; 2) encourage CMS to revise Medicare materials to include a clear explanation of Medicare and COBRA decisions; 3) encourage COBRA carriers to use updated COBRA notices; and 4) coordinate anti-fraud efforts with state Senior Health Insurance Information Programs (SHIIPs) and Senior Medicare Patrols (SMPs).

Thomas Callahan (Massachusetts Affordable Housing Alliance) asked Ms. Blackburn if companies should be using their reserves for investments that address racial equity, such as affordable housing. Ms. Blackburn said UnitedHealthcare is providing affordable housing with onsite healthcare and treatment at this time.

5. **Heard a Presentation on Additional Areas for State Leadership and Consumer Protection**

Lucy Culp (Leukemia & Lymphoma Society) said the COVID-19 pandemic has served to highlight the importance of comprehensive health care plans and emphasize the lack of coverage provided along with the extremely high cost sharing evidenced in short-term limited-duration (STLD) plans—i.e., $45,000 versus $6,000 for comprehensive plans—in the first six months of lymphoma treatment. She said the marketing and misrepresentation of the benefits provided by such plans via cold calls and the re-routing of online consumer searches to STLD plans from HealthCare.gov continuing despite regulatory actions in some states intended to stop it. She said state insurance regulators need to ensure that consumers can afford the coverage
and the care they need by banning surprise medical bills, not just through COVID-19 but on an ongoing basis, and improving premium affordability through reinsurance, additional subsidies, and more premium support.

Ms. Keith said there is a need for permanent solutions, such as providing companies with the flexibility to meet consumers’ needs through special enrollment periods, premium grace periods, expanded access to telehealth, waiving prior authorization requirements, and ensuring access to medications. She said in looking to the 2021 rate review process, state insurance regulators should look at the record-high minimum loss ratio (MLR) rebates in the past two years, be concerned about the impact of COVID-19 on rates, and remember that rates should be informed by real-world experience. She said there is a need for more consumer education and support. She said insurance departments and other state officials, as trusted sources of information, should do more outreach and education, as it is even more critical now than ever before considering the increase in fraudulent activity surrounding COVID-19.

Commissioner Conway said Caitlin Westerson had successfully led the consumer outreach and education efforts in Colorado about STLD plans and surprise billing. Commissioner Altman said several good points were made with telehealth spurring the conversation, and she asked how they would recommend working with legislators on it long-term. Ms. Keith said the Health Insurance Portability and Accessibility Act of 1996 (HIPAA) is a big part of the question, especially in rural areas where issues it will address. She said the real concern is that those who are immune compromised still desperately need telehealth due to the pandemic. Commissioner Conway said he is hopeful that CMS will expand it as needed.

6. **Heard a Presentation on Stop the Spread—COVID-19 and Insurance Fraud**

Matthew J. Smith (Coalition Against Insurance Fraud—CAIF) said the full impact of COVID-19 on fraud has yet to be seen, but based on historical data, early indicators seem to point to it being the largest spike in insurance fraud ever seen, surpassing that during the Great Depression and catastrophic natural disasters. He said Goggle statistics show internet searches on arson have increased 125% since the pandemic began with questions like, “How do I burn my [home, vehicle, etc.]?” topping the list and other searches like email scams up 600% and auto disappearance and theft up 67%. He said life and health insurance scams such as fake plans and endorsements, vaccine scams, tele-medicine, cargo theft, and life insurance “incentives” are all on the rise. He said popular auto scams-rate rebate refusals; sanitizing scams by repair, towing and storage companies; staged accidents; “jump-ins”; vehicle arsons; and caregivers’ auto break-ins—are also on the rise. He said workers’ compensation scams are up as quarantining is redefining the workplace, so providing owed coverage has become increasingly difficult for claim investigations because there are no witnesses to interview and the only verifications are via tele-medicine, which is not optimal for the determination of claim authorization. He said property and commercial scams include business interruption, inventory losses, arsons, thefts and mysterious disappearances with their own set of investigation limitations. He said this all leads to a litigation explosion of coverage issues like business income and virus or pandemic exclusions; COVID-19 lawsuits regarding liability limits; and the public’s perception about the impact of fraud. He said state insurance regulators who ask what can be done about the approaching tide of insurance fraud can saturate department of insurance websites with current fraud data and tools that insurance consumers can use to help them detect and prevent fraudulent scams before those consumers become victims of it. He said bumping up media relations via free educational webinars and podcasts with live interviews and infographics would also be helpful as a line of defense and protection for consumers. He said states could more actively monitor insurers, expedite prosecutions, and work with the federal government to pass the Stop Senior Scam Act. He said state insurance regulators could also issue emergency orders, actively participate in the Antifraud (D) Task Force and seek to update state laws to address insurance fraud, especially that due to COVID-19. He said the CAIF is a valuable resource and ally in the fight against insurance fraud. He invited state insurance regulators to become partners with the CAIF, the National Insurance Crime Bureau (NICB), the Senior Medicare Patrol-SMP, and the Federal Trade Commission (FTC) in this battle.

7. **Observed a Tour of the United Policyholders COVID-19 Loss Recovery Library**

Amy Bach (United Policyholders—UP) said due to public safety orders and layoffs of employees, thousands of businesses need insurance benefits to cover losses brought about by required compliance with such orders. She said companies have paid hundreds of thousands of dollars in premium for this type of insurance only to find that the policies have exclusions for viruses and pandemics. To be clear, she said some policies have such exclusions and some do not; however, she said rumors are rampant about no coverage leading to insolvency. She said the sheer volume of claims being triggered by the COVID-19 pandemic has led insurance companies to clamp down on such claims and actively campaign against any such claims being
covered, even under policies without exclusions for viruses or pandemics. She said state insurance regulators need to go on facts such as the hard data on claims that is pending with the NAIC and state data calls to be reported to the U.S. Congress (Congress) on July 22. She said reinsurance is intended for catastrophic losses like this, and 30-day maximum benefits for Civil Authority losses is common in the industry. She said insurance benefits that businesses have already paid for need to be honored along with Paycheck Protection Program (PPP) funds needed to restore economic health, jobs and consumer confidence in the value of insurance as a viable consumer product. She said to assist policyholders, UP established a COVID-19 Loss Recovery initiative, a national advisory team, a searchable library, and Amicus briefs promoting fair and efficient resolution of claims disputes via a new Website at www.werbig.org. She encouraged everyone to contact UP for help or other questions and see www.uphelp.org/COVID to track the battle against COVID-19.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.
The NAIC/American Indian and Alaska Native Liaison Committee met via conference call Aug. 3, 2020. The following Liaison Committee members participated: Michael Conway, Vice Chair (CO); Trinidad Navarro (DE); Dean L. Cameron (ID); Steve Kelley (MN); Matthew Rosendale represented by Bob Biskupiak (MT); Mike Causey (NC); Jon Godfread (ND); Russel Toal represented by Paige Duhamel (NM); Andrew R. Stolfi (OR); Larry D. Deiter (SD); and Mike Kreidler (WA).

1. **Adopted its April 29 Minutes**

Commissioner Conway said the Liaison Committee met April 29 to discuss COVID-19-related state outreach to Native Americans regarding federal Affordable Care Act (ACA) coverage.

Commissioner Godfread made a motion, seconded by Commissioner Navarro, to adopt the Liaison Committee’s April 29 minutes (Attachment Two-A). The motion passed unanimously.

2. **Discussed the Significant Impact of COVID-19 on the Health and Economies of American Indian and Alaska Native Populations**

Commissioner Conway said the Navajo Nation in Colorado is comprised of two tribes. He said they were able to shut down quickly, so they were able to keep tribal infection and death rates down. However, their economy took a heavy hit. He said last year, Colorado passed internet gaming, so that also helped tribal nations. Mr. Biskupiak said a substantial amount of the federal stimulus dollars Montana received was committed to native tribes with mixed results. He said infection and death rates were kept low throughout the state except in the southeastern part of the state, where the Crow and Northern Cheyenne (especially assisted living and nursing homes) were hit hard. Ms. Duhamel said when the governor put half of the Navajo in New Mexico on lock down, especially over weekends when infection and death rates hit their peak, the numbers went down significantly. However, she said the numbers jumped up again following the July 4 holiday weekend.

3. **Discussed Coverage Available Through the ACA Plans and Tribal Programs**

Ms. Duhamel said the Exchange has done its outreach to tribal communities primarily through newspapers and that it has not been particularly effective. She said the numbers via commercial and Exchange coverage have not been coming in either, partially due to many of the protests in Albuquerque, NM, being led by tribal youth. Commissioner Conway said their Medicaid numbers were like those in New Mexico, but not too high yet. However, he thought the numbers would go up now that the $600 income stimulus was gone. Ms. Duhamel said New Mexico had started to include health care coverage flyers in the care packages being distributed to tribes, which is generating additional leads. She said she has heard that the best Boots on the Ground care has been delivered with food even though it is not specified in the flyer, but that the flyer does have the insurance department’s contact information in it. Ms. Duhamel said the “no wrong door” approach is being taken, offering a variety of coverages through brokers, high-risk pools and government ACA/ACA Exchanges with a warm handoff if the consumer is not eligible for other plans.

4. **Heard a General Overview on What the Recent U.S. Supreme Court Decision Means to the Insurance Industry, Health Care, Etc.**

Ron Kreiter (Oklahoma Insurance Department) said that what the recent U.S. Supreme Court decision, *McGirt v. Oklahoma*, U.S. Supreme Court, October Term, 2019, decided on July 9 means or could mean to the insurance industry, health care, etc. is yet to be seen. However, he said at this time any American Indian who commits an offense will argue that the definitions of “Indian reservation” in ancient cases applies, which means that the state lacks authority to prosecute the offense. Oklahoma maintained that land grants overruled the old definitions, but the Court said they did not when the tribes appealed the decision. Mr. Kreiter said the state was still looking into the possible effect on insurance but thought that it only applied to criminal offenses for now. Commissioner Conway said the main takeaway was that the treaty was still in effect, so state law could not apply. He said the potential overlap into insurance is yet to be seen. Ms. Duhamel asked if other states recognized tribal licenses for producers. Commissioner Conway said he did not know what Colorado does, but he would check. Mr. Kreiter said in
Oklahoma, tribal members must get a license through the state department of insurance (DOI) if the producers are to sell to nontribal consumers. Erica Eversman (Consumer Representative) asked when state DOI laws do not apply, are tribes to participate in state-based or federal ACA plans, or do the tribes set up their own Exchanges. Commissioner Conway said some states have open enrollment year-round, but he said he is not sure about what a tribal ACA would do. He said they probably would not have open enrollment year-round. Mr. Kreiter agreed with Commissioner Conway that if American Indian territorial rules apply for crime, then what about insurance and a myriad of other legal issues. Commissioner Conway said this decision will produce a host of questions searching for an answer. Ms. Alexander said the documents submitted by Oklahoma on this case would be posted to the NAIC website after the meeting.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.
The NAIC/American Indian and Alaska Native Liaison Committee met via conference call April 29, 2020. The following Liaison Committee members participated: Lori K. Wing-Heier, Chair, Sarah Bailey and Anna Latham (AK); Michael Conway, Vice Chair, Kate Harris and Debra Judy (CO); Trinidad Navarro and Leslie Ledogar (DE); Dean L. Cameron represented by Kathy McGill (ID); Steve Kelley represented by Grace Arnold, Mary Otto and Sergio Valle (MN); Mike Causey represented by Tracy Biehn, Ted Hamby and Kathy Shortt (NC); Jon Godfread represented by John Arnold (ND); Russel Toal, Colin Baillio, Leatrice Geckler and Paige Duhamel (NM); Larry D. Deiter and Maggie Dell (SD); Mike Kreidler represented by Jane Beyer and Steve Valandra (WA); and Jeff Rude (WY). Also participating were: Mary Boatright (AZ); Stephen Kim (CA); Angela Burke Boston (IA); Karen Dennis (MI); Rebecca Ross (OK); Courtney Bullard (UT); and Julie Walsh (WI).

1. Adopted its 2019 Fall National Meeting Minutes

Director Wing-Heier said the Liaison Committee met Dec. 8, 2019. Commissioner Conway made a motion, seconded by Director Cameron, to adopt the Liaison Committee’s Dec. 8, 2019, minutes (see NAIC Proceedings – Fall 2019, NAIC/Consumer Liaison Committee, Attachment One). The motion passed unanimously.

2. Discussed How the States Are Conducting Outreach to Native Americans Regarding ACA Coverage Opportunities

Director Wing-Heier asked the Liaison Committee vice chair to kick off the discussion of how the states are conducting outreach to Native Americans about the federal Affordable Care Act (ACA), specifically regarding COVID-19. Commissioner Conway said the biggest concern was with the unhoused in Denver, and he said he had been working with hotel partners to create more non-congregate housing for Native Americans. He said Colorado is looking into the best way to handle transitional housing for Native Americans in urban settings like Denver, as well as those in rural settings like those around Durango, which is in the southwest corner of the state and in close proximity to New Mexico, sharing the concerns of the Navajo nation with other states.

Ms. Duhamel said the Navajo nation is spread over Arizona, Colorado, New Mexico and Utah. She said the New Mexico Department of Health is doing COVID-19 contact tracing, and it has learned that the Native American community is at extremely high risk due to current living conditions with several family members living together in a limited amount of space—often one room—with no water and no access to health care or testing. She said that is why all casinos in Gallup and Farmington are closed at this time, with one of those casinos having been converted into transitional quarantine housing for those just out of the ICU and those testing positive. She said the insurance superintendent is leading the effort particularly with out-of-network air ambulance carriers airlifting COVID-19 patients to access care. She said one hospital has been designated as responsible for all medical billing.

Director Wing-Heier said most Alaska natives are enrolled at a health care facility only when the person comes in for an appointment. Like Colorado, she said Alaska has concerns about housing and access to health care, as this population is unable to get intensive health care where they are sheltering in place, with most patients needing this type of care having to be flown out because the limited number of ventilators sent out into communities could not handle the number of cases. She said one would think that a population spread out in as large an area as Alaska would not have social distancing concerns, except in the larger metropolitan areas. However, she said COVID-19 has been spreading to rural areas, surprising government officials who locked villages immediately to avoid a repeat of the 1918 pandemic, which decimated many native villages. She said government officials worked extensively with the Alaska Native Tribal Health Consortium (ANTHC) and Indian Health Service (IHS) in trying to keep “foreigners” out of villages by using media to note that villages do not want tourism or commercial fishing during the pandemic. She said the Alaska National Guard was instrumental in air lifting critical patients because half of the plans exclude government alternative sites from covered sites.

Ms. Duhamel said the Native American population in New Mexico was decreasing, so the Housing Commission declined requests for additional outreach assistance. She said enrollment into the exchange had slowed, so the Housing Commission did not see any need to promote year-round enrollment. She said the department of insurance (DOI) was putting pressure on the
exchange to do more outreach because the feedback that was received indicated that lots of Native American’s were eligible for Medicaid due to New Mexico enacting Medicaid expansion and Medicaid having retroactive coverage. However, she said there was a lot of confusion amongst Native Americans about how tribal members could access benefits through the U.S Department of Health and Human Services (HHS). She asked if New Mexico could get open enrollment and participation numbers for Native Americans separated by Medicare, the New Mexico Health Insurance Exchange, and tribal coverage. She asked Oklahoma if it would share information about outreach vehicles it used, as both states have similar numbers of tribal members who are eligible for open enrollment, yet the federal Centers for Medicare & Medicaid Services (CMS) reports indicated that New Mexico enrollment was in the hundreds and Oklahoma enrollment was in the thousands. She asked NAIC staff to obtain issuers’ enrollment data numbers for tribes, especially on 100% cost sharing and for those under 300% of the poverty level from the CMS, and then distribute this information to Liaison Committee members.

Superintendent Toal said an open enrollment flyer developed with the Oklahoma state high risk pool was sent to recipients of Medicaid and unemployment benefits, Native American groups, and two alternative care sites that had been opened with all participating carriers for plans covered. He said information sharing about billing instructions, claims filing and premium payments was completed with these groups within a 24-hour period. It was also shared through radio stations. Ms. Ross said she could not speak to this issue until the CMS releases the information. She said she spoke to the tribal chief about getting enrollment and other health information to tribal members. The tribes utilized television and radio to spread this information. She said the Oklahoma DOI staff went to tribal health provider locations to provide education about enrollment. As a result, she said thousands of children were enrolled who previously were not due to this proactive outreach to increase tribal enrollment. She said agents and brokers were active in this outreach effort, which was also successful because enrollees can join monthly rather than just during a limited open enrollment period. She said the hope is that other states will take similar action, but she said it does take a lot of time for DOI staff to do the outreach and build the trust amongst tribal chiefs and members. She said Oklahoma only saw a handful of zero cost sharing and zero premium during the outreach. She said it was seeing fewer now, and it wondered what effect this would have on the ratings for 2021. She said she will release Oklahoma information to other states if she can.

3. Discussed Retroactive Coverage Through ACA Plans and Tribal Coverage Programs

Ms. Duhamel said New Mexico is interested in how Alaska set up its retroactive coverage, and it would like to see if the CMS would allow other states to use similar practices under certain circumstances. Mr. Bailiò said his background is in consumer advocacy, and he has heard that tribal members who signed up for health coverage in a provider’s office could not get the care they needed until a later date when the coverage became effective. He said what tribal members really need now is for DOIs to guarantee part of the premium for consumers to ensure that services are available immediately and paid for retroactively. He said a federal change may be required to allow this to happen. He asked if anyone knows of a way that states could set up coverage like Alaska in order to get retroactive coverage.

Ms. Ross said Oklahoma did not expand Medicaid under the ACA, but it did establish rules in 2019 to not provide coverage retroactively, so their hands are tied with all coverage effective the first of the month following enrollment.

Director Wing-Heier said Alaska is on the federal exchange, but it wishes it had a state exchange. It is not perfect though, as natives enroll at their provider when they come in for care, then drop the coverage after two or three months when they no longer need care. She said tribal members go without coverage until the next time they need care, when the cycle starts all over again and repeats itself continually. She said her office pushed the CMS hard for open enrollment for all, but they were not successful. Commissioner Conway said Colorado recently opened a special enrollment for a month and a half, which will end soon. He said Colorado has seen a 7–8% increase to date, and it expects the final increase in enrollment to be even higher. Ms. Beyer said 10,000 individuals were enrolled when Washington opened enrollment for 60 days recently. She said Washington has 29 tribes and a tribal navigator program, so most tribes have their own navigator to assist with enrollment. She said American Indians account for 1.8% of the population in Washington, but only 1% of the exchange, so enrollment is still low.

4. Discussed Other Matters

Ms. Duhamel asked if other states were seeing junk insurance plans being sold to this segment of the population. Director Wing-Heier said Alaska is seeing some but not a lot, as the state is shutting them down quickly. Commissioner Conway said Colorado has generally not seen many, as it does not allow short-term health plans at all, which may have helped keep the
numbers down. Ms. Duhamel said New Mexico does not allow short-term health plans either, but it has had lots of junk plans to deal with.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) asked if the states are gathering granular information on discriminatory practices that are specific to the tribes as a subgroup. Director Wing-Heier said the NAIC issued a data call, but it is too early for credible information about trends regarding who and where to be available. She said Alaska is planning to review it closely, especially the data on individual surgeries, and it has reached out to Washington regarding how it is being coded so she can run its own data. She asked if the data call included the number of the American Indian and Alaska native population enrolled and how that number was determined. Ms. Duhamel said New Mexico’s tool requires self-declaration for the CMS to list it, but some states require more categories. Director Wing-Heier said it is on the CMS form for states that use the federal exchange, but states with their own exchanges have their own requirements. Ms. Beyer said Washington’s state exchange form uses self-reporting. Commissioner Conway said Colorado’s does as well.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.